Health Systems in Burma: Creating Unity, Peace and Sustainability

Cynthia Maung[*]

Introduction:

Conflict, Health and Peace Building Among Burma's Border Populations

Communities in Eastern Burma have been living with civil war for over 60 years. Protracted conflict and widespread and systematic human rights abuses have had severe impacts on the health of civilian populations, with health indicators from these areas highlighting a 'chronic emergency'.

Even with the current ceasefires and the resulting reduction in conflict in Karen State, health organisations working with populations on the Thai Burma border are treating a mobile population which moves back and forth across the border in order to access their basic needs including safety, work, education and health.

Mae Tao Clinic has been working with clients from Burma living along the Thai Burma border for over 25 years. It has worked with local Thai government health and public health since the beginning. There is a massive disparity between health services in Thailand and those in Burma, which is why about half of our clients travel from Burma to access health services. In Burma, there is a similar level of disparity between health service access availability in the urban and rural areas. Access for rural communities is extremely poor due to both the lack of facilities and health workers, as well as prohibitive costs. In Thailand, many migrant workers have come looking for work in Thailand, in order to pay the health bills of family members living in Burma.

When envisioning a nation of healthy citizens in Burma, the social determinants of health need to be addressed and communities need to feel empowered to address their health needs, by improving living conditions such as ending conflict, removing land mines, having access to land, work place safety, safe water, safe housing, minimising financial risks and improving access to education, health, legal and social services.

At the same time essential health services are not a privilege, but a basic need. People need to know how to protect themselves and to promote their own healthy communities. The current proposal for Universal Health Coverage is not sustainable and does not empower communities. Tax reform may be the first step in revenue generation for building a health system, however, working with communities to empower them to engage with the issues that affect them is a step that must be made at the same time.

---

[*] *Director of Mae Tao Clinic, Myanmar. Honorable Speaker in The 4th International Conference on Magsaysay Awardees:Good Governance and Transformative Leadership in Asia, 31 May 2016.*

In the absence of government health services, and in a context where international aid agencies were denied humanitarian access, indigenous health workers in ethnic minority areas have mobilised to provide life-saving care to their communities. With the changing political situation and fledging peace in Burma, these health workers now face new opportunities and challenges. Health has the potential to play a key role as a bridge to peace in Burma.

1. Community health systems in Burma's conflict areas

Decades of civil conflict and widespread and systematic human rights abuses had severe impacts on the health and wellbeing of communities in Burma's border areas. Health indicators from Burma's eastern border areas have been found to be far worse than those reported for the country as a whole.

	Eastern Burma 2004	Eastern Burma 2013	Burma (National)	Thailand
Infant Mortality per 1,000 live births (IMR)	91	94.2	26.7	11
Under 5 Mortality per 1,000 live births (U5MR)	221	141.9	34.9	13
Child malnutrition %	15.7	16.8	7.9	
Maternal Mortality per 100,000 live births (U5MR)	1,000-1,200	721 (2008)[3]	230	48
Maternal malnutrition %	16.7 (2008)	11.3		

Backpack Health Worker Team. 2004. Chronic Emergency Backpack Health Worker Team. 2004. Chronic Emergency
HISWG. 2014. Long road to Recovery – Ethnic and community based health organisations lead the way to better health in Eastern Burma. http://hiswg.org/wp-content/uploads/2015/02/The-Long-Road-to-Recovery-2015_Eng-1.pdf
Parmar PK et al. Health and human rights in eastern Myanmar prior to political transition. BMC
Ministry of Health. 2013. Health in Myanmar
World Bank. Data – Indicators. http://data.worldbank.org/indicator

Over the past twenty-five years, a network of indigenous healthcare providers has grown into a strong system for health service delivery in Burma's conflict-affected borderlands. Working as part of ethnic health organisations or of community-based health organisations, indigenous health workers have provided primary healthcare for displaced and conflict-affected communities.

The **ethnic health organisations (EHOs)** were initially established under the authority of armed ethnic groups, and are the building blocks of healthcare provision in areas that were historically controlled by these armed groups. The Karen Department of Health and Welfare, Shan Health Committee, Mon National Health Committee and Karenni mobile Health Committee all recruit and train local health workers, and support the delivery of healthcare services in their respective areas. Services are provided through a mix of both village outreach and community clinics, with a focus on preventative and primary healthcare.

The **Back Pack Health Worker Team (BPHWT)** was established in 1998. BPHWT is a multi-ethnic community-based organisation, which provides mobile healthcare services to communities who have little no other access to health services. With over 300 health workers, BPHWT now serves a target population of approximately 250,000 villagers in Karen, Karenni, Mon, Shan, Kachin, Chin and Arakan State, and in portions of Pegu, Tanintharyi, and Sagaing Divisions of Burma. Each team of 3 to 5 medics serves a target population of 2,000 villagers. The teams work in partnership with a network of over 300 Village Health Workers and over 700 Traditional Birth Attendants. Over time, the organisation has developed a community health care system in its different target areas. The teams can access very remote and unstable areas; they refer severe cases needing more advanced care to clinics run by the ethnic health organisations or to hospitals in Thailand and Burmese Government Township and sub township hospitals.

The **Burma Medical Association (BMA)** was established in Karen State in 1991 by a group of health professionals from Burma under auspicious of the National Coalition Government of the Union of Burma (NCGUB). Over the years, BMA has supported community health worker training, health education outreach, collaborative forums, and technical assistance and training. BMA now serves as the leading body for health policy development and capacity building for the provision of quality healthcare services in ethnic areas of Burma. In 2015, BMA supports 42 clinics serving more than 500 villages, providing primary healthcare services including reproductive and child health services, medical care and community health promotion education to approximately 180,000 people across six states in Burma.

Over the past 25 years, these ethnic and community-based health organisations developed primary health services for more than 600,000 people living in conflict-affected and isolated communities in Burma. Services provided by the ethnic and community-based health organisations are based on a comprehensive primary healthcare model, and include: basic medical services, reproductive and child health, community health and disease prevention, and specialised health programmes. There are now around 250 primary healthcare clinics and mobile outreach teams, and a handful of secondary care facilities. Ethnic and community-based health organisations have a workforce of approximately 2,000 staff – medics, maternal and child/ reproductive health workers and community health workers.

Since their beginnings, ethnic and community-based health organisations have found ways to work together, recognising the importance of developing common health policies, standards and protocols, and of standardising their health information systems and health worker training curricula. Together, these ethnic and community-based health organisations have worked to build a sustainable community-level primary healthcare system, which could provide health services and education in a context of civil war.

2. A fledging peace and new challenges for local communities and health service providers

2.1 Ceasefire discussions, Burma's elections and ongoing insecurities

With the November 2015 elections and the signing by some armed ethnic groups of a Nationwide Ceasefire Agreement and the election of Burma's first civilian President, there is now much hope that Burma will finally see genuine political change and peace.

The National League for Democracy (NLD) won the November 2015 elections by a landslide. However, constitutional issues will continue to limit the power of the government, and the military will maintain a high degree of control. Tension between the military and the government is likely, and may cause further instability in the country.

In October 2015, the month before the elections, the Burmese government and eight armed ethnic groups signed a Nationwide Ceasefire Agreement. Yet this is a fragile peace. Throughout the negotiations, conflict continued between government forces and the Kachin Independence Army in Kachin State. The National Ceasefire Agreement is also not as inclusive as it needs to be, with only half of the recognised armed ethnic groups signing on, and the Kachin Independence Army, the Shan State Army and the United Wa State Army being notable absences. And while 14 out of 16 ethnic armed groups now have bilateral ceasefire agreements with the government, these ceasefires have not yet led to a political resolution to the conflicts in Burma.

The ceasefires have resulted in a reduction in fighting and increased freedom of movement for many people in eastern Burma. On the ground, the ceasefires are also making travel, communication and accessibility to health services easier, creating more stability for the work of service providers. Yet this fledging peace also presents a number of new difficulties for local communities and service providers.

Local communities in eastern Burma face increasing dispossession and displacement driven by foreign investment and development projects, as well as ongoing human rights abuses. There has been growing encroachment by the military into areas previously controlled by armed ethnic groups. International investment in development projects is going ahead without public consultation, and there are still no

real protection systems for communities at risk of dispossession and displacement. Existing legal frameworks and the enforcement of these do not protect against land confiscation for development projects. There are currently plans for six dams to be built on the Salween River in Shan, Karenni, and Karen States. Land confiscation often involves violence, as well as separating communities from their homelands and livelihoods. This is a growing driver of protest and unrest, potentially undermining the peace process.

The election of a new NLD government and the appointment of a civilian President brings some hope for the changes necessary for building a healthy nation. Yet, the government has huge barriers to overcome to bring about lasting peace and to build a genuine federal democracy with the empowerment of communities at its heart.

2.2 A highly centralised government and healthcare system

Within this current political situation, the ethnic armed organizations are continuing to strive for a federal system of government. However, there is an on-going disconnect between the ceasefire negotiation process and ethnic peoples' aspiration for a federal political structure. Meaningful constitutional change will be a slow process and until then the Burmese government will have a highly centralised administrative, legislative and financial system. Without decentralisation, effective improvements in health and education, as well as justice and protection, will be minimal.

Burma's official health system is highly centralised. The central government has exclusive legislative power over health policymaking, with state/region governments having only a coordination role. All the financial, legislative and administrative powers are central. Healthcare facilities are directly administered by the Ministry of Health, and are centrally funded, with fiscal authority resting with parliament and Ministerial-level officials. The Ethnic Health Organisations are therefore trying to negotiate for devolution of powers

Additionally, and while providing the backbone for primary health service delivery in remote border areas, ethnic and community-based health organisations are still not officially recognised in Burma. Some 2,000 skilled primary healthcare providers have no official recognition and are not legally allowed to provide healthcare in their communities. Yet their work remains essential for communities in Eastern Burma.

Historically, international donors and Non-Government Organisations had funded the ethnic and community-based health organisations, as a way to support healthcare for local communities who had little to no other access to even basic services due to government disinvestments in health and restrictions on international humanitarian access. However, since Burma's 2010 elections, a number of major donors have withdrawn support from these systems, preferring to work with the Burmese government and to fund aid programmes that are implemented with government approval. As a result, ethnic and community-based health organisations have faced an increasingly precarious funding situation. Although a number of donors and INGOs

continue to support these systems, there is a risk that indigenous healthcare providers will be increasingly side lined, rather than gaining official recognition and accreditation as service providers in their communities. With increased optimism in the new government, the risk of losing funding community health services has only increased.

In Thailand, on the other hand, the Thai MoH is embracing collaboration with community health workers, as evidenced in their Border Health Master Plan. They are working with health workers from Burmese ethnic health organisations and community organisations in order to maximise their access to border communities, thus strengthening disease outbreak response, vaccination coverage and disease prevention campaigns.

The Burmese ministry of health has the potential to play a key role in peace building by collaborating with ethnic and community health organisations, as is already being done in Thailand. Indeed, although many challenges lie ahead, health can play a critical role as a bridge to peace in Burma.

3. Health as a bridge to peace in Burma? Current efforts and opportunities

The ethnic and community-based service organisations view future opportunities for coordination and cooperation with the Burmese government as critical to improving the lives of people in eastern Burma. The concept of expanding and enhancing services through increased coordination between ethnic service organisations and the Burmese government has been broadly defined as "convergence".

Over the past five years, ethnic and community-based health organisations have made concerted efforts to build dialogue and cooperation with those within official government systems, and to develop models of what "convergence" with government health systems could look like. There have been a number of practical examples on the ground of peace building and convergence in healthcare systems. Yet these examples also highlight current challenges to health truly becoming a bridge to peace in Burma, as well as difficulties and issues that need to be taken into account in the peace process.

The Health Convergence Core Group

These include the establishment of the Health Convergence Core Group in 2012, a group of ethnic and community based health organisations working in Mon, Karen, Karenni, Shan, Kachin and Chin State. The HCCG aims to explore policy options for achieving the convergence of ethnic, community-based, state, and national health systems through political dialogue. The HCCG defines "convergence" as follows: *Convergence is the systematic, long term alignment of government, ethnic, and community-based health services.*

In many ways, HCCG members have led the way so far in engaging the government on health issues, having had multi-level stake holder meetings. An initial seminar held in 2014, bannered as 'Health as a Bridge for Peace' was held by HCCG actors and their technical partners on the Thailand-Myanmar border. The event was attended by 96 participants including MoH Kayin State department officials and others from central Burma such as the NLD Health Network, Myanmar Medical Association and Myanmar Health Assistance Association. A similar meeting was hosted in March of 2016.

So far, discussions with the Myanmar MoH have progressed and allowed collaboration in these key areas:

- The establishment of health coordination offices in four state capitals by ethnic health organisations
- Skill sharing and joint trainings with participants from both the Ministry of Health and ethnic and community health organisations
- Joint activities in mixed administration areas to address specific infectious disease threats: measles, rubella, filariasis and leprosy
- Cooperation to address the common threat of drug resistant malaria.
- Coordination to address geographic gaps and overlap in maternal and child health service provision, with particular efforts addressed at extending vaccination coverage.
- Inclusion of ethnic and community health representatives in important policy consultations such as Universal Health Coverage.
- Certification of some health workers as auxiliary midwives, and the adoption of national curriculum for the Certificate of Public Health Course for mid-level staff in the ethnic and community health system.
- Greater transparency of ethnic and community-based health organisation health care provision in areas of mixed authority

As a result of broader changes in the country, health organisations and their staff have benefited from improved transport links, supply chains, communication and security in the less isolated areas where they are working. While there have been small skirmishes throughout ceasefire negotiations, and reports of land rights violations, this has not affected service delivery, or the overall mood of cautious optimism in the peace process, including the opportunities it presents for expanding health programs.

Recognition and accreditation of health workers

The recognition and accreditation of health workers from ethnic and community-based health organisations is essential to ensuring that medics aren't at risk of arrest, and that they are recognised as equals to government healthcare professionals. It is also a natural early step towards convergence, and to developing a joint approach toward addressing shortages of professional health workers in ethnic minority areas.

Steps in this direction have been taken, with for example, a partnership between ethnic and community-based health organisations, the Myanmar University of Community Health (UCH) in Magway, and Thammasat University in Thailand. Through the partnership, Ethnic Health Organisations and Community Based Health Organisations health workers are able to undertake courses with the UCH curriculum to received UCH Public Health Service Accreditation. To date, a total of 140 health workers from ethnic and community-based organisations have been trained and accredited with the UCH curriculum.

While there are numerous potential avenues for further cooperation, inconsistencies between the types of health worker recognised by the Myanmar MoH and by the ethnic and community-based health organisations remain an obstacle for full standardisation. The MoH's priority in healthcare provision and training is diseased-centred and hospital-focused, and centred on patients as individuals, rather than on healthy communities. In contrast, the systems of the ethnic and community-based health organisations are based more closely on a public health approach, emphasising a greater focus on population wide programmes, preventative care, and elements of population and social sciences. Decisions to prioritise earning MoH accreditation therefore potentially involve a trade-off of immediate practical benefits in favour of more long-term convergence aims.

Birth Registration

One example of increased dialogue and cooperation between the government and community-based health organisations concerns birth registration. Officially, only accredited midwives can deliver babies and provide birth certificates. However, there is a chronic shortage of accredited midwives across the country, and none present in non-government controlled areas. Therefore auxiliary midwives and EHO trained MCH Workers who did not have official accreditation are not entitled to provide legal birth certificates, and many children in ethnic minority areas could not obtain legal documents. However, in a pilot project, BPHWT negotiated with state-level authorities, who have now allowed auxiliary midwives to obtain birth certificates by working together with government midwives.

Mapping of Health Services

With the on-going peace-building, ceasefire and election processes, the country has opened up to international development and humanitarian assistance. The work of INGOs, is controlled by Naypyidaw with MoUs signed by the central government for work in specific areas. Because of the disconnect between the government and the ethnic health organisations, the programmes permitted by the government often ignore the existing services provided by ethnic health organisations. For decades, ethnic community health services have been the sole providers in conflict-affected communities, and the community health workers often have a high level of trust with villagers. There needs to be mechanisms in place to ensure that the skills and experience of EHOs and community organisations are not over-looked.

MoUs for international agencies are usually targeted at selected townships or at vertical programming such as malaria, or maternal health. Health programming needs to look at the comprehensive services required throughout the country, and this kind of isolated programming will just result in overlap or the creation of gaps. A national mapping of services, together with the communities, is a process that can prevent overlap and gaps, as well as promote community voices for understanding their own health needs.

Since 2015, a pilot convergence programme in Kawkareik, Karen State has begun, aiming to promote cooperation between government health centres and the ethnic and community-based health organisations, and to strengthen health systems in the programme's target areas.

The programme has involved the mapping of health services in Kawkareik, in order to identify and locate services provided by the government health centres and the ethnic and community-based health organisations. The programme also aims to standardise Information, Education and Communication (IEC) materials as well as protocols for antenatal care, post-natal care and referral of obstetric emergencies.

The programme is still in its infancy. There have been some initial challenges in the mapping process, particularly since this involves overcoming decades of mistrust. This mistrust results from a history in which members of community and ethnic health organisations were considered "illegal" by the state and were detained and imprisoned. In areas of active conflict, health workers were killed because of their association with non-state actors. Health facilities and supplies were also destroyed, in a clear violation of medical neutrality.

In Burma, there are also more general discrepancies in information management and mapping, notably with ongoing divisions and lack of information sharing between the Myanmar Information Management Unit (MIMU) and the Health Information Systems Working Group (HISWG) of HCCG. These divisions are also linked to Burma's history of conflict and distrust. However, the gradual mapping of services in Kawkareik has already led to greater understanding and clarity in the provision of healthcare, as well as paving the way for further potential information sharing and trust building.

Mapping services can be seen as an essential component of building trust and lasting relationships between communities and government health services. After initial distrust, as mapping continues, so does openness and transparency about the work that is going on in each township. This openness will result in better health services, since overlap can be minimised and instead new health developments can focus on complimenting the already existing services. If the mapping is done together with the communities, then communities are also empowered to identify their own health needs. At the same time, deepened understanding of what services are available can result in health service referral systems and therefore widen the access to health care of communities. When health workers operating from the border areas and those

operating from the towns get together and discuss what is happening at the community level, they become able to share resources and develop important relationships.

Task-Shifting Approach

By mapping services, it is possible for the government and communities to shed light on the reality of the extremely limited capacity of government health task forces and authorisation systems. Until now, Burma's health system has been strongly hierarchical with an official dependence on a severely diminished supply of officially accredited health personnel such as doctors, nurses and midwives. There is a significant urban-rural divide in the availability of health workers, and the disparity is more acute in non-Burman majority areas.

In the next stage of national health sector reform, a participatory national mapping exercise would help to recognise the potential of working with the thousands of local community health workers and auxiliary midwives who have been filling the gaps resulting from a neglected and under-funded health system. There needs to be a joint effort to recognise and utilise the existing skill sets in the country. Recognition of the role of community health workers will also empower the community role within the health system. Until now health workers have felt discriminated by and isolated from mainstream health systems. Examining and realigning the role of all the health professionals in Burma is necessary to build unity and cohesion among health professionals.

4. Ongoing challenges to health as a bridge for peace

Key challenges to the vision and aims of the ethnic and community-based health organisations stem from the continuation of a centralised model of government administration in Burma. Health service delivery in Burma is still organised along a very top-down model, which does not allow for decision-making at more decentralised level, nor does it recognise the systems, resources or authority of ethnic and community-based health organisations.

While steps taken so far towards convergence represent significant milestones, the state remains on course to expand rapidly during the ceasefire period, and presents a number of risks to peace building. Development strategies pursued by the MoH with the backing of international donors and INGOs appear to be moving ahead with little space for input from those on the ground. This has resulted in service overlaps and gaps, in local human resources being poached by INGOs that offer higher salaries, as well as clashing with the strong community-managed primary healthcare approach that has been developed over the past decades in these areas.

Clinics are being constructed in numerous cases by INGOs in territories where the government has limited stable control, without consultation with community and ethnic health organisations. Five such cases have been confirmed and corroborated by a number of stakeholders in Thandauggyi, Hlaingbwe, Myawaddy Kawkareik, and Kyain Seigyi townships of Karen State. Meanwhile, some areas in Myawaddy and

Hlaingbwe townships appear to have attracted overlapping programmes of numerous INGOs, all guided towards specific areas rather than being part of a comprehensive primary healthcare approach. Such issues have been raised by community and ethnic health organisations in talks with the government, but have failed thus far to lead to a solution, and demonstrate a clear area for improvement.

Ultimately, the ethnic and community-based health organisations risk being further marginalised as the government increases its grip on national and international resources and continues to push forward a centralised model of healthcare provision.

5. Conclusions: ongoing challenges, the need for recognition and for trust building

For health to act as a bridge to peace in Burma, health workers from the ethnic and community-based health organisations and from the government need to work together in joint efforts addressing health policy, health systems strengthening, and service delivery. Conversely, peace building concepts and practices need to become an integral part of health policy and planning.

With more than 20 years' experience and trust already built with communities inside Burma, ethnic and community-based health organisations are best placed to take the lead in working to strengthen the existing primary health care services in their areas. However, concrete solutions need to be found, whereby the systems and resources of the ethnic and community-based health organisations are recognised and provided with the authority necessary to operate legally in ethnic minority areas, instead of simply being co-opted by the central government.
The recognition of existing health systems in the different ethnic minority areas is therefore essential, not only for the future of Burma's healthcare systems but also for peace building in Burma. As part of this process, there is also a need for:

- Clear principles of partnership between the government health system and the ethnic and community-based organisations, increasing transparency and accountability in formulating and implementing health projects of central government and international health organizations
- Transparency and a clear understanding of systems and services provided by each the ethnic and community-based organisations and by government health systems, as well as the health status and access needs of these communities
- Dialogue between the ethnic leaders and the government during the transition process about the recognition, financing and integration of health systems supported by the ethnic and community-based organisations
- As part of health sector reform, a devolution of power to regional and local levels, strengthening and development of community participation and networks, in order to ensure a accountable, community-based and community-managed health care system
- Recognition of the role of community health workers and task shifting, and the development of strategies to attract and retain higher cadres of health workers in ethnic and remote areas of the country.

Ultimately, underlying these issues is the need to rebuild trust after decades of conflict. And having provided healthcare in their respective areas for decades, with the state representing a hindrance, a long process of trust-building will likely be necessary before a single health system becomes possible.

References

Backpack Health Worker Team. (2004). Chronic Emergency Backpack Health Worker Team. 2004. Chronic Emergency.

HISWG. (2014). Long road to Recovery – Ethnic and community based health organisations lead the way to better health in Eastern Burma. http://hiswg.org/wp-content/uploads/2015/02/The-Long-Road-to-Recovery-2015_Eng-1.pdf.

Ministry of Health. (2013). Health in Myanmar.

Parmar PK et al. Health and human rights in eastern Myanmar prior to political transition. BMC.

World Bank. Data – Indicators. http://data.worldbank.org/indicator.