ReBUILD FOR RESILIENCE

ROLE OF NON-STATE ACTORS IN MYANMAR 2015-22 AND THEIR IMPACT ON HEALTH SERVICE DELIVERY AND HEALTH SYSTEM RESILIENCE

Non-state health education

Background

- Non-state actors (NSAs) account for large shares of health service delivery in fragile and conflict-affected settings, often due to an absence of public health services in hard-to-reach and remote areas
- These providers include private sector, not-for-profit and humanitarian organizations
- Myanmar has suffered multiple shocks since independence, including a military dictatorship, civil war, natural disasters and democratic reform

This study analyses how non-state health provision in Myanmar has changed with the shifting political, security and socio-economic environment from 2015 to 2022, and how this has affected equity, efficiency, and accessibility of healthcare, and health system resilience.

What we did

A document review, secondary data analysis and key-informant interviews with non-state actors (donors, international and local NGOs, civil society organizations and Ethnic Health Organizations (EHOs))

What we found

- Non-state health provision is important in fragile settings, linked to challenges to the role of the state.
- Historically, NSAs have played a major part in filling service delivery gaps in remote and hard to reach areas of Myanmar that state actors fail to reach, especially in conflict-affected border areas.
- In 2010-18, with progress to democracy and international engagement, there was a move to reduce fragmentation through a “policy of convergence”. This recognized NSAs and attempted to integrate public and non-state services, with civil society and government interacting constructively.
- 2018-20 was a golden period for Myanmar with a New National Health Plan, and all parties working towards Universal Health Coverage, system convergence and health system strengthening
- Since the military coup in February 2021, development partners and NSAs have reverted to pre-2010 approaches of working in parallel to the government system, which is not recognized.
- **Our analysis highlights the adaptations and adjustments not only in the relations between state, non-state and international actors, but also in:**
  - Delivery modes (e.g. through the use of mobile clinics and community health workers)
  - Disease/service focus (e.g. shifting to politically-neutral services)
  - New funding sources, which NSAs introduced to respond to changing circumstances and to ensure service delivery.

Fig 1. Political changes in Myanmar and their impact on the country’s health system 2015 to 2022

Transition period	Political change period	Golden period	Stormy period
• Democratic reforms begin: National League for Democracy (NLD) party involved in new government formation • Bilateral cease fire signed between Ethnic Armed Organizations (EHOs) and government	• Landslide victory for NLD party (preparation for new civilian parliamentary formation) • National cease fire agreement (NCA) signed	• Formation of new government and higher-level ministerial changes • Involvement of parliamentarians in the health sector • National election November 2020	• Military government seizes power (2 February 2021) • Nationwide civil disobedience movement
2010-2014	**2015-2017**	**2018-2020**	**2020-2022**
• Visibility to parallel ethnic health system • **2012** – Health Convergence Core Group (HCCG) initiative • **2013** - Myanmar Health Sector Coordinating Committee (MHSCC) established • **2014** - First national census since 1983 • Increased funding (bilateral donors, and various multilateral donors (3MDG fund))	• **2015 onwards** - Loans from World Bank & Asia Development Bank granted to support Myanmar’s fragile health system • **2015** - Demographic Health Survey • **New national health plan (2017–21)** : Comprehensive NHP towards convergence and UHC with involvement of EHOs and CSOs (Civil Society Organizations) • **MHSCC** momentum increases with transparency and active participation of non-state actors (NSA)	• Health as a bridge for peace • Myanmar’s CSO network increases in momentum towards UHC • National health funding increases x4 • Government provides funds to conduct research for HSS • Response to COVID–19 first and second waves with national collaboration and involvement of multi-sectors	• High health sector involvement in CDM • Health system collapses • COVID–19 third wave: thousands die due to lack of resources such as HR, medicines and O2 supplies • NSA health service delivery changes (humanitarian and emergency response)

Conclusion

The resilience of the health system and its capacity to absorb, adapt, and transform in the face of shocks is informed by past experiences, local actors’ relationships with the state, and previously developed ‘resilience capacities’. This affects how local systems respond to shocks and can ensure (more or less optimal) provision of services.

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Further information on this study and outputs

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