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On the frontline of eastern Burma's chronic conflict – Listening to the voices of local health workers

Katherine H.A. Footer [a,*], Sarah Meyer [b], Susan G. Sherman [c], Leonard Rubenstein [a]

[a] Center for Public Health and Human Rights, Department of Epidemiology, Johns Hopkins School of Public Health, 615 N. Wolfe Street/E7141, Baltimore, MD 21205, USA
[b] Department of International Health, Johns Hopkins School of Public Health, Baltimore, MD 21205, USA
[c] Department of Epidemiology, Johns Hopkins School of Public Health, Baltimore, MD 21205, USA

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ABSTRACT

Globally, attacks on and interferences with health workers and healthcare delivery, including targeted violence towards providers, attacks on hospitals and delays and denial of health care, represent a serious humanitarian and human rights issue. However, gaps in research about these events persist, limiting the evidence base from which to understand and address the problem. This paper focuses on experiences of local health workers in eastern Burma's chronic conflict, including their strategies for addressing security and ensuring access to vulnerable ethnic communities in the region. Face-to-face in-depth interviews were conducted in June and August 2012 with 27 health workers from three health organizations that operate throughout eastern Burma, with their operational head quarters located in Mae Sot, Tak Province, Thailand. Qualitative analysis found that health workers in this setting experience violent and non-violent interferences with their work, and that the Burmese government's military activities in the region have severely impacted access to care, which remains restricted. Data show that innovative security strategies have emerged, including the important role of the community in ensuring securer access to health care. This study underscores health workers' concern for improved data collection to support the rights of health workers to provide health care, and the rights of community members to receive health care in conflict-affected settings. Findings will inform the development of an incident reporting form to improve systematic data collection and documentation of attacks on health in this setting.

1. Introduction

In contemporary conflicts and fragile settings, health care is frequently under attack, with violence – both real and threatened – affecting access to and delivery of health care (ICRC, 2011b). Forms of violence include physical attacks on health workers (HW), patients and infrastructure, as well as indirect interference with healthcare delivery caused by general insecurity or intimidation (Rubenstein and Bittle, 2010). The impact of conflict on HWs and service delivery is wide ranging and includes destruction of health facilities, transports, supplies and equipment, as well as overall reduced access to health services, including disease control programs.

According to the International Committee of the Red Cross (ICRC), violence against HWs and patients is one of the most overlooked humanitarian issues today (ICRC, 2011a). In a study of 921 violent incidents affecting health care in 22 conflict-affected countries during 2012, of the 319 incidents involving health personnel, local HWs accounted for 91% of incidents (ICRC, 2013). Targeted violence and general insecurity are important drivers of displacement and migration of HWs (Betsi et al., 2006; Burnham et al., 2009). The loss of trained HWs presents one of the largest obstacles to meeting health care needs post-conflict (Leather et al., 2006; Nagai et al., 2007).

Despite the enormity of the problem, a paucity of data exists on the extent and nature of violence towards health care in conflict and other situations of civil unrest. A number of recent peer-reviewed studies describe HW's experience of violence in conflict, or the coping strategies HWs have developed (Dhar et al., 2012; Din et al., 2012; Sousa and Hagopian, 2011), but more country-based qualitative research is required to shed light on the context-specific aspects of violence. The need for a better evidence base has prompted attention at the international level (Rubenstein, 2012) with efforts to expand reporting mechanisms underway

* Corresponding author.
E-mail addresses: kfooter@jhsph.edu, kfooter1@gmail.com (K.H.A. Footer).

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(Security Council, 2011; WHO, 2012). To date, most documentation of attacks on health care has been ad hoc, through international and local human rights NGOs, and, in some settings, health providers.

In eastern Burma health providers and local human rights organizations have documented and published information on attacks, but without a validated reporting form. To determine the feasibility of developing an incident reporting form to enable systematic monitoring of attacks and interferences with health care in conflict affected areas of eastern Burma, a preliminary qualitative study was conducted on the Thai–Burma border. The study focuses on HW's experiences of providing care in conflict-affected eastern Burma, the results of which are presented here.

Burma is an ethnically diverse country, and minority groups are spread throughout the country's 14 provinces, particularly mountainous eastern frontiers (BPHWT, 2006). Burma is also known as Myanmar. We use Burma throughout, in accordance with the preference of the 1990 General Elector winner, the National League for Democracy. From 1962 to 2011, the Burma military ruled directly, or indirectly, through the guise of a civilian government. Throughout this period, and continuing to date in some areas such as Kachin State, ethnic populations have been affected by conflicts between a militarized state and dozens of insurgent groups. This included active resistance along the eastern frontier bordering Thailand, where a counter-insurgency strategy known as the Four Cuts led to forcible relocation of civilians, accompanied by confiscation of land and property, denial of food, curfews, placement of landmines, and other strategies giving rise to a large population of internally displaced persons (IDPs) in the region (Risser et al., 2004). A survey in 2012 by The Border Consortium of 36 townships estimated 400,000 IDPs in the southeastern region (TBC, 2012). Serious and widespread human rights abuses by the Burmese army (known locally, and referred to throughout this paper, as the *Tatmadaw*) and – less systematically Non-State Armed Groups (NSAGs) is well documented (Amnesty, 2013; HRW, 2012; KHRG, 2010). Although ceasefire agreements have been signed throughout this period, historically they have proved nothing more than temporary truces, with little improvement in conditions for civilians (South, 2012).

Over the last two years the government has taken significant steps towards democracy. The first general election in 20 years occurred in 2010 and by mid-2012, 10 of the 11 most significant NSAGs entered ceasefires. The last major group still in combat with the Burmese Army remains the Kachin Independence Army. However, reports by Physicians for Human Rights in 2011 and 2012 provide compelling evidence that the Burmese army continues to commit human rights violations in both Kachin and Karen States (Davis, 2011, 2012).

Poor quality and access to health care is reflected in Burma's overall health indicators. The under-5 infant mortality rate per 1000 live births is 41 in Burma, compared with 11 in Thailand (World Bank, 2013). In eastern Burma, previous higher estimates of infant mortality (89 per 1000 live births), and child mortality (218 per 1000 live births) appear linked to ethnic communities' exposure to human rights violations and systemic marginalization from clinical services (Lee et al., 2006; Mullany et al., 2008). Estimates of maternal mortality ratios (approximately 1000 per 100,000 live births) are high, particularly in areas of eastern Burma where low-level conflict has led to displacement and limited access to state health care (BPHWT, 2006). The additional impact of chronic conflict on health in eastern Burma has been evidenced by high prevalence of many infectious diseases, including malaria, HIV, and multi-drug resistant tuberculosis (Beyrer et al., 2007).

For the last two decades, the ruling junta blocked state and international humanitarian assistance to IDPs and vulnerable communities, with severely limited access to health care in Karen, Kayah, Mon, Arakan, Kachin, Shan States, and the Tenasserim Division. Denied reliable access to basic housing, food, water, and health care, many communities have hid in jungles or temporary settlements (BPHWT, 2006). Community health organizations have filled the service gap left by the state, but work has often proved dangerous. The direct targeting of HWs has included kidnappings by the Tatmadaw, while government restrictions on movement prevented patients and HWs accessing clinics. Individuals who contravened restrictions risked being shot on site by Tatmadaw forces (KHRG, 2010; Lee et al., 2006).

The targeting of health, including attacks on HWs and indirect interferences that impede access to patients, represent violations of international law. International humanitarian law (IHL) and human rights law, including the right to health, provide important frameworks for respect and protection of health care in conflict (Footer and Rubenstein, 2013). This paper adds to the small number of recent peer-reviewed articles focusing on HW's experiences of violations in a chronic conflict setting.

The results of this research informed development of an incident reporting form by a study team at Johns Hopkins Bloomberg School of Public Health (JHSPH) for use by partnering health organizations in the setting of eastern Burma. The content and validation of this form will be reported on elsewhere. It is hoped that the form will be used as a model for reporting in other conflict settings.

2. Methods

This paper is based on 27 semi-structured in-depth interviews with HWs from Burma, conducted in June and August 2012. The study design sought to elicit information to: 1) describe the types of attacks and interferences with health care in eastern Burma, 2) identify their impact on access and availability of health services 3) explore current approaches to protection and security of HWs and 4) examine attitudes toward reporting violations for the purpose of accountability. To ensure a richness of experiences was captured in the data, the study explored HW's exposure to conflict over the previous 10 years.

2.1. Setting

The research was conducted primarily in Mae Sot, a semi-urban setting in the Tak Province of Thailand. The town is 3 km from the Burmese border town of Myawaddy and functions as headquarters for many community-based organizations working in eastern Burma, including the administrative and training head quarters of the three participating health organizations. One field site visit was made to a clinic site in Umphang, a rural setting in the southwest district of Tak Province. Information on available state-provided health services in eastern Burma is limited, however innovative cross-border local partnerships still provide the majority of services to eastern Burma's border regions. All participating organizations work to strengthen local ethnic health infrastructure within eastern Burma, providing health services to populations who would otherwise go without. The organizations train hundreds of multi-ethnic HWs who work within their communities and implement a range of health programs, including: medical care programs, mother and child programs, community health education and prevention, malaria, tuberculosis, and Vitamin A supplementation programs, among others. The organizations collectively serve a target population of between 180,000 and 190,000 IDPs and other vulnerable people in Karen, Kayah Mon, Arakan, Kachin and Shan States and the Tenasserim Division. Some HWs operate as fully mobile teams carrying supplies and services to populations in eastern Burma's least stable and most remote areas, while others

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