

Achieving Health Equity in Contested Areas of Southeast Myanmar

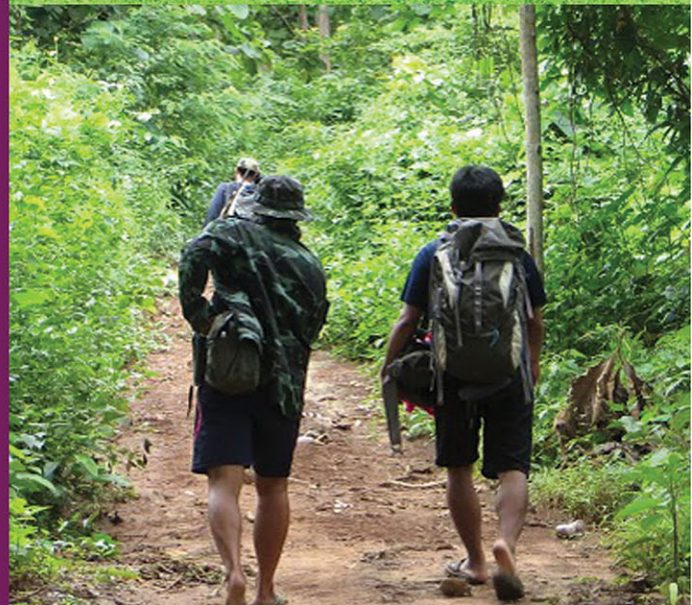
Bill Davis and Kim Jolliffe

June 2016



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The authors are grateful for the many people whose cooperation made this report possible. This report has benefitted greatly from the detailed information and perspectives supplied by staff from ethnic and community-based health organisations, particularly Mae Tao Clinic (MTC), Karen Department of Health and Welfare (KDHW), the Karenni National Mobile Health Committee (KnMHC), and the Burma Medical Association (BMA). We would also like to thank the various international non-governmental organisations, UN agencies, former Myanmar government officials and other community-based organisations who provided interviews, comments, feedback and additional info via email. Special thanks to Mim Koletschka and May Zin Aung at The Asia Foundation for administrative and logistics support, to Justin D. VanderBerg for map generation, and John Rieger for copyediting. The authors would like to acknowledge the Swiss Agency for Development and Cooperation, and the Health Information Systems Working Group for providing the maps of clinics across the southeast and in Kawkaeik township. We give final thanks to two Thailand-based experts on health in the southeast, as well as staff from KDHW, the Backpack Healthworker Team (BPHWT), MTC, BMA and the Three Millennium Development Goals Fund (3MDG), who all gave valuable feedback on early drafts of this paper.

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Preface

In many of Myanmar's contested regions, healthcare services are provided through two parallel governance systems – by the government's Ministry of Health, and by providers linked to ethnic armed organizations. Building upon efforts to build trust between these two actors following ceasefires signed in 2011 and 2012, the new National League for Democracy-led government offers an unprecedented opportunity to increase cooperation between these systems and to ensure health services reach Myanmar's most vulnerable populations.

In view of this, The Asia Foundation is pleased to present this research report on health equity and healthcare provision in Myanmar's contested regions. The report provides an overview of existing health service arrangements in these areas, from both the Ministry of Health and from ethnic and community-based health organizations. It then unpacks the concept of "convergence", highlighting key opportunities and policy recommendations for both government and non-government actors.

The key message here is that given the reality of parallel service systems, and the likelihood that they will remain in place for quite some time, the focus of all involved should be to carefully and patiently support greater coordination and cooperation between them to build both trust and viability for the challenging convergence process over time. In particular, attention must be paid to ensure that the political demands of the peace process and any related timelines do not undermine the goal of healthcare equity. We hope that this report will contribute to the ongoing discussion of the complex set of issues that must be considered to achieve durable peace.

This research paper is authored by Dr. Bill Davis and Mr. Kim Jolliffe, independent researchers based in Myanmar. Bill Davis specializes in public health, while Kim Jolliffe works on security, aid policy, and ethnic conflict. The report was generously funded by the United Kingdom's Department for International Development (DFID) and the Australian Department of Foreign Affairs and Trade (DFAT). The opinions expressed in this report are solely those of the authors and do not necessarily reflect those of DFAT, DFID, or The Asia Foundation.

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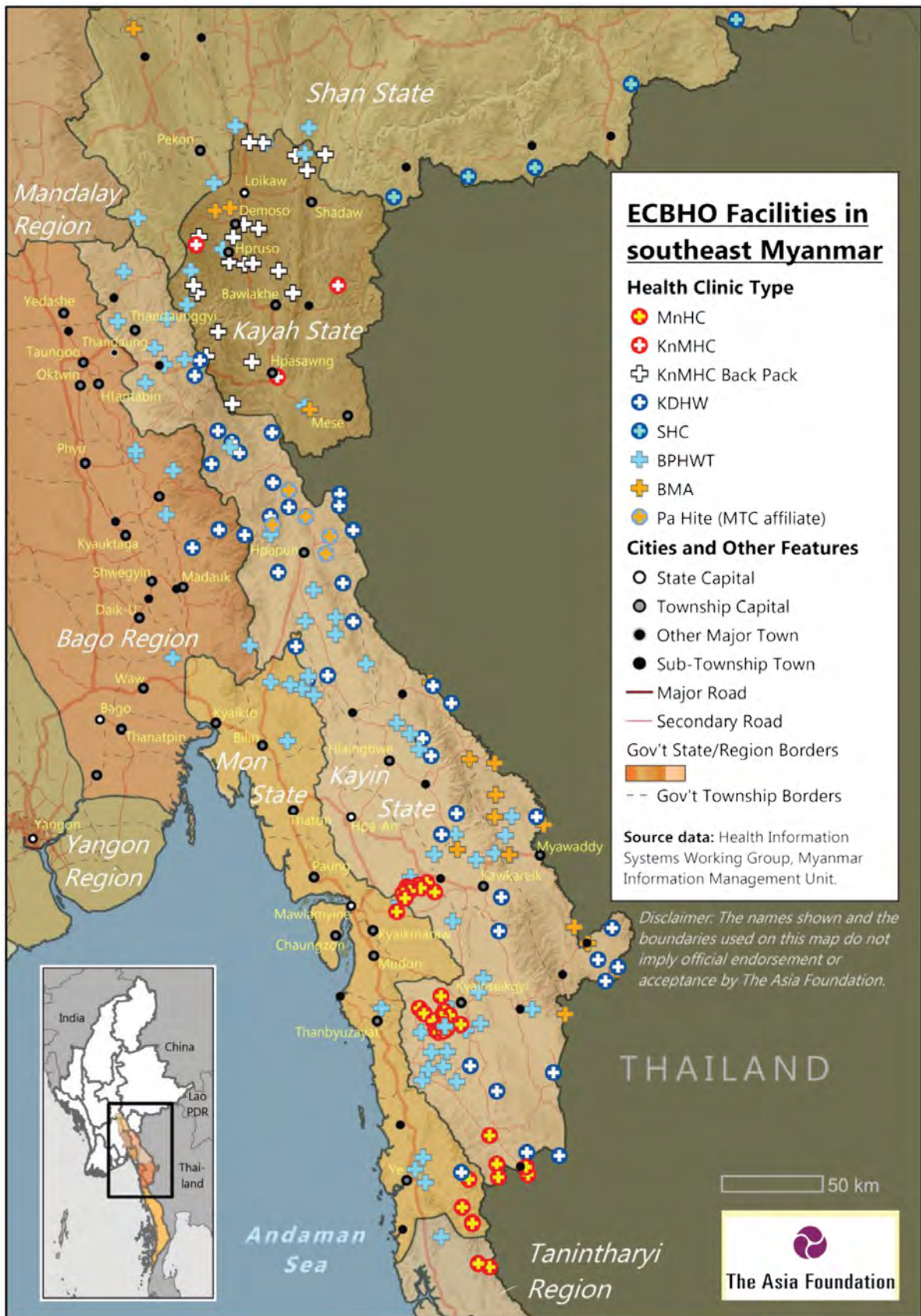
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List of Acronyms

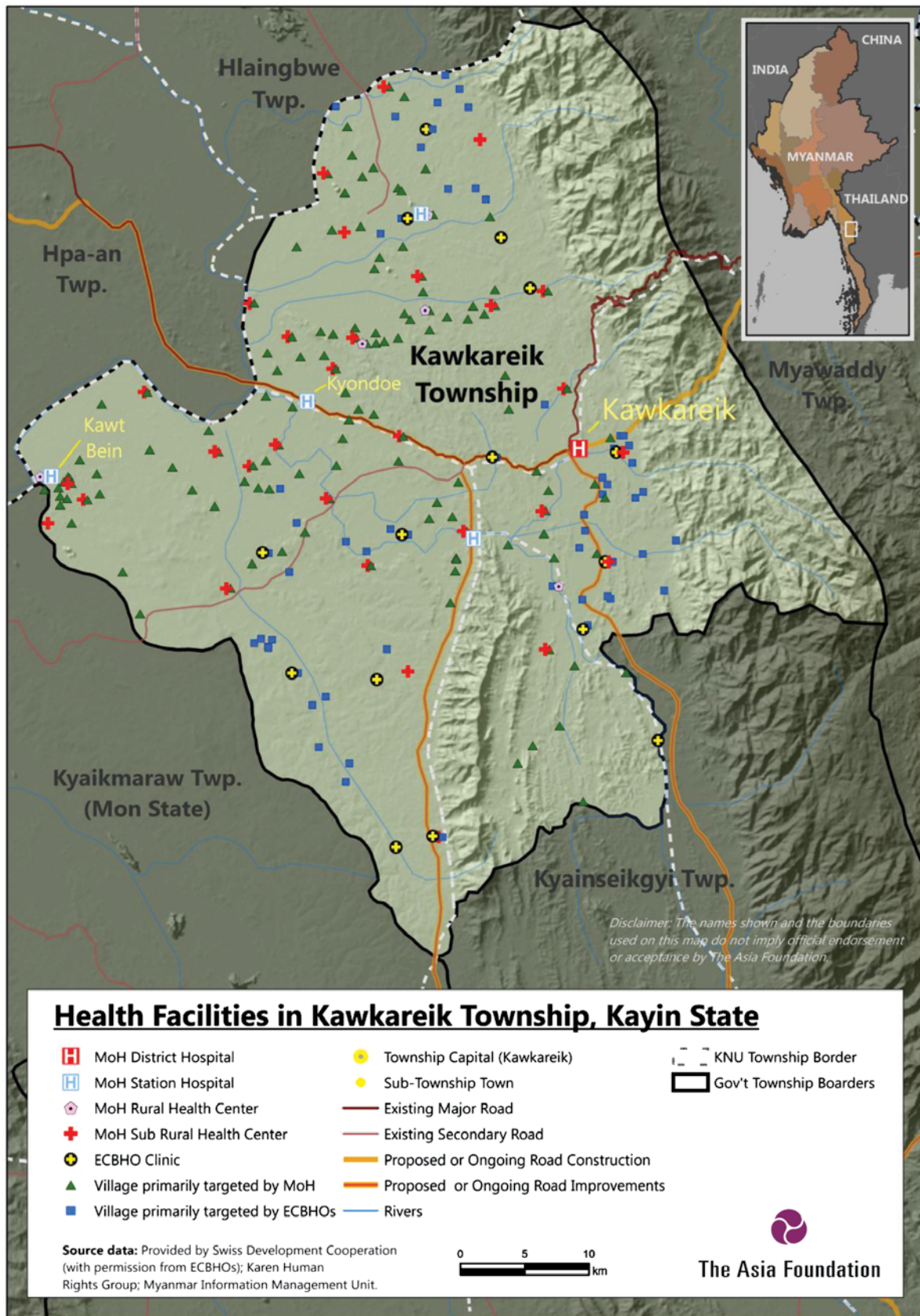
3MDG	3 Millennium Development Goals Fund
BGF	Border Guard Force
BMA	Burma Medical Association
BPHWT	Backpack Healthworker Team
CBO	Community Based Organization
CHDN	Civil and Health Development Network
CHW	Community Health Worker
CPI	Community Partners International
CTHP	Comprehensive Township Health Plan
DKBA	Democratic Karen Buddhist Army
EAO	Ethnic Armed Organization
ECBHO	Ethnic and Community-Based Health Organizations
EmOC	Emergency Obstetric Care
EHO	Ethnic Health Organization
EHSS	Ethnic Health System Strengthening
HCCG	Health Convergence Core Group
HISWG	Health Information Systems Working Group
IDP	Internally Displaced Person
INGO	International Non-Governmental Organization
IRC	International Rescue Committee
LNGO	Local Non-Governmental Organization
KA	Karenni Army
KDHW	Karen Department of Health and Welfare
KHRG	Karen Human Rights Group
KNLA	Karenni National Liberation Army
KnMHC	Karenni National Mobile Health Committee
KNPLF	Karenni Nationalities People's Liberation Front (KNPLF)
KNPP	Karenni National Progressive Party
KNU	Karen National Union
KWO	Karen Women's Organization
KPC	Karen Peace Council
MCH	Maternal and Child Healthcare
MNHC	Mon National Health Committee
MoH	Ministry of Health
MOPH	Ministry of Public Health (Thailand)
MTA	Mong Tai Army
MTC	Mae Tao Clinic

NCA	Nationwide Ceasefire Agreement
NHEC	National Health and Education Committee
NLD	National League for Democracy
NMSP	New Mon State Party
PU-AMI	Première Urgence - Aide Médicale Internationale
RCSS	Restoration Council of Shan State
RH	Reproductive Health
SDC	Swiss Agency for Development and Cooperation
SSDF	Shan State Development Foundation
TMO	Township Medical Officer
UHC	Universal Health Coverage
UN	United Nations
WHO	World Health Organization

Map 1



Map 2



*Maps courtesy of the Swiss Agency for Development and Cooperation and the Health Information Systems Working Group.

Section ONE: Introduction

Throughout decades of ethnic armed conflict, the governance environment in many of Myanmar's non-Burman areas has become deeply fractured, as ethnic armed organizations (EAOs) have established parallel governance systems, including healthcare departments. This report gives an overview of the parallel Ministry of Health (MoH) and EAO-linked health systems that exist in southeast Myanmar, and looks at how coordination and cooperation have increased since ceasefires were signed in 2011 and 2012. It provides guidance and actionable recommendations for government, ethnic organizations, and international aid actors on how to strengthen service delivery and improve levels of cooperation and coordination.

Since the late 1980s, a coalition of four EAO health departments and three local health non-governmental organizations (LNGOs) in southeast Myanmar has developed to provide primary healthcare services to hundreds of thousands of the country's hardest-to-reach and most vulnerable people. This coalition, which centers around the Mae Tao Clinic (MTC), does not have an official name, but refers to its member organizations collectively as the ethnic and community-based health organizations (ECBHOs), so this term will be used throughout this report.¹

Since ceasefires were signed between the government and the major EAOs in southeast Myanmar in 2011 and 2012, considerable space has opened up for greater cooperation between the ECBHOs and the MoH. Crucial progress has been made on trust building, ensuring ECBHOs more space to operate, information sharing, and a few joint projects.

Under the government of 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 ECBHOs and the need for greater engagement. Among other points, the document states, "In conflict and post-conflict areas, [ethnic health organizations] have long been providing essential services to populations that public sector providers do not reach."² It also recommends that "a communication and coordination mechanism with [ethnic health organizations] needs to be established," and that the government should "encourage different levels of health administration to collaborate and coordinate with EHOs."³

In 2014, The Asia Foundation released a report called "Ethnic Conflict and Social Services in Myanmar's Contested Regions," which explored the roles of various social service providers connected to ethnic armed organizations and looked particularly at examples of cooperation with state providers. The report included a case study looking at the Karen health networks connected to the Karen National Union (KNU), including the EAO's own health department, and assessed the early efforts of the Health Convergence Core Group (HCCG) to engage the government. This report is part of a series of studies undertaken by The Asia Foundation under its Social Services in Contested Areas Project, and it takes that work deeper, looking specifically at the healthcare sector in the southeast of the country.

In particular, this analysis focuses on the situation as it stands today with regard to healthcare provision in southeast Myanmar. 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 in achieving universal health coverage in Myanmar. 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 through complementarity, 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.

For the government, this involves a shift in thinking around its responsibilities as a state. While it has the absolute responsibility to ensure that every woman, man, and child is able to access adequate

healthcare as efficiently as possible, the state is not – and need not be – the only provider of healthcare. Rather, the state needs to create the right policy and legal framework to ensure that people have access to services of the highest quality, and as affordably as possible. In this light, ECBHOs should be seen as crucial partners in achieving universal healthcare coverage, due to their unique resources, experience, and territorial access. The overall strategy for reaching universal healthcare in the NLD’s Roadmap Towards Universal Health Coverage (UHC) is largely consistent with this approach, and demonstrates a very positive shift towards decentralization to ensure that healthcare is available to all through multiple providers.

ECBHOs also should ensure that their own convergence policies and efforts are conceived first and foremost in terms of what is best for ensuring health equity. This involves continuing to develop health strategies and approaches that enhance their unique capacities to reach rural populations, while also improving complementarity with other systems where it could be best for beneficiaries. ECBHOs should understand that the government now has at least a partially democratic mandate from the people,⁴ who expect government to serve their interests. Therefore, ECBHOs should respect the legitimacy of the MoH as the country’s primary provider of healthcare, despite the crucial role that ECBHOs continue to play in providing specialized services to hundreds of thousands of rural people in particular areas.

For international actors supporting the development of healthcare systems, this requires a slightly different interpretation of some key development principles. In contexts where there exist multiple governance actors – and where the legitimacy of various authorities remains contested – there is a need to ensure that development strategies are more broadly country owned, as government-only agendas can be impractical to implement on the ground and have negative effects on the political environment. In a context where multiple social service systems exist as a result of a fractured governance environment, the most politically sensitive way to work is to collaborate with multiple systems insofar as they are contributing to healthcare outcomes. As this report argues, the ECBHOs represent particularly important healthcare partners, due to their access to some of the hardest-to-reach and most vulnerable populations and their ongoing dependence on donor funds.

Methodology

Data and analysis in the report are based on a literature review of health, conflict, and politics in southeast Myanmar, 53 key informant interviews, and the authors’ combined 15 years of experience researching and working in the fields of conflict, health, and human rights in Myanmar. The authors travelled to Kayah, Kayin, and Mon states, as well as Mae Sot, Thailand, to interview leaders of ECBHOs, women’s groups, human rights groups, international non-governmental organisation (INGO) staff, and journalists. Interviews with representatives of former MoH staff, political parties, donors, UN agencies, and INGOs were conducted in Yangon. Preliminary findings were presented to ECBHOs at two workshops in Hpa-An and Mae Sot, and their feedback was incorporated into the report. Three reviewers familiar with ECBHOs, conflict, and politics in the southeast reviewed the report for accuracy.

This research has limitations. The research was conducted on health services in the southeast and the analysis and recommendations do not necessarily apply for ECBHOs or convergence activities in other areas of the country. The political situation and indeed level of conflict in the southeast is different from other areas of Myanmar.

Perspectives on convergence, the peace process and trustworthiness of the government are diverse among individuals who work for ECBHOs and among ECBHOs. We spoke with the several key informants from ECBHOs several times each, and we tried to summarize and present themes that arose from these interviews as well as official policy documents from ECBHOs. But it is possible that we did not capture or represent the layered politics or all of the opinions of the many people who work in management positions of these organizations.

Since the research on this report began in late 2015 health policy in the southeast went through several changes. The HCCG has been developing a draft action plan for convergence that lays out a 20-year plan for cooperation and coordination with the government; it addresses recognition of organizations, accreditation of health workers and financing models that include using government revenues. In March 2016 the HCCG released a strategic plan for health systems strengthening and shared it with the government, and the NLD released its roadmap to UHC, version 1.0. Policy continues to change, especially as trust continues to build and organizations refine their ideas about cooperation and coordination. The information and analysis in this report represents the current state of affairs and we recognize that this is likely to continue to evolve as time passes.

Overview of report

The remainder of this report is organized in four sections, followed by annexes. Section 2 provides a background overview, demonstrating how decades of armed conflict have impacted the health of civilians and have led to the emergence of separate health systems. It then looks at how things have changed since a series of ceasefires were signed in 2011 and 2012. Section 3 provides an overview of the MoH and ECBHO health systems in the southeast, demonstrating how they evolved to serve different types of populations and are thus fundamentally different in structure, workforce, and policy, and allowing for basic comparison.

Section 4 introduces the concept of convergence, as developed by the ECBHOs in 2012, and introduces the main examples of convergence activities that have taken place. Section 5 provides analysis and guidance to help government, ECBHOs, and international aid actors develop strategies for increasing cooperation and coordination going forward. Each of these sections provides analysis of the existing challenges and gives actionable recommendations for specific stakeholders. These recommendations are then consolidated in Annex 1.

Section TWO: Background

This section provides an overview of the impacts of conflict on health and healthcare delivery. Section 2.1 provides historic context demonstrating how conflicts have impacted civilians and have led to parallel governance structures and, thus, the emergence of separate health systems. Section 2.2 explores the impact that these conflicts have had on health indicators, leaving the region crippled and with significant health challenges to overcome. Section 2.3 introduces the role of ECBHOs in providing healthcare to some of the region's most vulnerable populations. Section 2.4 concludes by looking at the various impacts that ceasefires have had on the dynamics of healthcare delivery, particularly the operations of ECBHOs.

2.1: A short history of conflict and healthcare in southeast Myanmar

Southeast Myanmar lies along the border with Thailand, including Tanintharyi Region, Mon State, Kayin State, Kayah State, the most southern townships of Shan State, and the eastern part of Bago Region.⁵ This predominantly mountainous region is home to an estimated 11.5 million people,⁶ most of whom belong to ethnic groups with different languages and cultures from the ethnic Bamar population that has tended to control the central government and military.⁷ These non-Bamar groups, which include Karen, Mon, Shan, Karenni, 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 deeply harmful impacts 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.

1948-1988: Armed conflict and the emergence of parallel health systems

The longest-standing and most prominent ethnic armed movement in the region is that of the Karen National Union (KNU). The KNU was established in 1948 by Karen lawyers, politicians, and military commanders who had been prominent figures in Burma's self-government and security apparatus under the British colonial system. The KNU was established after the Karen ethnic group was unable to secure a semi-autonomous state in the 1947 Constitution, as the Shan, Kachin, Chin, and Karenni groups did. The armed rebellion was taken up in Karen areas reaching from the Ayeyarwady Delta (in today's Ayeyarwady Region) through Yangon, and through much of the southeast, and formal political processes were largely boycotted by Karen politicians.

In the 1950s, the KNU was instrumental in the establishment of both Mon and Karenni armed movements in the region, which by 1956 and 1957, respectively, became known as the New Mon State Party (NMSP) and the Karenni National Progressive Party (KNPP). During that decade, the KNU also established its first apparatuses for governing populations in its "liberated areas," organized at first under the Kawthoolei Governing Body. In 1956, it established its Karen Department of Health and Welfare (KDHW).

In the 1960s, a "federal movement" began, led by ministers and MPs from the Shan State government who were joined by government leaders from other ethnic states, to call for greater autonomy and political influence for ethnic states. The movement was brought to a sharp halt, however, halfway through a second round of talks with the central government, as the military took power in 1962. The military junta's spokesperson stated a few days after the takeover that "the issue of federalism [was] the most important [reason] for the coup," in order to avoid "chaos,"⁸ implying that the coup was necessary to prevent creation of a federal government. Dramatic administrative reforms focused on centralization were swiftly instated as General Ne Win put the country on the path toward his "Burmese Way to Socialism."

These events greatly catalyzed the rise of ethnic Shan armed movements, which soon came to dominate much of Shan State's border with Thailand. They also ushered in a new era of military brutality and highly centralized, top-down, hierarchical governance. The socialist military regime initiated its People's War doctrine that aimed to bring every man, woman, and child under the firm rule of the state, with the potential to be mobilized for war. Its armed forces (the Tatmadaw) then established the "four cuts" counterinsurgency strategy, which set out methods for cutting off community support for EAOs. In the southeast, this largely revolved around the forced relocation of entire communities into camps in areas under government control, where they were placed under sharp restrictions from returning to their land and homes.

In the 1970s, the KNU suffered heavy defeats in the Delta area and reconstituted itself just in the southeast of the country, where it established seven administrative districts that remain to this day and cover most of East Bago, Kayin, Mon, and Tanintharyi. Benefiting greatly from border trade and increasing international support, the KNU's governance systems also developed considerably during this period, and it became host to a range of alliances with other ethnic groups calling for the formation of a democratic federal union. In 1972, the New Mon State Party formed the Mon National Health Committee (MNHC) to serve populations under its control.

1988-2009: Boosting border-based healthcare as the region descends into war

Following mass demonstrations and the country's second coup d'état in 1988, additional medical capacity arrived on the border area as politically active doctors and other medical professionals fled to the KNU-controlled area and to Thailand. Dr. Cynthia Maung, an ethnic Karen physician trained in Rangoon, opened the Mae Tao Clinic in 1989 in Mae Sot, Thailand, initially to serve exiles and refugees. The clinic later evolved to serve migrant workers and people still in Myanmar unable to afford or access healthcare: in 2014, nearly half of the clinic's patient visits were by clients who reside in Myanmar.⁹

In 1991, Dr. Cynthia Maung and other exiles formed the BMA to provide support to community and EAO health services in Myanmar. During the 1990s, a coalition of armed groups and pro-democracy exiles established the National Health and Education Committee as an umbrella group for these providers. In 1992, Shan medics formed the Shan Health Committee, which was later brought under the Restoration Council of Shan State's Shan State Development Foundation (SSDF). The KNPP then established the Karenni Mobile Health Committee (KnMHC) in 1997.¹⁰ In 1998, exiles and health specialists linked to the KNU also established the Backpack Healthworker Team (BPHWT), to provide full mobile outreach services by training people to work in their own communities. The BPHWT initially focused on the southeast, but later spread across remote, non-Bamar areas throughout Myanmar. These networks formed the basis of the collective ECBHOs, on which this report focuses.¹¹

Throughout the 1990s and 2000s, aid donors – who had been restricted from working with the Myanmar government due to sanctions and the military government's self-isolation – directed the majority of their relatively meager aid to Burma to conflict-affected areas and pro-democracy movements.

As programs and partnerships between local health organizations expanded, there was an early recognition of the serious dearth of skilled, ethnic health personnel. Those working as health staff rarely possessed standardized, formal training. With financial support from development agencies, governments, and private donors, along with technical support from INGOs, standardized treatment protocols and training curricula for health workers were developed to build a cadre of health personnel, not only to deliver care, but also to build upon and strengthen health systems serving internally displaced persons (IDPs) in Myanmar. By the late 2000s, curricula included clinically oriented training programs for producing competent medics and maternal and child health practitioners, as well as courses for producing personnel for public health programming, including public health staff and health administrators, pharmacy staff, and clinical laboratory staff. Some of the public health trainings were conducted in collaboration with Thai universities. Accordingly, the ECBHOs and the populations they

served became increasingly dependent on support from the international community. The combined yearly budgets for ECBHOs operating in the southeast in 2015 is estimated at over six million USD, with a significant proportion supporting Mae Tao Clinic operations in Thailand, which include trainings for other ECBHOs.¹²

The 1990s also saw dramatic shifts in the conflict dynamics of the region. In 1994, ceasefires were signed between the government and the Karenni Nationalities People's Liberation Front (KNPLF, an EAO in Kayah State that had split from the KNPP in 1978), the New Mon State Party, and a large faction of the KNU that renamed itself the Democratic Karen Buddhist Army (DKBA). This allowed the Tatmadaw to then focus its counterinsurgency on the KNU and KNPP, with direct military support from the DKBA, and, to a lesser extent, the KNPLF, both of whom turned against their mother organizations. In 1996, militia leader-cum-rebel Khun Sa, whose Mong Tai Army (MTA) had controlled most of southern Shan State for decades, surrendered to the Tatmadaw. A large faction of the MTA then split and formed a new army which went on to be renamed the Restoration Council of Shan State (RCSS), as it remains known today.

Heavy Tatmadaw offensives against the KNU, KNPP, and RCSS followed in waves throughout the 2000s, often employing the four cuts strategy and targeting civilian communities to forcibly relocate them to government territory. Between 1996 and 2011, an estimated 3,724 villages were destroyed, relocated, or abandoned in the region.¹³ IDP numbers in the region soared to over 400,000, with refugees numbering between 120,000 and 150,000. In 2005, the mass resettlement of refugees from the Thailand border to third countries began, with more than 89,000 mostly Karen and Karenni refugees moved by 2014, predominantly to the USA.¹⁴

More broadly, in this era, the Tatmadaw and its proxies became responsible for regular human rights abuses, including shoot-on-sight tactics across areas designated as insurgent strongholds, systematic destruction and confiscation of food and property, arbitrary arrest and torture, extrajudicial and summary killing, widespread sexual abuse, forced labor, forced portering, excessive taxation, and extortion.¹⁵ The military government and state-backed militia also placed extensive limitations on humanitarian assistance to these areas, and in numerous cases were implicated in harassment, abductions, and killings of ECBHO medics and other staff.¹⁶ According to the Backpack Health Worker Team, between 1998 and 2010, nine backpack medics and one traditional birth attendant were killed by gunfire or landmines.¹⁷

2009-2016: A fledgling peace process in southeast Myanmar

In 2009, in the lead-up to the 2010 election, the military government demanded that all EAOs with ceasefires form border guard forces (BGFs), new militia units firmly under Tatmadaw command, or face new offensives. Sixteen of the country's 23 BGFs are in Kayin and Kayah states alone, primarily formed by the former DKBA and KNPLF, while two of the others are in the southern part of eastern Shan State.¹⁸ A large faction of the DKBA, however, as well as another KNU splinter faction, the Karen Peace Council (KPC), refused to transform, and instead launched attacks on the Tatmadaw in 2010.

Despite a short spike in conflict, in 2011 and 2012, a string of new ceasefires were achieved between the government and 14 armed organizations, including the KNU, KNPP, RCSS, KPC, the rebel faction of the DKBA, and three smaller groups with operations in the southeast.¹⁹

In Karen and Karenni areas especially, these ceasefires achieved a marked decrease in hostilities and levels of abuse faced by civilians, but a wide range of issues continued due to ongoing militarization. A 2014 report by the Karen Humans Rights Group (KHRG), which draws on over 600 pieces of data, found that since these ceasefires had been signed there had been overall decreases in some forms of abuse, particularly the systematic destruction of villages, while other abuses had persisted, such as arbitrary acts of violence, forced recruitment, extortion, and sexual abuse by armed actors.²⁰

Meanwhile, other new sources of insecurity were found to have become more prevalent, such as land confiscation for military and commercial purposes, as well as issues related to drugs.²¹ A 2013 household health survey in southeast Myanmar estimated that 10 percent of households in the survey area experienced a human rights violation in 2012, with “destruction or seizure of food, livestock, and crops” the most common rights violation.²² These violations continue to provoke mistrust between residents of southeast Myanmar and the government, and demonstrate the scale of the challenges to achieving sustainable peace.

Despite the onset of new, heavily armed conflicts in the north of the country, a multilateral peace process began in 2013, bringing together a core bloc of pro-federal EAOs to negotiate with the government. By mid-2015 a text was agreed to, which even its critics said “encapsulates virtually every issue important to minority communities in war zones” despite a lack of binding commitments on most of these points.²³ Most crucially, the text committed all signees to establishing “a union based on the principles of democracy and federalism, in accordance with the outcomes of the political dialogue and in the spirit of Panglong,²⁴ that fully guarantees political equality, the right to self-determination, and democratic practices based on the universal principles of liberty, equality, and justice.”

Talks quickly deteriorated, however, as the government stated that six EAOs would not be allowed to sign.²⁵ As a result, on October 15, 2015, only eight armed groups agreed to sign the deal, alongside the president, commander in chief, and other government officials. But among those signing were the two largest groups in the southeast, the KNU and the RCSS, as well as the DKBA, the KPC, and numerous smaller groups operating in KNU territory.²⁶

In 2015, the NLD won a landslide election victory, and in March 2016 formed a government alongside the Tatmadaw, which maintains constitutional authority over one vice president, three powerful ministries, and 25 percent of Parliament. The NLD did not sign the NCA, likely due to the controversy surrounding its lack of inclusivity, but the party and the new government have repeatedly committed to holding a political dialogue explicitly to establish “a genuine democratic federal union.”²⁷ The NLD also attended the first Union peace conference, which was held in January 2016 as the first session of the political dialogue. The conference was largely a symbolic affair, however, as it included few of the country’s major EAOS, and the future direction of the peace process remained in the balance due to the new government.

The NLD sent representatives in late 2015 to meet with ECBHOs in Mae Sot, and in 2016 hosted ECBHOs in an information-sharing meeting in Yangon.²⁸ A health adviser to the NLD said that coordination activities between MoH and ECBHOs is a priority that is in line with Daw Aung San Suu Kyi’s ideology of reaching out to ethnic groups. This point and several others recognizing ECBHOs as service providers are reflected in the NLD National Health Network’s 2016 policy document, “Program of Health Reforms: A Roadmap Toward Universal Health Coverage in Myanmar (2016-2030).”²⁹

2.2: The impacts of armed conflict on health in southeastern Myanmar

The horrors of war are not easily forgotten by those who have experienced them. In southeast Myanmar, the effects of armed conflict on the security and governance environment, on the economy, on transportation, education, and health infrastructure, and on the levels of trust between EAOs, ethnic communities, and the government all have deep implications for the strengthening of healthcare service systems.

Under successive military governments, even non-conflict areas suffered from poor health conditions, as the state health system was severely underfunded and highly centralized and suffered significant gaps in capacity. In 2011-2012, shortly before the country began implementing health reforms, the country was spending only about 0.3 percent of GDP on health, about \$1.60 per person,³⁰ making it

one of the lowest in Asia.³¹ In 2000, the WHO ranked Myanmar's health system as 190th out of 191 countries.³² These deficiencies, which are discussed in more detail in Section 3.1, resulted in extremely poor national health outcomes, such as some of the highest infant and child mortality rates in Asia.³³ As is the case globally, nearly all health indicators were worse in rural areas.

Poor conditions in rural areas were compounded further in places affected by armed conflict. Table 1 draws on data provided by the MoH and ECBHOs to demonstrate a series of health indicators in areas accessible for documentation. MoH data is taken for the national average, the national urban average, and from three selected states in southeastern Myanmar: Kayin, Kayah, and Mon. While the ECBHOs' areas also cover these states, it can generally be assumed that ECBHOs are most active in rural, conflict-affected areas (particularly, but not limited to, areas with an EAO presence), while government data is from areas close to towns and main roads where the MoH is most active. These indicators are then compared to targets set by the MoH under various agendas, as noted.

Table 1 : Health indicators in southeast Myanmar³⁴

Indicator	MoH Data						ECBHO areas ^g	Target	Target set by
	National	Urban	Rural	Kayin	Kayah	Mon			
Infant (< 1yr.) mortality rate (per 1000 births) ^f	37.5	24.5	42.8	7.6 ^h	9.8 ^h	10.5 ^h	94.2	22	MoH 2030
Maternal mortality rate (per 100,000 live births)	200 ⁱ	112 ^h	154 ^h	110 ^h	120 ^h	80 ^h	721	90	MoH 2030
Child (< 5 yr.) mortality rate (per 1000 live births) ^f	46.1	29.1	52.9	11.2 ^h	15.3 ^h	14.3 ^h	141.9	29	MoH 2030
Antenatal Care coverage (% with at least one visit) ^f	93.1	98.3	91.01	95.2	90.5	99.6	60.4	80	MoH commitment to sustainable development goals (SDGs)
Births with a skilled attendant present (%) ^f	70.6	89.6	63.0	64.5	69.0	81.7	73% ^e	80	MoH commitment to SDGs
Expanded Immunization ^f (% coverage)	96.0	97.4	97.2	97.6	94.9	100	Very low	100	MoH Commitment to SDGs
Not using contraception ^f (%)	54.0	48.7	56.3	64.0	67.7	54.4	54.1 ^j	10 ^j	MoH Commitment to SDGs
HWs per person	1.49 ^a	--	--	--	--	--	1.29 ^b 2.10 ^c	2.3	WHO minimum

^a MoH counts doctors, nurses, and midwives as healthworkers for this statistic.

^b Calculated using medics, Emergency Obstetric Care (EmOC) and Reproductive Health (RH) workers, approximate equivalents of MoH doctors, nurses and midwives.

^c Calculated using medics, EmOC and RH workers, and community health workers (CHWs). CHWs and midwives have significant overlap of clinical skills – see Tables 2 and 3 for a more complete comparison.

^e Includes traditional birth attendants, who have extremely limited training and clinical skills.

^f UNICEF Multiple Indicator Cluster Survey, 2011.

^g Parmar, et al. (2015): see note 47. Maternal Mortality Ratio is from *Diagnosis Critical*: see note 119.

^h MoH data.

ⁱ WHO estimate.

^j Defined as “unmet need” for contraception.

For populations in southeast Myanmar, the burdens of sickness and death did not stand in isolation: statistical analyses have consistently linked these health indices with the experiences of abuse suffered by civilians. In particular, counter-insurgency practices employed by the Tatmadaw, and human rights abuses by a wide range of armed actors, have left communities devastated and have resulted in the displacement of hundreds of thousands of civilians. By 2014, an estimated 400,000 people remained internally displaced in the region.³⁵

In addition to the direct effects of attacks on populations, the protracted conflict and associated abuses, coupled with longstanding central neglect of social services and strict limitations on humanitarian assistance to IDPs in southeast Myanmar, have also resulted in poor transportation infrastructure, weak education systems, and poor supply chains for clinics, all of which have been documented as determinants of health.³⁶ Studies from this area 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.³⁷

Surveys dating to 2002 in ECBHO areas show consistent associations between rights violations and poor health outcomes, and indicate that human rights violations are determinants of health in southeastern Myanmar. 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).³⁸ 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 3.22, compared with households that had not been displaced.³⁹ Data from 2013 found that households that reported forced labor were 2.2 times more likely to report infant mortality and 2.1 times more likely to report child mortality than households that did not report forced labor. The same study showed that children in households that were forcibly displaced were 3.3 times more likely to have moderate or severe malnutrition compared with children who had not been displaced.⁴⁰

While ceasefires signed in 2012 have led to steady decreases in armed conflict in southeast Myanmar, human rights abuses have persisted. In 2014, the Karen Human Rights Group reported that militarization, or the heavy presence of soldiers, continued to drive human rights abuses, despite some improvements.⁴¹ Additionally, a household survey published in 2012 demonstrated that proximity to military bases was associated with increased risks of food insecurity, human rights violations, and poor health, even when armed conflict was latent. Specifically, for every hour of walking distance closer to

an army base that a village was located, the risk of human rights abuses increased by 30 percent, food insecurity increased by 5 percent,⁴² and the risk of having a household member sick and unable to access healthcare increased by 29 percent.⁴³

These studies have found that morbidity and mortality from indirect effects of conflict such as restricted access to clinics, poor infrastructure, and depressed economies, far exceeded that caused by direct violence itself, such as by landmines or other weapons. The burden was borne disproportionately by women and children, and surveys consistently demonstrated that child, infant, and maternal mortality in southeastern Myanmar IDP communities was higher than official figures, already among the worst of ASEAN member states.⁴⁴ In addition, the main identified causes of mortality were overwhelmingly infectious and easily preventable ailments, such as respiratory tract infections, malaria, and diarrheal diseases.⁴⁵ Childhood malnutrition is also disproportionately higher in IDP communities of 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 or severe malnutrition. The corresponding figure for women of childbearing age was 11.3 percent.⁴⁶ Recent surveys suggest that this area had significantly worse health indicators than the national averages: a 2013 survey suggests that infant and under-age-five mortality rates are double those of national averages and similar to those of Somalia.⁴⁷

Prior to ceasefires, the Ministry of Health was not able to access most conflict-affected areas. Meanwhile, people in those areas often faced restrictions on their movement, limiting them from reaching health facilities, including those operated by the government and by ECBHOs. Even those able to access MoH facilities found services to be limited, and struggled with the necessary out-of-pocket costs due to widespread poverty. While these deficiencies were particularly bad prior to the ceasefires, government clinics in southeast Myanmar, especially in rural areas, continue to be understaffed and to lack equipment and supplies.⁴⁸ Finally, ethnic communities in particular have long faced language and cultural barriers in accessing the state services that are available, as health facility signs and written materials are mostly in Myanmar language, and MoH staff have tended to be unable to speak local languages.

2.3: ECBHOs respond to the need for healthcare

In the face of such dire health conditions and severe government neglect, the ECBHOs have attempted to fill the healthcare void. The MTC has expanded from a small clinic providing basic curative health services to become a large facility providing more advanced care, a training center offering standardized health courses, and a driver of health policy for EAOs and civil society health organizations. It also operates a network of clinics in Kayah State, a school for migrant and stateless children, and child protection programs. Meanwhile, the BMA now supports specialized programs such as maternal and child healthcare (MCH) in 39 clinics run by EAOs and some state-backed militias across Myanmar, and the BPHWT operates over 100 mobile teams and employs more than 1,200 staff, serving over 200,000 people, in nine states and regions.

The ECBHO collective consists of MTC, BMA and BPHWT described above, along with the health departments of four EAOs: the KNU's Karen Department of Health and Welfare (KDHW), the NMSP's Mon National Health Committee (MNHC), the RCSS's Shan State Development Foundation (SSDF), and the Civil and Health Development Network (CHDN), a coalition of health professionals from six Kayah State-based EAOs, BGFs, and state-backed militias,⁴⁹ informally led by the Karenni National Mobile Health Committee (KNMHC). The combined ECBHOs in southeast Myanmar employ about 3,000 health staff, working in 139 clinics and 93 mobile teams, with a target population of about 600,000 people.⁵⁰

Although they are heterogeneous in their programs and services and were started independently of each other, the ECBHOs have often collaborated on human rights advocacy, training advanced health workers, and sharing information about the conflict to improve the security of health workers. Formal

collaborations began in 2002 with the creation of the Health Information Systems Working Group (HISWG). This has allowed the organizations to begin standardizing their health systems and engage in coordinated health data collection, addressing previous gaps in health information from their areas. Much of this cooperation has been carried out through the HISWG, and, since 2012, through the Health Convergence Core Group.

In particular, these groups have been able to develop their systems to meet the specific needs of IDPs. Many of their services have been based on a model of training villagers to become medics in their own communities. These medics would not require stationary clinics, and could follow populations as they were internally displaced – the medics, it was thought, would be displaced along with the populations they served. In areas less affected by conflict, stationary clinics are preferred, because they have larger and more secure areas for storing medicines and supplies.

Due to the shifting zones of conflict and administration, rural parts of southeast Myanmar are host to a mosaic of stationary clinics and mobile teams supported by these various actors. In general, stationary clinics provided by these actors are in areas under firm control of EAOs, while mobile medical teams have been particularly active in areas of mixed administration, where government and EAO authority overlap. Government services tend to be most prevalent in areas under firm state control, and closer to main roads and towns in mixed control areas. Map 1 shows the distribution of MoH and ECBHO clinics across the southeast.

ECBHOs typically have head offices and bank accounts in Thailand, despite the majority of their staff and beneficiaries being based in Myanmar and only leaving the country periodically for training or to collect supplies. This relates to the legacy of conflict, as their logistical operations have long depended on the security and infrastructure available in Thailand. It has led them, however, to often be inaccurately called “cross-border” organizations, implying that they are mostly based outside of the country and are crossing the border to provide occasional support.

2.4: The impacts of ceasefires and the politics of healthcare

Since new ceasefires were signed in the southeast, there have been a number of changes in the delivery of healthcare. Firstly, 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 exacerbated fears among some EAOs that the state will manipulate ceasefires to expand its territorial control rather than negotiate a political settlement. 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, have provided hope for effective and politically sensitive healthcare arrangements.

The sensitivities of Ministry of Health expansion

As was discussed in The Asia Foundation’s 2014 report “Ethnic Conflict and Social Services in Myanmar’s Contested Regions,”⁵¹ social service sectors are uncharacteristically politically sensitive in these areas, especially in the context of fragile ceasefires. ECBHOs were established first and foremost to provide healthcare services, and their work is focused entirely on this mandate. Nonetheless, they are unavoidably connected to the fragile politics of the region. At their root, ethnic armed movements have been motivated by claims for the right of ethnic communities to be governed by local leaders, rather than by the Bamar and urban elites that have long dominated the state. Many EAOs such as the KNU, NMSP, and KNPP have thus focused less on the use of insurgency to make explicit political demands, and more on the holding of territory and the maintenance of long-standing governance systems. A key part of their attempts to realize self-government has been the provision and facilitation of social services to populations in their areas.

Such sensitivities have been particularly prominent in KNU and KNPP areas, where new ceasefires have allowed the state to expand its territorial presence dramatically. Social service provision has tended to be at the forefront of its expansion efforts, with government administrators and health and education officials reaching out to remote communities in new areas, and typically failing to coordinate with existing local providers.

On the whole, EAOs in the southeast remain committed to the peace process in the hope of achieving a political settlement. However, state expansion has damaged some leaders' confidence in ceasefires and has helped the government to manipulate talks in their favor. According to a member of the KNU's executive committee who has been involved in negotiations, "[the KNU] wanted to establish a ceasefire with a code of conduct, then to move to political dialogue before development activities got underway. But we are still at the ceasefire stage, and they are already moving ahead with development to expand into our area.... They have a greater capacity than us [in negotiations], so we feel like we are just making requests but ultimately following their way."⁵²

Meanwhile, on the ground, commanders from the armed wings of the KNU and KNPP, named the Karen National Liberation Army (KNLA) and Karenni Army (KA) respectively, have become particularly distrustful of the state's intentions, and have viewed new government attempts to expand social services without prior coordination as a strategic threat. In discussions with one of the authors, groups of battalion commanders from six out of seven KNLA brigades stated that the expansion of the government's administration through development and social service delivery was the most pressing security threat they face, citing the concomitant strengthening of the Tatmadaw as of less immediate concern. Commanders from the KNLA's seventh brigade listed government investments in social services, including healthcare, as the primary risk.⁵³ KA commanders noted ongoing Tatmadaw militarization as the primary threat they faced, but also raised concerns about new clinics built in their areas.

Perceptions of a donor shift

These sensitivities have been compounded further by the common perception among ECBHOs of a sudden and intentional shift by the international community to working with the government, rather than ethnic actors, across a variety of sectors including healthcare.

As described in Section 2.1, throughout the 1990s and 2000s, ECBHOs and the populations they served benefited greatly from international support for funds and technical support. Following the normalization of international relations with the Myanmar government in 2012, however, new space opened for donors to work in government-controlled areas and directly with the Ministry of Health. At least one major donor, Norway, explicitly withdrew funding from health programs administered from Thailand, citing "positive political changes in Burma/Myanmar and improved access from Yangon to border areas of eastern Burma/Myanmar."⁵⁴

Although numerous other donors maintained or strengthened support, the shifts in funding that were experienced were felt to be premature by ECBHOs, who were concerned that ceasefires were frequently violated and human rights violations in many ethnic homelands continued. In addition, ECBHOs were wary of the highly centralized government system, including in healthcare, whereby priorities and programs were determined by officials in Nay Pyi Taw, authorities that they did not feel represented them.⁵⁵

Meanwhile, EAO leaders have also perceived the international community to be directly or indirectly helping the government improve its image and to expand into ceasefire territories. According to an executive committee member of the KNU, "INGOs are just working with government from their side; people will just see it all as government support, even though we have been supporting them for years....We have done a lot of hard work to develop our system and want to stand on our own two feet,

but now we just feel like we are [below them].”⁵⁶ According to the chief commander of the KNLA fifth brigade, “The international community gives support to the government, and so they can provide for our people; and then it becomes like they are government people. So when we go to negotiate, what can we say? Because we look like we have no people.”⁵⁷

KNU leaders also repeatedly mentioned the practical difficulties associated with an influx of assistance from government-controlled areas. For example, a member of the KNU executive committee explained, “We also have a short-term and long-term plan for healthcare, but if the government just sends lots of outside groups [e.g., INGOs] for short term projects, it will be hard to tackle long-term issues systematically.” Furthermore, he added, “now there is so much [humanitarian and development assistance] coming from the [government-controlled areas]; we have all the rules and regulations for cross border aid but are not prepared to manage this.” Additionally, as explained by the joint secretary of the KNU’s Mu Traw District, which has experienced increased Tatmadaw presence since the ceasefire, “We are mostly trying to stay prepared for [a situation where] our ceasefire breaks down,” indicating the need to remain focused on locally based service providers with their logistical arrangements in place, rather than shifting to become dependent on government sanctioned channels.

New space for ECBHOs and for cooperation

At the same time, however, ceasefires and government reforms created more space for ECBHOs to work and for increased cooperation with MoH. Health workers and clients became able to move more freely without fear of persecution from the military. Increased freedom of movement has meant that remote clinics can be accessed more regularly for supplies and other administrative purposes, including efforts to build health information systems through routine data collection. Space has also opened for INGOs to work in some conflict-affected areas, and to support ECBHOs more openly from their offices in Myanmar. For ECBHOs linked to organizations that signed the nationwide ceasefire agreement (NCA), most notably the KNU and the RCSS, the removal of their organizations from the list of “unlawful associations” in October 2015 has helped to open that space further. The NCA also provides for recognition of EAO’s governance roles “in their respective areas,” including “projects concerning...health.”⁵⁸

Significantly, these changes opened the space for greater cooperation with the state, as discussed in Section 2.1. If peace continues to build, areas of political control will become increasingly blurred, and these two systems will need to cooperate and collaborate in order to ensure equitable delivery of health services and resulting health outcomes. Although tensions and mistrust run deep, ECBHOs and the MoH have shown willingness to engage with each other. The dynamics of this new space for coordination and cooperation are discussed in detail in Sections 3 and 4.

Section THREE: Current and future health systems in southeast Myanmar

The MoH and ECBHO health systems evolved to serve different types of populations and are thus fundamentally different in structure, workforce, and policy. This section provides a comparative overview of each system, with a particular focus on the MoH's role in conflict-affected areas of southeast Myanmar, where it is particularly weak.

However, the data presented here cannot be used to generate conclusions about which system performs better in the southeast. The MoH system has been scrutinized by multiple assessments that have been made public and thus it is easy to identify areas in need of improvement. In contrast, there are no comparable assessments of ECBHO systems that are publically available; this is a significant limitation in the analysis presented here and on making such judgments. Rather, this analysis provides for general discussion of each system's design, strengths, and weaknesses in the focus areas.

The MoH system is more centralized, much larger, better funded, and has historically focused more on advanced care in urban settings than has the ECBHO system. It runs over 3,000 clinical facilities, including over 900 hospitals, and it employs over 70,000 doctors, nurses, and other health workers. Government support for the MoH has increased fivefold in five years, and international donor funds have increased by hundreds of millions of dollars in the same period. Historically, MoH staff have not worked in their home areas, and staff were rotated frequently between positions to ensure control at the central level.⁵⁹ The MoH is faced with multiple challenges in delivering healthcare across the country, and service delivery in rural parts of the southeast is just one of them.

The ECBHO system employs around 3,000 staff and operates 232 clinics and mobile teams in southeast Myanmar alone, with a target population of around 600,000 people. It has a strong focus on training communities to deliver primary healthcare. Most health workers in this system are recruited from the communities where they work, and thus are familiar with local languages and cultures. As such, it is a decentralized system, in that district- and clinic-level management have significant control over human resources, day-to-day operations, and engagement with communities and other local actors in their catchment areas. These health workers assume higher-level clinical responsibilities than their MoH counterparts; ECBHOs employ very few doctors and use other cadres of health workers to meet clinical service needs. The ECBHOs are focused on providing primary healthcare and do not provide secondary or tertiary care in the field, although plans are in place to introduce some limited secondary care services.⁶⁰ They refer most patients to MTC, INGO or government health facilities in Thailand and the rest to MoH hospitals. Meanwhile, the ECBHO system is faced with multiple challenges in improving the quality of its services and adapting to peacetime operations.

3.1: Ministry of Health in southeast Myanmar

An in-depth analysis of the MoH and all of its challenges is beyond the scope of this report. However, its system is analyzed here in the context of delivering healthcare in conflict-affected southeast Myanmar.

The Myanmar health scholar Dr. Than Tun Sein described how Myanmar's five political eras have influenced government health service provision in the country.⁶¹ This section will focus on the two most recent of these eras, the "State Law and Order Restoration Council / State Peace and Development Council" period (1988-2011) and the "democratization" period (2011-present), which are most relevant in helping to understand health in southeast Myanmar today.

For decades, Myanmar's military governments underfunded the MoH. In 2011-2012, shortly before the country began implementing health reforms, the country was spending only about 0.3 percent of GDP on health, about \$1.60 per person,⁶² which was an increase from around \$0.70 per person in 2007.⁶³

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 meant that clients were required to buy their own medicine, dressings, and other disposable equipment, as well as to pay staff for clinical services.⁶⁴ This had the dual effect of encouraging people to use private clinics (perceived to offer better care than the government), and encouraging government staff to open private clinics to supplement their incomes while neglecting duties at MoH clinics. A decade after this trend toward privatization began, Myanmar had one of the highest percentages of healthcare costs paid for by individuals (out-of-pocket) globally.⁶⁵ In 2000, the last year for which rankings are available, the WHO ranked Myanmar's health system as 190th out of 191 countries.⁶⁶

Today, the MoH leadership is tasked with reviving this system, and it has new support to address these problems. 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.⁶⁷ Foreign aid in the health sector has increased steadily since 2010, and the former and current governments have been developing new policies and programs to strengthen the system and increase coverage. Even further budget increases are expected under the new government. 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 healthcare expenditures, and to make up for the difference with a significant increase in government spending, as well as some increase in external funding.⁶⁸

Ministry of Health structure

The MoH system is complex and employs large numbers of workers, but these numbers are still inadequate to ensure coverage of services up to WHO standards. In 2014, the Ministry of Health operated 988 hospitals, 348 maternal and child health centers, 87 primary and secondary care centers, and 1,684 rural health centers.⁶⁹ It managed 13,000 doctors, 30,000 nurses, 22,000 midwives, and 11,000 other health workers,⁷⁰ and had, in principle, targeted Myanmar's population of 51 million people,⁷¹ despite failing to reach full coverage.

In 2010, the number of health workers (doctors, nurses, and midwives) per 1000 people nationally was 1.49, which is lower than the WHO and Millennium Development Goal-recommended minimum rate of 2.3 per thousand.⁷² In southeastern Myanmar, staffing levels fell further short of targets. In Kayin State, for example, an analysis of human resources data from 2012, combined with current staffing targets per population, suggests the MoH needs 53 additional public health supervisors, 25 more health assistants, 107 midwives, 250 public health supervisor-level 2s, 1300 auxiliary midwives and 1200 community health workers.⁷³ These needs are not unique to Kayin: national estimates using staff-to-population ratio goals adopted in 2015 suggest that the MoH needs to exceed 2012 staffing levels by nearly 3000 public health supervisors and 900 health assistants.⁷⁴ Current rates of training will not be able to fill these needs quickly: national health training schools produce about 1200 midwives and 150 health assistants per year.⁷⁵

Low funding and national health policy priorities under the military governments served to widen the gap in service provision between urban and rural areas. The MoH 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.⁷⁶ During this time there was very little increase in the numbers of primary healthcare facilities or maternal child health centers,⁷⁷ and by the end of this era, half of health workers were located in urban areas, while 70 percent of the population lived in rural areas.⁷⁸

The legacy of poor education services in rural ethnic areas led to a lack of people in these areas qualified for university programs, including those in the health-related fields such as medicine, nursing, public

health, midwifery, and others⁷⁹. Thus, most medical staff were not recruited from rural areas, and preferred to work closer to their homes in urban centers. The rotation system decreased the burden on staff of working in rural areas, as they would only be required to stay for a short time. Rapid turnover, however, created a gap in the relationships between clinic staff and the communities they served. A recent assessment concluded that these staff rotations “led to lack of understanding of the local situation and the community, reducing trust of and rapport with the local community, and [weakening] working relationships with other sectors including local administration.”⁸⁰

Today the Ministry remains centralized, with decision-making power consolidated at the national level, but with operational levels also at the state and township. Health infrastructure is organized by township; Myanmar has 330 townships across 14 states. The health system at the township level is run by the township medical officer (TMO), a doctor who oversees a township hospital, one or two station hospitals, four to seven rural health centers, and several rural health sub-centers (sub-RHCs) for each rural health center. Rural health centers are staffed by a health assistant and cover a catchment area of about 20,000 people. The most basic public health facility is the sub-RHC, staffed usually by a midwife, lady health visitors, and health assistants. Volunteer community health workers and volunteer auxiliary midwives, usually from the area, also work at this level. Sub-RHCs offer immunization, malaria control, antenatal care, and other outpatient services. The typical catchment population for a sub-RHC is about 5,000 people.

Ministry of Health policy and planning

The Myanmar Ministry of Health, emerging from an era of neglect, has set ambitious goals for improving health in Myanmar. It needs to address severe deficiencies in all sectors of healthcare delivery, coordinate an ever-increasing number of international health actors, manage large increases in budget, and immensely scale up all of its services, while simultaneously improving quality. Many of these shortcomings were acknowledged and targeted for improvement by the NLD in its Roadmap Towards UHC,⁸¹ continuing earlier reform efforts by the Thein Sein government.

MoH health planning is done at the township level. Historically, TMOs used a micro-plan framework developed by the MoH, but more recently the MoH initiated a Comprehensive Township Health Plan (CTHP). The framework for the CTHP includes a situational analysis, stakeholder assessment, prioritization of problems, and budgeting and planning for interventions. CTHPs are supported by INGOs in several states in Myanmar, but the initiative has yet to be implemented nationally.

In Myanmar, approaches to healthcare are based on several policies dating back decades. Although they have not always been implemented as such, national health policies suggest attention should be given to the health needs of people in rural areas like southeastern Myanmar, and that decentralizing and coordinating services among different providers is one way to do this.

An early policy still in effect is from 1993 and sets 15 points with an overarching goal of using a primary care approach to achieve “health for all.”⁸² In 2000, the government produced an updated policy, the “Myanmar Health Vision 2030,” which states ambitions for achieving universal health coverage as well as improving human resources for healthcare within the country. The document includes direction for health policy, preventive and curative services, human resources, research, health system development, and roles for the private sector, LNGOs, and INGOs. Success is measured by an increase in life expectancy at birth, and decreases in infant, child, and maternal mortality.

Since 1991, the MoH has developed quadrennial national health plans. 2016 marks the end of a four-year cycle that focused on, among other things, ensuring that quality healthcare services are equitable and accessible to all citizens, strengthening preventive and curative services, planning and investing in training to improve human resources for healthcare, and promoting collaboration with local and international partners, including health-related organizations and the private sector. The national

health plan describes 11 areas of program implementation, including expanding healthcare coverage in rural, peri-urban, and border areas, where services have been weak.

Other government policy commitments to healthcare include the Nay Pyi Taw Accord for Effective Development Cooperation, which reaffirms commitments to MDGs, calls for “people-centered development,” highlights the importance of international cooperation, and places focus on empowering and engaging civil society. Although no direct mention is made of healthcare, the Nay Pyi Taw Accord seems to encourage decentralization and a much stronger role for civil society organisations. Additional government policy on health includes Development Policy Options for Myanmar (Nay Pyi Taw 2012) and the Rural Health Development Plan (2001-2006).⁸³

The 2008 Constitution includes several articles relating to health.⁸⁴ Article 367 states that every citizen “shall...have the right to healthcare.” Other articles call for the Union to “earnestly strive to improve education and health of the people,” “care for mothers and children,” and enact laws enabling people to “participate in matters relating to their education and health” The Constitution restricts political and fiscal control of government activities at the state level, however, which limits the MoH’s ability to decentralize control of operations to these levels.⁸⁵

The Framework for Economic and Social Reform (2013) lists government priorities for working towards the goals of the national comprehensive development plan.⁸⁶ It highlights the need for improved quantity and quality of healthcare services, including innovative healthcare financing that should focus on MCH services, rural primary healthcare, and strengthening township-level health financing.

The government made commitments to the Millennium Development Goals in 2000, and in 2015 Myanmar made its first health commitment, under Goal Five of the Sustainable Development Goals, which is dedicated to health. The commitment includes two deliverables, as follows:

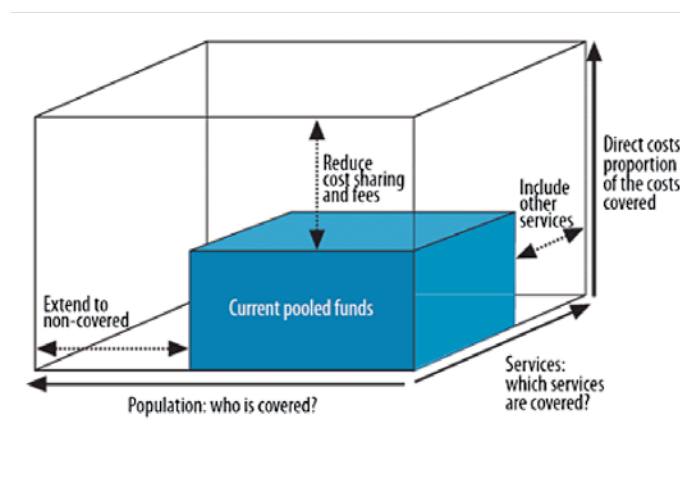
- *“Myanmar commits to ensure 80% ante-natal care coverage; 80% of births attended by a skilled attendant; 70% access to emergency obstetric care; and 80% coverage for [prevention of mother to child transmission of HIV] as well as its integration with MCH [sic].”*
- *“Myanmar will also ensure universal coverage for the expanded immunization; increase the proportion of newborn who receive essential newborn care at least two times within first week of life by 80%; increase contraception prevalence to 50%; reduce unmet need for contraception to under 10%; improve ratio of midwife to population from 1/5000 to 1/4000; and develop a new human resources for health plan for 2012-2015 [sic].”⁸⁷*

Setting goals for universal healthcare

The transition in government in 2011 was accompanied by renewed interest in achieving UHC. Several international donors are supporting this process, with a focus on funding primary healthcare, capacity building for management support, and systems strengthening. It is thus useful to frame the central agenda for reform of healthcare delivery in the southeast in terms of achieving UHC.

Health economists define three key components of UHC: (1) population coverage, (2) which services are covered, and (3) how these services are paid for. These components can be visualized as axes in three dimensions, in which the extent of coverage, percent of population covered, and costs covered extend along the axes and represent progress toward UHC. This is shown in Figure 1.

Figure 1: Three dimensions to consider when moving toward universal coverage⁸⁸



At the most basic level, any government implementing UHC needs to decide what services are provided and how to ensure that people can receive these services without having to pay an amount of money that would result in financial hardship.⁸⁹ The Myanmar government has made some progress on this thinking. In 2013, the government committed to providing free healthcare services that included childbirth, an expanded program on immunization (EPI), maternal and child health including emergency obstetric care, treatment for minor ailments, communicable disease control, and environmental health. The commitment also includes a list of essential medicines that should be free in rural health centers.

But UHC policy development in Myanmar is still at an early stage. Government officials recently prioritized strengthening primary healthcare and rural healthcare delivery capacity, collecting evidence on healthcare financing to inform policy, coordinating donor funds, and developing plans for strengthening human resources.⁹⁰ The government is still in the process of defining exactly what package of services will be delivered and how it will pay for these services. A key challenge will be delivering these services in rural, remote, and conflict-affected areas: these areas are often the last to receive UHC because of the logistical difficulties in reaching them.⁹¹

The NLD's Roadmap Towards UHC reinforced the government's commitment to UHC and gave some specifics on how it could be achieved.⁹² Broad in scope, the policy addresses determinants of health and prioritizes providing services to poor and other vulnerable populations. Significantly, the policy recognizes that other healthcare providers, including ECBHOs, have been delivering services in areas where government services were not available, and repeatedly states that these other providers could be enlisted to achieve UHC, with the MoH providing oversight and regulation. The acknowledgement of multiple providers working at local levels as contributing to national healthcare represents a type of decentralization that was not previously recognized by the government. However, it does not speak explicitly about devolution of significant healthcare responsibilities to the state/region governments as ECBHOs and other ethnic organizations have called for.

3.2: Ethnic and community-based health organizations

ECBHOs 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, mostly living in mixed administration areas and areas controlled by EAOs and including IDPs.⁹³ The combined annual budgets for ECBHOs operating in the southeast are over six million USD, with a majority of this supporting Mae Tao Clinic

operations in Thailand, which include running trainings for other ECBHOs.⁹⁴

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. Furthermore, 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.

Box 1: Overview of each ECBHO operating in southeast Myanmar

Mae Tao Clinic was founded by Dr. Cynthia Maung and other medical workers who had fled the military government crackdown against democracy activists. These medics saw a need to provide health services to thousands of refugees and exiles who were fleeing persecution and flooding into Thailand. Having fled through the jungle, many of these people had malaria and diarrhea, as well as gunshot wounds and other trauma from fighting.

In 1989, Dr. Cynthia Maung coordinated with the KNU and Thai authorities to set up a permanent clinic in Mae Sot, Thailand, to provide primary services and triage patients as needed for referral to Mae Sot Hospital. The clinic has since developed into a comprehensive healthcare facility with a primary focus on serving Burmese migrant worker populations along the Thai border as well as receiving referrals from inside Myanmar. Because of its high caseload, Mae Tao Clinic has also been the primary practical training site for medics and other health workers from ECBHOs.

According to its mission statement, "The Mae Tao Clinic (MTC) is a health service provider and training center, established to contribute and promote accessible, quality healthcare among displaced Burmese and ethnic people along the Thai-Burma border. In addition to the comprehensive services provided at its onsite facilities, MTC also promotes general health through partnerships with other community-based organizations. We work together to implement and advocate for social and legal services, as well as access to education for people living along the border." Mae Tao clinic also supports five clinics in Kayin State that serve 10,000 IDPs.

Burma Medical Association (BMA) was founded in 1991 by a group of health professionals from Burma under the exiled National Coalition Government of the Union of Burma (NCGUB). BMA has been the leading body for health policy development and capacity building for the provision of quality healthcare services in ethnic areas of Myanmar. It supports service delivery in several states in Myanmar. In southeast Myanmar, BMA supports 166 reproductive and child health workers, 131 community health workers, and 549 traditional birth attendants at 39 BMA-supported clinics. BMA's model is to support specialized health programs housed inside clinics of other ECBHOs. For example, in Karen areas, BMA manages MCH programs in KDHW, DKBA, and KPC clinics by providing training and salaries for MCH workers, supplies, and monitoring and evaluation for these programs.

The ***Back Pack Health Worker Team (BPHWT)*** was founded in 1998 by Dr. Cynthia Maung of MTC and health leaders from Karen, Karenni, and Mon states to provide health services for displaced persons in conflict areas in eastern Myanmar. The concept of the mobile health team was to train villagers to provide health services to the people in their own communities. When villages were displaced, the medics would be displaced with them, and were able to provide medical services during flight and relocation. BPHWT has more 1,352 staff, excluding traditional birth attendants, and operates over 100 mobile teams across 32 townships in Karen, Karenni, Mon, Shan, Chin, Kachin, and Shan states and Bago, Saigaing, and Tenasserim regions, targeting a population of 213,341.⁹⁵ The 100 teams include 37 stationary primary healthcare clinics' in areas of the southeast that have more stability and security.

The ***Karen Department of Health and Welfare (KDHW)*** was founded in 1956 as a line department of the KNU. Its initial aim was to provide free healthcare for everyone living in all Karen areas. In the 1970s, along with the KNU, the KDHW shifted its focus to primary healthcare in KNU-influenced areas in the southeast, and from the 1990s onwards worked together with BPHWT, MTC, and other Karen relief groups to develop the mobile health clinic model. Today KDHW serves a target population of around 190,000 people through 61 clinics, employing over 700 health workers.

The ***Civil and Health Development Network (CHDN)*** was founded after the government and KNPP's 2012 ceasefire, as a coordination mechanism for the health wings of six Karenni and Kayan armed actors, including EAOs and state-backed militia. CHDN currently operates 21 clinics and 37 backpack mobile teams in rural areas of 10 townships in Karenni and Shan states, targeting around 112,000 people. CHDN employs 292 staff who run PHC, MNCH, malaria, and environmental health programs. The largest health department in the CHDN is the Karenni National Mobile Health Committee (KnMHC), which is the health department of the ENPP, the KNPP. KnMHC was formed in 1983 to serve civilians and KNPP troops. In response to heightened conflict in the late 1990s, KnMHC expanded its operations to serve more civilians and adopted the BPHWT model of mobile clinics, establishing an office in Thailand and running cross-border operations.

The ***Mon National Health Committee (MNHC)*** is the health department of the New Mon State Party, and was founded in 1992 to provide essential healthcare services to mostly Mon IDPs in Mon State, Kayin State, and Tanintharyi Region. MNHC works primarily in the NMSP autonomous ceasefire areas in this region, and in other rural areas where the government provides few if any health services. The Mon National Health Committee has 19 clinics along the Thai-Myanmar Border and further inside Myanmar. MNHC employs 92 medics, who are responsible for providing healthcare to a target population of about 90,000 people, including around 40,000 long-term IDPs. MNHC clinics provide primary healthcare, including general care, MCH services, diagnosis and treatment of malaria, and vaccinations, to about 20,000 people per year. MNHC also has set up a referral system to a hospital in Thailand for patients that need advanced or acute care.

The ***Shan State Development Foundation (SSDF)*** is mandated by the RCSS to engage with other ECBHOs, INGOs and donors to implement social projects in its areas; the foundation is included in the RCSS constitution, but is not an official department. It was created when three Shan social services organizations, the Shan Health Committee, the Shan Relief and Development Committee, and the Shan Education Committee merged in 2012. SSDF assumed responsibility for activities and clinics previously run by the Shan Health Committee. SSDF operates a clinic in each of the five Shan IDP camps in RCSS territory along the Thai-Myanmar border.⁹⁶

ECBHOs provide care through stationary primary healthcare clinics (PHCs) and mobile teams. PHCs provide the same services as mobile teams, but they have secure facilities for storage and in which to treat patients. Clinics target a population in the geographical area that is within four to five hours walk; this population ranges from 2,500 to 10,000 people, although ECBHOs report that some people walk for several days to reach a clinic. Clinics employ from 10 to 40 staff, depending on the size of the catchment area, and they see from 10 to 50 patients per day. Mobile teams comprise three to five medics who provide MCH, medical care, and health education. Teams also include a complement of village health workers and trained traditional birth attendants. The team members live in villages in their catchment area, which comprises about 2,000 people.⁹⁷

Some of these clinics and mobile teams are interspersed with each other and also with MoH clinics, as shown in Map 2, as a result of the history of fighting and areas of control. It should be noted that the example of Kawkareik Township, shown in the map is an area where MoH has greater access overall than the ECBHOs, which explains its greater coverage. The overall distribution of ECBHO clinics and mobile teams across southeast Myanmar is shown in Map 1.

Collaboration within the ECBHO network

The ECBHOs formed the Health Information Systems Working Group in 2002 to standardize approaches to data collection and analysis and to collaborate on population surveys.⁹⁸ The HISWG serves as a clearinghouse for the ECBHOs' data, and it manages an every-five-years household survey of catchment areas called the Eastern Burma Retrospective Mortality Survey, or EBRMS, as well as smaller surveys as needed. Work continues on standardizing routine data-collection forms and protocols across different ECBHOs. The Health Systems Strengthening Project, Eastern Burma, is a consortium of the same ECBHOs that is working to standardize healthcare delivery systems in southeast Myanmar. In 2012, the ECBHOs formed the Health Convergence Core Group to develop a policy for engagement with the government and the MoH in the context of the peace process (discussed in Section 3).

Staffing and training

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 that perform advanced clinical tasks to fill in gaps created by a lack of available doctors and nurses in ECBHO target areas. 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.⁹⁹ The table below lists general clinical services (in bold, in the center column), the corresponding MoH and ECBHO staff who would perform those services (on adjacent sides of the clinical skill column), and the type of facility where those services would be delivered (in the outer columns). Most ECBHO facilities do not provide secondary or tertiary care.

Table 2: Approximate comparison of clinical services¹⁰⁰

MoH health facilities	MoH position	Clinical skill	ECBHO position	ECBHO health Facilities
Township, district, state hospital	Doctor, nurse	Secondary and tertiary care	NA	Refer to MTC, Thai hospital, or MoH
Township hospital	Doctor, nurse	Treatment of land mine and war injuries, amputations	Trauma medic	Clinic level
Station hospital	Doctor, nurse	Treatment of illness, outpatient and inpatient treatment, referral services, some severe treatment	Medic	
Rural health center	Health assistant, public health supervisor 1, lady health visitor			
		Treatment of minor illness, malaria testing and treatment, health education	Community health worker	
		Antenatal care (ANC), childbirth, perinatal care (PNC), emergency obstetric care, family planning	Maternal and child health worker, emergency obstetric care worker	

Rural health sub-center	Public health supervisor 2, midwife	ANC, childbirth, PNC, family planning, nutrition screening and referral, support for immunization campaigns	Traditional birth attendant, trained traditional birth attendant	Village level
	At village level, auxiliary midwife	Acute respiratory illness (ARI) treatment	Village health worker	
		Diarrhea treatment with zinc and oral rehydration salts	Village health worker	
		Malaria diagnosis and treatment, health education	Village health worker	
Village level	Village malaria worker, malaria volunteer worker, community health worker	Health education and patient referral	Village health worker	

Clinical diagnostic and treatment protocols specific for morbidities in ECBHO catchment areas are described in the Burmese Border Guidelines (BBG), a 300-page manual developed by MTC with support of INGOs and UN agencies.¹⁰¹ Currently in their fourth edition, the guidelines were adapted from international treatment guidelines and WHO and INGO medical protocols, with inputs from ECBHO medics. The skills needed to address morbidities described in the BBG are covered in specialized training curricula developed by MTC, BMA, and KDHW.

All cadres of health workers are trained using similar curricula. Individual ECBHOs give their own training programs for basic field staff (generally following a common curriculum), and more advanced health workers, regardless of ECBHO affiliation, are trained at MTC. Medic training programs began in 1979, and CHW trainings followed two years later, based on a curriculum developed by WHO. These basic courses have continued since, and in 2014 and 2015, Mae Tao Clinic and other ECBHOs trained about 450 health workers. KDHW and MTC are now developing training sites in Myanmar that will increase training capacity.

Medics must have previous healthcare work experience and complete nine months to two years of training. They are able to diagnose and treat malaria, acute respiratory infection, anemia, worm infestation, diarrhea, and dysentery, as well as emergency trauma cases. Maternal and child health workers are trained to perform deliveries, provide antenatal and perinatal care, give immunizations, and provide child healthcare, family planning, and emergency obstetric care. A listing of ECBHO health workers and training is provided below.

Table 3: ECBHO health workforce training

Level	Position	Duration		Experience required
		Theory	Practical	
Clinic	Public Health Institute (PHI) graduate	1 year public health curriculum		Medic
Clinic	Clinic in charge	Public health and mgmt certificates 6 months training		
Clinic	Clinical supervisor	M&E, pharmacy mgmt		Medic
Clinic	Medic, HW level 2	6 months	4 months	Community health worker
Clinic	Emergency obstetric care (MCH level 2)	4 months	6 months	Maternal child health worker
Clinic	Maternal child health worker (MCH level 1)	1 month	3 months	Community health worker
Clinic	Community health worker (CHW/HW level 1)	6 months	3 months	
Clinic	Maternal health worker (MHW)	1 month	3 months	
Mobile team	Medical care program, outreach medic	6 months	4 months	12-18 months as Community Health Education and Prevention Program medic
Mobile team	Community health education and prevention program, community health worker outreach	6 months	4 months	10 th standard education
Village	Village health worker	4 weeks	6 months	6-monthly refreshers
Village	Trained traditional birth attendant	4 weeks	6 months	6-monthly refreshers

Facing new challenges as the region evolves

The challenges of delivering healthcare in conflict-affected areas in southeast Myanmar are changing as conflict wanes. Freedom of movement has dramatically increased, enabling more monitoring and evaluation, more regular outreach services, better communication between clinics and headquarters, improved supply chains, and more stationary clinics.

ECBHOs face the challenge of making the transition to a system better suited to delivering services in a more stable security environment 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 also meant that through decades of conflict, monitoring and evaluation exercises were limited, external evaluations were nearly impossible (because of access issues), and the management system relied on senior leadership to make most major policy decisions such as fundraising, developing partnerships with other organizations, and prioritizing which major health programs to implement. The system that emerged from the conflict environment was one that could respond quickly to ongoing crises, but one whose management had little time to work on increasing efficiencies.

Security risks during the conflict caused uneven service delivery, and prevented regular travel for health workers to attend and conduct refresher trainings, immunization programs, supply and supervisory

visits to clinics (including quality improvement programs), and regular collection and reporting of health data. As such, these areas of operations are now in need of strengthening. The security risks also hindered travel for health workers to conduct public health outreach and education, water and sanitation, school health and other programs focused on prevention. During the conflict, ECBHOs did not implement these programs widely but they now have the opportunity to take such steps.

ECBHOs rely heavily on international donor funds to run their operations, although EAOs and local donors such as monasteries, churches, and business owners have paid for construction of some clinics. Finances of EAOs are not made public, and it is thus difficult to estimate what funds are or could be available for health programs, or even where those funds are sourced. In general, however, EAO health departments receive basic funding from their EAOs for central offices as well as food rations for staff and support in the field then depends on the local EAO administrations in each district or township. 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. ECBHOs have not developed health financing schemes beyond these funding mechanisms, and a sustainable long-term source of financing is needed.

HCCG policy is addressing some of these challenges; the HCCG has been developing a draft action plan for convergence that lays out a 20-year plan for cooperation and coordination with the government that addresses recognition of organizations, accreditation of health workers and financing models that include using government revenues. In March 2016 the HCCG released a strategic plan for health systems strengthening and shared it with the government, and the NLD released its roadmap to UHC, version 1.0. Policy continues to change, especially as trust continues to build and organizations refine their ideas about cooperation and coordination.

Section FOUR: The “convergence” of health systems in southeast Myanmar

When bilateral ceasefires were signed in 2012, political space opened up for increased engagement between MoH and ECBHOs. Accordingly, ECBHOs initiated a discussion about how the two systems might be able to increase cooperation and coordination by laying a policy for “convergence,” aimed at bringing the two systems incrementally closer together in line with stages of progress in the peace process.

This was a crucial development politically, and 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 to rural areas of the southeast, but they also face the challenges of strengthening their health systems, staffing, and financing. Attempts to improve coordination and cooperation will be crucial to reaching mutual health goals.

By 2014, the term “convergence” had caught the attention of multiple international development partners and featured in health strategy documents of organizations ranging from humanitarian INGOs like the International Rescue Committee (IRC), to intergovernmental banks like the World Bank, to UN agencies such as UNICEF. Convergence activities have formed a key area of programming for ECBHOs and, to a lesser extent, the MoH, with support from a wide range of international development actors.

This section looks at some of the major developments in the convergence process, and paves the way for Section 5 to provide more detailed guidance going forward. Section 4.1 gives an overview of the ECBHOs’ convergence policies, before Section 4.2 introduces some examples of convergence activities that have taken place.

4.1: HCCG convergence policy

ECBHOs began discussing convergence policy when bilateral ceasefires signed in 2012 created openings for international development actors to begin working in the region, as well as possibilities of engagement with the MoH. ECBHOs saw the need for a policy to guide how they would interact with new players, and to clarify how they believed these new players should approach healthcare delivery in their catchment areas, and they formed the Health Core Convergence Group and developed the convergence model to do this. The HCCG comprises Chin, Karen, Karenni, Mon, and Shan ethnic health organizations (departments of EAOs), and BPHWT, MTC, the National Health and Education Committee (NHEC), and BMA. These groups meet quarterly to review political developments and modify policy.

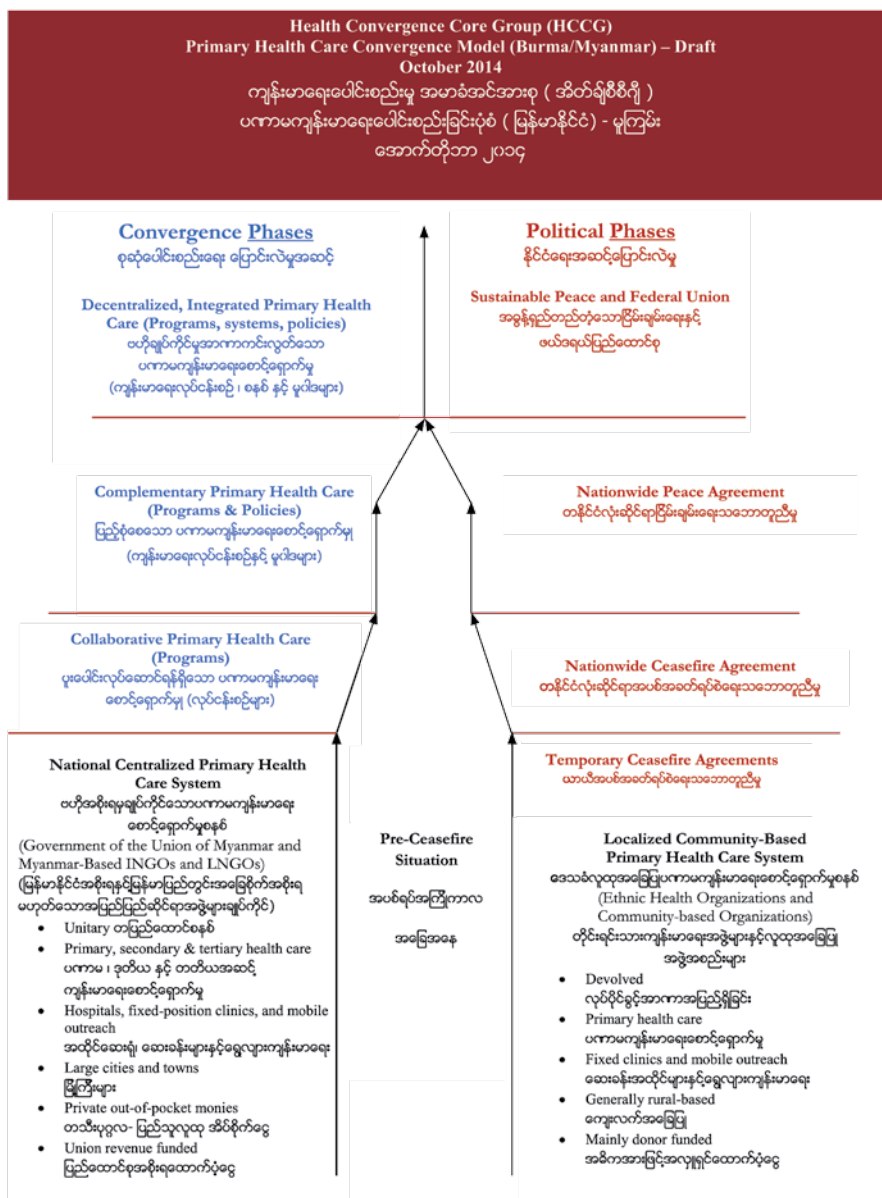
“Convergence” is defined by the HCCG as “the systematic, long-term alignment of government, ethnic, and community-based health services,” with a focus in the short term on “consultation and coordination between ECBHOs, MoH, and INGOs.”¹⁰² Through multiple documents,¹⁰³ HCCG’s policy and principles revolve firmly around the desire for a federal system of government, implying extensive devolution of healthcare responsibilities to the state/region level of government, as well as significant participation and control at the local level.¹⁰⁴ HCCG convergence principles, intended outcomes of convergence, and recommendations for other actors are displayed in Annex 1.

Despite the focus on building relations with the MoH, the HCCG’s policy and principles regarding service delivery repeatedly call for outside actors who intend to work in southeast Myanmar to support and expand ECBHOs’ existing primary health care approach.¹⁰⁵ This approach includes a plan to deliver a

package of services, including medical care (essential medicines and trauma management); maternal, neonatal, and child health; reproductive health; family planning; infectious disease control; health education and information; child nutrition; and vaccinations.¹⁰⁶ HCCG policy recommends a process of “ethnic health system strengthening” (EHSS) following the WHO’s six building-blocks approach, which prioritizes programmatic, policy, and systems-level strengthening as first steps.¹⁰⁷

HCCG policies focus to some extent on how health and political systems in southeast Myanmar are linked, and argues that the two systems can come closer together, collaborating increasingly, in line with progress in the peace process. The basic concept is illustrated in the policy’s “rocket ship” diagram in Figure 2. This incremental process largely reflects a hesitancy among ECBHOs to change their modes of operation too quickly, as the ceasefires were far from guaranteed. It also reflects the reality that neither the MoH nor the EAO health departments have the authority to start collaborating with each other at a faster pace than their respective political leaders.

Figure 2: HCCG rocket ship diagram



HCCG policy also 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 healthcare, 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.¹⁰⁸

4.2: Examples of convergence activities

This section considers seven examples of cooperation and coordination between ECBHOs and the MoH, often understood as “convergence” activities. Each of these examples offers both positive and negative lessons, which will be discussed in detail in Section 4; here a basic overview of each one is provided.

Information sharing and trust-building seminars

Perhaps the simplest but most important step in ECBHO-MoH relations has been increased engagement and sharing of information about their systems, policies, and strategies. Before the ceasefire, ECBHOs and the MoH knew almost nothing about each other, but after four years of engagement, trust and understanding have increased. Several high-level meetings between the deputy health minister, other MoH officials, and ECBHO leadership occurred in Nay Pyi Taw, Hpa-an, and Mae Sot starting in 2013, and regular meetings are now ongoing between state health directors in Kayin and Kayah states and ECBHO representatives.

Furthermore, the ECBHOs have regularly received MoH officials, particularly state health directors, at HCCG and HISWG seminars and conferences on topics such as decentralized health systems and “health as a bridge for peace,” where presentations have spurred discussions of various issues. Many of these events were also attended by the NLD’s health network prior to the party gaining power. Following the November 2015 general election, the NLD invited the ECBHOs for an information-sharing meeting in Yangon. The HCCG also engaged with civil society organizations, communities, and departments of other EAOs across Myanmar in 2014 and 2015.

These trust-building meetings are a key component of any jointly implemented activity. Leaders from BPHWT, KDHWT, and BMA suggested that continued meetings would be beneficial, “so we can better understand each other.” They explained that MoH staff initially thought of them as “quacks” for practicing medicine without a license or government training, but after several discussions of ECBHO health systems, a mutual respect began to form. Indeed, such engagements were instrumental in creating space for the other activities listed in this section.

Joint trainings

In 2013, the BPHWT collaborated with the MoH on an auxiliary midwife (AMW) training. This training was one of the earliest cooperative activities beyond meetings and consultations. Both BPHWT workers and MoH staff attended the training, which was implemented by the MoH following an MoH curriculum. After the training, AMWs returned to their villages and worked for BPHWT, but received ongoing technical supervision from an MoH midwife. Joint training on vaccination programs is discussed below.

Steps towards accreditation

Accreditation of ECBHO workers has consistently been noted as a priority in ECBHO policy statements; this would allow them to legally work inside Myanmar, and would be a sign that the MoH recognizes ECBHO capacity and thus a significant step in trust building. Progress has been very slow, however, as the previous government remained relatively silent on accreditation.

Despite hesitation from the government, the IRC facilitated a partnership between Myanmar and Thai universities that resulted in Thai certification for ECBHO workers. IRC negotiated with Thammasat University in Thailand and Magwe University of Community Health in Myanmar to use the Magwe public health supervisor curriculum to train ECBHO staff at Mae Tao Clinic and in refugee camps in Thailand. Graduates of the program would receive certificates from Thammasat University. Although graduates of the program were not officially recognized as accredited by the Myanmar MoH, the IRC felt that this was a first step towards accreditation, as the ECBHO workers who received certificates were from an internationally recognized university, and the training program was similar to one that MoH uses.

Such efforts will hopefully be boosted under the NLD government, as the party's Roadmap Towards UHC states that "a process for the recognition and licensing of existing health professionals from EHOs should be established," and refers repeatedly to the need for health workers and facilities of all types to be accredited to allow them to contribute to the "essential package of health services."¹⁰⁹

Joint trip to the USA

In August 2015, a dialogue between ECBHOs, the former government, the NLD, and Tatmadaw was convened in Washington, DC, to develop a joint strategy for the eradication of malaria by 2030. The event was organized collectively by the Institute for Global Health at the University of Maryland School of Medicine, the American Society of Tropical Medicine and Hygiene, and the Center for Strategic and International Studies. The talks included representatives from the ECBHOs, KDHW, CHDN, SSDF, and BMA. A joint statement was released stating that "success [in eliminating malaria] requires expanded cooperation among governmental and non-governmental organizations, civil and military medical expertise, ethnic health organizations, and technical and donor partners," and that "the dialogue should be carried forward urgently" in-country.¹¹⁰ Overall, the event was said by participants to be a positive step towards building trust and jointly committing to eradicate (not just control) malaria, regardless of political developments. However, one ECBHO representative pointed out in an interview that the one-off event only had limited practical potential, and that media articles trumpeting it as a big success for peace did not fully reflect the ECBHOs' difficulties in being seriously engaged by the MoH under the Thein Sein government.¹¹¹

Swiss Agency for Development and Cooperation (SDC) mapping project

In 2015, a detailed mapping of a small area of mixed health coverage was undertaken as part of the SDC-funded Primary Health Care Project Myanmar, which is a health system-strengthening program in Kawkaik Township, Kayin State, implemented jointly by MoH, MTC, KDHW, BMA, BPHWT, and KBC with support from Save the Children (SC), Christian Aid and Community Partners International (CPI). The goal of the mapping was to identify areas in the township that lacked health services, and to identify other areas where health coverage overlapped, in order to then design interventions to achieve 100 percent coverage for maternal and child health services. Collaboration and coordination between MoH and ECBHOs were instrumental to these aims.

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. The mapping process took months, as some ECBHO district-level data was not immediately available at headquarters, in addition to the difficulties with place names and boundaries. A final map was eventually developed and recognized by both sides (see Map 2).

The project funded both the MoH and ECBHOs, and encouraged collaboration and consultation on programming that would benefit population health. Multiple meetings were required for what were often seemingly minor agreements leading to limited practical changes on the ground, but this should not be surprising or disconcerting, given that the two actors have coexisted but rarely engaged in dialogue for the last six decades.

The project also supported establishment of a referral system from ECBHO clinics to MoH hospitals. This required discussions on transport and funding protocols as well as efforts to standardize medical charts that would be easily understandable by both ECBHO and MoH staff and could be sent along with patients. Multiple meetings between field staff and leadership were required to advance this process, which is ongoing.

During this project, the director of the MoH's Kayin State Health Department at the time stated that INGOs should respect ECBHOs catchment areas and activities, suggesting a rare level of formal recognition of the ECBHOs' from the state-level MoH.¹¹² ECBHOs' reported that multiple meetings and workshops with state and district-level officials, supported by the project, helped each side to understand the other's systems better, and that it has become a model for how ECBHOs would like to engage with MoH in other areas. These meetings have helped to build relationships and lay groundwork for dialogue on the UHC agenda. Nonetheless, this example demonstrates how patience on both sides and sometimes lengthy dialogue are required for meaningful collaboration and cooperation.

Joint immunization programmes in Kayin and Kayah

In 2014 and 2016, respectively, initiatives began in Kayah and Kayin states that saw MoH and the health departments of EAOs cooperate to deliver polio vaccinations to rural communities in areas previously inaccessible to the MoH.

Implementing vaccination programs is challenging in ECBHO target areas. Particularly in the most remote areas, where there are no power supplies and few roads and bridges, establishing cold chains for vaccine transport has been extremely difficult. ECBHOs have long had weak cold chain capacity and have not had funding available to deliver vaccines in a majority of their catchment areas. But today, developing vaccination programs has become a high priority; globally, over ten percent of deaths in children under five years old could be prevented with vaccines.¹¹³

The April 2012 government-KNPP ceasefire enabled the expansion of healthcare activities in Kayah State, and UNICEF made funding available for a vaccination program. As an intergovernmental body with a government Memorandum of Understanding (MoU), however, UNICEF was initially restricted to engaging only with the government, meaning it could only provide vaccines to MoH workers and could not work directly with ECBHOs. Meanwhile MoH workers were not familiar with ECBHO catchment areas in Kayah State, as they were controlled by EAOs, and MoH staff were concerned about their personal safety and the risk of upsetting the ceasefire if they travelled into EAO territory on their own to give vaccinations.

A solution could have been for CHDN to implement the vaccinations, but they were unable to receive supplies directly from UNICEF. Meanwhile, the MoH was uncomfortable handing vaccines directly to CHDN workers, as it did not know if CHDN had capacity to deliver them, and the MoH was concerned about ensuring safe implementation of the program.

The International Rescue Committee (IRC), which had been working separately with ECBHOs and the MoH, intervened. The IRC convinced state-level MoH and ECBHO leadership that if they implemented vaccinations jointly, MoH could receive supplies and health workers could collaborate in the field to deliver the vaccines. IRC would provide transport and cold-chain logistics support. Both sides agreed at the state level, but it took two years of advocacy and negotiating for permission in Nay Pyi Taw to get approval to proceed. Finally, in 2014, teams comprising ECBHO and MoH workers went into the field in Kayah and delivered the vaccinations.

This project later received some criticism from ECBHOs, because they felt CHDN staff were being treated as guides for MoH staff, who in the end physically gave most of the injections. At one HCCG coordination event, a CDHN medic said he felt like CDHN was being used as a "medical border guard

force”, referring to the Tatmadaw’s programme for converting EAOs into militia under its command. According to one CHDN senior staff member, however, this feeling of subordination arose partly because, during the implementation, CHDN staff were actually allowed to give injections but felt intimidated by MoH staff and so let them take the lead. A CHDN senior leader said that since their staff are now trained and experienced with vaccinations, they plan to implement vaccinations on their own in the future, but had been frustrated with the process of having to convince MoH that CHDN had staff capable of doing so. He said CHDN was also upset because the MoH had made initial comments that it was already able to access all the areas planned for the vaccinations, even though it clearly had not been working in those areas since the conflict began.

The same situation developed in Kayin State between MoH and KDHW: KDHW could not receive polio vaccines directly from UNICEF, and the MoH once again was the intermediary. But the MoH was reluctant to give vaccines to KDHW without assurances that KDHW staff had capacity to run a vaccination campaign. With lessons learned from Kayah, IRC again intervened, but this time supported the MoH to train KDHW staff on vaccinations. After delays in receiving government permission to give the training, KDHW staff went into the field in late 2015 with IRC cold-chain and transport logistics support, but without MoH staff. In this adapted model, MoH assured itself that KDHW workers could implement the vaccinations by training them, while KDHW staff retained full ownership of the field implementation in their long-established area of authority.

The barriers to vaccinating children that were overcome in this example included strict requirements that prohibited transferring vaccines from an international organization to ECBHOs, the consequent need to obtain Myanmar government permission for the collaboration between MoH and ECBHOs, and the fact that even though ceasefire agreements have been signed, EAOs still control areas of southeast Myanmar in which government services are not officially welcome. This example illustrates the importance of understanding the dynamic between EAOs and the government, and of being flexible with funding mechanisms to accommodate this relationship.

Response to a cholera outbreak in 2015

This example, which looks at the emergency response to a cholera outbreak in 2015, highlights how a crisis may require coordination between both systems, but also underscores the challenges posed by restrictions on direct support to ECBHOs from international agencies. Importantly, these challenges were overcome, providing key lessons on how agencies and field staff can navigate these issues successfully.

In late 2015, KDHW identified an outbreak of diarrhoea in Kayin State in the region just north of Three Pagodas Pass. Some patients were referred to the closest hospitals, in Thailand, where the Thai Ministry of Public Health (MOPH) confirmed the presence of cholera. KDHW deployed interventions from their headquarters in Mae Sot, Thailand, as well as from their office in Hpa-An. The cross-border team was supported by Solidarités International, Partners Relief & Development, Free Burma Rangers, and Thai MOPH, and coordinated activities with staff from the BMA and BPHWT, who also had teams based in the area.

Coordination from the teams based inside Myanmar was more complicated. The Hpa-An KDHW team requested help from the UNICEF Mawlamyine office, but did not want to rely on the MoH or give MoH staff access to KNU territory, which might often be necessary when receiving support from a UN agency like UNICEF. After consideration, UNICEF headquarters in Yangon agreed to give more direct support, and they brought in an INGO, Première Urgence - Aide Médicale Internationale (PU-AMI), as a third-party contractor to provide field staff. This avoided having UN staff working directly with ECBHOs and upsetting the government.

Informing the government was still important, however, to get approval for international organizations

to work with ECBHOs, and to give the government itself an opportunity to respond to the outbreak. UNICEF contacted the WHO representative in Yangon, who, after some time, spoke with officials in Nay Pyi Taw. But KDHW leaders assert that WHO did not respond. UNICEF's southeast Myanmar office in Mawlamyine also contacted the MoH's Kayin State health director and obtained a verbal "non-objection" for the intervention plan. (A written non-objection could not be obtained, as the director, probably for unrelated reasons, was transferred to another posting two days later, and immediately approaching his replacement on such a politically sensitive matter would have been too difficult.) KDHW obtained permission from KNU for the intervention, and also invited the MoH's Kayin State health director to send a representative to the intervention area, but that offer was declined. A KDHW senior leader reported that the MoH had been reluctant to engage in the process, possibly because it was just before the election, he thought, or possibly because the refusal of past military governments to acknowledge cholera in Myanmar made this a sensitive topic with the MoH.

PU-AMI trained KDHW staff for cholera response and also provided medicine, epidemiology analysis, hygiene kits, and financial support, and by November 2015 the outbreak was under control. PU-AMI, UNICEF, and KDHW are now continuing water, sanitation and health (WASH) programs in the area. This campaign was a major achievement, successfully coordinating responses from inside Myanmar and Thailand, and engaging with the government, the UN, and INGOs, with at least tacit approval from the MoH. As in the vaccination example, delays were encountered, because international actors needed permission from Nay Pyi Taw, the MoH state health director, and KNU to move forward. The response could have been faster if less coordination were required.

Section FIVE: Assessing convergence and identifying steps forward

This section provides analysis and guidance to help government, ECBHOs, and international aid actors develop strategies for increasing cooperation and coordination going forward. Each subsection provides analysis of the challenges and gives actionable recommendations for various stakeholders, which are then consolidated in Annex One. It begins in Section 5.1 by suggesting an overall framing for understanding and approaching convergence, focusing primarily on the challenges of improving health equity, rather than on political aims. Section 5.2 then discusses a number of notable obstacles to building trust and increasing cooperation that will need to be overcome. Section 5.3 outlines some key areas where increased coordination and cooperation will be particularly necessary or beneficial to improving health outcomes. Section 5.4 then explores a few trends towards problematic conceptions of convergence, particularly among international aid actors, and suggests why such approaches might be unhelpful.

5.1: Finding the right framing for “convergence”

“Convergence” has different meanings to different actors. Although the HCCG has laid out detailed policies on its views of convergence, these sometimes leave a lot of space for interpretation. This subsection puts forward an original framing for the concept of “convergence” and provides broad recommendations for how government, ECBHOs, and international aid actors should understand and approach it.

It is the view of the authors of this report 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 prioritized, planned, and evaluated based on what will achieve equitable services in ECBHO and MoH catchment areas, rather than what will improve political relations or advance the peace process. Inevitably, however, such an approach will still depend 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, and with it international and domestic 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. The MoH needs to expand services and train new staff, while at the same time improving quality in every component of the health system and managing ever-increasing budgets. This scaling up of services will be done on a national level, making service delivery in southeast Myanmar just one of many priorities. 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 in engaging in wider reform efforts. ECBHOs use local human resources, which helps to circumvent language and cultural barriers and increase trust among the local population. 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 be primarily about enhancing coordination between these systems, in order to ensure equitable delivery of services, and to maximize their complementarity by reducing overlap and gaps in services, and avoiding counter-productive strategies. The main areas where such collaboration is most needed are discussed in Section 5.3.

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. Assumptions about the relationship between convergence and peacebuilding as well as 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 in southeast Myanmar poses 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 examination of staffing levels and rates of health worker training in Sections 3.1 and 3.2 suggests that neither the MoH nor ECBHOs will be able in coming years to deliver healthcare on their own to everyone 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.¹¹⁴ As discussed in Section 5.3, efficiency of services in southeast Myanmar could be improved with consultation and coordination on patient referrals, areas of coverage, and joint trainings, among other measures.

For the government, this involves a shift in thinking about its responsibilities as a state. While it has the absolute responsibility to ensure that every man, woman, and child has sufficient access to adequate healthcare, the state is not – and need not be – the only health provider. Indeed, the private sector is already assuming a huge portion of that burden in Myanmar. Rather, the state needs to create the right policy and legal framework to ensure that people have access to services of the highest quality, and as affordably as possible. In this light, ECBHOs should be seen as crucial partners in achieving UHC, due to their unique resources, experience, and territorial access. Furthermore, hundreds of thousands of people currently known to lack state healthcare could be correctly recorded, allowing the government to better monitor actual progress towards domestic and international development targets. The overall strategy for reaching universal health care in the NLD’s Roadmap Towards UHC is largely consistent with this strategy, and demonstrates a very positive shift towards a more decentralized approach to ensuring that healthcare is provided to all through multiple providers.

ECBHOs also should ensure that their own convergence policies and efforts are conceived first and foremost to achieve health equity. This involves continuing to develop health strategies and approaches that enhance their unique capacities to reach rural populations, while pursuing all options to increase their complementarity to the government system wherever it would serve beneficiaries. ECBHOs should understand that the government now has at least a partial democratic mandate from the people, who expect the government to serve their interests. Therefore, ECBHOs should respect the legitimacy of the MoH as the country’s primary provider of healthcare, despite the crucial role that ECBHOs continue to play in providing specialized services to hundreds of thousands of people in particular conflict-affected areas. As the MoH now has this legitimacy, as well as a much wider mandate, geographical area, and array of services, ECBHOs should appreciate that aligning their own strategies, targets, and approaches with those of the government will sometimes be the most practical approach, with no implication of inferiority.

For international actors supporting the development of health systems, this requires a slightly different interpretation of some key development principles. The Busan Partnership and the New Deal frameworks, among others, all emphasize the need to support country-owned (generally government-owned) development strategies. This is seen as critical to avoiding the establishment of parallel

systems by international aid actors themselves. In contexts where there are multiple governance actors, however, and where the legitimacy of various authorities is contested, development strategies must be more broadly country-owned, as government-only agendas can be impractical on the ground, and can have negative effects on the political environment. 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.

Development actors therefore should challenge conventional thinking on development, including the widely-held perception that non-state armed groups are spoilers in the development process, or are unable to support state building.¹¹⁵ Although this is often true, it is not always the case: there are precedents from India, the Philippines, Syria, and Ethiopia that non-state armed groups can play positive roles in development and social service provision.¹¹⁶

Southeast Myanmar may require an alternative model of development because of the presence of multiple governance actors. Fighting has greatly reduced, but EAOs still maintain governance roles throughout much of the region, and the Myanmar government does not yet enjoy legitimacy in the eyes of local people in some areas. The government is a development actor, but it is also a party to past and current conflict.¹¹⁷

Ideally, the peace process will eventually be able to define the roles of the state and EAOs in governance more clearly. However, “interim arrangements” to this end in the nationwide ceasefire agreement (NCA) are still vague, and many EAOs have yet to sign the deal (see Section 5.2). Until such arrangements can be formalized, the most conflict-sensitive approach to delivering assistance in southeast Myanmar is to support both the government and EAOs, in an unbiased way, to the extent that they are able to deliver quality healthcare in the most efficient way. Several large donors and multi-donor trust funds are already adopting this balanced approach, and it is crucial that all donors working in rural and remote parts of southeast Myanmar follow suit.

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. As the government increases its budget commitments to health, the international community undoubtedly can play a crucial role in enhancing these commitments and providing technical assistance to MoH. At the same time, however, ECBHOs are particularly reliant on donor funds, and should be considered particularly high-value health partners, as they can reach vulnerable populations at relatively low cost and have the potential to connect such 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 to maintain and improve the care available to these populations, but also to ensure readiness for a potential return to conflict.

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

- This involves developing the right policies and practices to enhance the role of ECBHOs and enable them to continue providing quality services, as covered in later recommendations.

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

- Given the increased legitimacy of the NLD-led government, ECBHOs should recognize the formal mandate of the government to oversee the development of the country’s health sector, and of the MoH to be the main provider of health services in the country.

- Given the MoH’s much wider mandate, alignment of ECBHOs strategies and targets with those of the MoH could be of great practical benefit, and would not imply inferiority of ECBHOs.

International aid community recommendation #1: In the near term, supporting both MoH and ECBHO systems is necessary, both politically and programmatically, 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.

- This requires donors to adjust conventional approaches to development that focus solely on government-owned agendas, and to support the approaches of both MoH and ECBHOs, while helping them to align where beneficial for achieving equitable healthcare.
- These efforts should be driven by a bottom-line interest in reaching as many people as possible with quality care, particularly the most vulnerable and poorly served.
- Donors should recognize that, in today’s political climate, ECBHOs are particularly reliant on donor funds to maintain services to these populations, but represent relatively low-cost interventions.
- Donors should pursue a systems-strengthening approach, through long-term partnerships between appropriate technical partners and ECBHOs, rather than a fund providing project-by-project commitments.
- Such instruments could take the form of dedicated components within single-donor and multi-donor health strategies.
- These instruments should be developed following deep consultations with ECBHOs and study of their existing structures.
- Technical agencies that already have well established, trusting relations with ECBHOs should be given priority for such programs.

5.2: Overcoming barriers to cooperation and trust building

Assessing the current status of convergence efforts and envisioning best steps forward will require, first of all, an appreciation of the difficulties in building trust and achieving greater cooperation and coordination between the two systems. As the NLD’s Roadmap Towards UHC states, “Critical will be to establish a process of constructive dialogue and confidence building.”¹¹⁸ This section explores the main hurdles in this area, and recommends concrete steps that can be taken to build trust between the government and ECBHOs.

The need for formal recognition of ECBHOs

Mistrust between ECBHOs and the MoH stems from decades of civil war. ECBHOs’ experiences working in conflict areas, and reporting on human rights violations, have generated deep skepticism of the central government and military, which remains today.¹¹⁹ The state, on the other hand has seemingly viewed ECBHOs in the long run as extensions of armed and exiled opposition movements.

In particular, a lack of legal recognition of ECBHOs as health providers, as well as 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 the risk of arrest, but MoH staff cooperating with ECBHOs have run the risk of being punished by their supervisors or other agents of the government. The Unlawful Associations Act, though not currently enforced against health workers, is still law in Myanmar. The Act was used as recently as April 2016,¹²⁰ and at least 50 people (though not medics) have been arrested under it since 2011.¹²¹ Lower-ranking MoH staff are aware of this, and may not feel secure meeting with staff from ECBHOs without explicit permission from Nay Pyi Taw. This creates a barrier to regular consultation among field-level staff.

In negotiations for a nationwide ceasefire agreement, EAOs pushed consistently for “interim arrangements” to comprehensively recognize their roles in governance and to ensure their autonomy in providing development and other services in the period prior to a political settlement of the conflict. This, they hoped, would include formal recognition of their health departments and the services they provide. Failing to reach a full agreement on this, the final text provides loose recognition of their role in healthcare, among other sectors, while emphasizing their need to cooperate with the government in such activities.

The text first states that the Tatmadaw and EAOs shall work in consultation with one another to “improve livelihoods, health, education, and regional development for the people.”¹²² It later states that “the ethnic armed organizations that are signatories to this agreement have been responsible for development and security in their respective areas,” and that prior to a political settlement, signatories are, “in consultation with one another,” to undertake “projects concerning the health, education, and socioeconomic development of civilians.”¹²³

While this provides a basic formal mandate to the signatories that could protect 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 nationwide ceasefire agreement, so they hinge on the political status of groups, rather than on what is best for the provision of health services.

Building meaningful, trusting relationships will be a long, difficult process that is discussed throughout the remainder of this report; however, a crucial first step forward would be for the government to unambiguously recognize the role of ECBHOs in providing health services in their communities. The NLD’s Roadmap Towards UHC represents a key advance in this direction, frequently referring positively to the roles of “ethnic health organizations.”¹²⁴ The government should solidify this recognition, by making clear reference to ECBHOs and their roles in legislation, or by issuing a presidential notification. At the very least, such recognition should be stated in formal MoH policy.

Such steps will be important in navigating barriers imposed by the Unlawful Association Act, but, even more so, as a sign of respect for the capacity of ECBHOs and their staff. This is needed to dispel stereotypes spread by military governments that ethnic groups are inferior and need the central government for support. These stereotypes, developed decades ago, still play out in the attitudes of some MoH staff, which creates tension at meetings and other joint activities.

Such provisions would ideally state that ECBHOs (or another term agreed on by the groups themselves) are important providers of health services in the country; that they can receive funds from local and international sources (including government, to allow for that possibility in the future); that MoH should coordinate its activities with ECBHOs when operating in areas where services overlap; and that the government should consult EAOs on matters of health policy and strategy. Such a law would not need to be overly prescriptive, and it would ideally allow some room for interpretation by relevant government bodies that will need to cooperate with ECBHOs on the ground.

Such efforts should be seen as first step towards NLD’s longer-term aim of accrediting, licensing, and establishing oversight over ECBHOs. At this stage, however, for the sake of peacebuilding and as a show of good faith, no special registration process should be required for ECBHOs to be recognized

as existing providers of health services. This would also create space for the MoH to cooperate with health networks linked to EAOs even in the absence of formal relations, as might be necessary, for example, in an emergency. Crucially, it should apply to all significant providers of health services, and should not be restricted to those connected to NCA signatories or to any other political category.

Nonetheless, ECBHOs should also appreciate that the NLD-led government has a democratic mandate to govern, giving the state greater legitimacy than in the past. It would not be unreasonable for this government to initiate and encourage a process of formal registration to establish a basis for basic regulation of health providers, as will likely be necessary for full accreditation. Indeed, the NLD's March 2016 health policy frequently mentions the need for independent accreditation of all types of health providers, stating that, while ethnic health organizations will be critical to maximizing coverage, "this will require strengthened regulation and oversight (including, for example, accreditation and licensing), and the adoption and enforcement of common quality standards."¹²⁵ The need for greater cooperation in moving toward accrediting ECBHO health workers is discussed in Section 5.3.

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

- Based on terminology mutually agreed to with the groups.
- Stating that ECBHOs are providers of health services.
- Stating that ECBHOs may receive funds from government, domestic and international aid actors, and local communities.
- Stating that MoH should cooperate and coordinate with ECBHOs in areas of overlapping coverage.
- Stating that MoH and other government bodies should consult ECBHOs on national health policy and related strategies and reforms.
- Requiring no specific registration process, but providing a more formal recognition of the status quo that ECBHOs exist as important providers of healthcare.
- Applying to all significant providers of healthcare, not just those connected to NCA signatories or to any other political category.
- This should be seen as a first step toward providing ECBHO health workers with accreditation and licensing and establishing greater government oversight, in line with NLD policy (see Section 5.3).

The need for greater government commitment to cooperation with ECBHOs

ECBHOs and the MoH see convergence differently. For ECBHOs, convergence is a central component of their policy and planning for the future. On an almost daily basis they are confronted with ceasefire developments, donor pressures, and new INGO partners, and they are constantly assessing the risks of modifying their health systems to operate in peacetime while a return to conflict is still possible. ECBHOs still have many reservations and much skepticism about the MoH, as discussed in subsequent sections, but on the whole, they have placed a huge stake on building relations with the government, and they remain committed to continuing engagement.

For the MoH, however, convergence with ECBHOs is one of a myriad of challenges the ministry is facing, 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. The MoH also faces challenges working in areas where the Tatmadaw and the Tatmadaw-controlled ministries of Border Affairs and Home Affairs

are strong and may not have interests that are directly aligned with those of the MoH. Thus, for the MoH, convergence has largely been seen as a medium- to low-priority activity that carries the risk of upsetting the military unless executive action is taken to establish an institutional commitment.

While the ECBHOs have a formal policy and an agreed-upon institutional direction for engaging 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 become formally institutionalized.

Where there have been successes in coordination and cooperation between MoH and ECBHOs, these have usually depended on concerted engagement by ECBHOs with specific individuals within MoH. Individuals in the MoH, such as the former deputy minister and numerous state health department directors, have reached out to ECBHOs, met with them, and encouraged learning for both groups. But other individuals have been openly hostile to ECBHO staff, and in multiple cases, decisions needed from Nay Pyi Taw to allow for increased consultation and collaboration have been delayed.

This problem is made worse by the consistently high turnover of MoH staff, which was a key characteristic of many government departments under successive military regimes, intended to keep decision-making power centralized and local-level officers focused on central-level priorities.¹²⁶ Kayin and Kayah States have each had three state health directors since the 2012 bilateral ceasefires were signed, and township medical officer turnover in most townships is just as high. Meanwhile, it usually takes MoH officials a long time to become sensitized to the ECBHO system. Particularly when higher-level MoH officials are replaced, the trust-building process must start anew.

The new government should therefore take steps to develop a clearer policy for the MoH's convergence with ECBHOs, and ensure that engagement with ECBHOs is a clearly understood responsibility for ministry staff at the appropriate levels. Such a policy should aim to fully institutionalize MoH's relations with ECBHOs, so that engagement does not depend primarily on personal relationships. The NLD's Roadmap Towards UHC provides an encouraging starting point for initiating such a policy, with frequent references to the need to engage ECBHOs and establish a "communication and coordination mechanism." Such a mechanism should certainly be established, and could consist of both Union-level and local-level bodies, as appropriate. 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.

- Ensure that staff at all appropriate levels are properly briefed on the importance of engaging with ECBHOs.
- Develop a set of priorities and protocols for engaging with ECBHOs, and task staff accordingly.
- A "communication and coordination" mechanism, as advised in the NLD's Roadmap Towards UHC, should certainly be established, and could include Union-level and local-level bodies.

Government recommendation #4: Develop and implement policies that will:

- Keep TMOs and basic health staff in positions for longer periods of time,
- Establish multi-year terms for state health director positions, and
- Encourage the appointment of people to these positions who are willing to serve their full terms.

Uncertainty in the peace process among ECBHOs

Their trust in the government is increasing, but not enough time has passed for ECBHOs, their networks, and their target communities to forget lessons learned in 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 to do it on their own terms and their own timeline.

ECBHOs' confidence in the peace process and democratic reforms is a central determinant of the extent to which they are willing to engage with the government. Perceptions of these processes vary by organization. Relationships between health departments of EAOs and MoH often depend on relations between that EAO and the government more broadly: KDHW has been willing to engage more closely with the MoH since the KNU signed the NCA, while MNHC has had little interaction with MoH, per instructions of NMSP. Although the Karenni and Kayan EAOs have not signed the NCA, CHDN regularly meets with MoH officials. Health LNGOs like MTC, BMA and BPHWT are less influenced by EAO policy; BMA and MTC leaders said the actions of the NLD government – especially how it engages with ethnic groups – will influence their decisions on how closely to engage with the MoH. These leaders said that although they have had positive interactions with high-level officials in the former government, they do not want to be forced to trust individuals, and are ultimately calling for systematic government change, per HCCG policy, to a decentralized MoH and a federal system of government before they attempt full integration into government.

As time passes and ECBHOs and the MoH better understand each other, trust will continue to increase. The mistrust and risk of a return to conflict are real, however, and because of this, ECBHOs want to avoid reliance on the government (and therefore MoH) until they are confident that a durable peace has been reached.

There are examples of some international aid actors pressuring ECBHO operations to be run and funded from central Myanmar, requiring them to adopt different lines of supply and open new offices in Myanmar towns. BMA and MTC senior leaders said they were reluctant to stop cross-border supply lines and source their medicine and equipment in Yangon. This might sometimes – though not always – be financially and logistically easier than securing medicine in Thailand and transporting it across the border. However, if fighting broke out again, ECBHOs' supply lines would be ruptured and it would be hard to quickly revert to cross-border operations. Some groups have opened new channels through Yangon while keeping the old cross-border channels open. Meanwhile, remote areas along the border, and especially those without solar cold chains, are in fact easier to supply from Thailand, because transportation infrastructure is more developed in Thailand. Furthermore, there remain some EAO-controlled areas where local authorities refuse to allow supply lines to be opened from the rest of Myanmar, and only permit cross-border aid. Drastically changing lines of supply will not be possible until ECBHOs and their associated EAOs feel secure with the peace process. ECBHOs are also reluctant to commit to long-term programs or channels of financing that might be disrupted or cause them increased risk if conflict were to resume.

Therefore, ECBHOs have preferred a step-by-step approach in which they are able to assess the conflict situation at each step of implementing a project and to delay or alter implementation if they feel risk is unacceptable. Development actors have expressed frustration at this sometimes seemingly noncommittal attitude of ECBHOs and the potential for delays this creates in implementation of projects. But development actors should respect ECBHO perceptions of risk to their operations and work with ECBHOs to design conflict-sensitive interventions, such as ones that allow ECBHOs to manage their own risks if fighting should break out. 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.

- Understand that ECBHOs will need to maintain cross-border activities as well as increase activities implemented from bases inside the country to maintain access to their target populations.
- Help ECBHOs to design systems and project plans that let them manage potential risks and improve the overall resilience of their systems to future shocks and crises.
- Basic conflict sensitivity frameworks could help to ensure that log frames are flexible and can be adapted to political developments or the emergence of new risks.
- As a basic principle, channels of support to ECBHOs should help them exploit new opportunities for improving services in the context of ceasefires, while ensuring that they are prepared to respond to future emergencies or protracted conflict situations.

The politics of healthcare expansion

Another challenge to building trust is the push from both the government and EAOs to expand the catchment areas of their systems. Although the MoH and ECBHOs remain primarily focused on health, they are still influenced by EAOs, Tatmadaw and other government bodies such as the General Administration Department, which take a more aggressive approach towards claiming territory. With ceasefires signed, the government and EAOs, restricted in their ability to use combat troops to mark territories, have in some cases resorted to doing so more subtly through provision of social services, including healthcare.¹²⁷

ECBHOs, human rights groups, and women's groups have complained of new government clinics and schools being built in contested areas and in areas controlled by EAOs, and fear that this could trigger conflict and continue to create mistrust.¹²⁸ Referring to such expansion, a senior leader at the Karen Women's Organization (KWO) said, "As civilians, we feel like we are still being invaded by the government."¹²⁹ The concerns of EAOs about this issue were examined in Section 2.2. As argued in The Asia Foundation's 2014 study, "Ethnic Conflict and Social Services in Myanmar's Contested Regions," government expansion of social services has the potential to damage confidence in the peace process by undermining EAO social service structures and, in the longer term, to usurp ethnic people's aspirations for autonomy and self-determination.¹³⁰

ECBHOs are also planning to expand coverage into areas where the delineation of authority remains contested, and re-establish clinics in areas that they were forced to evacuate after Tatmadaw offensives in the mid-2000s. Senior leaders have said they feel it is still their responsibility to deliver health services to the people in these areas, per their organizations' missions and visions.¹³¹ For example, as one ECBHO leader explained, "The Tatmadaw took over much of [southern Kayin State] in 1996... and now has troops all over that area, but failed to establish its rural health centers there. We don't want government to serve our people; we still want to serve those areas if we can." But a push for more clinics could easily outpace the rate at which health workers can be trained, and appropriate systems developed, to support these clinics. Therefore, it risks reducing the 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 were competing for territory.

The territorial claims of EAOs and government are extremely fluid, and ceasefires have failed to establish clearly demarcated territories. As a result, health coverage inevitably continues to overlap substantially. If the two systems can coordinate more effectively, then resources can be best used to ensure maximum quality of coverage.

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 work together to demarcate their territories or agree on 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. This is important for preventing mistrust and reducing the risk of triggering conflict, as well as ensuring equitable coverage of services.

A “communication and coordination” mechanism, as recommended in the NLD’s Roadmap Towards UHC, could be used to address these issues of coverage. Ideally, such a body could be mandated by both the government and EAOs to formally engage in discussions about catchment areas for health services, and be empowered to make final decisions. However, it might not be realistic 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. Indeed, if overlap gives communities more choice and ability to receive whichever services they prefer and most trust, this could stimulate improved quality overall. Such mechanisms would likely be best organized according to geographic area, and could be at the state/region, district, or township level, depending on the density of service providers in a given area. Section 5.3 discusses particular areas of operations that should be prioritized for increased coordination.

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.

- The use of social services to define territory risks politicizing these services and shifting the focus from equity and quality of services to a race for territory.

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 enable regular, formal discussions and decision-making about catchment areas for health services.

- This mechanism could consist of state/region-, district-, or township-level committees or forums, depending on the density of service providers in a given area.
- This mechanism should be focused on achieving health equity as its central aim, and would ideally be mandated to make final decisions on such matters, rather than requiring members to negotiate with associated political actors.
- Government and EAOs should empower state and local-level officials to make final decisions regarding coordination of health activities in their areas without seeking approval from Nay Pyi Taw or EAO senior leadership.

5.3: Key areas for convergence activities

In addition to the core areas of relationship building described in Section 5.2, there is a range of areas for convergence activities that this study identified as of particular value and importance. The degree of progress already achieved in each of these areas varies considerably. This section provides an overview of these areas, which 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

become possible. In the meantime, continued information sharing on various levels between ECBHOs and MoH is of great importance to building trust and understanding, and ECBHOs and MoH could undertake independent data collection to better prepare for such joint exercises.

Sharing information, particularly data on coverage, will be critical to building cooperation towards UHC. Joint mapping exercises, in particular, could become increasingly useful for identifying areas of no coverage, avoiding overlap and duplication, identifying opportunities for joint projects and programs, and building strategies for reaching the most underserved.

In the SDC mapping project in Kawkaik township, Kayin State (see Section 4.2 and Map 2), the clinic and catchment area mapping exercise was necessary to identify areas of no coverage. Ultimately, the project was successful in developing maps and other key datasets that, in fact, showed a number of areas of overlap rather than areas of no coverage. Joint mapping and data collection activities of this kind could be expanded to other areas, and provide the bonus of promoting trust, cooperation, and understanding through active participation in learning about the other system.

However, a key lesson from the SDC project was that, due to an initial lack of available data, data collection consumed several months and delayed the design of health-strengthening interventions, because it was not yet known if and in what ways adjustments in coverage were needed. If this initial mapping work had been done by ECBHOs and MoH in advance, project delays would have been reduced. Though the mapping delays were unavoidable in this project, mapping exercises done now in other areas could help to prevent delays in future projects. Therefore, data collection activities, even if they are done separately, will help future coordination efforts, and should be seen as important convergence activities.

ECBHOs have expressed interest in securing international assistance for implementing rigorous mapping of clinics, catchment areas, and village-based workers, and also for clinic assessment programs, so that they can have data ready to share quickly with the MoH when the timing is appropriate. Furthermore, as trust in some areas still remains too low for full sharing of information, data generated by these activities would not need to be shared until ECBHOs or MoH were ready, thus reducing the risk of creating insecurity, and perhaps speeding the data collection process.

Mapping coverage is a difficult and time-consuming process in southeast Myanmar. Boundaries of states and townships defined by the Myanmar government are different from those of EAOs, and villages have names in Myanmar language, in local languages, and sometimes in English, too. This can make it difficult to communicate clinic locations and catchment areas between MoH and ECBHOs, or to determine which players should be involved in MoH township health planning activities. For example, one township defined by the Myanmar government may cover parts of three KNU townships. This creates challenges for health planning; where it is attempted by the MoH at the township level, it requires the participation and coordination of multiple township-level leaders from ECBHOs. Additionally, ECBHOs have been reluctant to share maps (or even make them) and population data, for self-protection during the conflict. Protecting villages from attacks, extortion, or forced labor was easier if the Tatmadaw did not know where the villages were or how many lived there.

Less intricate information-sharing activities and seminars, like those hosted by HCCG numerous times, and by NLD in December 2015 (Section 4.2), should also be continued to further trust building, and should be recognized as worthwhile convergence activities. Indeed, most forms of cooperation so far have been looser engagements where general overviews of operations, strategies, and visions are shared. Further policy research to help each side learn how the other system is organized would also promote collaboration. As noted in Section 3.2, senior ECBHO leaders commented that meetings helped to dispel negative stereotypes as well as create understanding of the structures and staffing of each health system.

International aid actors should continue to support these kinds of activities, and donors should recognize such engagements as worthwhile convergence activities in light of the longstanding mistrust that needs to be overcome. MTC and BMA leaders said that some donors expressed frustration to them that not enough cooperative activities were taking place and that mere meetings were not making enough progress toward joint activities. MTC and BMA leaders have remained certain that more meetings are needed so the MoH and ECBHOs can continue to learn about each other's systems, policies, catchment areas, and needs, and continue to build trust before more joint activities can take place.

In particular, such activities could be used to begin discussions around alignment of health strategies and targets. For example, to develop a common vision for UHC, government and ECBHOs could develop a common view of what package of services which demographics should be entitled to and at what – if any – costs. As noted previously, given the much wider mandate of the MoH, and the growing political legitimacy of the government, ECBHOs should make efforts to align their strategies with national strategies in cases where this does not contradict their core values and principles. This would provide a stronger basis for cooperation and would likely make it easier for donors to build instruments aimed specifically at strengthening ECBHOs, with specific targets in mind.

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.

- In some cases, undertaking such activities separately will increase preparedness for future forms of engagement.
- Joint coverage mapping activities have been slow to initiate due to lack of existing information, but have also been useful for trust building and cross learning.

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

- The NLD-hosted event in 2015 was a good first step, and future ones formally hosted by government could be highly beneficial.
- Particularly if there are logistical hurdles to engaging all relevant actors in concerted “communication and coordination” mechanisms, looser information-sharing activities could be a useful way to build initial trust and understanding.
- In particular, such activities could be used to begin discussions around alignment of health strategies and targets, for example, towards UHC.

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

- This could include supporting separate and joint activities, such as mapping, health systems assessment, and policy development, that will facilitate cooperation in the future.
- This could also include support for seminars and information-sharing conferences aimed at providing basic understanding and building trust.
- Meetings that focus on information sharing, mapping, and other activities that would facilitate future cooperation and health equity should be considered legitimate convergence activities in terms of indicators for donor reporting.

Countering infectious diseases

Coordination is required to combat diseases like malaria and lymphatic filariasis, transmitted by mosquitoes, that are not isolated in geographic areas. Mosquitoes can easily spread malaria across different health catchment areas and international borders, for example, potentially re-introducing it into areas where it has been eliminated. Interventions to control these diseases thus need to be implemented across wide geographic areas. These programs require coordination of 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 2012,¹³² 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.

The August 2015 dialogue in Washington, DC, provided a limited space for discussion of the topic, and led to a rhetorical commitment to cooperation. Perhaps more comprehensively, the Karen Department of Health and Welfare and other ECBHOs have long been working with the Thailand-based Shloko Malaria Research Unit and a range of INGOs, LNGOs and community-based organizations in a malaria taskforce that has engaged with the Thai health authorities in various capacities for many years.

ECBHOs and MoH could continue to conduct clinical and village-level malaria control activities separately in their own target areas. But cooperation is needed to ensure that malaria diagnosis and treatment services are available in all areas, to collect and share epidemiological data for more robust analyses, and, if needed, to facilitate procurement and transport of lab and drug supplies to remote areas.

Patient referrals from ECBHOs to MoH facilities

Coordination is also required to ensure that patients treated at some 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, to clinics in refugee camps, or to Thai hospitals. Many ECBHO clinics are located along the Thai border, and this was logistically easy to do. But for clinics located further inside Myanmar, referring to Thai-based clinics has been difficult due to travel costs and time.

The ceasefire and subsequent lifting of restrictions on movement in the southeast created opportunities to refer patients to MoH hospitals in addition to Thai-based facilities. MoH facilities are more easily accessed by ECBHO clinics far from the border. The ceasefire has increased access to advanced-care facilities, and created an opportunity for timely referrals to be given to patients in some areas for the first time. Developing referral systems to MoH hospitals will become increasingly important as the impending closure of refugee camps in Thailand, along with the clinics serving those camps, threatens to remove these options for advanced care for people living inside Myanmar. Several projects with international support that are focused on obstetric referrals are ongoing in southeast Myanmar, but detailed information on these initiatives and the challenges they face was not collected for this study.

The NLD's Roadmap Towards UHC repeatedly refers to the need to strengthen referrals between different types of providers, including EHOs, and states that "legal and political barriers are partially responsible for the reluctance of EHOs to refer patients to public facilities."¹³³ This acknowledgement is very encouraging, and should be adopted as a key area for improvement of coordination between the government, ECBHOs, and MoH.

Specific challenges include standardizing reimbursement for transport, and establishing mechanisms for clinical payment as the MoH transitions from a fee-for-service model to one that covers basic services for free. In addition, the systems will need to develop mutually compatible 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.

- These issues could be addressed through “communication and coordination mechanisms,” as recommended in the NLD’s Roadmap Towards UHC.
- Existing coordination efforts should be continued under the new government where they are succeeding, but ultimately the government and ECBHOs, rather than international aid actors, should be encouraged to take the initiative and be responsible for such mechanisms where possible.

Accreditation of ECBHO health workers

A significant challenge to building trust and formalizing relations has been the reluctance of the former government to recognize and give accreditation to ECBHO health workers. 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 identifies the need to improve accreditation and licensing processes, specifically out of a recognition that ECBHOs and other actors (such as the private sector) are crucial to its efforts to ensure maximum coverage. From the NLD’s perspective, “This will require strengthened regulation and oversight (including, for example, accreditation and licensing), and the adoption and enforcement of common quality standards.”¹³⁴ The roadmap recommends the establishment of an independent accreditation body for health workers outside of government, as well as for 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 be able to give formally recognized training in the future.

In working for accreditation of ECBHO health workers, ECBHOs will naturally be focused primarily on having their current models and ways of working recognized, while the government will rightly be concerned with ensuring that certain quality standards are being met and that all citizens are being served by capable professionals. Indeed, as any accreditation might also be recognized in other ASEAN countries, the government has legal responsibilities to ensure that the standards for health workers are adequate. Both sides will have to approach coordination and negotiations on this issue with an understanding of the other’s basic positions and priorities, and find the best way to achieve both sets of aims.

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 3000+ ECBHO workers to fit the cadres currently defined by the MoH would be inefficient and politically impossible, and other approaches should be considered. Therefore, the accreditation body would ideally work closely with the ECBHOs to better understand their current training and staffing methods. Field visits to ECBHO clinics may be necessary to help this body learn about ECBHO training and staff competencies.

The certification program developed by IRC and described in Section 4.2 has already defined clinical competencies for some ECBHO workers based on a training curriculum developed by the MoH. The government should recognize that these clinical skill sets are the same as those used by their own staff, as shown in Table 2, even though different cadres of ECBHO health workers perform those tasks. The government’s accreditation body should be able to use a similar process to translate accreditation for these skill sets and define new cadres of health workers based on the models that are used by ECBHOs.

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

- Coordination and negotiations will likely be necessary to develop appropriate processes.
- Recognize that ECBHOs have an existing system of training and accreditation in place, and that they should be able to continue preparing their health workers for their specific models of delivery.
- Focus on individual clinical skills and acknowledge task-shifting in ECBHOs rather than focus on the combinations of skills that define cadres of MoH workers.

ECBHO recommendation #2: ECBHOs should understand that the government has a mandate to ensure that all citizens are served by qualified professionals, and a responsibility to set certain basic requirements for accreditation.

Health Financing

Coordination between MoH and ECBHOs could have the potential to 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, that can purchase services from a range of available providers on behalf of the population.¹³⁵ The establishment of a mechanism to purchase ECBHO services with government funds would be highly political, as it would effectively transfer money and supplies between the government and EAO-affiliated entities.

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, ECBHOs will need to consider ways of financing their operations domestically. Currently EAOs provide limited funds to their health departments. As ceasefires allow EAOs in the southeast to increase their revenues through new business endeavours, social service spending should be increased. However, as the NLD has indicated an interest in using state funds for ECBHO services, this might ultimately be more sustainable.

Discussions with some ECBHO leaders on this topic suggest that they would not rule it out as a future possibility but maintain serious reservations, especially in the short-term until they have more confidence in the peace process. Some ECBHO leaders see accepting resources from the national government as a threat to their autonomy, with the risk that they would get drawn into a centralized government health system that is antithetical to their philosophy of health services delivery. Senior leaders at MTC and BMA said that they are reluctant to engage closely with a system that they feel needs major structural changes, although they also admitted that relying solely on external support was not sustainable.¹³⁶ Furthermore, there might be perceived risks around becoming dependent on government, in case resources were later withheld for political and other reasons, making it harder to re-establish old donor channels. If ceasefires in the southeast were to break down, such channels could become particularly fragile, unless deep trust can be established between the government and

non-political entities like MTC and BMA. ECBHOs would likely seek to develop conditions for resource-sharing agreements with the government that would protect their autonomy and service delivery model. Despite the clear difficulties, it is crucial that all stakeholders begin discussions around possible 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.

- Such discussions will inevitably be sensitive, and should not be pushed too far ahead of political progress. ECBHOs' willingness to accept such funding is unlikely to outpace their confidence in the peace process and broader reforms.

ECBHO recommendation #3: ECBHOs should recognise that international aid financing is not sustainable, particularly as the government increases healthcare spending, and should initiate internal policy dialogue on securing more sustainable sources of financing. Such discussions should focus 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.

- Where assistance is requested, donors should facilitate dialogue between ECBHOs and the government on financing reform, particularly where they are already supporting the government in such processes.
- However, international donors should remain cognizant of the deep political challenges following decades of war, and should not encourage ECBHOs too soon to become solely government financed.

5.4: Problematic conceptions of convergence

Coordination and other convergence activities are currently not practical for all health services. Cooperation in most areas requires multiple meetings and, often, permission from government and EAO officials who are not working on health and have little understanding of it. Where unnecessary, these procedures can be frustrating and time consuming, and can delay delivery of crucial health services to sections of the population, creating health inequity.

Early HCCG policy documents describing convergence laid out a plan for progressive engagement with the MoH, but, beyond that, few specifics of how this engagement might happen were given. Overall, these plans provided only limited guidance to stakeholders trying to conceptualize a convergence process, and in some cases they lent themselves to diverse interpretations. Finding the right approach to convergence can be particularly difficult for external actors trying to navigate this unique development environment in an area that has long been affected by conflict and had previously seen relatively little international engagement.

There are a number of key reasons that international aid actors have become eager for the MoH and ECBHOs to work together: the idea that parallel health systems are problematic, a reluctance to accept EAOs in state-building processes, and the concept that convergence activities might help to advance the peace process. But, as argued, the context of conflict-affected southeast Myanmar calls for maintaining parallel systems and engaging EAOs and their affiliates in development work.

The rush to promote joint activities between the MoH and ECBHOs risks delaying delivery of essential services and creating frustration within MoH and ECBHOs. As discussed in Sections 4.2 and 5.3, information-sharing and trust-building activities might seem slow-moving at this stage, but they should be understood by international aid partners as necessary and worthwhile convergence activities, and as crucial investments in long-term progress towards greater cooperation. This section looks at two key areas where international actors risk encouraging convergence in an unhelpful way.

Convergence for gaining government permissions

In the examples of vaccination programs and cholera response discussed in Section 4.2, coordination was required, not to address health inequity, but because restrictions on international actors (namely UNICEF) prevented them from directly engaging with or giving resources to ECBHOs, thus requiring the involvement of the MoH. These examples show the exceptional problem-solving skills and determination of multiple international actors who overcame limitations on their operations, but they also reveal how such regulations can delay essential health services in the first place. These regulations also risk reinforcing the very grievances that have led to conflict in the past when they force ECBHOs, despite their long-running investments in their own communities, and often in spite of state policy, to act as subordinates to the MoH. Development actors in positions to influence coordination should be aware of these pitfalls.

In these cases, which effectively amounted to externally driven convergence activities, health services could have been provided more efficiently if only the international actors managing resources were able to work more directly with ECBHOs. This could be achieved if donors had better-established mechanisms for directly funding and monitoring ECBHOs, potentially in partnership with technical agencies that have more flexibility than those in the UN system. While ECBHOs and government should continue to develop processes for joint disaster response and joint delivery of other services where practical, international actors should not require them to do so in order to convince the government to allow ECBHO and international collaboration. Particularly in the context of disasters, more direct response mechanisms need to be established.

Convergence for convergence's sake

There is an added risk that convergence may be viewed as an end in itself, particularly by international actors looking to spend peacebuilding funds on projects that bring antagonists more closely together. Both of the authors have frequently had discussions with international actors – including those with no experience in health – looking to orchestrate convergence activities as a means for peacebuilding or in order to drive social cohesion. Such approaches are unlikely to have the desired effect, however, as meaningful cooperation depends on concerted efforts from both ECBHOs and MoH to overcome barriers because mutual aims depend on it. The most successful forms of cooperation will always be based on genuine common needs, where cooperation is more beneficial than independent action. If donors push too hard for such activities, or even incentivize them artificially, there is a risk that pleasing the international partners will become the main perceived benefit, undermining actual trust building.

In other cases, high-profile, one-off events have been organized by international actors to showcase apparent cooperation between ECBHOs and the government, leading to media fanfare and triumphant statements, but making no meaningful, long-term contribution to genuine cooperation on the ground. While such events have the potential to bring antagonists into the same room, and can help break the ice, they also run the risk of alienating skeptics within these organizations, who will be further convinced that convergence activities and other forms of cooperation are just superficial and not worth engaging in. Furthermore, such activities distract health providers from their core objectives, and from other more critical forms of cooperation.

Ensuring that convergence interventions are effective requires appropriate theories of change, and associated indicators that focus on measuring improvements in health equity, not acts of cooperation for the sole purpose of cooperation or peacebuilding. More rigorous work is needed to develop methods for doing this, which could be commissioned by donors that have built convergence activities into their strategies.

ANNEX ONE: Consolidated recommendations for southeast Myanmar

Government recommendations

1. *The government should view ECBHOs as crucial partners in reaching UHC, due to their unique resources, experience, and territorial access.*

- This involves developing the right policies and practices to enhance the role of ECBHOs and enable them to continue providing quality services, as covered in later recommendations.

2. *Provide firm recognition to ECBHOs, ideally in legislation or presidential notification.*

- Based on terminology mutually agreed to with the groups.
- Stating that ECBHOs are providers of health services.
- Stating that ECBHOs may receive funds from government, domestic and international aid actors, and local communities.
- Stating that MoH should cooperate and coordinate with ECBHOs in areas of overlapping coverage.
- Stating that MoH and other government bodies should consult ECBHOs on national health policy and related strategies and reforms.
- Requiring no specific registration process, but providing a more formal recognition of the status quo that ECBHOs exist as important providers of healthcare.
- Applying to all significant providers of healthcare, not just those connected to NCA signatories or to any other political category.
- This should be seen as a first step toward providing ECBHO health workers with accreditation and licensing and establishing greater government oversight, in line with NLD policy (see Section 5.3).

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

- Ensure that staff at all appropriate levels are properly briefed on the importance of engaging with ECBHOs.
- Develop a set of priorities and protocols for engaging with ECBHOs, and task staff accordingly.
- A “communication and coordination” mechanism, as advised in the NLD’s Roadmap Towards UHC, should certainly be established, and could include Union-level and local-level bodies.

4. *Develop and implement policies that will:*

- Keep TMOs and basic health staff as well as TMOs in positions for longer periods of time,
- Establish multi-year terms for state health director positions, and
- Encourage the appointment of people to these positions who are willing to serve their full terms.

5. *Develop a process for accrediting ECBHO health workers, in coordination with the ECBHOs.*

- Coordination and negotiations will likely be necessary to develop appropriate processes.

- Recognize that ECBHOs have an existing system of training and accreditation in place, and that they should be able to continue preparing their health workers for their specific models of delivery.
- Focus on individual clinical skills and acknowledge task-shifting in ECBHOs rather than focus on the combinations of skills that define cadres of MoH workers.

ECBHO recommendations

1. ECBHOs should continue their concerted efforts towards convergence with the MoH, and should frame and approach such efforts with improving health equity as the primary aim.

- Given the increased legitimacy of the NLD-led government, ECBHOs should recognize the formal mandate of the government to oversee the development of the country's health sector, and of the MoH to be the main provider of health services in the country.
- Given the MoH's much wider mandate, alignment of ECBHOs strategies and targets with those of the MoH could be of great practical benefit, and would not imply inferiority of ECBHOs.

2. ECBHOs should understand that the government has a mandate to ensure that all citizens are served by qualified professionals, and a responsibility to set certain basic requirements for accreditation.

3. ECBHOs should recognise that international aid financing is not sustainable, particularly as the government increases healthcare spending, and should initiate internal policy dialogue on securing more sustainable sources of financing. Such discussions should focus particularly on the possibility of, and the preconditions for, accepting government funding.

Government and EAO/ECBHO recommendations

1. Areas of government and EAO control should be established through the ceasefire and political dialogue processes, not by establishing social services.

- The use of social services to define territory risks politicizing these services and shifting the focus from equity and quality of services to a race for territory.

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 enable regular, formal discussions and decision-making about catchment areas for health services.

- This mechanism could consist of state/region-, district-, or township-level committees or forums, depending on the density of service providers in a given area.
- This mechanism should be focused on achieving health equity as its central aim, and would ideally be mandated to make final decisions on such matters, rather than requiring members to negotiate with associated political actors.
- Government and EAOs should empower state and local-level officials to make final decisions regarding coordination of health activities in their areas without seeking approval from Nay Pyi Taw or EAO senior leadership.

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.

- In some cases, undertaking such activities separately will increase preparedness for future forms of engagement.

- Joint coverage mapping activities have been slow to initiate due to lack of existing information, but have also been useful for trust building and cross learning.

4. *General information-sharing activities and seminars should also be continued to build relationships, trust, and broader understanding between the two systems.*

- The NLD-hosted event in 2015 was a good first step, and future ones formally hosted by government could be highly beneficial.
- Particularly if there are logistical hurdles to engaging all relevant actors in concerted “communication and coordination” mechanisms, looser information-sharing activities could be a useful way to build initial trust and understanding.
- In particular, such activities could be used to begin discussions around alignment of health strategies and targets, for example, towards UHC.

5. *Countering infectious diseases and establishing mechanisms for patient referrals should be considered key areas for systematic coordination.*

- These issues could be addressed through “communication and coordination mechanisms,” as recommended in the NLD’s Roadmap Towards UHC.
- Existing coordination efforts should be continued under the new government where they are succeeding, but ultimately the government and ECBHOs, rather than international aid actors, should be encouraged to take the initiative and be responsible for such mechanisms where possible.

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.*

- Such discussions will inevitably be sensitive, and should not be pushed too far ahead of political progress. ECBHOs’ willingness to accept such funding is unlikely to outpace their confidence in the peace process and broader reforms.

International aid community recommendations

1. *In the near term, supporting both MoH and ECBHO systems is necessary, both politically and programmatically, to ensure that all people have access to health services.*

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.*

- This requires donors to adjust conventional approaches to development that focus solely on government-owned agendas, and to support the approaches of both MoH and ECBHOs, while helping them to align where beneficial for achieving equitable healthcare.
- These efforts should be driven by a bottom-line interest in reaching as many people as possible with quality care, particularly the most vulnerable and poorly served.
- Donors should recognize that, in today’s political climate, ECBHOs are particularly reliant on donor funds to maintain services to these populations, but represent relatively low-cost interventions.
- Donors should pursue a systems-strengthening approach, through long-term partnerships

between appropriate technical partners and ECBHOs, rather than a fund providing project-by-project commitments.

- Such instruments could take the form of dedicated components within single-donor and multi-donor health strategies.
- These instruments should be developed following deep consultations with ECBHOs and study of their existing structures.
- Technical agencies that already have well established, trusting relations with ECBHOs should be given priority for such programs.

3. When working with ECBHOs, allow them to assess their own risks of cooperation and coordination with government.

- Understand that ECBHOs will need to maintain cross-border activities as well as increase activities implemented from bases inside the country to maintain access to their target populations.
- Help ECBHOs to design systems and project plans that let them manage potential risks and improve the overall resilience of their systems to future shocks and crises.
- Basic conflict sensitivity frameworks could help to ensure that log frames are flexible and can be adapted to political developments or the emergence of new risks.
- As a basic principle, channels of support to ECBHOs should help them exploit new opportunities for improving services in the context of ceasefires, while ensuring that they are prepared to respond to future emergencies or protracted conflict situations.

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

- This could include supporting separate and joint activities, such as mapping, health systems assessment, and policy development, that will facilitate cooperation in the future.
- This could also include support for seminars and information-sharing conferences aimed at providing basic understanding and building trust.
- Meetings that focus on information sharing, mapping, and other activities that would facilitate future cooperation and health equity should be considered legitimate convergence activities in terms of indicators for donor reporting.

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.

- Where assistance is requested, donors should facilitate dialogue between ECBHOs and the government on financing reform, particularly where they are already supporting the government in such processes.
- However, international donors should remain cognizant of the deep political challenges following decades of war, and should not encourage ECBHOs too soon to become solely government financed.

ANNEX TWO: Health Convergence Core Group policies

1.1 Health Convergence Core Group: convergence principles¹³⁷

1. Current health services, which are based on the Primary Health Care approach, must be maintained and expanded.
2. The role and structure of the ECBHOs must be maintained.
3. Communities and community-based health organisations must be involved in the decision-making process and the implementation of health care services in the ethnic states.
4. INGOs must cooperate with local CBOs and ECBHOs by promoting their roles and capacity.
5. Health care programming should not create conflict among the community and between the health care providers.
6. Development of a national health policy and system should be according to the framework of a federal union.
7. Health programming and policy should complement and support the federal aspirations of the ethnic peoples throughout the peace process.
8. Any acceptance of health-related humanitarian and development aid must be in line with the existing health infrastructure that has been established by ECBHOs and CBOs.
9. The implementation of any health activities in ethnic areas should have approval from the local ethnic health organisations.

1.2 HCCG: Potential outcomes of convergence¹³⁸

1. Increased access to health care for populations in need
2. Positive impact on peace-building
3. Basic needs and human rights are addressed
4. International partnerships and networking are promoted
5. Recognition and accreditation of ethnic health workers
6. Ethnic and community-based health programmes are supported and strengthened
7. Increased decision-making and power sharing at the state and local level

1.3: HCCG Recommendations¹³⁹

1. Recognise and support ethnic groups as key service providers in ethnic areas.
2. Encourage the involvement of ethnic leaders in the participation of coordination meetings, workshops, etc.
3. Consider how planned projects may support programme, system, or policy convergence.
4. Strengthen and/or develop community participation networks.
5. Promote and directly support ethnic and community-based health programmes (financial support, capacity building, technical assistance).
6. Explore funding opportunities that support convergence and the peace process (i.e.: joint funding for programmes in government controlled and ethnic areas, cross-border funding, etc.).

Endnotes

- 1 This term has been chosen specifically to refer to this network of organizations. The term “ethnic health organizations” (EHOs) officially refers to the health departments of these ethnic armed organizations, but does not include the supporting LNGOs. The term “ethnic and community-based health organizations” originated from the Health Information System Working Group (HISWG) report, “The Long Road to Recovery: Ethnic and Community-Based Health Organizations Leading the Way to Better Health in Eastern Burma,” *Reliefweb* (Feb. 27, 2015), <http://reliefweb.int/report/myanmar/long-road-recovery-ethnic-and-community-based-health-organizations-leading-way-better>.
- 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), 19.
- 3 *Ibid.*, 24.
- 4 While the NLD itself indisputably won a landslide victory in the 2015 election, the military is constitutionally required to appoint the vice president and the ministers of defense, border and security affairs, and home affairs, as well as 25 percent of the country’s MPs, all from within its ranks. In particular, the Ministry of Home Affairs plays a dominant role in everyday governance, as the main body responsible for coordinating between government departments, and as the most influential and central governance actor at the district, township, and village tract levels. Additionally, the security of the NLD’s role in government depends more broadly on its cooperation with the military and with members of the former military government, and it has thus appointed a number of former military commanders to other ministry positions.
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- 8 Smith, *Insurgency and the Politics of Ethnicity*, 196. It has been argued, of course, that this was largely a guise for General Ne Win to seize power. See Smith, 196-197.
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- 13 Thailand Burma Border Consortium, “Displacement and Poverty in South East Burma/Myanmar” (2011), 17, <http://www.refworld.org/docid/4ea7e9652.html>.
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- 18 For a full list of the BGFs and their locations see Kim Jolliffe, “Ethnic Armed Conflict and Territorial Administration in Myanmar” (The Asia Foundation, 2015), 24-25, <http://asiafoundation.org/publications/pdf/1521>.
- 19 These three armed organizations were the Pa-O National Liberation Front, which had emerged in southwestern Shan State since 2009 and allied with other pro-federal groups, and two small armies that were based in KNU territory and fought alongside it, the Arakan Liberation Party and the All Burma Student and Youth Congress.
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- 22 Eastern Burma Retrospective Mortality Survey (EBRMS) 2013 data, unpublished.
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124 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 LNGOs like MTC, BMA, and BPHWT; hence the use of “ECBHO” in this report. It is fair to assume, however, that the NLD document also includes these local LNGOs when referring to “EHOs.” More generally, the NLD is likely referring primarily to the coalition of ECBHOs that this report focuses on, as it has particularly well-developed relations with this group compared with other ethnic health providers in other parts of the country. See also endnote 1.

125 NLD, “Roadmap,” 9.

126 The MoH has instituted policies such as increased pay for health workers who are based in rural and remote areas. The MoH changed policy in Chin state: ethnic Chin doctors now hold TMO positions, and the policy of frequent rotations has ended. This could be a good model for the southeast, although it will be a challenge to find people from this region with medical training.

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

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