DO NO HARM:
CROSS-BORDER AND THAILAND BASED ASSISTANCE TO REFUGEES, IDPS AND MIGRANTS FROM BURMA/MYANMAR- REPORT ON FINDINGS FROM CONSULTANCY

Contents

Introduction

Norway has supported cross-border assistance to the Back Pack Health Worker Team since 1998 and Thailand-based humanitarian assistance to the Mae Tao Clinic since 2005. Such support has been consistent with Norway's commitments to advance humanitarian principles in conflict and disasters and to ensure that people in need receive necessary protection and assistance.

In 2010, Norway decided to cut cross-border assistance citing accountability concerns and difficulties of monitoring such assistance. In 2012, NCA was informed by MFA of an impending cut in all cross-border and Thailand- based assistance, due to positive political changes in Burma/Myanmar and improved access from Yangon to border areas of Eastern Burma/Myanmar.

NCA is concerned about the impact of such a decision. NCA therefore hired a consultant in order to verify the impact of a cut in assistance on access to services for rights holders in border areas and for local peace building efforts, and to assess whether such a cut stands at risk of violating humanitarian principles of Do No Harm. NCA further notes that other concerned parties, most recently the European Parliament, have instead called on the Burmese government to allow cross-border assistance to take place. NCA also has reason to believe that an abrupt cut in assistance to refugees, internally displaced people and migrants at this stage

would not be conducive to the ongoing peace making efforts of the Burmese government and ethnic armed groups in the country.

Over a period of three weeks in April 2012, the consultant conducted 35 single interviews and/or group interviews with respondents in four locations (four in Bangkok, 18 in Yangon, seven in Mae Sot and six in Chiang Mai). Two additional sources were contacted by email. The respondents belonged to the following categories: (1) Representatives of the UN system in Burma/Myanmar, including the UN Resident Coordinator; (2) Representatives of INGOs working in Burma/Myanmar and/or along the border; (3) Representatives of national and local NGOs in Burma/Myanmar; (4) Representatives of FBOs/CBOS in Burma/Myanmar and along the border; (5) Representatives of ethnic health authorities in border areas; (6) Three medical doctors with experience working with border-based health providers including two doctors from the Thai healthcare system, and (7) One independent evaluator of one border-based health provider. The consultant also attended one meeting of the Coordinating Committee for Stateless and Displaced Persons in Thailand (CCSDPT) and one press conference on the situation in Kachin State organized by Human Rights Watch, both in Bangkok[1].

This report is a case study focusing primarily on the provision of healthcare services. However, NCA believes that many of the considerations and concerns raised in the report also apply to other service deliveries and that the potential consequences of a cut as described in this report would also apply to other sectors.

By seeking to gain better understanding of current dynamics of aid in the political and peace reforms in Burma/Myanmar, NCA hopes this report will contribute to the transition towards peace and reconciliation for local communities in Burma/Myanmar.

Background

Assistance to refugees fleeing fighting in Burma/Myanmar started in Thailand with the establishment of refugee camps in 1984. Thailand-based assistance and cross-border humanitarian assistance into Burma/Myanmar outside of these camps started in the wake of two seminal events in Burma/Myanmar; the 1988 uprising against military-dominated rule, which led to an outflow of political exiles from urban to border areas, and the mid-1990s military offensives against ethnic armed groups, which led to an outflow of internally displaced people and refugees. These developments have led to the emergence of two categories of border-based community-based service providers; those which are part of the camp structures and those outside of the camps. The present report primarily focuses on the impact of a cut for community-based service-providers who do not belong to the camp structures.

Initially, humanitarian assistance to border-based population groups was offered from or in Thailand because of a lack of humanitarian access into the conflict zones of Eastern Burma/Myanmar from Yangon/Rangoon, which meant that aid could not be provided in other

[1] The list of meetings and interviews is on file and available upon request from Norwegian Church Aid (NCA).

ways. Those providing such assistance have been strongly dedicated to their work. Several community-based health workers from border-based organizations have been killed or injured on duty over the years. For instance, between the inception of the Backpack Medic Program in 1998 and 2006, seven medics and one midwife were killed by landmines or government soldiers (BPHWT 2006: 8).

By the mid-2000s, increased attention was being paid by the United Nations and international humanitarian agencies based in Yangon to the need of securing access to these areas from Yangon. Despite the intentions of the humanitarian community, effective access continued to remain piecemeal, as experienced for instance by the UNHCR after securing access in principle to Southeastern Burma/Myanmar in 2004. Around the same time, efforts were made to start comparing data from border areas with data from Yangon and improve the coordination between the two sides. in 2007, UNOCHA subsequently initiated a review of humanitarian assistance to vulnerable populations in Southeast Burma/Myanmar that sought to examine the situation in border areas from the perspective of border-based as well as Yangon-based agencies. Taken together, these steps came to constitute the starting point of what is now known as the convergence process. The term convergence has generally come to refer to humanitarian assistance provided on the basis of a principle of complementarities between border-based and Yangon-based aid providers, based on coordination and cooperation between the two sides.

In addition to these developments, there are international humanitarian agencies that have worked on both sides of the border, based on principles of impartiality and neutrality, and that have sought to avoid taking sides in the inside/outside divide. They include *i.a.* Norwegian Church Aid (NCA), DanChurch Aid (DCA), Swedish Diakonia and Christian Aid. These agencies are members of the Thailand Burma Border Consortium (TBBC), while at the same time supporting humanitarian work by local partners in border areas and having programs with partners inside the country. Some of these organizations have long experience of working along both sides of the border with a partnership and community-based approach.

Indeed, living in a border area has different implications for different beneficiaries of humanitarian assistance. Border communities are very diverse; they represent ethnic minorities with affinities to both sides of the border, ethnic minorities fleeing fighting, repression and neglect in Burma/Myanmar, and people originally from deeper inside the country, including urban areas. Within Burma/Myanmar, they come from conflict zones, mixed administration areas as well as so-called white areas. Many networks run across these communities, making the distinction between "inside groups" and "outside groups" much less meaningful for the communities concerned.

Main findings

Criteria for strategizing around cross-border and Thailand-based assistance

With increased donor access from Yangon to border areas, the challenges of monitoring aid going to these areas are likely to improve, thus bringing an end to the former rationale behind a cut in cross-border and Thailand-based assistance. At the same time, and given ongoing reforms in Burma/Myanmar, most notably political progress at national level and ongoing peace talks with ethnic armed groups, there is also a need to re-strategize around cross-border and Thailand-based assistance. Such re-strategizing needs to take a number of factors into account:

1. The border is not monolithic, and political progress is being felt differently in different areas of the border. The April 2012 agreement between the government and the Karen National Union (KNU) includes provisions on plans to resettle and rehabilitate internally displaced people, de-mining, resettlement of refugees, citizenship accreditation, implement rule of law and working together towards "sustainable development", land right issues, the participation in the peace building process of INGOs and local NGOs and the release of Karen political prisoners (Karen News Group, 7 April 2012). The January 2012 agreement between the Chin State Government and the Chin National Front (CNF) also includes provisions on humanitarian assistance. But the ceasefire in Shan State remains unstable, and several Shan respondents noted that beneficiaries of cross-border aid in Shan State remain people fleeing from conflict. Talks with the Karenni National Progress Party (KNPP) and the New Mon State Party (NMSP) in Karenni and Mon areas still have to become more substantial. All talks and agreements remain at an early and fragile state.

2. Border-based communities are mobile populations. There is uncertainty about what decisions beneficiaries from refugee, migrant and IDP communities will make when they eventually start moving from current locations. While some might return to Burma/Myanmar, others might remain in or move to Thailand and become part of the migrant population there. Youth are a particular group of concern. Unless youth who have been born and raised on Thai soil have skills and confidence that they can work in Burma/Myanmar, they may not opt to join their families in a return to a homeland they have never lived in. Instead, they may remain in Thailand. This means that the direction in which the need for humanitarian assistance migrates remains unpredictable.

3. The term cross-border is confusing and does not reflect realities as experienced on the ground. Respondents noted that they see the term as belonging more to the world of donors or supply chain mechanisms, or conveying too strong links to Thailand. Instead, the experience of community-based groups is that they are part of local communities living on one or both side of the border. As organizations providing these services, they have a base in Thailand for political and practical reasons. This is also confirmed by independent observers. For instance, Dr Vit Suwanvanichkij of the Center for Public Health and Human Rights at the Johns Hopkins Bloomberg School of Public Health notes

that the Back Pack Health Worker team and other CBOS are usually coordinated and supplied from Thailand, but their field staff are mainly in their home communities, and that they return to Thailand for re-supply and trainings perhaps every six months. One respondent from a local donor organization based in Thailand proposed that a better term for reflecting this reality would perhaps be community-based and border managed services.

4. Ongoing political change at national level and the peace talks have yet to have tangible impact at community level. For instance, respondents from the Back Pack Health worker Team Humanitarian expressed concern that a peace process in their country be not only about ending fighting between armed groups, but also about achieving peace and reconciliation at community level and about the re-integration and rehabilitation of communities following decades of warfare, abuse and separation. Any decision related to cross-border and Thailand-based assistance ought not to hinge only on securing political agreement on access with the government of Burma/Myanmar and ensuring effective access for Yangon-based agencies, but also on how these issues are addressed in a comprehensive solution for the country that includes all stakeholders. There is a need for donors to support solutions that will enable peace and reconciliation at national, as well as local and community levels in Burma/Myanmar.

5. The question of timing for a change in policy is crucial. Cutting in cross-border assistance at a key period in which peace talks are in progress undermines principles of neutrality and impartiality for humanitarian aid. Indeed, several respondents noted that they would regard such a policy decision as an attempt to force ethnic groups into signing on agreements.

6. Finally, it needs to be noted that while this report focuses on the consequences of a potential cut in assistance for healthcare provision, such a cut would also have implications for other sectors.

7. Such diversity calls for a strategizing around cross-border aid that is adapted to local needs, concerns and to sectors, rather than a general cut in assistance.

Access

8. *Different meanings of the word:* This report is looking at the issue of access from the perspective of a range of stakeholders, with a notable distinction between UN and international humanitarian actors on the one hand, and national and local NGOs, FBOs and CBOs on the other. Indeed, as noted by one respondent from a border-based clinic, access has more to do with local populations being able to access necessary services than international actors accessing a geographical area. The assignment has therefore focused primarily on understanding access from the perspective of national and local stakeholders rather than international stakeholders.

9. *Changes in political constraints of the past:* Local CBOs and FBOS have a long history of accessing more remote and rural border areas, but have been constrained by the political conflicts in the country. With new political conditions, access to the border areas from Yangon is improving. For instance, different NCA partners from both sides of the border can now enter each other's areas. However, partners both in Yangon and from border-based groups maintain that they engage in different activities and generally agree that there are no overlaps. Some contact between Yangon-based organizations and border groups, which had been cut off over the past few years, has resumed, and will help ensure that overlaps continue to be avoided also in the future.

10. *Limited capacity:* While access to the border areas from Yangon is better, interviews with several respondents in Yangon reveal that such access continues to be constrained by lack of capacity in Yangon-based agencies. As preparations for the return of refugees and IDPs speed up, there is also a need for a greater diversity of capacity. Indeed, several respondents from Yangon-based as well as border-based organizations highlighted the numerous needs that will arise as part of preparations for return, including demining, rights issues such as statelessness for those born in Thailand and land rights for those fleeing from Burma/Myanmar, transitional justice, psychosocial needs and reconciliation at community level, and their own need for capacity development in order to handle these issues. There is a clear need to build capacity in Yangon to enable CBOs and FBOs to continue to play a key role in their communities. This is a suitable time to develop capacity.

11. *Need for confidence in a sustainable process:* Yangon-based FBOs/CBOs also emphasized the need for them and their communities to feel confident and have guarantees that ceasefire/peace agreements are durable before making substantial preparations on the ground. One Yangon-based FBO/CBO thus expressed concern that to start preparing too quickly for a post-conflict situation put them at risk of loosing the trust of their communities if agreements were to break down at a later stage.

12. *Structural constraints on access:* Another constraint on access is related to the categories of healthcare being provided by various organizations. Border-based respondents thus noted that FBOs/CBOs based in Yangon tend to focus more on preventive healthcare due to type of registration with the authorities, while all aspects of healthcare - covering prevention, cure and promotion - are being provided by border-based health workers. As noted by an observer from a training organization, healthcare workers from border areas are trained into following fairly complex procedures and being able to provide a high level of care. Other observers also noted that border based groups also often have more experience in curative medicine adapted to border needs than CBOs based in Yangon due to the context in which they train and have to operate. Other observers noted that even when more emphasis tends to be given to cure rather than prevention by border health workers, this is partly caused by training, but partly by the circumstances and the demands being put on the health workers, rather than as a result of choice.

13. *Lack of access to quality medication:* Concerns about poor quality of medication available in Burma/Myanmar were raised by several border-based respondents. They noted the possibility of forged medicine and contrasted the poor quality of medicine in Burma/Myanmar with the quality of medicine from Thailand. One area being mentioned in particular was medication against malaria and concerns related to the emergence of drug resistant malaria.

14. *Lack of supportive infrastructure:* The lack of infrastructure in Burma/Myanmar to support the work of health workers also acts as a constraint on access to services. Indeed, ethnic health authorities and one of the border-based health providers noted that their organizations have experienced that health workers trained by the government in Burma/Myanmar have come to border areas to work for border-based organizations due to the greater capacity of these organizations to provide ongoing support for staff to work more effectively.

15. *The importance of trust:* Overcoming language and cultural barriers and having trust between providers and beneficiaries of aid are important components of access. For instance, one respondent highlighted some of the challenges that are expected to come for agencies working with IDP communities that have been deeply traumatized. He noted that for instance many IDPs communities tend to flee when being approached by other persons. Such reaction patterns highlight the need not only for technical expertise when dealing with vulnerable populations, but also of trust from long-term engagement and commitment. During a group discussion with ACT alliance staff, respondents also highlighted that it cannot be taken for granted that aid workers coming from Yangon will automatically be able to enter border-based communities - even if they come from the same ethnic group. Instead, they emphasized the need to make use of those who have worked in an area for a long time in order to introduce new aid workers and agencies.

16. *From international access in principle to access in practice:* Following agreement between the UN and the Government for access into Kachin State, UN sources note that a stronger push for access into Eastern Burma/Myanmar is expected under the leadership of the UNHCR and inclusive of INGOs. Securing such access is also expected by the UN Resident Coordinator to be quicker given that trust has been built between the international humanitarian community and government authorities. At the same time, the UN Resident Coordinator acknowledged that even after political agreement has been secured, securing effective access will take time due to bureaucratic hurdles, the need for consultations, capacity and funding.

17. *Locally based actors as channels for access:* Access by the UN and INGOs cannot replace local actors. While the push for access may bring new humanitarian actors into border areas, the respondent from UNOCHA highlighted that the experience of the UN in Kachin State had been that local NGOs, FBOS and CBOS were essential for reaching out

to IDPs and refugees in connection with the fighting there because of their local knowledge and their ability to have the trust of communities, including across conflict lines. Access into Eastern Burma/Myanmar has already improved significantly for INGOs, as noted by a number of respondents. For instance, there are now several organizations operating openly around Pa'an, Karen State. However, Pa'an is not a conflict area and has not been for a long time. One respondent from a Yangon-based agency further noted that INGOs still tend to operate around cities and towns, while smaller NGOs and CBOs still have better access to more remote rural areas. In addition, the need for INGOs to rely on local partners was also noted by several respondents.

18. *Not put the cart before the horse:* Under such circumstances, it is essential that cross-border aid not be cut before effective access is really secured. To cut cross-border aid at this stage is to put local aid providers under stress and to risk that rights-holders will be deprived of services vital for survival.

19. *Role of border-based actors in securing access:* Several respondents, both in Yangon and along the border, highlighted the relevance of border based groups due to their skills, experience and current programs for healthcare to remote communities in border areas. Yangon-based agencies highlighted the need for border groups to consider returning to Burma/Myanmar, but emphasized that such decisions need to be made in close coordination between border and inside groups, and as part of a planned process. Notably, border-based groups will only be able to establish themselves in the country after a settlement to this effect has been reached between the government and ethnic armed groups and with the acceptance of the Burmese military. Once an agreement on the principles for community based organizations to establish themselves has been reached, practical obstacles will have to be overcome, such as the need for registration and a bank account. This is also expected to take time. In the meantime, it is important not to cut off support that put in jeopardy border-based civil society.

20. *Durable development:* Donor investment in border-based aid structures have proved effective in the past and are likely to be invaluable in the reconstruction and rehabilitation of border areas. Most refugee and cross-border programs for IDPS are mainly provided by members from within these communities themselves. This is the case of the refugee camps in Thailand, but also of services provided outside of the camps. Supporting and strengthening such structures offers better potential for ensuring durable development than trying to introduce new structures of support from outsiders who may not be familiar or sensitive to local structures.

21. *Monitoring and accountability:* Challenges of independent monitoring have earlier been seen as a drawback for cross-border assistance. Two issues have often received the attention; possible risks for beneficiaries because of the manner in which aid is provided, including the use of armed escorts for aid workers, and the risk of assistance being diverted to armed groups with the need for independent monitoring. NCA and its partners have addressed such risks by maintaining a strong and consistent focus on the

principles of Do No Harm (Anderson 1999). As access from Yangon stands to improve, it should also be easier to monitor border-based assistance from Yangon. Hence, positive changes can also be expected in relation to the monitoring of cross-border and Thailand-based assistance.

22. *Discrepancies between urban and rural areas:* There is significant discrepancy in level of access to health care between central and border areas in Burma/Myanmar. As noted by several respondents, official healthcare services are basically non-existent in many border areas, and, where they do exist, they are usually inaccessible to the people for a variety of reasons. Background data produced in connection with a recent evaluation of the Back Pack Health Worker Team is revelatory of the healthcare situation in areas operated by BPWHT and provides strong evidence of the lack of access to services in these areas. Demographic data collected in connection with the evaluation indicate that most areas covered by BPHWT do not have other health facilities, included facilities operated by other providers. In most places, there are also no other health workers, while in some areas, there are health workers from the government. In some cases, there can be informal cooperation with health workers from BPHWT. But in most areas, the nearest health facility can be days away. Hence, emergency cases often have a terminal outcome. When patients are sent to a clinic, the clinic has limited capacity. When patients go to hospital, they have to pay for everything and costs are very expensive for villagers. Often, the hospitals have no or little medicines, and medicines and other equipments are sold in nearby shop. If they have medicine, there is little availability of physicians, so that some services are not available.

23. *Building access takes time:* Under previous ceasefires in Burma/Myanmar, successive governments have made little effort to improve access to health, education and other social services to inhabitants in former conflict zone. The case of Thailand demonstrates that it is not necessary to wait for peace to start the process of building sustainable health systems in remote border areas. The challenges facing the Burma/Myanmar heath sector are numerous and diverse, as was also acknowledged by Burma/Myanmar's Health Minister, Pe Thet Khin in a recent address to the Johns Hopkins School of Public Health (Mizzima, 17 April 2012). The lead evaluator of BPHWT - himself a former official with the Thai Ministry of Health - noted for instance that with clear priorities and good access to human, financial and other resources, it took Thailand 15 years to set up a primary health care system for ethnic minorities in remote areas of Northern Thailand.

24. *The human resources of border-based health workers:* Border areas are likely to remain remote for the foreseeable future, with poor infrastructure and a lack of medical personnel. Under such circumstances, several respondents highlighted that health workers who have been trained by border-based organizations and are already working represent a valuable human resource for the country. Health workers trained by border-based organizations also represent a much needed diverse work force for the Burmese/Myanmar health care system. Border based health providers also constitute

an important location for training of health workers from ethnic minority groups in Burma/Myanmar, including clinical training, in a context where such training facilities are not widely available.

Community-based convergence and preparations for transition

25. In Yangon as well as along the border, respondents welcome the changes in Burma/Myanmar and spoke of the need to support change. At the same time, respondents from both sides also stress that it is too early to end support for border-based and cross-border assistance and expressed concern that such a cut in assistance will add to conflicts and problems, rather than solving them.

26. Indeed, several notable changes along the border in recent years were made possible because of dialogues between inside-outside groups. They are the result of contact as part of the convergence process, but also of informal networks of colleagues, family and friends, and include plans being made for the future as well as efforts to scale up dialogues. CBOs on both sides of the border are concerned that a cut in cross-border aid now will harm local/community based peace-building, and be detrimental to ongoing dialogue and future plans on both sides of the border.

27. For instance, there are efforts in Yangon to bring various Karen organizations together in connection with the talks between the government and the Karen National Union. In border areas, several respondents noted that much has already happened over recent years in terms of information sharing and coordination among border based groups and ensuring growing cooperation between communities across ethnic lines. A number of partnerships have already been established across conflict lines.

28. Respondents also expressed that significant progress in terms of capacity development along the border, with a key focus on knowledge about international standards, the need to adapt international standards to local needs and to align with what is being provided by the Ministry of Health of Burma/Myanmar in order to facilitate integration in the future. Hence, while border based groups run health systems, they argue that these are not parallel and competing systems with those of the government, but have been designed in order to facilitate integration/merger at later stage.

29. There needs to be a gradual integration between the two sides and a coordination of strategies and policies. This is recognized by border-based organizations, but needs to happen as part of a dialogue process, not by donors cutting assistance.

30. Instead, several respondents noted that donors need to continue to support convergence, though funding mechanisms that encourage cooperation as well as other ways. Respondents also urged donors to expand dialogues beyond funding issues to strategic and other issue areas.

31. Border based organizations are calling on the government of Burma/Myanmar to recognize the competence that is available from border areas (certificates, qualification and trainings) as well as border-based programs - i.e. find a way to develop community-based primary health care in Burma/Myanmar. There is also a need for both sides to have a dialogue on issues to which they have a different approach and possibly to have staff from both sides working together. Border based groups are concerned that if assistance is cut prematurely, such recognition and collaboration may not take place.

32. There is an urgent need for an officially recognized mechanism that will allow for dialogue between Yangon- and border-based organizations to take place and to be scaled up. Notably, respondents on both sides highlighted their sense of insecurity - on the one hand because repressive laws, notably the Unlawful Associations Act have yet to be repealed, and on the other hand because of the lack of physical security in conflict and former conflict areas with a strong present of government troops and continued violations of human rights.

The case of the Mae Tao Clinic in Thailand

33. A number of issues distinguish the Mae Tao clinic (MTC) from other healthcare providers examined during this assignment, notably its base in Thailand and the fact that it caters to the needs of populations from both sides of the border. The clinic works in all aspects of heath services - curative, preventive, promotion. Patients at the clinic come from the migrant/refugee communities in Thailand as well as from within Burma/Myanmar.

34. MTC cooperates closely with other community-based healthcare providers along the Thai-Burma/Myanmar border. Notably, the centre fills an important function as a location for clinical training. Clinical training facilities are not widely available in ethnic minority areas of Burma/Myanmar. An abrupt cut in assistance to the clinic could therefore have a negative impact on the capacity building of border-based health workers.

35. Furthermore, as noted by several respondents, including Dr Francois Nosten from SMRU and Dr Wittaya Sawaddiwuttiphong from the Mae Sot General Hospital, MTC fills an important function and responds to a need that really exists in the Mae Sot-Myawaddy area. This need will not disappear with political change and peace in Burma. It is also highly dependent on developments in Thailand.

36. Notably, the clinic is the first line service that many people prefer to go to when in need of treatment. As a result, MTC is often the first to know about an outbreak of communicable diseases in border areas. MTC thus fills a key function in preventive efforts to hinder communicable diseases from spreading from Burma/Myanmar into Thailand. The clinic also plays an important role in health promotion for the Burma/Myanmar communities in Thailand, notably child immunization in the Mae Sot area, and in providing curative healthcare for those who may not be able to access other

facilities for various reasons. Given those functions, the clinic fills a key role in alleviating a burden on the Thai healthcare system.

37. While current reforms in Burma/Myanmar are having an impact on the clinic - notably, health workers from the clinic often come from the mixed administration zones, and some of them have started to look at options for going back and building facilities in Burma/Myanmar - developments in Thailand and in the Thai-Burma/Myanmar borderlands also underscore the continued need for the clinic. Indeed, there is little change yet in the migrant community in Thailand. There is also uncertainty whether refugees and IDPs will eventually return to Myanmar or join the migrant communities in Thailand. Some user groups for the clinic have also increased over the past year. For instance, the clinic works in child protection, and many unaccompanied children continue to be sent to the border for safety, education or other purposes. Family reunion remains an issue of concern for the clinic.

38. Mae Sot is slated to become a special economic zone. As economic conditions improve, it is expected that people's health will gradually improve, but that this will take time. But respondents express doubt that the Thai and Burma/Myanmar governments will be able to deal with issues related to migrant health as a result of such changes in the short term.

39. The experience of local CBOs is that advocacy towards Thai authorities has been useful over time. Hence, conditions in Thailand for migrants and refugees from Burma/Myanmar have gradually improved over the years, due to advocacy by active CBOs as well as changes in Thai policy. Notably, Thai authorities have come to recognize the importance of access to health and education for migrants from Burma/Myanmar. But much more still needs to be done to improve access to the Thai healthcare system for migrants from Burma/Myanmar. Access to social services remains a major issue of concern for MTC.

40. An improvement in health facilities across the border in Burma/Myanmar will help the situation both in Burma/Myanmar and in Thailand. MTC wants and needs collaboration with Burma/Myanmar health institutions, most importantly a referral system. If Myawaddy hospital were able to handle more services, it would take away some of the burden on MTC and other community-based health providers operating in the Mae Sot-Myawaddy border areas, and make services more effective.

41. However, past experiences have been negative. Thai national policy is to encourage local collaboration between health institutions in border areas. The Mae Sot General Hospital has sought to collaborate with the Myawaddy Hospital but this has proven difficult because of political and bureaucratic hurdles in Burma/Myanmar. While this may change with a new situation in Burma/Myanmar, other respondents have also noted the lack of capacity of the Myawaddy hospital.

42. This stands in contrast to the close cooperation that already exists between the Mae Sot General Hospital, the Mae Tao Clinic and the Shoklo Malaria Research Unit and the role already played by the Mae Tao Clinic in alleviating a burden on the Thai health system and being a key node in preventive healthcare in the Mae Sot-Myawaddy area.

43. There is a need to strategize around Thailand-based assistance in a manner that takes into account developments in Burma/Myanmar as well as in Thailand. As of now, migrant workers and refugees will continue to depend on the community-based services that are available from MTC. Until and unless healthcare becomes more widely available in the borderlands of Burma/Myanmar, patients are also likely to continue crossing the border to seek assistance from MTC. A rapid cut in Thailand-based assistance is therefore also likely to have a negative impact on the situation of public health in one key border area of Thailand-Burma/Myanmar.

Concluding remarks

Over the years, much effort has been made to understand the context of armed conflicts in Burma/Myanmar, and how conflict interacts with the provision of aid. This has often meant giving a strong focus to issue areas in which aid can contribute to conflict. However, the principles of Do No Harm also highlight the role of aid in peace-building, notably the role of local capacities for peace and local peace connectors. Indeed, citizen-based peacemaking by local people and communities is instrumental and integral for sustainable change (Lederach 1997: 93-95). Aid workers living and working in conflict-affected communities can play a positive role in conflict resolution in everyday settings because of the trust placed in them by their local communities, their ability to make strategic use of networks for conflict resolution purposes and their ongoing presence in times of need. The long-term commitment, relationship building and consistency displayed by community-based aid workers from the Thai-Burma border is thus crucial for conflict transformation coming from within societies.

Change is clearly taking place in Burma/Myanmar, although the impact of change continues to be felt more at national than community level. At community level, doubts continue to be expressed about the motivation of the government and some of the larger NGOs involved with the current peace process. Trust building between all parties remains needed.

In a period when community-based actors both in Yangon and along the border are in transition, it is essential to support ongoing processes of change and to work with all actors. Border-based groups are duty bearers ensuring rights that would not otherwise be secured for ethnic minority populations in remote rural areas of Burma/Myanmar. Continuing to support them is essential as a step towards ensuring that they will be able to play a role as actors of change in a new Burma/Myanmar.

Donors need to recognize that issues of access are integral to dialogues for peace and reconciliation in the country. While preparations should be made inside Burma, support for cross-border aid should therefore be maintained for now. As more funding is made available for

Burma/Myanmar, donors need to develop mechanisms that can integrate what has been built up over the years with what is coming, rather than replacing it. Donors should therefore continue to look for opportunities to encourage cooperation between the two sides and to support the convergence process. The Peace Mechanism funded by Norway and other countries is one example of such a mechanism that could be used to bring parties together. Donors also need to be prepared to engage in dialogue with border-based organizations on how to assist in a transition as well as how to continue to assist in empowering communities beyond the transition.

Most importantly, all parties, including border-based community organizations are in need of time to adapt to changes. By cutting access to humanitarian aid for one side while ceasefire/peace talks are in progress, donors are putting at risk the perception that they are neutral and impartial actors prepared to support sustainable peace-building and reconciliation at community level. Instead, donors could help facilitate a harmonious and inclusive transition process for Burma/Myanmar, thereby contributing to a better future for a country that has been deeply divided for too long.

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