

Delivering Healthcare amid Crisis: The Humanitarian Response in Myanmar

ALICE DEBARRE



Cover Photo: A doctor from Médecins Sans Frontières does a medical checkup on a patient with tuberculosis and HIV confection, Shan state, Myanmar, July 5, 2013. Eddy McCall/MSF.

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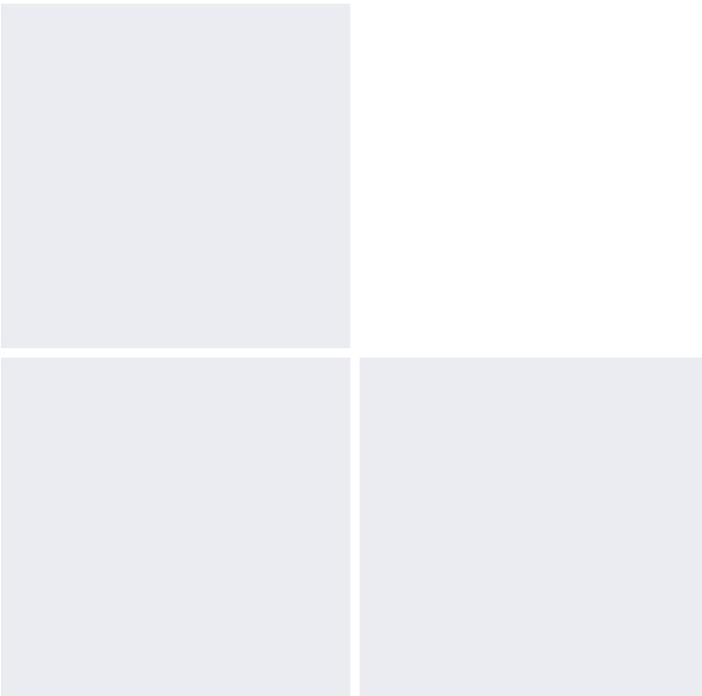
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Abbreviations

ARSA	Arakan Rohingya Salvation Army
IDP	Internally displaced person
KIA	Kachin Independence Army
KIO	Kachin Independence Organization
NLD	National League for Democracy
OCHA	UN Office for the Coordination of Humanitarian Affairs
OHCHR	Office of the UN High Commissioner for Human Rights
UNDP	UN Development Programme
UNFPA	UN Population Fund
UNHCR	UN Refugee Agency
WHO	World Health Organization
WFP	World Food Programme

Executive Summary

Myanmar simultaneously faces multiple armed conflicts and crises, each with its own challenges. In Rakhine state, the government's persecution of the Rohingya people has led to massive displacement, as have decades of armed conflict in Kachin and northern Shan. Combined with chronic underdevelopment, these humanitarian crises have left people without access to adequate healthcare, leading international humanitarian actors to step in. This paper looks at the state of healthcare in these three states, the role of humanitarian actors in the provision of health services, and the trends and challenges affecting the humanitarian health response.

The public health system in Myanmar is generally poor, and government funding for health services is among the lowest in the world. There are wide discrepancies in health services between rural and urban populations and between central and peripheral states such as Rakhine, Kachin, and Shan. In Rakhine, there are only nine public health workers per 10,000 people, and access to secondary and tertiary healthcare is limited. The Rohingya—many confined to camps for internally displaced persons (IDPs)—are particularly affected by barriers to accessing healthcare. In Kachin and northern Shan, access to healthcare is similarly inadequate, with insufficient trained personnel and specialized services. Community-based or ethnic health organizations provide primary healthcare in many areas without government facilities. However, these organizations often have limited capacity and are not equipped to deal with serious health issues.

In these crisis-affected areas, UN agencies and international and local NGOs play an important part in providing healthcare services. However, much of the international focus has been on Rakhine state, with less funding for programs in Kachin and northern Shan. Within Rakhine, international organizations face accusations of bias toward the Rohingya community, despite efforts to develop programming for all communities in Rakhine. Moreover, health actors have focused on the response to malaria, HIV/AIDS, and tuberculosis, leaving a critical gap in mental health services and clinical health responses to sexual and gender-based violence.

Lack of access to people in need is one of the main challenges to the international humanitarian response in all three states. All humanitarian actors, including those providing health services, have to apply for travel authorizations from the government. Most international organizations, and all international staff, have been refused access to non-government-controlled areas in Kachin and northern Shan since 2016. As a result, many international organizations work through local NGOs, which comes with its own challenges. Efforts to ensure meaningful participation of affected populations in the development and implementation of programs also remain inadequate, partly due to access constraints.

Finally, the relation between humanitarian and development efforts, as well as peace and human rights efforts, has been a key question in Myanmar. As the crises become protracted, there is a push for more development work, not least from the government. Some fear this comes at the expense of the humanitarian response. Furthermore, the political and human rights situation has led humanitarian organizations to question the nature of their engagement with the state, in particular in IDP camps.

This paper makes several recommendations for improving the humanitarian health response in Myanmar. These include:

- **Adjusting the scope of the humanitarian response:** Humanitarian actors and donors should not lose sight of the humanitarian needs in Kachin and northern Shan. They should also improve outreach, communication, and trust building to correct the perception of bias toward Rohingya communities in Rakhine. There should be more programming on mental health and clinical responses to sexual and gender-based violence.
- **Advocating for better humanitarian access:** Humanitarian actors should constantly advocate for better access. UN member states and donor agencies should also put its weight behind the humanitarian response in Myanmar.
- **Strengthening local capacities:** Donors should ensure they have the flexibility to fund local organizations that do not fit within their traditional requirements. International organizations should also continue to fund and train

ethnic and community-based health organizations in Kachin and Shan, as well as community health workers and volunteers. Efforts to give a voice to affected populations should be strengthened.

- **Addressing the dilemmas inherent in providing aid amid a development and human rights crisis:** In Rakhine in particular, finding a common position on engagement is vital to ensuring the humanitarian response does not perpetuate the unsustainable status quo. The UN country team and other humanitarian and development actors in Myanmar need to better align their humanitarian, development, and human rights efforts. UN member states also need to take a strong stance to push for change in both the humanitarian and human rights situation in the country.

Introduction

Over the past decade, Myanmar has undergone a series of transitions. Since independence from British colonial rule in 1948, Myanmar's military, known as the "Tatmadaw,"¹ has heavily dominated the country's political space. The transition from military rule to an (at least nominally) civilian parliamentary government began in March 2011. The 2015 general elections brought a landslide victory for the National League for Democracy (NLD), which forms the current "Union Government" under the de facto leadership of State Counsellor Aung San Suu Kyi. Although the government is under civilian leadership, the military still holds significant power. The 2008 Constitution provides that the military hold 25 percent of parliamentary seats, enough to veto any constitutional amendments that may threaten its control. It also heads three key ministries—the Ministries of Defense, Home Affairs, and Border Affairs—independent of civilian oversight.² The 2008 Constitution also put a decentralized political structure in place, making Myanmar a federal state.

Myanmar is extremely ethnically diverse, with

135 ethnic groups officially recognized by the government. The country is majority Bamar, and minority ethnic groups reside primarily in Myanmar's peripheral states. Historically, there is a chasm between the Bamar central regions and peripheral states, which have long been marginalized and disenfranchised. Ethnic minority parties suffered a devastating defeat in the 2015 election and are therefore under-represented in parliament.³ During the elections, some ethnic parties felt undermined by the NLD, which campaigned hard against them, and some members of ethnic minorities chose to support the NLD over their own parties, revealing fractures within these groups. The most marginalized group is the Rohingya—most of whom reside in Rakhine state—which the government of Myanmar does not recognize as an official ethnic group. The government and its policies have effectively rendered the Rohingya people stateless, which has made them the world's largest stateless population and led to severe violations of their human rights. Myanmar is also religiously diverse, with a Buddhist majority and minority Christian, Hindu, and Muslim populations.

Myanmar has been plagued by internal armed conflict, with the Tatmadaw fighting against ethnic armed groups. The various groups are engaged in separate but parallel armed conflicts, notably on the southeastern border with Thailand and the northern border with China in Kachin and Northern Shan states. Starting in 2011, former president Thein Sein's government signed bilateral cease-fires with fifteen ethnic armed groups. After years of negotiations with most of these groups, a Nationwide Ceasefire Agreement was signed in October 2015. However, due to concerns about inclusivity and other political factors, only eight groups, mainly from the southeast, signed the agreement that year, with two additional groups signing on in early 2018.⁴ Most of the larger groups abstained, including those in Kachin and northern Shan states. Those groups remain in varying

1 UN Human Rights Council, *Report of the Detailed Findings of the Independent International Fact-Finding Mission on Myanmar*, UN Doc. A/HRC/39/CRP.2, September 17, 2018, p. 21.

2 Brandon Paladino and Hunter Marston, "Myanmar's Stable Leadership Change Belies Aung San Suu Kyi's Growing Political Vulnerability," Brookings Institution, April 5, 2018.

3 Marte Nilsen and Stein Tønnesson, "Double Marginalisation of Myanmar's Ethnic Minorities," *Myanmar Times*, April 26, 2016; Fiona MacGregor, "Ethnic Parties Fall Short of Expectations," *Myanmar Times*, November 16, 2015.

4 Mona Christophersen and Svein Erik Stave, "Advancing Sustainable Development between Conflict and Peace in Myanmar," New York: International Peace Institute, April 2018, p. 5.

degrees of armed conflict with the government and, in some areas, among themselves. Several non-signatory groups formed the Northern Alliance to strengthen their military and political power. In 2016, the government launched the “21st Century Panglong” peace process, which, although lauded for its broad inclusion of ethnic armed groups, faces fundamental challenges.⁵

In April 2018, as mandated by the UN General Assembly, the UN secretary-general appointed Christine Schraner Burgener as the new UN special envoy to Myanmar, the fifth such special representative mandated to help mediate Myanmar’s internal conflicts and promote human rights.⁶ The current special envoy’s mandate was triggered by the crisis in Rakhine state and includes specific reference to this issue.

Several parts of the country are facing humanitarian crises. The humanitarian situation in the country is characterized by “a complex combination of vulnerability to natural disasters, food and nutrition insecurity, armed conflict, inter-communal tensions, statelessness, displacement, trafficking and risky migration.”⁷ Underdevelopment and chronic poverty further compound this, as well as structural inequalities and discrimination. Systematic marginalization of and discrimination against certain ethnic groups have contributed to the vast needs for humanitarian assistance and protection, most notably in Rakhine state. Numerous reports of violations of international humanitarian and human rights law raise serious protection concerns, including

gender-based violence, statelessness, and movement restrictions.⁸

Approximately 244,000 of the people in need in Myanmar have been internally displaced by armed conflict and violence and are living in camps or camp-like settings in Kachin, Kayin, Shan, and Rakhine states.⁹ Many of the displaced remain dependent on humanitarian assistance to meet basic needs due to restrictions on freedom of movement or limited livelihood opportunities, most acutely among the displaced Rohingya population in Rakhine state.¹⁰ Most are living in overcrowded and inadequate shelters. Hundreds of thousands have fled what some have described as ethnic cleaning and genocide in Rakhine state.¹¹ Most have gone to Bangladesh, which currently hosts close to a million refugees from Myanmar, and some have then gone on to Thailand, Malaysia, and Indonesia.¹²

Access to healthcare is a major concern in Myanmar, as an estimated 941,000 people continue to face obstacles in accessing healthcare services.¹³ Myanmar is facing a double burden of communicable and noncommunicable diseases.¹⁴ Among communicable diseases, the leading causes of death and illness are tuberculosis, HIV-AIDS, and malaria. Among noncommunicable diseases, cardiovascular disease, diabetes, cancer, and chronic respiratory disorders are prevalent. Noncommunicable diseases cause 59 percent of deaths in Myanmar, a figure that is rising as wealth increases.¹⁵ For the UN humanitarian response in 2019, the priority needs in the health sector include

5 See, for example, Bobby Anderson, “Stalemate and Suspicion: An Appraisal of the Myanmar Peace Process,” *Tea Circle*, June 6, 2018.

6 UN General Assembly Resolution 72/248 (January 23, 2018), UN Doc. A/Res/72/248.

7 UN Office for the Coordination of Humanitarian Affairs (OCHA), *Myanmar 2019 Humanitarian Response Plan: January–December 2019*, December 2018.

8 UN Human Rights Council, *Report of the Detailed Findings of the Independent International Fact-Finding Mission on Myanmar*, UN Doc. A/HRC/39/CRP.2, September 17, 2018; Advisory Commission on Rakhine State, “Towards a Peaceful, Fair and Prosperous Future for the People of Rakhine: Final Report,” August 2017; UN General Assembly, *Report of the Special Rapporteur on the Situation of Human Rights in Myanmar*, UN Doc. A/73/332, August 20, 2018.

9 UN Office for the Coordination of Humanitarian Affairs (OCHA), *Myanmar: 2019 Humanitarian Needs Overview*, December 2018.

10 UN OCHA, *Myanmar 2019 Humanitarian Response Plan: January–December 2019*, December 2018.

11 Ginger Gibson, “Bipartisan Senators Call for U.S. ‘Genocide’ Label of Myanmar Killings,” Reuters, December 19, 2018; UN Human Rights Council, *Report of the Detailed Findings of the Independent International Fact-Finding Mission on Myanmar*, UN Doc. A/HRC/39/CRP.2, September 17, 2018; Office of the UN High Commissioner for Human Rights (OHCHR), “End of Mission Statement by the Special Rapporteur on the Situation of Human Rights in Myanmar,” January 25, 2019, available at www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=24114&LangID=E.

12 Note that Bangladesh is not a signatory to the 1951 Refugee Convention or its 1967 Protocol and does not formally recognize them as refugees. As of November 2017, 150,000 registered Rohingya were in Malaysia, though tens of thousands of others are in the country unregistered. Eleanor Albert and Andrew Chatzky, “The Rohingya Crisis,” Council on Foreign Relations, December 5, 2018, available at www.cfr.org/backgrounder/rohingya-crisis.

13 UN OCHA, *Myanmar 2019 Humanitarian Response Plan: January–December 2019*, December 2018.

14 World Health Organization (WHO), *Joint External Evaluation of IHR Core Capacities of the Republic of the Union of Myanmar, Mission Report: 3–9 May 2017*, 2018. For detailed statistics on public health in Myanmar, see Ministry of Health and Sports, Department of Public Health, “Public Health Statistics (2014–2016),” available at www.themimu.info/sites/themimu.info/files/documents/Report_Public_Health_Statistics_Report_2014-2016.pdf.

15 Nazaneen Nikpour Hernandez and Soe Myint, “Can Myanmar’s Older People Lead the Way to Universal Health Coverage?” *The Lancet*, January 14, 2017; Oxford Business Group, “Myanmar’s Government Makes Health Care Investment Key Policy in Health and Education,” in *The Report: Myanmar 2017*.

access to essential healthcare services, reproductive, maternal, adolescent, and child care, disease surveillance, and mental health and psychosocial support.¹⁶

This paper analyzes the humanitarian response in Rakhine, Kachin, and northern Shan states—the three areas accounting for the bulk of the response—with a focus on the health sector. It starts by outlining the dynamics that have created or contributed to the humanitarian crises in those areas and assesses the state of health provision in the country. It then dives deeper into the specific contexts of Rakhine, Kachin, and northern Shan, looking at access to healthcare and analyzing the trends and challenges in the humanitarian health response. Finally, it offers concluding thoughts and recommendations for humanitarian and development actors, donor agencies, and the broader international community.

This paper is based on a combination of desk research, expert interviews, and a two-week field study in Myanmar in November 2018. Over thirty interviews were conducted with representatives from various UN agencies, international and national NGOs, government representatives, researchers, and journalists. Interviews were conducted in Yangon and in Sittwe, Rakhine state. The author did not travel to Kachin and northern Shan but designed the interviews to include views from those states.

Myanmar: A Complex Web of Crises

Barriers to accessing healthcare in Myanmar, particularly in Rakhine, Kachin, and northern Shan states, include armed conflict, displacement, underdevelopment, and the marginalization of minority ethnic groups. These factors also affect the ability of humanitarian actors to provide healthcare to populations in need.

VIOLENCE, SEGREGATION, AND UNDERDEVELOPMENT IN RAKHINE

Rakhine state is situated in western Myanmar, bordering Bangladesh on the north. The majority of the population is ethnically Rakhine Buddhist and resides in the central part of the state. The Rohingya, who for the most part are Muslim, have traditionally resided in the northern regions. There are also a number of other ethnic minorities.¹⁷

Rakhine state is simultaneously facing human rights, security, development, and humanitarian crises. Since independence in 1948, successive governments have refused to recognize the Rohingya as an official ethnic group, perceiving them as foreigners. Myanmar's 1982 citizenship law allowed authorities to deny the Rohingya citizenship, rendering them effectively stateless. As a result, they are denied the right to vote and face severe restrictions on their freedom of movement and access to education and healthcare. They have suffered generations of economic, social, and religious discrimination and suppression. Amnesty International has described the treatment of the Rohingya in Rakhine state as “apartheid.”¹⁸ The September 2018 report of the Independent International Fact-Finding Mission on Myanmar found “reasonable grounds to conclude the existence of the imposition of conditions of life calculated to bring about the physical destruction of the Rohingya group, as an underlying genocidal act.”¹⁹ The UN, United States, and others have described the government's tactics against the Rohingya as “ethnic cleansing.”²⁰ While other communities in Rakhine, particularly other minorities, face abuse and violations of their human rights, protracted statelessness and profound discrimination have made the Rohingya particularly vulnerable.

Rakhine has been plagued by long-standing tensions between the government, the Rakhine community, and the Rohingya community,

16 UN OCHA, *Myanmar 2019 Humanitarian Response Plan: January–December 2019*, December 2018.

17 These include the Chin, Mro, Chakma, Khami, Dainet, and Maramagri. Oxford Burma Alliance, “Ethnic Nationalities of Burma,” n.d., available at www.oxfordburmaalliance.org/ethnic-groups.html.

18 Amnesty International, “Caged without a Roof: Apartheid in Myanmar's Rakhine State,” November 2017.

19 UN Human Rights Council, *Report of the Detailed Findings of the Independent International Fact-Finding Mission on Myanmar*, UN Doc. A/HRC/39/CRP.2, September 17, 2018, p. 356.

20 “‘No Other Conclusion,’ Ethnic Cleansing of Rohingyas in Myanmar Continues—Senior UN Rights Official,” *UN News*, March 6, 2018, available at <https://news.un.org/en/story/2018/03/1004232>; Rich McKay, “Pompeo Decries ‘Abhorrent Ethnic Cleansing’ in Myanmar on Anniversary,” *Reuters*, August 26, 2018.

sometimes leading to violence and conflict. Some Rakhine perceive the Rohingya as illegal migrants from Bangladesh and profess concern about becoming a minority in the state. At the same time, statelessness and discrimination have created strong resentment among some Rohingya. In 2012, widespread violence led the government to declare a state of emergency and deploy military units to conflict-affected areas. As a result, 140,000 Rohingya were placed in internal displacement camps—that, over time, have turned into what some describe as internment camps—where they remain.²¹

In October 2016, a new insurgent group, the Arakan Rohingya Salvation Army (ARSA), attacked a military border post. In response, the Tatmadaw conducted clearance operations throughout northern Rakhine state, reportedly killing 1,000 people and causing further displacement.²² The crisis worsened after ARSA attacked police and army posts in August 2017 and the military responded with a brutal campaign that destroyed hundreds of Rohingya villages in northern Rakhine and triggered a mass exodus of Rohingya to Bangladesh. There have been increasing reports of clashes between the Tatmadaw and another armed group, the Arakan Army, displacing over 5,000 people as of January 2019.²³ A recent International Crisis Group report warns of the risk that an escalation would reinforce ethnic divisions in Rakhine and further jeopardize the peace process.²⁴

The government's steps to tackle this displace-

ment have caused concern in the international community. None of these steps has yet addressed the underlying discrimination or disenfranchisement that drove the violence, including severe restrictions on freedom of movement and access to services. To address the refugee crisis, in November 2017, Myanmar and Bangladesh agreed to a procedural framework for the repatriation of refugees from Myanmar. Unlike agreements of this sort between other countries, the UN Refugee Agency (UNHCR) was not involved. The government of Myanmar nonetheless signed a memorandum of understanding with the UN Development Program (UNDP) and UNHCR in June 2018 establishing a framework for cooperation aimed at creating the conditions conducive to the voluntary, safe, dignified, and sustainable repatriation of Rohingya refugees to their place of origin or another place of their choosing.²⁵ The memorandum was criticized for conceding too much to the government and for its lack of guarantees for the safety of returnees²⁶—though one interviewee thought getting the government to sign an agreement at all was a positive step.²⁷ After a visit to Bangladesh in July 2018, the UN special rapporteur on human rights in Myanmar stated that, given the absence of progress or will on the part of the government to dismantle its discriminatory system and make northern Rakhine safe for the Rohingya, the displaced would not be returning to Myanmar in the near future.²⁸

Nonetheless, Myanmar and Bangladesh agreed to start returning over 2,000 people starting on

21 Brandon Paladino and Hunter Marston, "Myanmar's Stable Leadership Change Belies Aung San Suu Kyi's Growing Political Vulnerability," Brookings Institution, April 5, 2018.

22 See, for example, Adam Withnall, "Burmese Government 'Kills More Than 1,000 Rohingya Muslims' in Crackdown," *The Independent*, February 8, 2017. ARSA was a new insurgency group born of desperation after decades of oppression and posed a new challenge to the government's efforts to address the complex challenges in Rakhine state. Laignee Barron, "Rohingya and the 'Paper Tiger' Insurgency," *The Diplomat*, June 1, 2017; International Crisis Group, "Myanmar: A New Muslim Insurgency in Rakhine State," Report No. 283, December 15, 2016.

23 UN OCHA, "Asia and the Pacific: Weekly Regional Humanitarian Snapshot (8–14 Jan 2019)," January 2019, available at <https://reliefweb.int/report/indonesia/asia-and-pacific-weekly-regional-humanitarian-snapshot-8-14-jan-2019>. The Arakan Army is an ethnic armed group operating mainly in Kachin and Rakhine states, made up largely of members of the Buddhist Rakhine ethnic group. See, for example, Moe Myint, "Arakan Army Claims It Killed 3 Tatmadaw Soldiers in Remote Clash," *The Irrawaddy*, November 23, 2018; Nan Lwin Hnin Pwint, "Tatmadaw, Arakan Army Clash in Buthidaung Township," *The Irrawaddy*, December 6, 2018; Ministry of Information of Myanmar, "AA Launches Massive Coordinated Attacks on Four Border Police Outposts in Buthidaung Township, Leaves 9 Injured, 13 Police Personnel Killed," Facebook, January 4, 2019, available at www.facebook.com/MOITWebportalMyanmar/posts/1870725416388649?_tn_=-K-R.

24 International Crisis Group, "A New Dimension of Violence in Myanmar's Rakhine State," Briefing No. 154, January 24, 2019.

25 This memorandum of understanding was a confidential document that was eventually leaked. *Memorandum of Understanding between The Ministry of Labour, Immigration and Population of the Government of the Republic of the Union of Myanmar (GoM) and the United Nations Development Programme and the Office of the United Nations High Commissioner for Refugees*, May 30, 2018, available at <https://progressivevoicemyanmar.org/wp-content/uploads/2018/05/382854287-The-MOU-between-Myanmar-Government-and-UNDP-and-UNHCR.pdf>.

26 See, for example, Poppy McPherson and Zeba Siddiqui, "Secret U.N.-Myanmar Deal on Rohingya Offers No Guarantees on Citizenship," *Reuters*, June 29, 2018.

27 Interview with civil society representative, Yangon, November 2018.

28 OHCHR, "Myanmar: Discriminatory Policies Means No Return for Refugees Anytime Soon, Says Expert," July 9, 2018, available at www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23348&LangID=E.

November 15, 2018.²⁹ Two reception centers and one transition center meant to temporarily host refugees have been set up in northern Rakhine. The UN and other NGOs, as well as all those interviewed for this research, made clear that they considered this move premature.³⁰ UNHCR said it would not facilitate returns but that “Myanmar authorities should allow these refugees to undertake... go-and-see visits without prejudice to their right to return at a later date.”³¹ One interviewee expressed concern at this suggestion, stating that such visits, if conducted, should be monitored and protected by the UN.³²

As of January 2019, no refugees have come back through official channels. Rather, tens of thousands have continued to leave Myanmar.³³ Refugees in Bangladesh are terrified at the prospect of being forcibly returned to Rakhine. Following announcements of possible returns in November 2018, some fled the camps, and others threatened or attempted suicide.³⁴ In one of the camps, there were large demonstrations by Rohingya refugees against plans for repatriation, while others demonstrated near the border.³⁵ Some ethnic Rakhine also oppose returns and have held demonstrations to stop them, calling for the vetting of returnees and their resettlement in certain secure areas in order to maintain “Muslim-free zones.”³⁶ However, some experts argue that increasing diplomatic pressure from China, which has economic and geostrategic interests in Myanmar and Rakhine state in particular, as well as the perceived emerging global consensus that most refugees are unlikely to return

voluntarily in the foreseeable future, could incentivize Bangladesh to push through limited returns.³⁷

Even though most Rohingya ultimately would like to return to the places they consider home, voluntary returns will only be possible if conditions in Rakhine state improve. One obstacle is that many refugees’ places of origin are no longer habitable. Villages have been destroyed, land has been bulldozed, and there have reportedly been massive land grabs, with the military and private companies building infrastructure on land formerly owned by Rohingya.³⁸ The Office of the UN High Commissioner for Human Rights also continues to receive reports of ongoing violations of the rights of the Rohingya in northern Rakhine, including allegations of killings, disappearances, and arbitrary arrests, as well as widespread restrictions on freedom of movement and access to healthcare and education.³⁹

Except for the government’s establishment of a Commission of Enquiry,⁴⁰ which has yet to produce any results, there has been no real movement on the questions of citizenship, freedom of movement, and security for the Rohingya or accountability for the events of August 2017. In fact, administrators in northern Rakhine recently stated it would be impossible for the government to agree to citizenship demands. Those who return will instead reportedly be forced to enroll in the government’s National Verification Card scheme, through which they may be able to apply for citizenship but without any guarantee as to whether or when they

29 International Crisis Group, “Bangladesh-Myanmar: The Danger of Forced Rohingya Repatriation,” Briefing No. 153, November 12, 2018.

30 See, for example, “42 NGOs Warn That Return of Refugees to Myanmar Now Would Be Dangerous and Premature,” November 9, 2018, Reliefweb, available at <https://reliefweb.int/report/myanmar/42-ngos-warn-return-refugees-myanmar-now-would-be-dangerous-and-premature>.

31 UN Refugee Agency (UNHCR), “Statement by UN High Commissioner for Refugees on the Repatriation of Rohingya Refugees to Myanmar,” November 11, 2018, available at www.unhcr.org/en-us/news/press/2018/11/5be7c4b64/statement-un-high-commissioner-refugees-repatriation-rohingya-refugees.html.

32 Interview with humanitarian donor, Yangon, November 2018.

33 International Crisis Group, “Bangladesh-Myanmar: The Danger of Forced Rohingya Repatriation.”

34 Ibid.; Meenakshi Ganguly, “Rohingya Refugees Terrified of Being Forced Back to Myanmar,” Human Rights Watch, November 14, 2018.

35 UNICEF, “Geneva Palais Briefing Note: Rohingya Refugee Repatriation and the Situation in Rakhine State, Myanmar,” November 16, 2018, available at www.unicef.org/press-releases/geneva-palais-briefing-note-rohingya-refugee-repatriation-and-situation-rakhine; Mohammad Nurul Islam, “Bangladesh Faces Refugee Anger over Term ‘Rohingya,’ Data Collection,” *Reuters*, November 16, 2018; “Rohingya Rejection Ruins Bangladesh Repatriation Effort,” AFP, November 15, 2018.

36 International Crisis Group, “Bangladesh-Myanmar: The Danger of Forced Rohingya Repatriation”; “Protest in Myanmar’s Rakhine State Opposes Rohingya Return,” AFP, November 25, 2018.

37 Ibid.

38 Interview with humanitarian actor, Sittwe, November 2018.

39 OHCHR, “Bachelet: Returning Rohingya Refugees to Myanmar Would Place Them at Serious Risk of Human Rights Violations,” November 13, 2018, available at www.ohchr.org/FR/NewsEvents/Pages/DisplayNews.aspx?NewsID=23865&LangID=E.

40 Office of the President of Myanmar, “Government of the Republic of the Union of Myanmar Establishes the Independent Commission of Enquiry,” Press Release 8/2018, 30 July 2018.

would receive it.⁴¹ According to one civil society representative, the opposition to citizenship lies mainly in the state government in Rakhine rather than the national government.⁴² While the decision will ultimately be made at the national level, the national government is reportedly adept at deferring to various departments and agencies rather than providing clear-cut answers.

Approximately 128,000 people, most of them Rohingya, remain in twenty-three camps and sites for internally displaced persons (IDPs) in central Rakhine, which they require government permission to leave.⁴³ However, the government has been developing and implementing a National Strategy for Closure of IDP camps in Myanmar.⁴⁴ According to the government, this is in line with the recommendations of the Advisory Commission on Rakhine state (the “Annan Commission”) and part of development efforts. While camp closures were indeed among the commission’s recommendations, there is widespread concern about the way the government is going about these closures.⁴⁵ It is focusing on building what it describes as permanent shelters for IDPs in or close to existing camps. IDPs have for the most part not been consulted in this process.

Some humanitarian actors describe the process as “camp reclassification” rather than camp closure. Indeed, conditions in these shelters remain largely unchanged from the camps, notably in terms of the lack of freedom of movement. Moreover, some fear they will no longer be able to access humanitarian services, as they are no longer considered IDPs. One interviewee described the camp closures as forcing the Rohingya population further to the margins.⁴⁶ More broadly, there is now a generation of Rakhine and Rohingya people who

do not have the experience of interacting with each other. Previous linkages and relationships are being replaced by a narrative that says letting the two communities live alongside each other would pose a security risk.

Beyond its human rights and security issues, Rakhine is Myanmar’s second poorest state, with a poverty rate of 78 percent compared to the national average of 38 percent.⁴⁷ It suffers from historic underinvestment in infrastructure, healthcare, education, and human capital and a lack of employment opportunities.⁴⁸ Movement restrictions on the Rohingya have hurt the economy, and intercommunal tensions continue to deter private sector investment.⁴⁹ Rakhine is also susceptible to natural disasters such as storms and floods.

The security and human rights crises, compounded by historical underdevelopment, have triggered a humanitarian crisis. According to the UN, 715,000 people are in need of humanitarian protection and assistance in Rakhine state alone.⁵⁰ IDPs are cut off from most livelihood and educational opportunities and depend on humanitarian aid for survival. As people fled, the crops and livestock they left behind were torched, looted, or seized, and those who stayed have limited access to markets because of movement restrictions, leading to high rates of malnutrition. More generally, there are protracted trends of both acute and chronic malnutrition across the state. Communicable diseases such as dengue fever, malaria, and measles are endemic in Rakhine due to poor access to clean water and sanitation and low rates of immunization.⁵¹ Many Rohingya—men, women, and children—have been subjected to rape and other forms of sexual violence.⁵² Women often remain without medical care and treatment during

41 Su Myat Mon, “Refugees’ Citizenship Demands ‘Impossible’: Myanmar Govt,” *Frontier Myanmar*, November 20, 2018.

42 Interview with civil society representative, New York, October 2018.

43 UN OCHA, “Myanmar: IDP Sites in Rakhine State (as of 31 Mar 2018),” May 1, 2018, available at <https://reliefweb.int/map/myanmar/myanmar-idp-sites-rakhine-state-31-mar-2018>.

44 “Workshop on National Strategy for Closing IDP Camps Held,” *Global New Light of Myanmar*, November 30, 2018. The first workshop was held in June 2018.

45 See, for example, Emanuel Stoakes and Ben Dunant, “As Camps Close in Rakhine, Humanitarians Fear Complicity in Permanent Segregation,” *Frontier Myanmar*, October 13, 2018.

46 Interview with humanitarian actor, Sittwe, November 2018.

47 Albert and Chatzky, “The Rohingya Crisis.”

48 Center for Diversity and National Harmony, “Building Resilience to Communal Violence: Lessons from Rakhine State,” September 2017, p. 1.

49 Advisory Commission on Rakhine State, “Towards a Peaceful, Fair and Prosperous Future for the People of Rakhine,” p. 10.

50 UN OCHA, *Myanmar 2019 Humanitarian Response Plan: January–December 2019*, December 2018.

51 WHO, *Bangladesh/Myanmar: Rakhine Conflict 2017—Public Health Analysis and Interventions*, October 10, 2017, pp. 5, 11; Advisory Commission on Rakhine State, “Towards a Peaceful, Fair and Prosperous Future for the People of Rakhine.”

52 Médecins Sans Frontières, “‘No One Was Left’: Death and Violence against the Rohingya,” March 9, 2018; Women’s Refugee Commission, “It’s Happening to Our Men as Well’: Sexual Violence against Rohingya Men and Boys,” November 2018.

pregnancy,⁵³ and only 19 percent give birth in professional health facilities.⁵⁴ Although there is no comprehensive data, interviewees consistently mentioned the enormous mental health needs of the population in Rakhine.

ETHNIC ARMED ORGANIZATIONS AND DISPLACEMENT IN KACHIN AND NORTHERN SHAN

Kachin and Shan are situated in the northeast of the country and share a border with China. In both areas, ethnic armed groups are fighting for influence and autonomy against Tatmadaw campaigns for better control of these areas. In Kachin, a seventeen-year cease-fire between the Kachin Independence Organization's (KIO) armed branch, the Kachin Independence Army (KIA), and the Tatmadaw collapsed in 2011 when government forces attacked KIA-controlled areas.⁵⁵ Since then, armed conflict has varied in intensity and frequency, and UNICEF has described Kachin as the state most affected by conflict in recent years.⁵⁶ This has led large sections of the civilian population to lose trust in the government and the Tatmadaw.⁵⁷ In August 2011, fighting in Kachin spread to northern Shan state, which also has a long history of armed conflict. With the collapse of cease-fires there, fighting continues sporadically both among ethnic armed groups and between these groups and the Tatmadaw.⁵⁸ Ethnic armed groups control areas of both Kachin and northern Shan states.

The KIO and other ethnic armed groups in these states have not signed the Nationwide Ceasefire

Agreement, which the government and Tatmadaw have made clear they see as the only way into the peace process. Instead, four groups, including the KIA, formed the Northern Alliance in December 2016, as a military coalition to fight the Tatmadaw.⁵⁹ China has been brokering peace talks between the KIO and Tatmadaw since 2013 but has also continued to sell arms to the Tatmadaw and to block those fleeing the violence from crossing into China.⁶⁰ For most of those interviewed for this research (in November 2018), there were few prospects for change in the near future. In December, however, the Tatmadaw announced it would halt military operations in Kachin and Shan states for four months and hold talks with armed groups that have not signed the Nationwide Ceasefire Agreement. The Northern Alliance declared it would not negotiate unless the cease-fire is extended nationwide, including to Rakhine state.⁶¹

The civilian population has been widely affected by the continued fighting.⁶² In Kachin, around 97,000 people remain displaced across 139 camps or camp-like settings, some since the breakdown of the cease-fire in 2011.⁶³ Over 43 percent of these IDPs live in non-government-controlled areas where humanitarian access is limited.⁶⁴ The number of those displaced outside of camps in urban areas is unknown. In Shan, approximately 9,000 people are displaced.⁶⁵ As opposed to Kachin, where displacement can be described as chronic, displacement in northern Shan is more dynamic. People tend to stay close to their home to access their land and tend to their crops, which often

53 UN OCHA, *Myanmar 2019 Humanitarian Response Plan: January–December 2019*, December 2018.

54 Advisory Commission on Rakhine State, "Towards a Peaceful, Fair and Prosperous Future for the People of Rakhine."

55 Catherine Lee et al., "Mental Health and Psychosocial Problems among Conflict-Affected Children in Kachin State, Myanmar: A Qualitative Study," *Conflict and Health* 12, No. 39 (2018).

56 UNICEF, "Where We Work: Kachin," available at www.unicef.org/myanmar/overview_25053.html.

57 Ashley South, "Protecting Civilians in the Kachin Borderlands, Myanmar: Key Threats and Local Responses," Humanitarian Policy Group, December 2018.

58 See, for example, "Myanmar: 19 Die in Fresh Clashes between Army and Rebels in Shan State," AFP, May 12, 2018.

59 The other members of the Northern Alliance are the Ta'ang National Liberation Army (TNLA), the Arakan Army, and the Myanmar National Democratic Alliance Army (MNDAA).

60 Gavin Kelleher, "Beyond the Rohingya: Myanmar's Other Crises," *The Diplomat*, February 8, 2018. Since international criticism of the NLD government increased in 2016, China has been reasserting its diplomatic support for the government and is also keen to ensure that unrest in Kachin does not spill into its territory.

South, "Protecting Civilians in the Kachin Borderlands, Myanmar," p. 6.

61 Office of the Commander-in-Chief of Defence Services of Myanmar, "Statement on Ceasefire and Eternal Peace," December 21, 2018, available at www.seniorgeneralminawngkhlaing.com.mm/en/10817/statement-on-ceasefire-and-eternal-peace/; Lawi Weng, "Northern Alliance Demands Ceasefire Covers Rakhine State," *The Irawaddy*, December 28, 2018.

62 Lee et al., "Mental Health and Psychosocial Problems among Conflict-Affected Children in Kachin State, Myanmar."

63 World Food Programme (WFP), "WFP Myanmar Country Brief," September 2018, available at <https://docs.wfp.org/api/documents/bd9a4dc295764531a9054a8eba263d8d/download/>.

64 UN OCHA, *Myanmar: 2018 Humanitarian Needs Overview*, November 2017; UNICEF, "Where We Work: Kachin."

65 UN OCHA, *Myanmar 2019 Humanitarian Response Plan: January–December 2019*, December 2018.

exposes them to danger, and the same people can be displaced multiple times.⁶⁶ There have also been reports of forced displacement for no military or security reasons.⁶⁷ In both Kachin and northern Shan, those displaced often live in overcrowded conditions with inadequate shelter.⁶⁸ People living in camps also continue to be subject to threats such as domestic violence, nearby airstrikes and heavy artillery fire, and drug addiction.⁶⁹

As in Rakhine, the government has been talking about closing IDP camps. In Kachin, the government is looking to pilot small-scale resettlement and return initiatives. In some cases, it has reportedly forcibly moved IDPs into camp-like “model villages” that lack adjoining agricultural land.⁷⁰ Unfortunately, in closing IDP camps, the government has given little consideration to people’s living conditions, access to services and livelihood opportunities. As displacement becomes protracted and assistance in IDP camps decreases, some people are starting to want to return to their places of origin. However, they face ongoing insecurity, landmine contamination, and the lack of livelihood opportunities.⁷¹

There are also widespread violations of international humanitarian and human rights law by both sides of the conflict, but particularly by the Tatmadaw.⁷² Trafficking is a concern, with women and girls being sent to China where they are sold as brides to address that country’s gender imbalance. Once purchased, they are reportedly locked in a

room and raped repeatedly with intent to cause pregnancy.⁷³ Grave violations against children have also been committed, including through the recruitment and use of child soldiers. In its 2018 report, the UN Human Rights Council’s Independent International Fact-Finding Mission on Myanmar details arbitrary arrests, torture, indiscriminate shelling of civilian areas, destruction of property, restrictions on humanitarian access, and egregious sexual violence.⁷⁴ Gender-based violence against both women and men is high, although likely still significantly underreported.⁷⁵

In general, the needs of civilians in conflict-affected areas are not well understood. The level of trauma is high.⁷⁶ Drug use is a public health concern in both Kachin and Shan and has an impact on productivity, security, and health.⁷⁷ General restrictions on freedom of movement, including checkpoints, documentation checks, and curfews, make it harder for civilians to obtain livelihoods and access basic services.⁷⁸ For example, the government will not issue identification documents to people involved with ethnic armed groups, which may hinder their access to services.⁷⁹ Furthermore, tens of thousands of people live in non-government-controlled areas, which few actors are able to access to provide services. In Kachin, over 96,000 people lack access to effective healthcare services.⁸⁰

66 Interview with humanitarian actor, Yangon, November 2018.

67 UN Human Rights Council, *Report of the Detailed Findings of the Independent International Fact-Finding Mission on Myanmar*, UN Doc. A/HRC/39/CRP.2, September 17, 2018, p. 53.

68 *Ibid.*, p. 92.

69 South, “Protecting Civilians in the Kachin Borderlands, Myanmar,” p. 11.

70 Interview with humanitarian actor, Yangon, November 2018.

71 See, for example, UN OCHA, *Myanmar 2019 Humanitarian Response Plan: January–December 2019*, December 2018; UN Human Rights Council, *Report of the Detailed Findings of the Independent International Fact-Finding Mission on Myanmar*, UN Doc. A/HRC/39/CRP.2, September 17, 2018, pp. 94–95.

72 UN Human Rights Council, *Report of the Detailed Findings of the Independent International Fact-Finding Mission on Myanmar*, UN Doc. A/HRC/39/CRP.2, September 17, 2018.

73 Heather Barr, “You Should Be Worrying About the Woman Shortage,” Human Rights Watch, December 2, 2018.

74 UN Human Rights Council, *Report of the Detailed Findings of the Independent International Fact-Finding Mission on Myanmar*, UN Doc. A/HRC/39/CRP.2, September 17, 2018.

75 Interview with humanitarian actor, Yangon, November 2018.

76 See, for example, Lee et al., “Mental Health and Psychosocial Problems among Conflict-Affected Children in Kachin State, Myanmar.”

77 See, for example, International Crisis Group, “Bangladesh-Myanmar: The Danger of Forced Rohingya Repatriation.”

78 UN Human Rights Council, *Report of the Detailed Findings of the Independent International Fact-Finding Mission on Myanmar*, UN Doc. A/HRC/39/CRP.2, September 17, 2018, p. 73.

79 Interview with humanitarian actor, Yangon, November 2018.

The Provision of Healthcare in Myanmar

The primary responsibility for providing the population of Myanmar with health services rests with the government. However, given the historical underinvestment in the public health sector, ongoing armed conflict and violence, and natural disasters, the international humanitarian and development communities play an important role in Myanmar's health sector, notably in the peripheral states of Rakhine, Kachin, and northern Shan.

A POOR PUBLIC HEALTH SYSTEM

The Ministry of Health and Sports (MoHS) heads Myanmar's public health system, acting as both a governing agency and a healthcare provider.⁸¹ It is composed of seven departments, including the Department of Public Health, which is responsible for primary healthcare. At the national level, the country has general, specialist, and teaching hospitals. Each administrative level theoretically has a health facility, with regional or state, district, township, and sub-township or station hospitals, as well as rural health centers in wards or village tracts and sub-rural health centers in villages.⁸² There is also a private health system for the Tatmadaw within the public health system, which is reportedly of high quality.

The systematic marginalization of peripheral states where ethnic minorities form a regional majority and long-standing grievances between these ethnic minorities and the Tatmadaw have led to the development of subnational structures outside of the public health system. These include primary healthcare facilities led by "ethnic health organizations" or civil society organizations.⁸³ Health workers in these facilities are trained outside the public health system and are therefore unaccredited. The government does not recognize

these organizations and facilities and many are unregistered, making it harder for the unrecognized organizations to attract funding. The government aims to make Myanmar a fully federalized state with a decentralized health system that incorporates ethnic health organizations, provides them their own budget, and brings all health workers under a uniform accreditation system.⁸⁴ However, there appears to be no plan to guide these efforts. Health budgets are still currently managed at the central level, and the government health sector remains highly centralized.⁸⁵

Alongside the centralized public health system, Myanmar has an extensive private health sector, which includes for-profit hospitals as well as specialist and general clinics.⁸⁶ Many government health workers also have private practices on the side. An increase in the number of tourists and foreign workers has also led to better quality services and hospitals. For the vast majority of people, particularly in urban areas, the first contact with healthcare is the private sector.⁸⁷ Until 2014, foreigners were barred from investing in Myanmar's health sector, but they can now invest in private healthcare structures and services as long as they do not own more than 80 percent of the venture.⁸⁸ In addition, there is a vast network of UN agencies and national and international non-governmental organizations providing health services across the country (see below).

Overall, the state of Myanmar's health system is poor. It lags behind in all components of the World Health Organization's (WHO) health system building blocks, and the country remains a Grade 3 emergency for the WHO—the highest level of concern. This is attributable to poverty, ongoing conflict, endemic and institutional inequality, weak institutions and poor governance, poor infrastructure, and seasonal natural disasters.⁸⁹ Access to adequate healthcare is also hindered by financial,

81 WHO, *Bangladesh/Myanmar: Rakhine Conflict 2017—Public Health Analysis and Interventions*.

82 Nyi Nyi Latt et al., "Healthcare in Myanmar," *Nagoya Journal of Medical Science* 78, No. 2 (2016).

83 Elliot Brennan, "Myanmar's Public Health System and Policy: Improving but Inequality Still Looms Large," *Tea Circle*, August 30, 2017; Health Information System Working Group, "The Long Road to Recovery: Ethnic and Community-Based Health Organizations Leading the Way to Better Health in Eastern Burma," February 2015, p. 5.

84 Interview with development actor, Yangon, November 2018.

85 Health Information System Working Group, "The Long Road to Recovery," p. 7.

86 WHO, *Bangladesh/Myanmar: Rakhine Conflict 2017—Public Health Analysis and Interventions*, p. 11.

87 Interview with development actor, Yangon, November 2018.

88 Oxford Business Group, "Myanmar's Government Makes Health Care Investment Key Policy in Health and Education."

89 Brennan, "Myanmar's Public Health System and Policy."

transport, and cultural barriers and, in states like Kachin and northern Shan, by conflict-related displacement and restrictions on movement.

Government funding for health services is limited except when it comes to the Tatmadaw. Despite increases in government spending for health from a dismal 0.2 percent of GDP in 2009, it remains only 3.65 percent of the total budget, among the lowest in the world.⁹⁰ As a result, health-care costs are high, and cost is the main determinant of when and where people seek treatment. Almost all government health services require patients to pay out-of-pocket.⁹¹ Out-of-pocket financing decreased from 81 percent to 65 percent of Myanmar's total health expenditure in 2015, but this still far exceeds the global average of 32 percent and remains the dominant source of financing for health.⁹² A recent government policy set the goal of reducing out-of-pocket expenses to 25 percent of the overall health expenditure.⁹³

Public hospitals lack many of the basic facilities and equipment for adequate service delivery. In general, the healthcare infrastructure outside of Yangon and Mandalay is extremely poor, with wide disparities in health services between urban and rural areas, where the majority of Myanmar's population lives.⁹⁴ There is also widespread inequality in health services between central and peripheral states.⁹⁵ The government's health information systems are inadequate and characterized by the lack of timely, complete, and relevant data. In conflict-affected regions and states, data collec-

tion has been constrained for decades, although some ethnic health organizations have set up their own data collection mechanisms and health information systems under the Health Information System Working Group.⁹⁶

In 2014, there were 16.4 doctors, nurses, and midwives per 10,000 people,⁹⁷ well below the 22.8 considered necessary to provide basic health services.⁹⁸ Health workers are also insufficiently representative of the population in terms of ethnicity (a vast majority of doctors are ethnically Bamar), gender, and language capabilities, and many have insufficient training.⁹⁹ These shortfalls primarily affect remote areas and areas inhabited by ethnic minorities. The government has a budget and commitment to improve human resources for health, but it is a challenge to recruit staff, in particular for remote areas.¹⁰⁰ Another challenge is that international organizations tend to attract the most qualified health workers by offering more attractive salaries and benefits.

Because many remote areas have few secondary and tertiary health professionals,¹⁰¹ most people only have access to primary healthcare services, which are not robust enough to provide care for noncommunicable diseases.¹⁰² One gap is mental healthcare, for which services are "practically nonexistent," according to one interviewee.¹⁰³ There are only two mental health hospitals in the country, with limited capacity, and in 2016, there was one psychiatrist per 260,000 people.¹⁰⁴ Only 0.3 percent of spending on health goes to mental health

90 Ministry of Health and Sports of Myanmar, *Myanmar National Health Plan 2017–2021: Executive Summary*, December 2016, available at https://themimu.info/sites/themimu.info/files/documents/Executive_Summary_Myanmar_National_Health_Plan_2017-2021_ENG.pdf; Emergo, "Worldwide Spending on Healthcare," July 2016, available at www.emergobyul.com/resources/worldwide-health-expenditures; In 2007, Myanmar had the world's smallest budget for healthcare. See "Almost Half of All World Health Spending Is in the United States," Progressive Policy Institute, January 17, 2007; and Oxford Business Group, "Myanmar's Government Makes Health Care Investment Key Policy in Health and Education."

91 Health Information System Working Group, "The Long Road to Recovery," p. 9.

92 Ministry of Health and Sports of Myanmar, *Myanmar National Health Plan 2017–2021: Executive Summary*, December 2016.

93 Brennan, "Myanmar's Public Health System and Policy."

94 Health Information System Working Group, "The Long Road to Recovery," p. 9.

95 Brennan, "Myanmar's Public Health System and Policy."

96 Health Information System Working Group, "The Long Road to Recovery," p. 17.

97 UN Population Fund (UNFPA), *Myanmar SRMNAH Workforce Assessment*, 2017, p. 5.

98 WHO, *World Health Report: Working Together for Health*, 2006.

99 Brennan, "Myanmar's Public Health System and Policy."

100 Interview with development actor, Yangon, November 2018.

101 WHO, *Joint External Evaluation of IHR Core Capacities of the Republic of the Union of Myanmar, Mission Report: 3–9 May 2017*, 2018; Health Information System Working Group, "The Long Road to Recovery," p. 27.

102 Interview with development actor, Yangon, November 2018.

103 Interview with humanitarian actor, Yangon, November 2018.

104 Brennan, "Year in Review: Public Health in Myanmar," *Tea Circle*, May 21, 2018; Jared Downing, "Mending Troubled Minds," *Frontier Myanmar*, October 21, 2016.

services, and the current legislation on mental health is the 1912 Lunacy Act.¹⁰⁵ A new mental health bill has reportedly been in the works since 2013 but has not reached parliament, though a mental health policy is incorporated into the country's National Health Policy.¹⁰⁶

There is also a gap in the availability of sexual and reproductive healthcare. There has been a gradual increase in the country's contraceptive prevalence rate, but in 2016 it was only 52.2 percent.¹⁰⁷ There is little comprehensive data on adolescent sexual and reproductive health, but studies show that there is a clear need for such services.¹⁰⁸ In 2017, sexual and reproductive health providers in Myanmar expressed deep concern at the impact of the US "global gag rule," estimated to result in 22,300 unintended pregnancies, 13,000 abortions, an additional 8,000 unsafe abortions, and 17 maternal deaths.¹⁰⁹ Indeed, outreach teams funded by the US Agency for International Development (USAID) have stopped providing contraceptives.¹¹⁰ The maternal mortality ratio is 282 deaths per 100,000 births, compared to an average of 140 in Southeast Asia.¹¹¹ Sixty-three percent of deliveries take place at home, and deaths are significantly higher in rural areas, where access to reproductive health services is limited.¹¹² The availability of skilled birth attendants is far below the average recommended by WHO.¹¹³ As a result, Myanmar's Five-Year Strategic Plan for Reproductive Health (2014–2018) prioritized scaling up and strengthening midwifery. Necessary efforts are also ongoing to

improve the quality of services provided by midwives, including by upgrading the midwifery curriculum and the duration of their training.¹¹⁴ However, such programs must still overcome constraints relating to low levels of investment, health worker shortages, and limited access to areas affected by armed conflict.¹¹⁵

Despite these gaps and challenges, there has been increased recognition of the importance of public health and investing in health. Aung San Suu Kyi has stressed that healthcare is a priority for her party's government,¹¹⁶ and a number of health policies and plans have been developed.¹¹⁷ As mentioned above, government expenditure on health remains low but has increased. Since 2016, the government has established universal healthcare and access to a basic essential package of health services as central policy objectives.¹¹⁸ The country's National Health Plan (2017–2021) aims to strengthen the country's health system and support the implementation of universal healthcare, with a focus on improving access to essential health services and reducing out-of-pocket costs.¹¹⁹ This policy includes annual operational plans, with efforts in 2017 focused on providing essential service packages and conducting vaccination campaigns.¹²⁰

One challenge to establishing a comprehensive public health system is that—because the government was slow in developing health policies—ethnic health organizations, NGOs, and donor

105 Brennan, "Mental Illness: Myanmar's Hidden Epidemic," *Frontier Myanmar*, October 28, 2018.

106 Htike Nanda Win, "Government Urged to Draft Mental Health Care Policy," *Myanmar Times*, February 19, 2018.

107 World Bank, "Contraceptive Prevalence, Any Methods (% of Women Ages 15–49)," accessed January 2019, available at <https://data.worldbank.org/indicator/SP.DYN.CONU.ZS?locations=MM>. The global average was at 62.662 in 2014.

108 UNFPA, *Myanmar SRMNAH Workforce Assessment*, p. 11.

109 Michael Safi and Kate Hodal, "Global Gag Rule Jeopardizes Future of Asia Health Initiatives, Campaigners Say," *The Guardian*, January 26, 2017.

110 Sasha Ingber, "Kenyan Clinic Rejects Trump Abortion Policy, Loses \$2 Million in U.S. Aid," NPR, May 2, 2018.

111 Ministry of Labour, Immigration and Population of Myanmar, *Myanmar Population and Housing Census: Thematic Report on Maternal Mortality*, September 2016.

112 Ministry of Health and Sports of Myanmar, *Myanmar Demographic and Health Survey, 2015–2016*, March 2017.

113 UNFPA, "Myanmar: Sexual and Reproductive Health," available at <https://myanmar.unfpa.org/en/node/15221>.

114 UNFPA, *Myanmar SRMNAH Workforce Assessment*, p. 7.

115 *Ibid.*, pp. 12, 25.

116 Oxford Business Group, "Myanmar's Government Makes Health Care Investment Key Policy in Health and Education."

117 See, for example, the *5-Year Strategic Plan for Young People's Health (2016–2020)*; *National Strategic Plan for Newborn and Child Health Development (2015–2018)*; *National Vaccine Action Plan*; *Multiyear Plan for Immunization (2017–2021)*; *National Action Plan for Health Security (2018–2023)*, and Expanded Programme on Immunization (EPI) in Myanmar.

118 Brennan, "Myanmar's Public Health System and Policy." See National Health Network, *A Roadmap Towards Universal Health Coverage in Myanmar (2016–2030)*, March 2016; and Oxford Business Group, "Myanmar's Government Makes Health Care Investment Key Policy in Health and Education." The goal is to achieve universal healthcare by 2030, if not earlier.

119 Ministry of Health and Sports of Myanmar, *Myanmar National Health Plan 2017–2021: Executive Summary*, December 2016.

120 Brennan, "Year in Review: Public Health in Myanmar."

governments have invested in structures outside the government's system. This has led to the creation of parallel health programs primarily funded and run by nongovernmental actors, creating challenges for the sustainability of the health services they provide, notably as donor funding decreases.¹²¹ The implementation of the National Health Plan will therefore require the active engagement of health providers outside the public sector.¹²² The plan provides for an inclusive approach and for prioritizing townships with the greatest needs. However, it will be challenging to implement in conflict-affected regions with ethnic health organizations affiliated with armed groups that have not signed the Nationwide Ceasefire Agreement.¹²³

ACCESS TO HEALTHCARE IN RAKHINE

Access to health services in Rakhine is inadequate, and the health system is severely under-capacitated. The state of the health infrastructure is poor in most areas of the state. In a 2016 statewide survey, 52 percent of respondents said they did not have adequate access to healthcare.¹²⁴ Given the poor state of the health system in Rakhine, nongovernmental health actors are crucial to the provision of health services there. Many international actors and national NGOs work with the state health department to provide and improve access to healthcare services both in IDP camps and in non-displaced communities through government health structures and mobile and fixed clinics.

Rakhine is a restrictive, highly politicized operating environment for humanitarian actors. With the massive outflow of Rohingya to Bangladesh, the state minister reportedly stated that the state health department could handle the current population in Rakhine and does not need support from the UN and international NGOs.¹²⁵ This reflects the government's general reluctance to

allow an international humanitarian response in Rakhine. Nonetheless, some interviewees mentioned that international actors in the health sector were able to communicate more openly with the Ministry of Health than were those in other sectors with their relevant ministries and that a number of government health staff are doing good work. For one interviewee, this is likely due to the inherently inclusive and humanitarian nature of health work.¹²⁶ However, state security policies and practices are often not coordinated with state health policies, so even if health policies improve, access can remain difficult. Furthermore, working with the state health department is challenging, not least because a majority of its staff is ethnic Rakhine and refuses to work in Rohingya-majority areas.

There are only 9 health workers per 10,000 people in the state health system, compared to the national average of 16 and the 22 recommended by WHO.¹²⁷ Many villages lack full-time access to a health worker. Where there are health workers, training has been limited and turnover is high. A key goal is therefore to increase the government health workforce, as shortages strongly affect the delivery of services. Health workers are also poorly paid, provided with poor equipment, and housed in inadequate facilities. All of these factors negatively affect both the quality of care and recruitment.

More generally, healthcare is fragmented and not standardized throughout the state, which undermines the quality of services provided, particularly to marginalized populations.¹²⁸ Despite NGO support, immunization rates are low, as vaccination campaigns are not conducted regularly and do not reach everyone, and many people do not get follow-up vaccinations. There is access to basic care in most parts of central Rakhine, but in remote areas, particularly in northern Rakhine, many health facilities are either partially functioning or no longer functioning, and people

121 Interview with development actor, Yangon, November 2018.

122 Ministry of Health and Sports of Myanmar, *Myanmar National Health Plan 2017–2021: Executive Summary*, December 2016.

123 Interview with development actor, Yangon, November 2018.

124 Advisory Commission on Rakhine State, "Towards a Peaceful, Fair and Prosperous Future for the People of Rakhine."

125 Interview with humanitarian actor, Yangon, November 2018.

126 Interview with humanitarian actor, Sittwe, November 2018.

127 Rakhine State Health Department and Ministry of Health and Sports of Myanmar, *Health Implementations on Health Related Recommendations of Rakhine Advisory Commission*, September 2018.

128 Advisory Commission on Rakhine State, "Towards a Peaceful, Fair and Prosperous Future for the People of Rakhine," p. 42.

Box 1. Coordinating the humanitarian response in Rakhine

In 2018, sixty-seven organizations reported conducting humanitarian and development activities in Rakhine state. Of these, 30 percent targeted IDP populations, and 70 percent targeted other communities. For IDPs and host communities, health is the third biggest sector of intervention, with eight organizations reportedly providing mainly basic healthcare, reproductive healthcare, and mental health and psychosocial support programs in eighteen camps. For other communities, health is the most widespread intervention, with eighteen organizations working mainly on maternal and child health, tuberculosis and malaria, basic healthcare, and reproductive healthcare programs.¹²⁹ Sittwe has the highest concentration of active organizations. While the biggest gap is limited geographic reach rather than the scope of services provided, some interviewees highlighted the lack of clinical support for mental health, as well as for sexual and reproductive health.

In central Rakhine, the humanitarian response is coordinated through the UN cluster system, run by OCHA through the Inter-Cluster Coordination Group. The health cluster is chaired by the state health director with the support of WHO and meets monthly. The health cluster addresses both the humanitarian and development health response, which are generally conducted by the same actors. In northern Rakhine, the response is coordinated through a sector system run by UNHCR through the Maungdaw Inter-Agency Group. The resident coordinator leads the Rakhine Coordination Group, which is responsible for overall coordination of the UN response in Rakhine.

Most interviewees noted that the health cluster in Sittwe was a good, open platform that functioned relatively well. Beyond the usual issue of overlap of some activities, the main issue is that there are two coordination structures in the state. There have reportedly been many conversations around whether to revise these arrangements. For the health sector in particular, having two coordination structures does not necessarily make sense and presents some challenges. The health cluster in Sittwe is chaired by the state health department, so its discussions concern all of Rakhine state. The coordination of responses to health concerns in the state, such as suspected cases of communicable diseases, therefore also take place in the health cluster in Sittwe. The Maungdaw Inter-Agency Group in northern Rakhine is supposed to coordinate the humanitarian response in the north but, given that the state health department does not attend its meetings, cannot do so effectively for the health response.

have resorted to seeking advice from non-professionals. Furthermore, there is limited access to healthcare services provided by NGOs, which do not have access to most of northern Rakhine. According to several interviewees, community healthcare is limited. However, some NGOs train and fund community health workers who can reach more remote communities, obtaining information on their health needs and referring them to secondary healthcare providers.

In terms of secondary and tertiary care, capacity is even more limited. Sittwe General Hospital is Rakhine's biggest hospital and only tertiary care center, but even it faces shortages in technical

capacity and supplies, overcrowding, and degraded infrastructure, although it is currently undergoing renovations. State-level services for noncommunicable diseases are extremely limited and only accessible to those who can afford them. Mental healthcare is largely nonexistent. Even among NGOs, there are reportedly no clinical psychiatrists on staff, although some do have psychologists.¹³⁰ Private healthcare is limited in Rakhine, with one private clinic in Sittwe and a number of specialized clinics run by government health workers in addition to their work in the public health sector.¹³¹

Healthcare in IDP camps is also inadequate. NGOs operate mobile clinics that provide primary

129 Myanmar Information Management Unit, "Overview of the Aug 2018 3W, Rakhine State," October 16, 2018, pp. 2, 5, available at https://themimu.info/sites/themimu.info/files/documents/Overview_SubSectorSummary_VT_Map_of_the_Aug_3W_Rakhine_16Oct2018.pdf.

130 Interview with humanitarian actor, Sittwe, November 2018.

131 Interview with humanitarian actor, Sittwe, November 2018.

healthcare in camps, but capacity remains limited, and they are prohibited from staying overnight.¹³² One stationary clinic is operational in Thet Kal Pyin camp, run by the state health department with the support of Mercy Malaysia. However, it is the sole clinic available to 100,000 people and is far from certain parts of the camp, which makes it challenging to provide emergency services.¹³³ NGOs therefore recruit and train community health workers in camps to deliver more sustainable services.

Beyond the poor state of the health system itself, people face a number of barriers to accessing services. Accessing secondary and tertiary healthcare is particularly challenging in Rakhine, both outside and inside IDP camps, as it requires a referral. Referrals in Rakhine are difficult and complicated to obtain. Policies, practices, and procedures differ from township to township or community to community. Those in IDP camps with severe health issues are mostly referred to Sittwe General Hospital, the procedures for which are cumbersome and time-consuming.¹³⁴ Even when patients can secure a referral to a hospital, they may have to travel for hours and pay bribes for transport, and transport infrastructure is poor, particularly for those in remote areas. Flooding and heavy rains during the rainy season also affect communities' ability to travel. NGOs provide transport to township hospitals or Sittwe General Hospital in the limited areas they can access, but some NGOs have also had to pay bribes, and there have been complaints that some drivers solicit money from patients for a service meant to be free.

The cost of accessing services, particularly beyond primary healthcare, is high. Health services should be relatively inexpensive, as the government subsidizes hospital stays and consultations. However, there are many accessory costs, including formal and informal payments for surgeries, medicine, and preferential or priority care. There is

systemic corruption and extortion, particularly in camps. According to one person interviewed, "People are likely making health decisions based on what they can afford."¹³⁵

While accessing health services does not require proof of citizenship, the Rohingya are particularly affected by these barriers. They are disproportionately affected by referral requirements, as they generally have less access to primary care. Costs are higher, in particular for those in camps, as they have to pay additional fees and bribes and have to obtain permission to travel through arbitrary and cumbersome procedures.¹³⁶ IDP camps are managed by camp management committees appointed by the General Administrative Department, which falls under the Ministry of Home Affairs. However, many perceive these committees as not representing the camp population, and there have been reports of extortion. In northern Rakhine, many Rohingya reportedly do not seek health services in government clinics for fear of abuse at military checkpoints.¹³⁷

Government health workers also need prior permission to go to certain areas where Rohingya reside. Most government health workers are ethnic Rakhine rather than Rohingya, as working for the government requires having citizenship. This creates language and cultural barriers, as well as trust issues, for the Rohingya. Moreover, some government and NGO health workers from Rakhine or non-Rohingya communities are afraid of going to Rohingya-majority villages in the north.¹³⁸

The Ministry of Health and Sports says that all its health facilities are open to all communities, but this is not the case in practice. While some health providers serve both Rohingya and Rakhine populations, others refuse to provide health services to Rohingya. Moreover, some ethnic Rakhine communities have threatened health staff working in Rohingya-majority areas or barred

132 The main health actors in the IDP camps in central Rakhine are Médecins Sans Frontières, the International Rescue Committee, Mercy Malaysia, and the Myanmar Health Assistant Association. They provide direct health services to the population.

133 From some areas, it can take up to forty-five minutes to reach the clinic. A second clinic is currently being built in the camp.

134 Advisory Commission on Rakhine State, "Towards a Peaceful, Fair and Prosperous Future for the People of Rakhine."

135 Interview with humanitarian actor, Sittwe, November 2018.

136 UN Human Rights Council, *Report of the Detailed Findings of the Independent International Fact-Finding Mission on Myanmar*, UN Doc. A/HRC/39/CRP.2, September 17, 2018, p. 130.

137 United Nations, *Joint Response Plan for Rohingya Humanitarian Crisis, March–December 2018*, p. 14.

138 Interview with humanitarian actor, Sittwe, November 2018.

Rohingya from accessing township hospitals.¹³⁹ According to one interviewee, only six or seven hospitals in Rakhine admit Rohingya patients. Most need to be referred to Sittwe General Hospital, and the resulting increase in travel time and costs often has drastic health consequences.¹⁴⁰

Fear, distrust, misinformation, and misperceptions also play a major role in the decision by Rohingya to seek medical care. Rumors that patients are killed by health staff or unexpectedly die in Sittwe General Hospital circulate widely. Even when they manage to access government health facilities, Rohingya have faced discriminatory treatment. For example, in Sittwe General Hospital, they are placed in a small, segregated ward under constant surveillance by security guards and need permission to leave.¹⁴¹ Rohingya patient also often have to pay bribes or higher fees for treatment. The Rohingya also face discriminatory hospital policies and practices, despite new policies introduced by the state public health department in 2017.¹⁴² Entrenched gender inequality and sociocultural norms magnify the impact of discrimination, especially against women and girls, exacerbating their needs and creating barriers to accessing services, including life-saving care.¹⁴³

ACCESS TO HEALTHCARE IN KACHIN AND NORTHERN SHAN

Access to healthcare is also poor in Kachin and northern Shan. Healthcare services are provided by state health authorities, UN agencies, international and national NGOs, and ethnic and community-based health organizations.

Given the active armed conflict, lack of government control of some areas in Kachin and northern Shan, and the above-mentioned underinvestment in periphery states, many ethnic or community-

based health organizations were established in areas where there are no government health structures. For the vast majority of people in Kachin and northern Shan states, official government health facilities remain unavailable or inaccessible, and ethnic and community-based health organizations are the main source of healthcare. Ethnic health organizations (EHOs) are tied to EAOs and operate only in their ethnic areas. In non-governmental controlled non-government-controlled parts of Kachin, many health services are provided by the KIO; patients are referred to KIO hospitals or, sometimes, to medical facilities across the border in China. Ethnic health organizations also provide primary healthcare through mobile teams or stationary clinics.¹⁴⁴ The Ministry of Health and Sports recognizes ethnic health organizations as crucial partners in achieving universal healthcare, especially in hard-to-reach areas.¹⁴⁵

Despite their importance, these organizations often have limited capacity and are not equipped to deal with serious health issues.¹⁴⁶ The ministry is concerned with ensuring quality standards are met and has the legal responsibility of ensuring standards are adequate. Indeed, health workers in ethnic health organizations are not trained in recognized institutions, and one interviewee expressed doubts as to the quality of services provided.¹⁴⁷ Another interviewee mentioned that because these health workers are often not accredited, they can face arrest for providing services.¹⁴⁸

In some areas, both authorities from ethnic armed groups and government authorities are present, but health services rarely overlap. There are instances of government and ethnic health organizations collaborating to address local health needs.¹⁴⁹ In 2012, ethnic and community-based

139 This has been the case in Kyauk Taw Township Hospital, for example.

140 Interview with humanitarian actor, Sittwe, November 2018.

141 According to one interviewee, the concern justifying this policy is that visiting families may fight among each other, and healthcare providers are not well equipped to handle these tensions.

142 Amnesty International, "Caged without a Roof: Apartheid in Myanmar's Rakhine State," November 2017.

143 UN OCHA, *Myanmar 2019 Humanitarian Response Plan: January–December 2019*, December 2018, p. 10.

144 These services include treatment for common diseases, war casualty management, reproductive and child health services, community health education, and water and sanitation programs. Health Information System Working Group, "The Long Road to Recovery," p. 6.

145 Ministry of Health and Sports of Myanmar, *Myanmar National Health Plan 2017–2012: Executive Summary*, December 2016; National Health Network, *A Roadmap Towards Universal Health Coverage in Myanmar (2016–2030)*.

146 Center for National Dialogue and Harmony, "Shan State Needs Assessment," May 2018, p. 27.

147 Interview with humanitarian actor, Yangon, November 2018.

148 Interview with humanitarian actor, Yangon, November 2018.

149 Health Information System Working Group, "The Long Road to Recovery," p. 22.

Box 2. The international health response in Kachin and northern Shan

Many international actors and national NGOs work with the Kachin and Shan state authorities and the ethnic health organizations to provide and improve access to healthcare both in IDP camps and in non-displaced communities. In 2018, fifty-nine organizations reported humanitarian and development activities in Kachin state. The majority are working on development projects. For non-displaced populations, health is the most widespread intervention. Nineteen organizations implement projects that reach all eighteen townships in the state. They work mostly on malaria and harm reduction, with a smaller number of interventions on tuberculosis, reproductive healthcare, and HIV/AIDS. Seven organizations implement health projects in IDP camps and host communities, with reproductive health care being the most frequent intervention. Organizations reported an increase in the reach of health projects both in and outside IDP camps.¹⁵⁰ In northern Shan, twenty-six organizations are implementing health projects, and most interventions are focused on HIV/AIDS, malaria, tuberculosis, and maternal and child health.¹⁵¹

One interview described a “patchwork of services,” and another stressed the need to focus on hard-to-reach areas, where the needs are most acute.¹⁵² Humanitarian actors are currently focusing on providing services in IDP camps in government-controlled areas, but this is not where there is the most need, because there are state health services available nearby and fewer restrictions on movement. There is also a risk that international NGOs focusing on particular diseases may result in other health issues receiving less attention and contribute to a fragmented health system that relies on external actors and cannot provide comprehensive care.¹⁵³

organizations working in eastern Myanmar formed the Health Convergence Core Group to work toward convergence of ethnic, community-based, and government health systems through political dialogue.¹⁵⁴

Little information is available about private health services in Kachin and Shan, although one interviewee mentioned that doctors from military and government hospitals often open private clinics. In some non-government-controlled areas, private clinics operated by Chinese doctors exist.¹⁵⁵

Overall, the lack of trained personnel and the cost of medication are major challenges for the health sector. Nonetheless, a 2018 needs assess-

ment in Shan reported that accessing basic health-care was relatively easy.¹⁵⁶ Similarly, basic health services are available in many areas of Kachin.¹⁵⁷ In remote areas that the Ministry of Health and Sports cannot reach, community health workers provide basic services. However, accessing specialized services and treatment for serious conditions is difficult for most.¹⁵⁸ There is a lack of specialized services such as medical care for rape victims or mental health and psychosocial support.¹⁵⁹ In Shan, there is only one specialist hospital, and there are only four general hospitals with specialized services.¹⁶⁰ Pregnant women are often unable to access good maternal and perinatal care.¹⁶¹

150 Myanmar Information Management Unit, “Overview of the August 2018 3W, Kachin State,” October 3, 2018, pp. 2–6, available at https://themimu.info/sites/themimu.info/files/documents/Overview_SubSectorSummary_VT_Map_of_the_Aug_3W_Kachin_03Oct2018.pdf.

151 Myanmar Information Management Unit, “Myanmar Who/What/Where Health: All Agencies, Projects under Implementation by Township as of 27th August 2018,” available at http://themimu.info/sites/themimu.info/files/documents/3W_MapnReport_Country_Wide_Tsp_Health_MIMU476v15_01Oct18_A3.v28_0.pdf.

152 Interviews, humanitarian actors, Yangon, November 2018.

153 Center for National Dialogue and Harmony, “Shan State Needs Assessment,” May 2018, p. 43.

154 Health Convergence Core Group, “Building Trust and Peace by Working through Ethnic Health Networks Towards a Federal Union,” Burma Partnership, March 11, 2013, available at www.burmapartnership.org/2013/03/building-trust-and-peace-towards-a-federal-union/.

155 Interview with humanitarian actor, Yangon, November 2018.

156 Center for National Dialogue and Harmony, “Shan State Needs Assessment,” May 2018, pp. 27–28.

157 Interview with humanitarian actor, Yangon, November 2018.

158 Center for National Dialogue and Harmony, “Shan State Needs Assessment,” May 2018, pp. 27–28.

159 UN Human Rights Council, *Report of the Detailed Findings of the Independent International Fact-Finding Mission on Myanmar*, UN Doc. A/HRC/39/CRP.2, September 17, 2018, p. 96; Lee et al., “Mental Health and Psychosocial Problems among Conflict-Affected Children in Kachin State, Myanmar.”

160 Center for National Dialogue and Harmony, “The State of Social Harmony in Shan State,” April 2018, p. 4.

161 Center for National Dialogue and Harmony, “Shan State Needs Assessment,” May 2018, p. 30.

In addition to lack of capacity, sustained threats to physical security hinder access to healthcare in Kachin and northern Shan. According to the report of the Independent International Fact-Finding Mission on Myanmar, many victims of torture and ill-treatment have faced extreme challenges obtaining medical services, and some have felt compelled to travel to China to seek medical attention. Victims have also reportedly died because of the lack of timely medical care.¹⁶² In Shan, however, immunization programs appear to be relatively successful, as village health workers often take on this responsibility, which enables these programs to reach most areas.¹⁶³

In IDP camps, access to health care is also limited, and psychosocial support is largely nonexistent.¹⁶⁴ A majority of IDPs, particularly in areas beyond government control, continues to rely

on humanitarian assistance. However, humanitarian actors' response is limited by logistical and security constraints, inadequate facilities, and limited medical supplies and skilled staff.¹⁶⁵

Trends and Challenges in the Humanitarian Health Response

A number of UN agencies and NGOs have been working in Myanmar for several decades. In 2016, there was a spike in the number of international NGOs due to the outbreak of violence in Rakhine. As of February 2017, the International NGO Forum in Myanmar had 100 members. There is also a vibrant and growing local nongovernmental sector.¹⁶⁶

Box 3. Coordinating the health response in Myanmar

The health cluster was activated in Myanmar in 2012 for Rakhine, Kachin, and northern Shan states.¹⁶⁷ It is co-led by the WHO and the Ministry of Health and Sports and has forty partners.¹⁶⁸ According to the UN 2018 Interim Humanitarian Response Plan, the health sector response has nine priority areas. These include ensuring a minimum package of primary healthcare, including sexual and reproductive health, strengthening emergency referrals, expanding immunization coverage, strengthening disease surveillance and response, providing mental health and psychosocial support, coordinating advocacy to promote access to healthcare, expanding health services through mobile clinics, and revitalizing health facilities.

For some, the leadership role of the Ministry of Health and Sports is a good example of sharing responsibility with the government and has contributed to a stronger health response. In Naypyidaw, the health cluster meeting is chaired by the minister of health and sports, who many feel plays a key role in advocating for access to better healthcare. Interviewees spoke positively about the health cluster meetings being open to all and relatively transparent.

However, despite good information sharing among partners, there is no real coordination of activities, and concerns about duplication remain. One representative of a local NGO also shared a concern that local actors have insufficient representation at the national level, which precludes their perspectives being considered in policy discussions. Another local actor commented that the health cluster often operates on inaccurate assumptions.

162 UN Human Rights Council, *Report of the Detailed Findings of the Independent International Fact-Finding Mission on Myanmar*, UN Doc. A/HRC/39/CRP.2, September 17, 2018, p. 92.

163 Center for National Dialogue and Harmony, "Shan State Needs Assessment," May 2018, p. 30.

164 UN Human Rights Council, *Report of the Detailed Findings of the Independent International Fact-Finding Mission on Myanmar*, UN Doc. A/HRC/39/CRP.2, September 17, 2018, pp. 92–93.

165 UN OCHA, *Myanmar 2019 Humanitarian Response Plan: January–December 2019*, December 2018, p. 22.

166 Kim Wallis and Carine Jaquet, "Local NGOs in Myanmar: Vibrant but Vulnerable," Overseas Development Institute Humanitarian Practice Network, September 2011.

167 WHO has coordination staff in Sittwe for Rakhine and in Myitkyina for Kachin but is only now in the process of hiring a coordinator for northern Shan.

168 Health Cluster Myanmar website, available at www.who.int/health-cluster/countries/myanmar/en/. The 2018 Humanitarian Response Plan states that there are twenty-three health partners.

THE SCOPE OF THE HUMANITARIAN HEALTH RESPONSE

Because of Myanmar's multiple, simultaneous armed conflicts and crises, each with its own specificities and challenges, there is no one-size-fits-all approach to the humanitarian response. According to the UN Humanitarian Response Plan for 2019, there are over 715,000 people with health needs in Rakhine, compared against 167,000 in Kachin and 48,000 in Shan.

Despite the greater humanitarian needs in Rakhine, some on the ground consider the humanitarian response to be imbalanced, and the focus on the crisis in Rakhine disproportionate. IDPs in Kachin reportedly feel increasingly isolated and forgotten by the international community.¹⁶⁹ Several interviewees reported that the vast majority of recent discussions in the health cluster meetings in Yangon focused on Rakhine. This may, however, be tied to the fact that international NGOs, which are the main attendees of cluster meetings at the national level, work mostly through local partners in Kachin and Shan states and therefore may not have the same level of understanding of those contexts. Overall, however, there are fewer humanitarian actors in Kachin and northern Shan than in Rakhine, and the number is decreasing.¹⁷⁰ This lack of attention to the crises in Kachin and northern Shan has real implications, not least in terms of funding for humanitarian assistance and protection in those areas.

Within Rakhine, many ethnic Rakhine perceive the international humanitarian response as biased. The 2012 violence in Rakhine led to a significant increase in relief efforts, largely directed at Rohingya communities, with the result that some Rohingya were able to access better healthcare than other communities. This has created a sense of injustice among some Rakhine communities, exacerbating existing intercommunal tensions.¹⁷¹ In

2014, some ethnic Rakhine rioted and attacked the offices of international humanitarian actors in Sittwe. This has highlighted the need for conflict-sensitivity in planning the humanitarian response. More recently, there has reportedly been an increased recognition of the need to support all communities in Rakhine, and many NGOs implement programs targeting both IDP camps and other communities in need. One interviewee suggested that perceptions of bias have decreased as humanitarian actors increase their communication with the Rakhine community and become more visible in their villages.¹⁷² Moreover, development funding, which mainly benefits ethnic Rakhine communities, far outweighs humanitarian funding in Rakhine, even if it is less visible—something international actors could better communicate.

In terms of the scope of services provided, international health actors in Kachin, Shan, and Rakhine have focused on malaria, HIV/AIDS, and tuberculosis. A number of health actors also work on control of communicable diseases more generally, maternal and child health, and reproductive healthcare.¹⁷³ However, there remains a need to increase immunization in hard-to-reach and conflict-affected areas.¹⁷⁴

Mental health and psychosocial support have been under-prioritized in the humanitarian response, partly because it is reportedly difficult to get government approval for such programming.¹⁷⁵ Nonetheless, there is a mental health and psychosocial support working group under the protection cluster, with which WHO coordinates and collaborates, and its members are implementing activities. However, these are mostly psychosocial support activities, and many are implemented by NGOs that do not necessarily understand what psychosocial support entails and what standards they should be following.¹⁷⁶ As a

169 South, "Protecting Civilians in the Kachin Borderlands, Myanmar," p. 23.

170 There are, however, many development actors.

171 See for example, Stephen Gray and Josephine Roos, "Intercommunal Violence in Myanmar: Risks and Opportunities for International Assistance," Mercy Corps, April 2014; Fiona MacGregor, "As Tragedy Unfolds in Myanmar, the People's Heroine Stokes the Flames of Hatred," *Foreign Policy*, September 22, 2017.

172 Interview with humanitarian actor, Yangon, November 2018.

173 Myanmar Information Management Unit, "Myanmar Who/What/Where Health."

174 This was noted by several interviewees. See also WHO, *Joint External Evaluation of IHR Core Capacities of the Republic of the Union of Myanmar, Mission Report: 3–9 May 2017*, 2018.

175 Note that within the government itself, there is an unclear division of labor between the Ministry of Health and Sports and the Ministry of Social Welfare on mental health and psychosocial support.

176 Interview with humanitarian donor, Yangon, November 2018.

result, a network of local NGOs has reportedly been developed in Yangon to ensure a more standardized response. In terms of mental health services, little is being done. According to one interviewee, organizations do not have sufficient capacity to conduct mental health programming, and few have psychologists on staff.¹⁷⁷ For another interviewee, mental health programs should be implemented by development partners, with humanitarian actors focusing on psychosocial support.¹⁷⁸

Given the prevalence of sexual and gender-based violence in Myanmar, there is also a need to strengthen access to and delivery of health services for survivors, which includes mental health services.¹⁷⁹ Twenty organizations reported working on twenty-four gender-based violence projects in the country,¹⁸⁰ but few work on the clinical response.

LIMITED HUMANITARIAN ACCESS

All humanitarian actors interviewed mentioned access to people in need as a challenge in Rakhine, Kachin, and northern Shan, and most agreed it is getting worse. The multiplicity of authorities contributes to this challenge. Humanitarian actors have to deal with different levels of authority within Myanmar's federal system that are not necessarily aligned. They may also have to deal with ethnic armed organizations that control territory and are engaged in active conflict with the government. Furthermore, the military remains a somewhat autonomous force that holds the power to make decisions about access for humanitarian activities.

In Rakhine, most organizations have been able to operate in central Rakhine, but they face onerous and burdensome bureaucratic procedures.¹⁸¹ The government has full control over where humani-

tarian actors can go, where they can operate, and who they can target with their programs. Organizations need to apply for monthly travel and work authorizations, which requires providing a detailed outline of planned activities. This process has become even more complicated since the August 2017 crisis. Prior to submitting a request to the Rakhine state government's Coordination Committee, organizations now require an endorsement letter from the state line ministry. For health activities, the state health department reportedly endorses all NGO applications. The challenges are mostly with the Coordination Committee, with some organizations facing delays in approvals or even denials. One interviewee mentioned that an international organization trained all the staff from their organization and provided medicine so they could provide basic health services from their homes, thereby bypassing the approval process.¹⁸² Another interviewee explained that if projects were solely supporting the state health system, no authorization was required.¹⁸³

Following the violence in August 2017, most organizations suspended their programming and evacuated their staff from northern Rakhine for safety and security reasons. Since then, they have been restricted from returning or resuming activities. Few organizations have been authorized to be based there, and those that have been are mostly concentrated in Maungdaw, with limited ability to implement programs. At the time the research was conducted, interviewees reported what one described as "little drips of access" being authorized.¹⁸⁴ Some organizations present in northern Rakhine have been able to restart activities, albeit on a much smaller scale than previously. Some have started to work through volunteers and community health workers to access more remote

177 Interview with humanitarian donor, Yangon, November 2018.

178 Interview with humanitarian actor, Yangon, November 2018.

179 UN Office of the Special Representative of the Secretary-General for Sexual Violence in Conflict, "Joint Communique Signed between the United Nations and the Government of Myanmar to Prevent and Respond to Conflict-Related Sexual Violence in Myanmar," Press Release, December 7, 2018, available at www.un.org/sexualviolenceinconflict/press-release/joint-communique-signed-between-the-united-nations-and-the-government-of-myanmar-to-prevent-and-respond-to-conflict-related-sexual-violence-in-myanmar/. This joint communiqué includes a commitment to strengthening service delivery and improving access for survivors of sexual violence.

180 Myanmar Information Management Unit, "MIMU 3W August 2018: Countrywide Overview," available at http://themimu.info/sites/themimu.info/files/documents/Overview_SubSectorSummary_VT_Map_of_the_Aug_3W_Countrywide_01Nov2018.pdf.

181 UN OCHA, *Myanmar: Humanitarian access in Central Rakhine (October 2018)*, available at <https://reliefweb.int/report/myanmar/myanmar-humanitarian-access-central-rakhine-october-2018>.

182 Interview with humanitarian actor, Yangon, November 2018.

183 Interview with humanitarian actor, Sittwe, November 2018.

184 Interview with humanitarian actor, Sittwe, November 2018.

communities. The government has authorized the Red Cross Movement to operate in northern Rakhine, and it is reportedly able to provide mobile primary health services in twenty village tracts. However, the recent upsurge in violence has led to severe restrictions in access in five northern townships.¹⁸⁵ Even those few organizations able to operate in the north have had to suspend most of their programming due to the ongoing fighting.¹⁸⁶

Access is also increasingly limited in Kachin and northern Shan, notably given unpredictable violent clashes between parties to conflict, during which activities have to be stopped and operations postponed.¹⁸⁷ Furthermore, travel authorizations involve a complex application system and several layers of authority, both civilian and military. They are approved by the national government, but the General Administration Department of the Ministry of Home Affairs also asks for information on staff movement and lists of activities. Since 2016, the government has refused most international organizations, and all international staff, access to non-government-controlled areas, where there are over 40,000 IDPs.¹⁸⁸ The UN, in particular, has little access to Kachin and northern Shan. International organizations have reportedly been told that if they want access, they should tell the ethnic armed organizations to sign the Nationwide Ceasefire Agreement.¹⁸⁹ The government has also suggested that IDPs cross conflict lines to access assistance, which would require them to repeatedly undertake long and dangerous journeys. In order to access IDP camps in non-government-controlled areas near the border, NGOs have therefore tried going through China, which has unofficially allowed aid to cross its border.

However, Chinese border police and immigration authorities have been increasingly restricting border crossings.

Even in government-controlled areas, international organizations face increasing difficulty obtaining authorizations. International staff are granted travel authorizations primarily only for urban centers and are unable to access the majority of displaced individuals located in other areas.¹⁹⁰ National staff of international organizations also face increasing restrictions, as their requests for travel authorization are often arbitrarily refused. Even local organizations, which have generally enjoyed better access and can operate in both government- and non-government-controlled areas, are facing more restrictions. Furthermore, even when the government of Myanmar has given travel authorizations, it reportedly blocks aid deliveries from being carried out. It also checks convoys and sometimes removes goods from them.¹⁹¹

Humanitarian workers in Kachin also face the risk of arrest. One staff member of the Kachin Baptist Convention, a faith-based organization providing humanitarian services in the state, was detained for crossing into a non-government-controlled area.¹⁹² The government is using the Unlawful Association Act to criminalize organizations that travel to non-government-controlled areas to provide aid. There are reports that humanitarian personnel in Kachin have been prosecuted and formally threatened with prosecution under this act and that individuals have even been beaten.¹⁹³ This has made some NGOs less willing and able to travel to the most hard-to-reach IDP camps and cross over into KIO-controlled

185 "Statement of INGOs in Myanmar," January 22, 2019, available at: <https://reliefweb.int/report/myanmar/statement-ingos-myanmar>.

186 "Red Cross Says Services in Northern Rakhine Stalled by Fighting," *The Irrawaddy*, February 8, 2019.

187 See, for example, "'They Block Everything': Avoidable Deprivations in Humanitarian Aid to Ethnic Civilians Displaced by War in Kachin State, Myanmar," Fortify Rights, August 2018.

188 UN OCHA, *2018 Humanitarian Needs Overview, November 2017*; UN Human Rights Council, *Report of the Detailed Findings of the Independent International Fact-Finding Mission on Myanmar*, UN Doc. A/HRC/39/CRP.2, September 17, 2018, pp. 74–75; UN Secretary-General, "Note to Correspondents: Statement Attributable to the Secretary-General's Special Envoy on Myanmar," October 20, 2018, available at www.un.org/sg/en/content/sg/note-correspondents/2018-10-20/note-correspondents-statement-attributable-secretary.

189 UN Human Rights Council, *Report of the Detailed Findings of the Independent International Fact-Finding Mission on Myanmar*, UN Doc. A/HRC/39/CRP.2, September 17, 2018, pp. 74–75.

190 UN Human Rights Council, *Report of the Detailed Findings of the Independent International Fact-Finding Mission on Myanmar*, UN Doc. A/HRC/39/CRP.2, September 17, 2018, p. 75.

191 Interview with humanitarian actor, Yangon, November 2018.

192 Interview with humanitarian actor, Yangon, November 2018.

193 Kyaw Thu, "Kachin Aid Group Halts Humanitarian Work After Threat by Myanmar Army," Radio Free Asia, June 15, 2018; UN Human Rights Council, *Report of the Detailed Findings of the Independent International Fact-Finding Mission on Myanmar*, UN Doc. A/HRC/39/CRP.2, September 17, 2018, p. 76; UN General Assembly, *Report of the Special Rapporteur of the Human Rights Council on Extrajudicial, Summary or Arbitrary Executions—Saving Lives Is Not a Crime*, UN Doc. A/73/314, August 6, 2018, p. 13.

areas.¹⁹⁴ There also seems to be a bilateral agreement between the national government and China to deny medical assistance to injured fighters from ethnic armed groups.¹⁹⁵

In some cases, the government has suspended or severely restricted access to areas in dire need of humanitarian aid in what some see as retaliation against international organizations. For example, the government justified some restrictions in Rakhine based on its alleged discovery of food assistance from the World Food Programme (WFP) in a supposed ARSA training camp in July 2018. It was later reported that the food had actually not been distributed directly by WFP.¹⁹⁶

Lack of access poses challenges not only to delivering aid but also to collecting data, conducting needs assessments, and monitoring projects. For example, the humanitarian country team's mid-year progress report highlights that "quality interagency needs assessments have become nearly impossible to conduct."¹⁹⁷ The government has been more amenable to allowing access for development-oriented activities, although these also face considerable obstacles.

Humanitarian actors and the broader international community are putting significant effort into advocating to the government for better access. Within the UN, OCHA consistently advocates for humanitarian access, its main interlocutor being the Ministry of Social Welfare. While OCHA also used to be in charge of negotiating access for humanitarian organizations, this is now done separately by each individual organization. In cases of emergency, however, OCHA continues to play a central coordination role.¹⁹⁸ For some, there is a need to advocate for access at the local level and to better understand the levers of power. One

interviewee stressed that it is important that this advocacy not be misdirected, for example, to the Ministry of Health, which holds no decision-making power over access issues.¹⁹⁹

WORKING WITH LOCAL ACTORS AND COMMUNITIES

Given the access challenges described above, local NGOs play a central role in the humanitarian response in Kachin and northern Shan, particularly in non-government-controlled areas. A Joint Strategy Team made up of nine local NGOs—mainly faith-based and Christian—provides the bulk of the humanitarian response in conflict-affected areas in these two states. They are financially and technically supported by the UN and other international humanitarian partners, who often work through local organizations, particularly in non-government-controlled areas.

These international partners often perceive local NGOs as less experienced. There is also high staff turnover, as they regularly lose their best staff to international NGOs. This often makes it harder for them to uphold standards, reducing the quality of their response. Conversely, local actors reportedly feel that international staff fail to recognize their capacity or their ability to understand and deal with risk and uncertainty on the ground.²⁰⁰ Moreover, while the Myanmar Humanitarian Fund has provided flexible and timely funding to local organizations, some donors are prohibited from directly funding local NGOs. As a result, some local organizations have had to stop programs such as health activities in IDP camps due to lack of funding.²⁰¹ Others are not registered, which makes working with them illegal, though the government reportedly looks the other way.²⁰² Because of restricted access, it is almost impossible for

194 South, "Protecting Civilians in the Kachin Borderlands, Myanmar," p. 13.

195 UN Human Rights Council, *Report of the Detailed Findings of the Independent International Fact-Finding Mission on Myanmar*, UN Doc. A/HRC/39/CRP.2, September 17, 2018, p. 77. According to one interviewee, during the conflict between the Tatmadaw and the Myanmar National Democratic Alliance Army (MNDAA) in 2015, MNDAA troops would fall back across the border and be cared for in Chinese hospitals, complicating China-Myanmar relations. Chinese nationals were also involved in volunteer work and moving medical supplies across the border to MNDAA forces. See, for example, Qiao Long, "Chinese Nationals Help Out in Northern Myanmar Conflict Zone," *Radio Free Asia*, February 23, 2015.

196 UN Human Rights Council, *Report of the Detailed Findings of the Independent International Fact-Finding Mission on Myanmar*, UN Doc. A/HRC/39/CRP.2, September 17, 2018, p. 136.

197 UN OCHA, *Myanmar Humanitarian Country Team: 2018 Mid-Year Progress Report on HRP Crosscutting Priorities*, September 2018.

198 OCHA tracks travel authorization requests by humanitarian organizations for Kachin, Shan, and Rakhine. See, for example, UN OCHA, *Myanmar: Humanitarian Access in Central Rakhine (September 2018)* available at <https://reliefweb.int/report/myanmar/myanmar-humanitarian-access-central-rakhine-september-2018>.

199 Interview with humanitarian actor, Sittwe, November 2018.

200 South, "Protecting Civilians in the Kachin Borderlands, Myanmar," p. 22.

201 *Ibid.*, p. 20.

202 Interview with humanitarian actor, Yangon, November 2018.

international organizations to monitor the activities of these local NGOs. Furthermore, their accountability mechanisms are reportedly weak.

In Rakhine, international organizations work less through local organizations. One of the reasons is that there are reportedly few local NGOs working on health issues. One of these is the Myanmar Health Assistant Association, which receives international funding and implements UNICEF projects. Several interviewees also mentioned that intercommunal tensions make it hard to work with locals, as some ethnic Rakhine are reluctant to work on projects that target the Rohingya.

Ensuring meaningful participation of affected people in planning, coordination, and decision making is a priority in the 2018 Humanitarian Response Plan and something that many humanitarian organizations have committed to improve. In most humanitarian responses across the world, this nonetheless remains a gap.²⁰³ Especially given the protracted nature of the crises in Myanmar, basic mechanisms to ensure meaningful participation of affected populations should be in place. For one interviewee, the “population of Rakhine has felt like they have not had a voice in their destiny going forward, and the international community needs to be attuned to this.”²⁰⁴

Actors on the ground in Myanmar describe a number of tools and processes used to collect community feedback, such as suggestion boxes, focus group discussions, meetings with village leaders, and a complaints-response mechanism in the IDP camps in Rakhine, which is reportedly effective. One interviewee stressed that organizations’ implementation of such measures is dependent on their staff’s motivation and interest.²⁰⁵ Furthermore, there are a number of barriers for crisis-affected people to be able to use such tools, chief among them the challenges around access. There are also barriers related to language and literacy and cultural barriers, such as the extent to which people in Myanmar see

themselves as being policed and therefore fear voicing criticism.²⁰⁶

Some tools have produced better results than others have. For example, communities have expressed a preference for face-to-face suggestions rather than suggestion boxes.²⁰⁷ One interviewee explained that a number of suggestion boxes were placed in IDP camps in Kachin and northern Shan without sufficiently communicating to the camp populations what their purpose was. As a result, some mistook them for donation boxes.²⁰⁸

While organizations have been able to collect some community feedback, the influence of this feedback on programming and implementation is limited. The tendency seems to be to respond to concerns raised in a case-by-case manner. The 2018 Humanitarian Response Plan specifically noted the need for “more common mechanisms... to ensure systematic community feedback to inform joint responses and overall strategic decision-making.”²⁰⁹ The next step for humanitarian actors is therefore to find ways for the feedback to influence their programming. This will require education and outreach to ensure communities understand and use feedback in a productive manner.

PROVIDING HUMANITARIAN AID AMID DEVELOPMENT AND HUMAN RIGHTS CRISES

The nature of the crises in Myanmar, as well as the political dynamics, raise the question of how humanitarian and development efforts, as well as peace and human rights efforts, interrelate. In the initial years of the response, there were concerns that engaging solely in humanitarian action led to a worsening situation on the ground and increasingly divided communities. Given that the Rohingya were facing the most acute needs, the impartial humanitarian response was perceived as biased toward them, increasing tensions in an already polarized context. By providing assistance in IDP camps, it also risked entrenching discrimi-

203 Alice Debarre, “Hard to Reach: Providing Healthcare in Armed Conflict,” New York: International Peace Institute, December 2018.

204 Interview with humanitarian actor, Sittwe, November 2018.

205 Interview with humanitarian donor, Yangon, November 2018.

206 Interview with humanitarian actor, Yangon, November 2018.

207 UN OCHA, *2018 Interim Humanitarian Response Plan for Myanmar*, November 2017.

208 Interview with humanitarian actor, Yangon, November 2018.

209 UN OCHA, *2018 Interim Humanitarian Response Plan for Myanmar*, November 2017.

natory government practices. Actors on the ground recognize the need to reset the way the UN has been engaging and to have a coherent approach across all aspects of the UN's work. The 2019 Humanitarian Response Plan specifically mentions the 2030 Agenda for Sustainable Development, the need to strengthen the linkages between relief, recovery, and development, and the need to reduce long-term dependency on humanitarian aid. This had already become a mantra within the UN and international NGO community in 2015 and 2016.²¹⁰ In Rakhine, the European Union and its partners have developed a strategic framework for international cooperation, and one is being developed for Kachin and Shan.²¹¹ The purpose of these frameworks is to bring together international humanitarian, human rights, development, and peacebuilding efforts in a holistic and complementary manner.²¹² The question remains whether the UN will be able to reinvent itself in Myanmar, and, at the very least, do no further harm.²¹³

In Kachin and northern Shan, which face protracted crises, the government and donors want to focus on IDP returns and resettlement and on more development-oriented activities. However, in many parts, humanitarian actors are struggling to provide even temporary services and maintain the status quo. On the other hand, while humanitarian needs remain, there also a need to build resilience, create livelihood opportunities, and provide better access to services. Humanitarian health actors, therefore, are not only providing humanitarian services but also building the capacity of state health authorities. One interviewee described that his organization is constructing and equipping health centers in remote areas that it will hand over to the state health department when finished.²¹⁴ However, the state health department has little capacity, particularly in terms of staff, which will make a complete handover challenging.

Given the access barriers and lack of government health services, planning for more sustainable services in non-government-controlled areas in Kachin and northern Shan is a challenge. Some international health actors are therefore building the capacity of community-based and ethnic health organizations, which have better access. Local NGOs operating in Kachin and northern Shan often operate across the spectrum of humanitarian, development, and peace activities. Many were development organizations that started to engage in humanitarian activities with the outbreak of armed conflict. Some also see peacebuilding as crucial and consider it to be part of their mandate.²¹⁵

As in Kachin and northern Shan, while the lack of access makes it difficult to plan for the long term, there has been more focus on development-oriented activities. Humanitarian programs have been in operation since 2012, leading to donor fatigue. The government is also pushing for development work, and there are a number of development actors present in Rakhine. The World Bank participates in the health cluster in Sittwe and supports the state health department. UNDP is engaged in a township development program, looking at livelihood opportunities, rule of law, gender equality, and other issues.²¹⁶ Many of the humanitarian health organizations present in Rakhine not only provide humanitarian health services but also work to strengthen the capacity of the health system. For example, they train government health staff and community health workers, support national health programs on HIV/AIDS, tuberculosis, and malaria, and provide referrals for secondary care.

This focus on development has led both UNHCR and UNDP to work more closely with the government in Rakhine.²¹⁷ The government has shown a clear interest in working with development actors

210 See UN OCHA, *2015 Myanmar Humanitarian Response Plan, December 2014*; UN OCHA, *2016 Myanmar Humanitarian Response Plan, December 2015*.

211 These are internal documents.

212 UN OCHA, *Myanmar Humanitarian Country Team: 2018 Mid-Year Progress Report on HRP Crosscutting Priorities*, September 2018.

213 Tellingly, the Myanmar humanitarian country team's 2018 mid-year progress report describes its commitment to "implement a conflict-sensitive/Do No (further) Harm" approach in all its work. Ibid.

214 Interview with humanitarian actor, Yangon, November 2018.

215 Interview with humanitarian actor, Yangon, November 2018.

216 UNDP has also been implementing quick impact projects, such as a three-month cash-for-work project, aimed at building confidence with the government, which one interviewee stressed was not sustainable development.

217 For example, UNDP and UNHCR signed a Memorandum of Understanding with Myanmar to work more closely with the government on any eventual return to Myanmar of Rohingya refugees from Bangladesh.

that have had a less confrontational and advocacy-oriented approach. Some see this as sidelining OCHA and the humanitarian response more generally.²¹⁸ For many humanitarian actors, development efforts should not be conducted at the expense of humanitarian activities, given the clear and acute needs, nor at the expense of the human rights situation. These tensions are coming to the fore as the government pushes to close IDP camps in Rakhine, Kachin, and northern Shan without any substantive improvements in people's living conditions, human rights, and livelihood opportunities. Several interviewees stressed the need for concomitant efforts on humanitarian, development, and human rights issues.

This speaks to a widespread criticism that the UN has been unable to leverage the different components of its work in Myanmar to protect the humanitarian space and achieve broader positive change. The UN seems to have succumbed to what some describe as the government's "divide-and-conquer" approach, with agencies at loggerheads with each other.²¹⁹ These internal divides, notably between development and human rights entities but also between the UN's humanitarian agencies and more political components, have been well publicized.²²⁰ The former resident coordinator, who left the country in October 2017, was criticized by UN staff and external actors for allegedly prioritizing building a strong relationship with the government while sidelining human rights and humanitarian concerns in Rakhine.²²¹ Some have described the role of the resident coordinator as inherently flawed because it reports to UNDP, something the reform of the UN development system aims to change.²²² Nonetheless, many also supported the former resident coordinator, notably when the NLD first came to power and the international community had high hopes for Aung San Suu Kyi's government and a real desire to give it

legitimacy. According to interviewees, these divides remain, particularly in Rakhine.

The political and human rights situation has also led NGOs to question the nature of their engagement in Rakhine, particularly in IDP camps. There have been reports of a growing fear by international NGOs and UN agencies that aid in Rakhine since 2012 has helped entrench the internment and segregation of the Rohingya, de facto supporting the government's policies.²²³ External voices have accused UN agencies, international NGOs, and donors of being complicit in ethnic cleansing by not publicly reporting on the abuses committed in Rakhine, capitulating to government demands to not use the word "Rohingya," and paying for the maintenance of IDP camps.²²⁴

The debate on what the red lines for engagement should be is very much alive among humanitarian actors in Rakhine, particularly as the government pushes forward in closing IDP camps and planning for the repatriation of the Rohingya from Bangladesh. One interviewee described the situation as an "impossible dilemma" between the humanitarian imperative and human rights.²²⁵ Should humanitarian actors stay to provide needed humanitarian services or pull out? Staying requires engaging with a government that is committing grave human rights abuses in order to avoid getting kicked out and to access populations in need. It can also entail providing de facto support to the government's segregation policies. For many, there are enough needs that is worth continuing to operate despite the difficult conditions. It is also clear that the direct consequences of pulling out would be dire for the local population. While there is recognition that the status quo is not sustainable, exerting leverage on the government requires a unified stance among aid groups, both humanitarian and development. The absence of such a unified stance has allowed the government to pick

218 There was no clear consensus amongst interviewees on this. See Emmanuel Stoakes, "Q&A: Why the UN Must Take a Stronger Stance in Myanmar," *IRIN News*, July 10, 2018, available at www.irinnews.org/interview/2018/07/10/qa-why-un-must-take-stronger-stance-myanmar.

219 Interview with humanitarian donor, Yangon, November 2018.

220 See, for example, McPherson, "Inside the 'Glaringly Dysfunctional' UN Mission in Myanmar," *IRIN News*, July 17, 2017.

221 See, for example, Sean Gleeson, "Top UN Official to Depart Myanmar amid Controversy over Rakhine," *Frontier Myanmar*, October 12, 2017.

222 McPherson, "Inside the 'Glaringly Dysfunctional' UN Mission in Myanmar."

223 Emanuel Stoakes and Ben Dunant, "As Camps Close in Rakhine, Humanitarians Fear Complicity in Permanent Segregation," *Frontier Myanmar*, October 13, 2018.

224 Liam Mahony, "Time to Break Old Habits: Time to Break Old Habits: Shifting from Complicity to Protection of the Rohingya in Myanmar," *Fieldview Solutions*, June 2018.

225 Interview with humanitarian actor, Sittwe, November 2018.

and choose whom to work with, choosing those with a more conciliatory and non-confrontational approach.

Even among humanitarian actors, there is no consensus on red lines. One interviewee stressed that if their organization does not engage, others will, and they will have lost the ability to know what is happening and use it for advocacy for better access.²²⁶ Organizations managing IDP camps in Sittwe have agreed on various scenarios for engagement and are encouraging other sectors to do the same. One option would be to provide only services that do not support segregation, such as psychosocial support and protection activities, and to stay away from infrastructure support. For example, the new hospital being built with international donor support in Thet Kae Pyin camp will service a larger population than the current temporary clinics but risks becoming the “Rohingya hospital,” further cementing camps originally intended to be temporary.

Similar discussions are happening regarding the potential return of Rohingya refugees from Bangladesh to northern Rakhine. While these returnees will have urgent humanitarian needs, many doubt that people will be repatriated beyond the government’s temporary camps. Should humanitarian actors be providing aid in such camps and risk them becoming the long-term government response? UNHCR has published a position paper arguing that it will not provide humanitarian assistance to repatriated refugees interned in long-term camps.²²⁷ Camp management agencies in Sittwe have also reportedly agreed that they would not work in northern Rakhine if people were forcibly repatriated. One interviewee states that these decisions should rest with the affected populations and lamented the fact that no one is asking them for their views and input.²²⁸

The solution to these dilemmas is ultimately a political one: the government needs to change its discriminatory policies. According to one interviewee, “humanitarian and development agencies have a role to play, but others, and in particular governments, need to play their part in

being forces for change.”²²⁹

Conclusions

Myanmar’s complex crises go beyond the humanitarian sphere, presenting development, human rights, and peace and security challenges, and thereby require a multi-faceted response. Humanitarian actors, however, face significant barriers to accessing populations in need. Given the poor state of the health system, particularly in peripheral states where the international humanitarian response is focused, this undermines the population’s ability to access healthcare services. While the primary responsibility for the health and well-being of Myanmar’s population lies with its government, the international response can make some changes in order to better respond to the needs of Myanmar’s people.

ADJUSTING THE SCOPE OF THE HUMANITARIAN RESPONSE

The crisis in Rakhine and the consequent flight of refugees to Bangladesh has captured the attention of the international community. As a result, many humanitarian actors have congregated in Sittwe and focused on displaced communities, which are majority Rohingya, creating a strong perception of bias among ethnic Rakhine. Humanitarian principles must guide a humanitarian response, and impartiality dictates that response must be directed at those most in need—in this case, the Rohingya. However, a humanitarian response must also do no harm and be implemented in a conflict-sensitive way. The international humanitarian community has for the most part corrected its course in Rakhine, with much of the programming reaching both displaced Rohingya and ethnic Rakhine communities. In addition, development programming benefits the Rakhine communities most directly. However, this perception of bias remains and therefore requires continued outreach, communication, and trust building.

The focus on Rakhine has also eclipsed the crises in other parts of the country, notably in Kachin and northern Shan states. While the humanitarian

226 Interview with humanitarian actor, Yangon, November 2018.

227 McPherson, “Exclusive: U.N. Will Not Help Myanmar with Long-Term Camps for Rohingya—Document,” Reuters, November 13, 2018.

228 Interview with humanitarian actor, Sittwe, November 2018.

229 Interview with humanitarian actor, Sittwe, November 2018.

needs in these states are lesser—notably in terms of the number of people displaced—and they do not have the added complexity of part of the population being stateless, humanitarian crises remain. Notably, people are still facing both protracted and new displacement and the threat of landmines. However, the number of humanitarian actors operating in those states is decreasing, and funding for humanitarian programming has constricted. With little progress on the peace process, humanitarian actors and donors cannot lose sight of the humanitarian needs in Kachin and northern Shan.

Regarding the humanitarian health response more specifically, humanitarian health actors in Myanmar have developed little programming aimed at addressing the vast mental health needs in the country. This is compounded by the government's lack of attention to mental health needs and the resulting dearth in capacity to address them, particularly in states like Rakhine, Kachin, and Shan. The government, with the support of international health actors, should make more efforts to understand the mental health needs of the population, and more programs and resources should be focused on tackling them. Moreover, a staggering number of acts of sexual and gender-based violence have been reported in Rakhine, Kachin, and Shan—and these numbers are believed to be vast underestimates. Some humanitarian actors have developed programs for survivors, mainly focusing on protection, but more need to focus on the clinical response.

ADVOCATING FOR BETTER HUMANITARIAN ACCESS

In Rakhine, Kachin, and northern Shan, the government has heavily restricted travel, thereby severely restricting humanitarian access. This is an enormous challenge for humanitarian actors, as entire parts of the population—often those most in need—are out of reach. International humanitarian actors are particularly constrained. Efforts to work through local organizations, as well as through community health workers and volunteers, have allowed them to access some hard-to-reach communities, but many areas remain what one interviewee described as “black holes.”²³⁰ While humanitarian actors constantly advocate for better

access and must continue these efforts, their influence is limited. As such, UN member states need to put their weight behind the humanitarian response in Myanmar and push for unimpeded humanitarian access. Senior UN leadership in Myanmar and donor agencies should also use development funding and programming as leverage over the government of Myanmar.

STRENGTHENING LOCAL CAPACITIES

In Kachin and northern Shan, lack of access has led international humanitarian actors to rely almost entirely on local NGOs to provide services in non-government-controlled areas. Investing in these local organizations therefore makes programmatic sense, and donors should ensure they have the flexibility to fund organizations that do not fit within their traditional requirements. Beyond local NGOs, there is a need to strengthen international support to ethnic and community-based health organizations in Kachin and Shan and to support government efforts to recognize and integrate them into Myanmar's health infrastructure. Increased training for community health workers and volunteers is also important to reach remote communities.

In Rakhine, a few international organizations have been working through local NGOs to provide health services. Such partnerships remain limited, however, partly because there are few local NGOs working on health issues, and partly because local organizations tend to have mostly ethnic Rakhine staff who may be reluctant to work with Rohingya communities. International actors have nonetheless trained community health workers and volunteers who have helped reach populations in northern Rakhine that international humanitarian actors cannot access and provide services in IDP camps, where international actors cannot stay overnight.

Empowering local communities will contribute to the provision of better services. Efforts to give a voice to affected populations in Kachin and Shan remain inadequate and should be strengthened. In Sittwe's IDP camps, the complaints-response mechanism is a positive example of a way to ensure that the concerns of affected populations are taken into account. Overall, however, the extent to which

230 Interview with Humanitarian actor, Yangon, November 2018.

community voices and concerns influence strategy and programming is limited, and more systematic efforts should be made to ensure that they do. In particular, these efforts should come hand in hand with initiatives that build the capacity of populations to better participate and contribute.

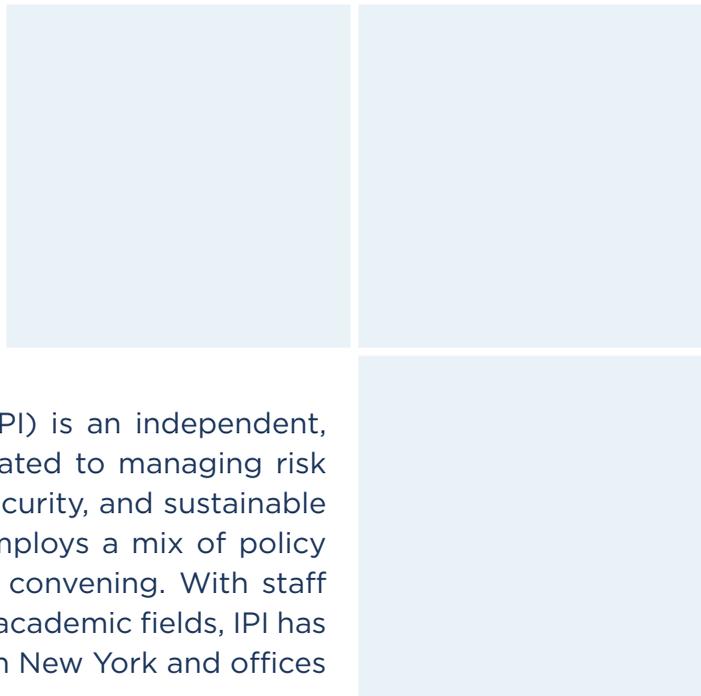
ADDRESSING THE DILEMMAS INHERENT IN PROVIDING AID AMID A DEVELOPMENT AND HUMAN RIGHTS CRISIS

Because of chronic underdevelopment, and as the crises in Myanmar have become protracted, most international humanitarian actors working in the health sector have been both responding to immediate humanitarian needs and strengthening health systems. The government has also started pushing for more development-oriented solutions. In Rakhine, in particular, this poses challenges for humanitarian actors and the broader international response. Indeed, there has been almost no change in the terrible human rights situation in the state, notably on the question of the statelessness of the Rohingya, their freedom of movement, and accountability for abuses.

Ongoing human rights abuses committed by the government have led to strong external criticism of the humanitarian response and soul-searching among humanitarian actors on the ground. For many, the humanitarian needs remain too many, and the risk of disengaging too great, to fully suspend humanitarian programming in Rakhine.

While the status quo is unsustainable, finding a common position on how to engage is challenging. Donor agencies should support humanitarian actors in this process. The camp management agencies have agreed on a series of non-binding principles for engagement that constitute a good practice: they will continue to provide life-saving assistance but refuse to engage in any endeavor that supports state-sponsored segregation of the Rohingya. Humanitarian actors should also consistently and constantly advocate that the government stop committing human rights abuses.

Humanitarian action in Rakhine has also suffered from the shortcomings of the broader international response, in particular that of the UN. The UN country team's focus on development has sidelined the humanitarian response, according to some interviewees and external commentators. The UN has not used the interest the government of Myanmar has in development programming as leverage to ensure better humanitarian access or improve the human rights situation. For some, the fact that the resident coordinator reported directly to UNDP was an inherent flaw. The restructured development system, with its newly "empowered" resident coordinator reporting directly to the UN secretary-general, may present an opportunity to correct the course. More generally, the international community needs to take a strong stance and push for change in both the humanitarian and human rights situation.



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