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COVID-19, Decentralization and the 2020 Elections in Myanmar

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EXECUTIVE SUMMARY[1]

- The first six months of the COVID-19 outbreak in Myanmar saw many achievements, despite predictions of disaster, in a whole-of-society effort to contain the virus.

- One of the core challenges facing Myanmar's health system is competition between the state and ethnic armed organizations. Both sides see the provision of health care – along with education and other services – as a way to establish their authority, and to control territories and populations.

- Nevertheless, the pandemic has prompted cooperation among actors on the ground, including the Ministry of Health and Sports and ethnic and community-based health organizations, despite a continuing mutual lack of trust.

- This cooperation offers opportunities to further decentralize the health governance system, through building on the respective advantages of state and non-state structures.

- Political parties, and their elected representatives at the Union and subnational levels, are ideally positioned to play a leading role in this process of decentralization.

- A surge in recorded COVID-19 cases, and deaths, in September 2020, serves as a reminder of the importance of health reform, and health decentralization.

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INTRODUCTION

The first six months of the COVID-19 outbreak in Myanmar saw many early achievements. Despite predictions of disaster, a whole-of-society effort to confront and contain the virus limited the outbreak to only a few hundred cases. As had happened in the wake of Cyclone Nargis in 2008, seemingly everyone in Myanmar – from medical doctors and nurses to the Ministry of Health and Sports and civil servants in the local administrative apparatus, civil society organizations and citizens all of social classes – organized to respond to the crisis in its medical, security and socio-economic dimensions.[2] Even as returning migrants flooded over the country's borders and dispersed throughout the country, village-level containment measures were established and cases remained low. We may never know if these measures contained this spread or if virus levels in Myanmar were low, but these measures did boost coordination and cooperation at the local level.

At the same time, the coronavirus crisis also laid bare shortcomings in governance,[3] as well as continuing distrust between the state and ethnic service providers. In recent months, too, cases have started to climb. Authorities have placed Rakhine State and Yangon in lockdown. This paper explores health system governance in Myanmar, the country's early successes in combating COVID-19 and what has worked and what has not. It addresses the possible impacts of COVID-19 on the November elections and on the future of decentralization. Humanitarian crises and natural disasters have proved to be potent catalysts for change. Convergence between state and non-state actors in the health sector could play a central role in the process towards a form of asymmetrical decentralization.[4]

THE HEALTH SYSTEM AND HEALTH STATUS IN MYANMAR

Over the past decade, health outcomes in Myanmar greatly improved, under successive governments.[5] The opening of the country from 2010 onward led to a flow of money into the health sector. Notably, health spending grew from US$98 million in 2011-2012 to US$820 million in 2019-2020, representing almost 1 per cent of gross domestic product or 3 per cent of the government budget. A similar increase in health-focused funding from NGOs and international organizations offers possibilities for deeper health sector engagement. Together, these developments have led to a tremendous net positive health outcome for people across the country. Unfortunately, these favorable indicators are often lost in a negative narrative of inefficiency and because of the government's poor communications with civil society organizations and the media. This failure to communicate has been particularly notable in the case of the National League for Democracy (NLD) government's renewed focus on implementing universal health coverage and an ambitious National Health Plan covering 2017-2021. By taking the lead on various health security measures, the government undoubtedly improved the country's pandemic preparedness. These measures included a joint external evaluation with the World Health Organization, a process to evaluate public health preparedness, and the five-year National Action Plan for Health Security covering 2018-2022.

Resources remain concentrated in cities, however. The low rate of intensive care beds available in Myanmar in early 2020—1.1 beds per 100,000 people, one of the lowest figures across Asia and amounting to 330 ICU beds or 660 critical care beds—exposed limits in the

country's capacity to respond to the pandemic.[6] Investment in health education has also lagged behind that in infrastructure and medical equipment. Shortages of health workers in rural and remote areas have remained a problem, albeit one that the National Health Plan aims to correct. These shortfalls in themselves should not overshadow the country's success in improving health outcomes. Moreover, in designing long-term solutions, the government and international community should not overlook the role played in health care delivery by ethnic and community-based health organizations.

HEALTH SYSTEM GOVERNANCE

One of the core challenges to Myanmar's health system has been competing governance between the state on the one hand and ethnic armed organizations on the other. Organizations such as the Karen National Union (KNU), the Restoration Council of Shan State (RCSS), the Kachin Independence Organization (KIO) and the United Wa State Army (UWSA) have controlled significant pockets of territory for several decades. They have cultivated strong community support and addressed health gaps through their respective ethnic health organizations, and in some instances limited the presence of the Ministry of Health and Sports. Indeed, the ability to provide services, including but not limited to education and health services, is an essential part of both the government's and the ethnic armed organizations' efforts to build political legitimacy and to assert control over territories and their population. In this context, ethnic armed organizations' leaders often view "government attempts to expand social services without prior coordination as a strategic threat".[7] While arguably an unavoidable consequence of seven decades of civil war, a lack of trust and limited cooperation remain significant hurdles to an adequate response to a pandemic, or to any health crisis. Despite seeing slow improvement in many parts of the country, and until the country's peace process bears fruit, Myanmar's health system governance is and will remain a system of actors that do not always work together. Over 70 years of conflict have created a "de facto decentralization" of health system governance.[8]

Conflict and geographical isolation also hamper health equity and local communities' access to health care, making them more vulnerable to disease and to adverse health outcomes.

The gravity of these challenges depends on the state of relations between ethnic armed organizations and the central government, and in some cases on those among ethnic armed organizations. In areas along the Thai-Myanmar border where the Karen National Union operates, the Karen Department of Health and Welfare provides significant primary care to Karen communities, though they also remain chronically under-resourced. Other regions may rely on the local economy, backpack health teams or civil society organizations, NGOs and faith-based organizations to prop up health services. The Ministry of Health and Sports has very restricted access in the Wa Self-Administered Division, while it acts in a secondary role for remote communities in parts of Kachin, Shan and Kayin (or Karen) States under the control of ethnic armed organizations, In those territories, conflict or local factors significantly hamper the central government's capacity to improve health outcomes and manage health emergencies.

In other contested or remote areas, weak health services can create conditions for health emergencies and poorer health outcomes. A 2016 outbreak of measles in the Naga Self-Administered Zone on the country's northwest border with India led to an emergency intervention by the health ministry, as the area had little capacity to respond to an outbreak that infected hundreds and killed dozens. Such an outbreak demonstrates the dangers that remote and rural areas of the country face, often in contested areas and with more vulnerable populations. These areas also sit on the borders of densely populated India and China. The risk that emerging and re-emerging diseases and novel contagions slip across borders in areas with reduced surveillance, poorer public health capacity and unregulated movement is considerable. Large volumes of formal and informal border trade and the cross-border movement of people heighten chances of community spread of communicable diseases, posing public health threats to urban populations in regional cities and in turn in Yangon, Mandalay and Naypyidaw.

Furthermore, there are significant limits to what can be achieved by localized and imperfect forms of decentralized health care. Non-state providers of health care offer practical and certainly valuable responses to day-to-day needs and represent an indispensable element in a decentralized health care system, given the geography and the politics of most regions in Myanmar. But as the pleas from ethnic armed organizations and ethnic and community-based health organizations for the government to help them in the response to COVID-19 have shown, coordination and cooperation with the Ministry of Health and Sports, and in some cases with hospitals in China and Thailand, is vital.

As noted in the National Health Plan, resource and capacity constraints mean that reform of health systems in Myanmar deserve high priority. For the first time, the plan outlines a role for ethnic and community-based health organizations, incorporating them into Township Health Working Groups and Inclusive Township Health Plans.[9] The inclusion, at least on paper, of important actors in health activities at the township level is crucial to improving the delivery of health care, especially as the country aims to introduce universal health coverage. Greater convergence or cooperation among health providers across the country will play a vital role in increasing overall preparedness, and have direct and consequential impact on health security and pandemic preparedness in the future.

AN OPPORTUNITY TO BUILD A COMMON FUTURE

These governance complexities create a myriad of potential problems during a public health emergency. Despite some exceptions during the COVID-19 response, there is as yet not enough cooperation on health policy between ethnic armed organizations and the government in contested areas of the country. On-the-ground realities in contested areas have important implications for urban centres in and around those areas. However, experiences of decentralized health governance in post-conflict countries like Nepal suggest that post-conflict health system decentralization can build strength through diversity.[10] The humanitarian aid organization Community Partners International echoed this view in early May 2020 when it noted that "if government and ethnic health systems work[ed] together to address the pandemic, Myanmar could emerge safer, stronger and more cohesive".[11]

Despite the challenges, practitioners interviewed do report some degree of progress in several "ethnic" states.[12] While in most cases better communication and in some cases cooperation remained limited to ethnic or community-based health organizations not directly affiliated to ethnic armed organizations, instances of direct cooperation have occurred. These have included support from government officials for the fundraising efforts of health arms of ethnic armed organizations.

In the context of the response to COVID-19 and beyond, the needs for a convergence between state and non-state actors in the health sector on the one hand and for further decentralization on the other are one and the same. As Myanmar people are almost certain to remember the 8 November 2020 as the "COVID-19 elections", those polls offer an opportunity to build on the momentum created by force of necessity in confronting the pandemic.[13]

The NLD's election manifesto sets out the party's aims in the area of health, with an overall goal of quality health care services with universal health care and national fitness for every citizen. Several elements of the proposed health policy are notable.

- Improving human resources, medicines and supplies in the delivery of public health.
- Improving health curricula in universities, and increasing tertiary programmes in health.
- Improving health literacy in schools.
- Improving extant and building new health infrastructure, including village health departments and branches.

Other more generic but important measures such as reducing the incidence of non-communicable diseases and starting to roll out universal health coverage are among the achievements of the NLD's first five-year term in office.

Ethnic political parties, while unlikely to be able to influence policy-making significantly or to control subnational governments during the 2021-2026 period, may nonetheless play a critical role as moderators and facilitators between ethnic armed organizations and ethnic and community-based health organizations on the one hand and the government and its agencies on the other.[14]

In fields such as education, decentralization in Myanmar is limited. It has come slowly under tight control from the Union capital, Naypyidaw.[15] Still, subnational parliaments and governments have acquired real authority in implementing reforms, especially when those reforms require cooperation with non-state actors and organizations.[16]

Under the leadership of state and regional chief ministers whose dual powers include a direct role in the implementation of national laws, subnational ministers of social affairs of ethnic affairs are best positioned to act as coordinators in promoting convergence between state and non-state health providers.[17] With government agencies, subnational governments and parliaments, ethnic armed organizations, ethnic and community-based health organizations and local communities participating directly in the process of decentralization, political parties, and ethnic political parties in particular, could play a central role in the fostering of local political eco-systems.

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The response to COVID-19 has shown the resiliency, and the capacity to organize, of communities across Myanmar. Despite significant improvements in the sector in the last decade, it has also shown both the importance of and the challenges in decentralizing health care. This holds particularly true following the surge in the number of COVID-19 cases, and deaths, in September 2020.[18]

In bringing together society, Cyclone Nargis had a direct impact on the political process in Myanmar, both ahead of and in the wake of the 2010 elections. The 2020 elections could prove to be not just "COVID-19 elections". They could also be a new "Nargis moment", for Myanmar.

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[12] Interviews were conducted by telephone in May and early June 2020, either in Burmese or in various ethnic languages, by Urbanize researchers.
[13] At the time of writing, the Union Elections Commission maintained that there were no plans to postpone the elections.
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