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Achieving access to health for mobile populations through community health systems on the Thai-Myanmar border

Cynthia Maung and Tara Russell

ABSTRACT—Over the past two decades, communities in the border areas of Tak Province, Thailand, and in neighboring districts of Myanmar, have established a primary healthcare system. Conflict, displacement and institutional neglect have left this region of Eastern Myanmar without functioning public health services. Forced displacement and statelessness excluded these same communities from health services in Thailand. This paper presents two short case studies that describe how the network prioritizes access to basic care at the village level, with ethnic and community organizations training village health workers to provide health education and to manage common diseases. More serious cases are referred to a network of field and community clinics, and to hospitals on both sides of the Thai-Myanmar border. This latter engagement with government hospitals in Thailand demonstrates an enabling policy environment that develops the adaptive capacity of migrants, rather than regulation that focuses on threat and victimhood. This paper concludes that this kind of approach can provide a future blueprint to guide early engagement between the community health system and national health system reform in Myanmar.

Introduction

Over the past two decades, communities in the border areas of Tak Province, Thailand, and in neighboring districts of Myanmar, have established a primary healthcare system. Conflict, displacement and institutional neglect have left this region of Eastern Myanmar

* An early version of this paper was presented at the Conference on Migration, Security and Development, 18 December 2014, entitled “Community health systems for access to healthcare across borders.
without functioning public health services. Forced displacement and statelessness excluded these same communities from health services in Thailand. Prioritizing access to basic care at the village level, ethnic and community organizations have trained village health workers to provide health education and to manage common diseases. More serious cases are referred to a network of field and community clinics, and to hospitals on both sides of the Thai-Myanmar border.

Cross-border communities have often been portrayed as a human security threat—as trafficked or trafficking, as smugglers, as refugees, as insurgents. In spite of this, and with limited access to social services in Tak Province, and in the absence of national social service infrastructure reaching Eastern Myanmar, they depend on their own social service network. In this way, they develop their communities' health and social security. This network presents a way of understanding migrant and refugee's adaption to be included in their new context, in spite of irregular status and exclusion. Understanding this "adaptive" mechanism provides opportunities for design of policy and programs that develop the community's strength and resilience, rather than creating substitutes or parallel programs.

This is a descriptive paper, which outlines this community's health system as well as some of its successes in addressing both systemic issues and immediate health needs. Two short case studies are presented, the first describing community efforts to address skill shortages, the second focusing on maternal healthcare services. Finally, this paper discusses the growing links between the cross-border community health system and the Thai public health system, and efforts to engage with the Myanmar national health system. These approaches bridge gaps in access to health services experienced by mobile communities and irregular migrants. They allow a continuum of care between patients from village services in remote and conflict-affected areas to hospital-level care in Thailand. And they provide a community-level platform for the implementation of regional disease control initiatives. Furthermore, the recognition of this health system challenges the perception that cross-border communities are either a threat to human security, or merely victims of specific threats such as HIV/AIDS, drugs, or human trafficking. Instead, they are local stakeholders who are constructing community protection mechanisms against these threats.

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Data and methods

This paper uses case studies to describe the community health system on the Thai-Myanmar border that serves displaced, migrant, mobile and refugee populations. It is based on information from a desk review of organization policy documents and annual reports. Some aggregate facility level data are used for illustrative purposes. These data were obtained from the Mae Tao Clinic’s Health Management Information System, as well as from a patient-satisfaction survey conducted in September 2013. Permission for access to these data was obtained from the Health Information Systems Working Group (HISWG). No formal approval study was obtained as it did not entail new data collection.

Frameworks of migration, protection and security

Migration occurs in three phases: departure, journey and destination (Zimmerman, Kiss and Hossain, 2011). The process can be repeated, or can stall at each phase. Specific health threats occur, and interventions are possible, in each phase. The Thai-Myanmar border is both a political border and a natural geographic border, with a river, mountain range, and dense jungle. In spite of this, there has been significant migration of communities crossing and re-crossing this border throughout the past sixty or so years of conflict in Myanmar, and prior to this period. Irregular migration occurs when the conditions for departure (“push factors”) and demands of the destination (employment and other “pull factors”) do not fit the regulatory and political contexts (Cvajner and Scioletino, 2010). At the present time, push factors include the ongoing conflicts, militarization, environmental disasters and human rights violations, creating mobile populations that include forced migrants and refugees. There are also “pull” factors across the border in Thailand, such as access to employment, health and social services (Rukumnuaykit, 2009). The population continues to be mobile, crossing back across the border after finishing work or for family reasons, bringing the “three phases” of migration—departing, journey and destination—into a permanent state/status, with consequences for healthcare access and health outcomes.

The scale of this issue for Thailand, and for universal health access
in Thailand, is massive. Thailand has an estimated 2.8 million irregular migrants (Pholphirul and Rukumnuaykit, 2010), of which 400,000 live in Tak Province (Tak Provincial Health Office, 2015), the area under consideration in this paper. Outside of the reach of government regulations, individuals and communities rely on other mechanisms for their protection, survival and health. As elsewhere, there are degrees of inclusion in the wider community and access to services, and governments are not the only regulators of this inclusion. Understanding these mechanisms of inclusion, Black et al. (2011) suggests that irregular migrants can be understood as threats, victims or adaptive. Historically, on the Thai-Myanmar border, far from central administration, communities have negotiated for protection in a patron-client relationship—providing agricultural commodities (or opium) in exchange for protection from local warlords and provincial commanders controlling territory (Sturgeon, 2004).

The historical patron-client relationship leaves migrants as victims, with protection only from certain kinds of violence and exploitation, and without access to services. In the current political context of Thailand, migrants and asylum seekers have been presented as a threat to peace, harmony and economic progress (RSIS Centre for NTS Studies, 2013). However, migrants fill labor shortages in Thailand, and consume goods and services. They send these goods and money back, contributing to development in their home villages (Benach et al., 2011). Within an adaptive framework, a broader understanding of protection can be seen, provided by social networks, employers and by operational limits of states or law enforcement and bureaucracy (Cvajner and Sciortino, 2010). This contributes to household and community resilience to various vulnerabilities and threats. Some policies and local responses recognize and build on the existing adaptive mechanisms that build household and community resilience (Black et al., 2011). The cooperation between the community health system and Thai provincial health programming is an example of this.

Community health system

As Myanmar goes through political and economic reforms, there remain obstacles to cross-border communities accessing healthcare services. Public health services are still in crisis, with insufficient and
underpaid health workers, run-down facilities and medicine shortages. Informal payments are high, with 82 to 85 percent of health-care expenditure still being out-of-pocket, compared to 14 percent in Thailand (MoH, 2013). The government increased spending on health from 100,825 million kyat ($83.2 million) in 2011-2012 (MoH, 2013) to 625,745 million kyat ($516.3 million) in 2014-2015 (MoH, 2014), but health still accounts for less than 3.9 percent of the national budget (MoH, 2014). Overseas aid increased from $9.70 per capita in 2012 (considerably below the $49 average for other least developed countries, according to Scott, 2014), to $143.70 in 2013 (Development Assistance Committee, 2015). However, international humanitarian access to border areas is still limited, and is generally confined to vertical programs and to specific areas, with international aid agencies still unable to reach all of the approximately 500,000 displaced persons in the east of Myanmar. The costs of accessing care, as well as the poor quality and limited availability of care, drives many people—not just mobile populations—to seek healthcare outside the country. In 2013, 57 percent of persons at the Tak community clinic were living in Thailand, and 43 percent had travelled from Myanmar for healthcare (MTC, 2015). Ceasefire negotiations have not led to a political resolution, sporadic fighting and militarization continues in some areas, and international investments in mega dams is fueling insecurity (TBC, 2014). In mixed administration areas, and in areas where community members travel between administrative areas for healthcare, dealing with multiple authorities and administrative systems continues to add to the day-to-day difficulties of villagers.

The community health system is a network made up of community- and ethnic-health providers. At the village level, health education, screening and prevention activities, as well as basic case management of the most common diseases, is provided by village health workers and trained birth attendants. These workers refer complex cases to community clinics, where skilled health workers are trained and supplied to manage endemic disease, maternal and child health programs, and carry out community health campaigns. In Eastern Myanmar, there are now over 200 primary healthcare clinics and mobile outreach teams, a handful of secondary healthcare facilities, around a thousand trained primary care workers, and several thou-

** Converted at a rate of 1,212 Myanmar kyat (MMK) to 1 US dollar.
sand village-based auxiliary healthcare workers. There have been some improvements in core health indicators in these areas. Communities now practice healthy behavior such as exclusive breastfeeding, can access antenatal services and safe delivery, and the average age of first delivery is post-adolescence (HISWG, 2015). However, there are also increasing disparities in some areas, as economic development reaches central Myanmar (Table 1 refers).

| Table 1: Key health indicators and comparators for Eastern Myanmar displaced population |
|-----------------------------------------------|-----------------------------------------------|---------------------------------|------------------|
| Infant Mortality rate (IMR) per 1,000 live births | 91                 | 94.2               | 40               |
| Under 5 Mortality rate (U5MR) per 1,000 live births | 221                | 141.9              | 51               |
| Maternal Mortality (MMR) per 100,000 live births | 1,000-1,200         | 721 (2008)         | 200              |
| Child malnutrition (%)                          | 15.7               | 16.8               | 7.9              |
| Maternal malnutrition (%)                       | 16.7 (2008)        | 11.3               |


Referral networks are improving, but the journey for those who are referred for healthcare services remains dangerous and expensive. Infant mortality and child malnutrition rates have both worsened, and although maternal malnutrition has improved, it remains a concern.
Malaria, acute respiratory infections and diarrhea remain the leading causes of death. The evidence of improved protective behavior noted above, without parallel improvements in child mortality and with worsening malnutrition rates, suggests that the social determinants of health in children have worsened in the period under analysis.

In Tak Province, community health service provision is centered around the Mae Tao Clinic (MTC). This is a 200-bed, community-managed primary health care facility, based in the border town of Mae Sot. It was established in 1989 to provide urgent care to people fleeing persecution and conflict at that time. It has developed into a comprehensive facility offering a wide variety of services and outreach with interventions in the languages spoken by communities in the border areas and that are culturally accessible. It serves as a training center, training its own health workers, as well as providing a clinically supervised experience for members of the community health network in Eastern Myanmar. Community outreach is also provided to the local migrant worker community. For individuals from Myanmar, access to government services in Thailand is not as simple as crossing the border. Individuals lack documents, resources and information to access their entitlements. Thai institutions face policy, logistical and political challenges to provide services to the large undocumented and mobile populations. The mobility of the population means that these categorizations are not always meaningful, and is a further challenge for accessing services. Many people who would describe themselves as living in Myanmar also travel into Thailand regularly to access medical care and other services. Many are still without documents. In 2012, out of 3,314 babies born at the Mae Tao Clinic, only 9 percent had a mother or father with legal documents (MTC, 2012). In 2014, as a result of migrant registration, around 33 percent had a mother or father with legal documents. This is a rapid improvement, but two thirds of the children born in the clinic still had parents with no legal documents, meaning they were without official access to Thai health or social services (MTC, 2012).

Successive Thai administrations have recognized the right of migrant workers to access healthcare under national universal coverage schemes. Yet barriers to access remain (Chamchan and Apipornchaisakul, 2012). Changes to the work permit system and improvements in access to health insurance for migrant workers have been welcome,
expanding access to care by particularly vulnerable groups such as people living with HIV and pregnant women. In spite of this, only 14.5 percent of migrant workers in Tak Province had purchased health insurance by the end of 2014 (Tak Provincial Health Office, 2015). In a survey (MTC, 2013) of patients accessing the community clinic in 2013, 67.5 percent of patients living in Thailand said that they were unaware of health insurance or social security schemes. Of these, 2.1 percent also stated that they did not think they needed health insurance or social security. There is a need for increased communication and information targeting the migrant community in Thailand, and including information about healthcare entitlements and Thailand's health insurance and social security schemes. Improving access to subsidized care would represent a major impact. Over 60 percent of patients in the 2013 survey also said that they came to the community clinic because they could not afford care in the official Thai or Myanmar health systems (MTC, 2013).

**Case Study 1: mobile communities as the health workforce**

Myanmar suffers from an acute shortage of health workers. Nationally, there are 0.68 doctors, nurses, and midwives (combined) per 1,000 people (Sein et al., 2014), which is below the World Health Organization (WHO) critical shortage threshold of 2.3 health workers per 1,000 people (WHO, 2006). In Eastern Myanmar, there are specific factors of geographical remoteness, poverty and conflict, which make it difficult to recruit and retain health workers. In areas of Thailand bordering Myanmar, there are also shortages relating to quantity and quality issues. Provincial health services face challenges recruiting and retaining workers, with many leaving for urban, private, or overseas employment (Pagaiya et al., 2011). While Thai health workers are trained to rigorous standards, further training is needed to address specific communication barriers and understanding of migrant health issues and rights.

The community health workforce also faces displacement, resettlement and limited access to education. To address this, the community and ethnic health network have adopted the following strategies to promote the retention of the health workforce.
Table 2: WHO guidance and corresponding community strategies for retaining the ethnic health workforce (HSSWG, 2014)

<table>
<thead>
<tr>
<th>WHO (2010) GUIDANCE</th>
<th>JOINT STRATEGY</th>
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<tbody>
<tr>
<td><strong>TRAINING</strong></td>
<td></td>
</tr>
<tr>
<td>Targeting admissions to increase the likelihood of graduates choosing to practice in isolated areas</td>
<td>Community nomination of trusted persons for training as village and community health workers</td>
</tr>
<tr>
<td></td>
<td>Deployment of health workers to match their home community</td>
</tr>
<tr>
<td>Locating schools and residency programs outside of cities</td>
<td>Transitioning training from cross-border training centers to field clinics</td>
</tr>
<tr>
<td>Revising curricula to include topics relevant to context</td>
<td>Refresher/upgrade trainings on drug-resistant malaria</td>
</tr>
<tr>
<td></td>
<td>New curricula for field monitoring and management</td>
</tr>
<tr>
<td>Design of relevant professional development accessible from where they live and work</td>
<td>Transition of CHW training to district sites</td>
</tr>
<tr>
<td></td>
<td>Provision of monitoring workshops at field sites</td>
</tr>
<tr>
<td><strong>FINANCIAL INCENTIVES PERSONAL AND PROFESSIONAL SUPPORT</strong></td>
<td></td>
</tr>
<tr>
<td>Sustainable financial incentives to outweigh opportunity costs</td>
<td>Review and standardising stipends</td>
</tr>
<tr>
<td>Provide a safe working environment</td>
<td>Non-monetary support—rations, housing support</td>
</tr>
<tr>
<td>Provide career development opportunities in isolated areas</td>
<td>Taking advantage of improved security situation in transport arrangements</td>
</tr>
<tr>
<td>Adopt public recognition measures</td>
<td>Mental health training for self-care and peer support</td>
</tr>
<tr>
<td>Adopt public recognition measures</td>
<td>Standardising health worker to population ratios</td>
</tr>
<tr>
<td></td>
<td>Decentralising decision-making, where appropriate, to district and clinic levels</td>
</tr>
<tr>
<td></td>
<td>Health workers recognised at cultural events</td>
</tr>
<tr>
<td></td>
<td>Development of village health committees</td>
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</tbody>
</table>
Introduce and regulate enhanced scopes of practice

Compulsory service requirements are accompanied by support and incentives

Providing education subsidies to increase recruitment

Introduce different types of health workers with appropriate training and regulation

Standardizing key competencies across partners

Linking training opportunities to compulsory service requirements for both field and administrative staff

Providing opportunities for advancement for all capable staff

Advocating to donors for provision of scholarships to suitably motivated ethnic health workers

Adopting task-shifting approach

This final strategy is recommended by the WHO as a means to address skill shortages in low resource settings (WHO, 2008). Specific tasks that are usually administered by doctors and nurses are allocated to lower-rank health worker cadres. In Eastern Myanmar, community-based medics, maternal health workers and community health workers are recruited from the community, trained and tasked with providing primary healthcare (Table 2). A study documenting the application of the task-shifting approach in the community health system in Karen State, Eastern Myanmar, was published in the *Global Health Action Journal* (Low et al., 2014). The authors conducted a rapid mapping exercise with clinic-in-charges in 110 clinics in 14 Karen townships. A one-page questionnaire recorded numbers and types of health workers, training received by these health workers, and services provided. This was supplemented with a desk review of organizational policies and training documents.

In the community health system in the area surveyed, the study encountered a regional average of 2.8 (combined) per 1000 people, well above the critical threshold. It showed evidence of a systematic approach to task-shifting, including 6-24 months theoretical and clinical training, as well as ongoing supervision, monitoring and support for health workers. The health workers were providing a standard primary health care (PHC) package, following clinical protocols that
have been recognized as effective in similar settings worldwide. It also found that the health workforce is recognized, accepted and trusted by local community members. The report concluded that task shifting can ensure equitable PHC access. Large numbers of people are receiving vital health services where otherwise there would be none. There is also indirect evidence of the positive impacts of primary healthcare coverage through task shifting, e.g.:

- increase from 20 percent (2008) to 58.2 percent (2013) in the proportion of children receiving vitamin A tablets;
- prevalence of malaria reduced from 6.9 percent (2008) to 2.2 percent (2013);
- 84 percent of people in community service area access trained in birth attendance.

**Case study 2: Migrants providing for safe motherhoods**

In 2013, Myanmar had an estimated maternal mortality ratio (MMR) of 200 maternal deaths per 100,000 live births (World Bank, 2015), Table 1 above refers. Even though the official figures represent a 4.5 percent annual reduction since 1990, the MMR still remains 20 percent above the Asia and Pacific regional average of 160 maternal deaths per 100,000 live births. Myanmar ranked second worst for the region, after Indonesia, in terms of maternal mortality ratios. MMRs in Myanmar’s eastern border areas were also found to be as high as 721 maternal deaths per 100,000 live births in a 2008 survey, or 3.5 times the national average (Stover et al., 2007). Adding to the complex situation, decades of civil conflict have resulted in thousands of children born without citizenship in either Myanmar or Thailand, and therefore without the protection that citizenship entails. Moreover, community health workers operating in the border areas continue to provide vital services despite lack of recognition and accreditation. Performing the role of healthcare professionals without documents means that they operate outside the law, and can be arrested. In the past, health workers and healthcare infrastructure were targeted by the military.

To provide maternal and child healthcare in these hard-to-reach areas, the network employs three levels of community health workers
comprising of specialized midwives, maternal child-health workers and trained traditional-birth attendants. This program provides specialized training in management and delivery of basic emergency obstetric care, focused antenatal care, family planning and essential neonatal care for remote and conflict-affected communities.

The community clinic in Tak serves as a referral point for the ethnic community network, as well as providing comprehensive reproductive health services for the migrant and wider community. With time, the growth of the network in Eastern Myanmar and Thailand has meant that it has gained recognition from Thai health services. The result has been improvements in safe delivery, access in obstetric emergencies and access to birth registration, family planning, post-abortion care and referral pathways to safe abortion. In 2015, community and ethnic providers in Myawaddy and Tak provided assistance to thousands of women (Table 3).

<table>
<thead>
<tr>
<th>Number of live births by selected service provider, 2014</th>
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<tbody>
<tr>
<td><strong>Tak public hospitals</strong> 1</td>
</tr>
<tr>
<td><strong>Myawaddy public hospital</strong> 2</td>
</tr>
<tr>
<td><strong>Community clinic, Tak</strong> 3</td>
</tr>
<tr>
<td><strong>Ethnic/community network, Myawaddy</strong> 4</td>
</tr>
<tr>
<td><strong>Refugee camp, Tak</strong> 5</td>
</tr>
</tbody>
</table>

1 Tak Provincial Health Office. Tak Population. Presentation for MoPH Minister visit on 14 January 2015.
2 Estimate provided to Mae Tao clinic by Myawaddy Hospital.
3 Mae Tao Clinic. 2012. Monthly Birth Registration Record.
Discussion: vulnerable communities engaging with Thai and Myanmar health authorities

Under security frameworks, migration is addressed as a "threat", with migrants monitored and screened, posed as a vector of disease (Zimmerman, Kiss and Hossain, 2011). Policies or programs that label migrants and refugees as victims, "vulnerable" to specific threats, employment hazards, exclusion and discrimination, needing support to access services, is also limiting when one considers the range and complexity of the community health system that has developed on the Thai-Myanmar border. This border is a place of transit as well as a destination, and an intersection of services. Within the migrant and refugee community, there are overlapping sub-groups with different risk profiles: "healthy workers" with non-communicable diseases; those who specifically travel for health care; individuals that have been detained, are traumatized and self-medicate; and many more.

The current changing political and humanitarian context provides an opportunity to form policy and program responses that strengthen rather than replace the community health system. Overcoming the issue of cost only addresses one of the multiple barriers that continue to prevent cross-border communities from accessing healthcare. Individuals with documents tend to be healthier, have higher skills and incomes, and better access to health services (Zimmerman, Kiss and Hossain, 2011). Multi-staged and circular migration means both an accumulation of health threats and multiple opportunities for intervention (Zimmerman, Kiss and Hossain, 2011).

There have been a number of notable efforts in promoting collaboration between the community health system and Thai health authorities. The current framework guiding this collaboration process is the "Border health master plan and health strategies on migrant health in Thailand 2012-2016". This plan aims to expand access to health services for migrants in Thailand, and specifically serves to advance public health along the border. The plan has three goals. The section below outlines activities of the community health system contributing to the achievement of these goals.

a. Develop a quality health service system. The community health system contributes to this goal through service provision at the Mae Tao Clinic (Thailand) and field clinics (Myanmar); surveillance of
endemic and reportable disease; development of a monitoring system for standard setting and quality improvement; safe disposal of medical waste; and a training hub for the community health network. Mae Tao Clinic manages a training center for the community health network. Lower cadres of health workers are increasingly trained at field sites in Eastern Myanmar, with the community clinic providing a venue for supervised clinical internships. Midwifery programs now cooperate with both Thai and Myanmar health authorities.

b. **Promote access to primary health services.** Through task-shifting to village-based health workers for common endemic diseases; health promotion in villages and schools; rehabilitation services (including counselling, prosthetic rehabilitation for landmine survivors, physiotherapy for early recovery and home-based care for HIV/AIDS); and strengthening referral networks between the community and government service. In 2014, from Mae Tao Clinic to Thai government services, there were 406 OPD (out-patient) cases referred, 444 in-patient cases and 5,753 dentistry cases. Specialist referral is provided for cases of sexual- and gender-based violence, and other protection issues, as well as cross-border for HIV/AIDS, PMPCT and ARV.

c. **Strengthen collaboration and participation from all stakeholders and sectors.** Is the goal area which shows the areas of most recent innovation:

**Certification of health workers:** Community health workers, some of whom are trained in advanced healthcare, do not have recognized qualifications in Thailand or Myanmar. Through collaboration with Thai and American Universities, health workers are receiving official certification, following curricula also used in Myanmar. These programs are working towards having these qualifications recognized in Myanmar.

**Malaria Elimination taskforce** began as a collaboration in 2013 and targets 800 villages in areas of identified drug resistance. The taskforce includes village health workers, community leaders, program managers, geographers, epidemiologists, biostatisticians, anthropologists and logisticians.

**Expanded program of immunization** is a collaboration between the Tak Public Health Office and the community networks. Field clinics in Eastern Myanmar are “twinned” with a neighboring health center on the Thai side of the border. Clinic workers are trained and supplied
by Thai health authorities in the transport and administration of an expanded program of childhood immunization in Eastern Myanmar.

d. Community health system collaboration efforts with the Myanmar government. Since 2012, civil society groups have made efforts to collaborate and meet with national and provincial health authorities in Myanmar. As a result of these meetings, there has been increased standardization between the parallel health systems in some areas—for example, malaria protocols for control of drug resistance. To date, there has not been tangible progress on key issues such as the recognition of health workforce and of the community healthcare system. The national regulations on international organizations also restricts access to these areas. The types of programs approved to date are vertical, and risk fragmenting the holistic, community-based approach, rather than strengthening the existing ethnic and community system (Jolliffe, 2014).

Conclusion

Myanmar still has a long and difficult road ahead to peace and stability. If political reforms in 2015 are to include the expansion of public health services to previously politically and geographically isolated areas of Myanmar, they will require:

- Continuing cooperation between Thailand and community health system in border areas for comprehensive primary healthcare;
- Investment in, and empowerment of, the existing community infrastructure and human resources within Eastern Myanmar and migrant and refugee communities in Thailand;
- Building on the success of the task-shifting approach by addressing barriers to secondary healthcare;
- Further development of cross-border coordination between the community health system and the official Thai and Myanmar health services.

The true measure of change in Myanmar will be the cessation of armed conflict and human rights abuses, when people provide a vote of confidence in the country’s changes by returning home in safety.
and dignity. They will no longer have to travel great distances, across borders, to access basic education and healthcare services. This is a community empowered to manage its health, with internal regulation and coordination for standardization. However, coordination with government and other non-government providers remains difficult with centralized decision-making, inadequate communications infrastructure and a need to overcome years of mistrust. The community-level healthcare system, structure and workforce are also still not officially recognized. These coordination issues are not just a problem in relation to government providers. Some international organizations who have not had access to these areas assume communities are passive victims of the insurgency needing their care, and not local actors who have mobilized to manage their community's health.

References

Abbreviations used in referencing

HISWG Health System Strengthening Working Group
MoH Ministry of Health, Myanmar
MTC Mae Tao Clinic
TBC The Border Consortium
WHO World Health Organization


Development Assistance Committee. 2015. “Query Wizard for Develop-


Mae Tao Clinic. 2015. Annual Report 2014. Mae Sot Mae Tao Clinic.


