I. INTRODUCTION

The Three Millennium Development Goal Fund (3MDG) was established in 2012 by a consortium of international donors. The 3MDG is the successor fund to the earlier 3 Diseases Fund (3DF) which ended in 2012 and both builds upon the earlier work of the 3DF as well as expanding it. The 3MDG Fund provides multi-donor funding support to address basic health needs of the most vulnerable people in Myanmar, and contributes towards the country’s efforts to achieve the three health-related Millennium Development Goals and Universal Health Care. These goals include reducing child, newborn and maternal mortality, and combating HIV, tuberculosis and malaria. 3MDG places a special emphasis upon provision of quality health services for mothers, newborn and children. 3MDG is supported by seven international donors (Australia, Denmark, the European Union, Sweden, Switzerland, the United Kingdom and the United States of America).

Since the conclusion of new ceasefire agreements between the Thein Sein Government and most of the armed ethnic opposition groups, a process that started in the end of 2011, several conflict-affected areas have opened up for possible health interventions. The 3MDG Fund is committed to ensuring that wherever it supports the provision of health services in areas previously or currently affected by conflict, that its approach is based on a robust assessment of the possible and likely impact of its programmes upon peace and conflict dynamics and a thorough understanding of the different social, political and institutional situations in these areas.

The 3MDG Fund Board believes that the actual health results of its programming will be more sustainable if developed using sound guidance for operating in such environments. Such guidance needs to be developed in line with a clear strategic approach for the 3MDG Fund on how to operate in conflict affected areas. Therefore the 3MDG Fund will ensure its interventions are conflict sensitive, ensure they ‘do no harm’, and where possible can contribute to peace-building where its interventions can promote cooperation across conflict lines and bring people together around health.

The 3MDG Fund’s strategy to operate in conflict affected areas is based on a sound conflict analysis, which is approached from a national, regional and local perspective, keeping in mind grievances and aspirations of communities that are at the root of the conflict and its resolution.

To ensure that the 3MDG Fund’s approach and programme is conflict sensitive, it will:

- Adhere to international best practices related to ‘do no harm’ practices and develop a set of principles for 3MDG engagement in conflict affected areas which will be monitored and reviewed regularly;
- Tailoring programme interventions so that they are appropriate to the different operating environments in conflict affected areas;
- Where possible, maximising the peace-building opportunities of its interventions by bringing people together around health.

The 3MDG strategic approach to guide interventions in conflict affected areas consists of three main elements:

- Understanding the context (conflict analysis at national and state/region level)
- The 3MDG principles for engagement in conflict affected areas;
- The 3MDG strategy to operate in conflict affected areas.

For more information on the 3MDG Fund, please visit our website at [www.3mdg.org](http://www.3mdg.org).

- The website contains the programme’s vision, what we do, where we work and key documents including progress reports.
- The 3MDG Fund accelerates progress towards the health MDGs and Universal Health Coverage in through a rights-based approach to achieve health for all in Myanmar. More information can be found on the website.
II. UNDERSTANDING THE CONTEXT

Myanmar has been at civil war virtually since independence at 1948, when the Communist Party of Burma (CPB) and several ethnic minorities took up arms against the central government to fight for equal rights and more autonomy. In 1962 the army took power in a coup, and since that time the Tatmadaw – the national army – has played a dominant role in the political arena. After decades of civil war and military rule, Myanmar has entered a pivotal stage in its political and economic development. Following the adoption of a new constitution in 2008, national elections were held in 2010, the first in over 20 years. A new military-backed government was then inaugurated in March 2011, headed by President Thein Sein, an ex-general and former Prime Minister in the previous military regime.

The Thein Sein government has initiated a political reform process, and concluded new ceasefire agreements with almost all ethnic armed opposition groups. In a welcome break with the failed policies of the past, the government has held talks with almost all groups and without preconditions, raising hopes that finally there could be movement towards a sustainable end to the decades old conflict. However, the talks need to transform into a political dialogue to address the underlying grievances and aspirations of ethnic minority groups. After decades of civil war, there is a lack of trust between all parties, and fighting has resumed in parts of the country, especially in Kachin State and northern Shan State.

The conflict in Myanmar is extremely complex because of the many actors. Apart from the Tatmadaw there are a large number of armed ethnic opposition groups, many of which have reached a cease-fire agreement with the Thein Sein government. Apart from that there are a large number of Tatmadaw-backed militias, who benefit from the status quo of political instability, and mainly have economic interests. The situation in conflict affected areas varies greatly from township to township, and also within townships. Many townships are partly under government control and partly under influence of ethnic armed groups, while a few townships are under complete control of ethnic armed groups. Some townships are partly controlled by Tatmadaw-backed militias, where government agencies also do not have automatic access.

Access to health in conflict areas is limited by several factors. Factors inhibiting government access in ethnic regions include lack of security due to the ongoing conflict and presence of many conflict actors as well as geographical factors and problems related to transportation and communication. The latter includes lack of means of transport and bad road conditions, with some villages and communities only accessible by motorcycle, boat, donkey or foot, especially during the rainy season. An additional complicating factor in these areas is that many of the government health staff – especially the higher echelons – are from the central part of the Myanmar and from different ethnic groups and often do not speak local languages.

There are different kinds of health systems in conflict affected areas, each with their own different strengths and weaknesses. These include the government health system; services provided by health departments of armed ethnic opposition groups including mobile backpack teams; and various health related services provided by local NGOs. Some ethnic armed opposition groups have their own health departments, and run clinics, often mobile in areas with active conflict. Their staff is often trained in neighbouring countries and/or receive trainings that are based on foreign curriculum and guidelines. Until recently, these areas were not officially accessible for international NGOs operating from inside Myanmar.

There are several reasons why it is important to work with and support existing health services in conflict affected areas, and to work with health departments of ethnic armed opposition groups. It is likely that these separate parallel systems will continue to exist for some time, especially as long as there is no political settlement between the conflict parties. These ethnic health departments work in conflict affected areas where health and other humanitarian needs are most urgent and where government departments usually have no access due to the conflict and/or is unable to provide services due to lack of capacity, resources, understanding of local culture and languages, and trust. These ethnic health departments are often
the only provider of basic services. It is unlikely for the government to be able to establish a presence in many conflict affected areas in the near future that would address the basic health requirements of the local population. The expansion of government departments and staff presence in conflict affected areas, even in the health sector, is seen with suspicion by ethnic armed opposition groups, and may impact negatively in the peace process, as there is yet little trust between the conflict parties.

The peace process provides a number of opportunities, as access to conflict areas and engagement with conflict actors has improved. Health is seen as shared issue that concerns everyone, around which cooperation and coordination can more easily be built compared to more politically sensitive issues such as for instance education and land rights. Health could also facilitate dialogue between conflict actors. The government, conflict actors and CSOs consulted all welcome health services provided by 3MDG in conflict affected areas, as the needs are great and often even the most basic health services are lacking. Many people still die of preventable and curable diseases. There is growing space for open discussions with the government on issues related to health and conflict, and there is also government support to provide health services in conflict areas, including in areas under control/influence of other conflict actors. Bringing people together around health could potentially contribute to peace building, provided it is done in a careful way and has the consent of all relevant parties. In some cases, actors from both health systems have taken a flexible and pragmatic approach and found ways to work together on the ground.

However, health interventions must ensure that they do not undermine the peace process, which is still very fragile. Clearly, scaling up and improving quality and quantity of health interventions is not just a technical exercise, but is deeply political with wide implications. Harmonising health services from the government and ethnic armed groups is in principle a good idea, provided that great care is taken that all parties agree to it. It is important to realise that this is likely to take considerable time. The planning and implementation of any health interventions in conflict affected areas must ensure to have the prior consent of all relevant stakeholders. Therefore it is important to be extremely careful how to operate in conflict areas, to undertake the conflict context analysis first, and work with all health providers, including CSOs and health departments of ethnic armed opposition groups.
III. PRINCIPLES FOR 3MDG ENGAGEMENT IN CONFLICT AFFECTED AREAS

The people of Myanmar are currently seeking to emerge from over six decades of conflict that has afflicted communities in many different parts of the country. The potential for conflict resolution is presently the most opportune in many years but, with such a legacy of division and state failure, the landscape is very complex in one of the most ethnically diverse countries in Asia. In order for 3MDG to adhere to international best practices related to ‘Do No Harm’, the following set of principles should guide the 3MDG in its engagement in conflict affected areas.

3MDG recognizes that realising these principles in implementation in areas affected by conflict will incur additional time and financial costs. These costs - through the lifecycle of programmes of support - and meaningful consultation will be accommodated in the budget and timeframe assumptions of 3MDG’s work in these areas. 3MDG will resource implementing partners to operationalise these principles.

3MDG supported activities in conflict affected areas should adhere as a minimum requirement to the following principles:

1. Understanding the conflict
   Using 3MDG national and state/region level conflict analysis, local conflict analyses should be made, including good understanding of the local conflict parties, conflict dynamics, and the underlying political and socio-economic drivers of the conflict. In these analyses, which will be updated regularly, the potential impact and consequences of 3MDG supported interventions on the conflict dynamics should be appraised. It is important to keep progress in the peace process in view, and avoid pushing interventions ahead of the peace process or presuming outcomes that have not been realized.

2. Prior and on-going consultation with all key stakeholders
   All key conflict stakeholders in the area should be properly consulted prior to the design and delivery of any interventions. This includes representatives from relevant government agencies, armed opposition groups (especially health departments where these exist), other health providers and civil society organisations. They should be consulted about where, how, if and what kind of interventions are best to take place. On-going, routine consultation with stakeholders should be effected throughout the programme lifecycle. In programmes facilitating co-operation on health interventions between government and non-government entities, this will be an important measure in contributing to confidence and ensuring an up-to-date shared understanding of the progress of health support.

3. Meaningful involvement and participation of civil society organisations
   It is important to consult with CSOs about where, how and with whom to work in conflict-affected areas. Civil society organisations are often better placed to understand local conflict dynamics and have better access to conflict areas. Their involvement and participation are crucial. It is essential that participation and consultation are real, and that participation is not limited to consultation, and that consultation is not just information sharing. It is also crucial that international non-governmental organisations and UN agencies do not undermine or overwhelm civil society and community-based groups.

4. Work with existing health structures and providers
   Existing health services and health providers, including government or those connected to armed opposition groups, should be included in programming and activities where it is possible and ethically sound. It is also important to work with local NGOs and community-based networks that play a significant role in crossing military and political front-lines in conflict affected areas. The 3MDG will support an expansion of areas serviced by different stakeholders only where this would not lead to increased potential of conflict.

1 The principles are numbered for easy reference. Please note that this is not an indication of priority.
5. **Inclusion and non-discrimination**

Intervention programmes should adhere to the principles of inclusion and non-discrimination, and ensure that services are provided equally to all population groups, regardless of ethnicity, language, religion, gender and age. It is important that the barriers to access to health services are fully understood and that interventions are designed according to realities on the ground. In selecting geographic target areas, and beneficiary groups, it is important to ensure a balance between populations/areas under government control, and populations/areas under ethnic armed group control. This principle applies to the selection of townships, as well as distribution of benefits within townships. In most conflict-affected townships, government controls the main towns, population centres and road corridors, while the ethnic armed groups tend to control the more remote, sparsely populated rural areas. While acknowledging that it is much more challenging to reach areas controlled by ethnic armed groups, it is critical to include the areas to demonstrate that the 3MDG is committed to reaching the areas with greatest need, and that 3MDG does not privilege areas under government control.

6. **Transparency and information**

At all stages of the intervention, it is important to have transparency towards all relevant parties on the objectives, activities, implementing partners, and availability of programmes and services. Information dissemination is vital in building community and stakeholder trust, as well as successful programme delivery.

7. **Recruit local staff from all population groups**

In a conflict and ethnically-divided country, it is vital to recruit staff from all population groups. Staff and projects need to be sensitive to local ethnic, linguistic, faith and cultural realities and, at the same time, not become socially or ethnically exclusive. Inclusion rather than separation must be the goal, whether in humanitarian or public education programmes.

8. **Balancing process and achieving health results**

Working in conflict affected areas with different conflict actors requires a lot of investment in building trust and understanding by the 3MDG and its implementing partners. In such volatile and contested areas, in the initial phase of 3MDG involvement priority should be given to ensure the process of intervention is sound, and accepted by all parties. This will require acceptance that scaling up of health service delivery in conflict affected areas may be slow and conditional on achieving a favourable working environment first.

9. **Pragmatism and flexibility**

In conflict areas, it is important to have a pragmatic and flexible approach, as different regions may need different approaches and the conflict situation may be fluid and subject to change. A ground-up rather than generalised view of conflict transformation challenges needs to be kept in sight. Standard and rigid approaches in conflict zones can carry great risks. Therefore 3MDG needs to be flexible and innovative.

10. **Cooperation and coordination**

A long-term goal of inclusion among the different communities and conflict parties needs to be maintained as part of the process of conflict resolution. Experience continues to warn that health and humanitarian aid in different parts of the country can become regarded as divisive rather equitable and inclusive. Thus strategies of cooperation and coordination need to be delivered, including health target working groups, implementing partner meetings, and regular programme assessments. The initiatives should aim to strengthen and improve health structures of the local government administration as well as of armed opposition groups, and ensure not to create unnecessary burdens and bureaucratic layers.
IV. THE 3MDG STRATEGY TO OPERATE IN CONFLICT AFFECTED AREAS

The 3MDG strategy to operate in conflict-affected areas adheres to the 3MDG principles for engagement in conflict-affected areas and is based on a sound conflict analysis. The 3MDG strategy to operate in conflict-affected areas provides clear guidance for each stage of 3MDG interventions in conflict affected areas:

- Implementation modes in conflict affected areas
- Selection of intervention areas (States/Regions and Townships)
- Call for Proposals
- Preparing for implementation
- Implementation
- Monitoring & Evaluation and Continuous learning

**Implementation modes in conflict affected areas**

The township-based approach of the 3MDG, where the MOH leads the implementation and the development of a Comprehensive Township Health Plan (CTHP) in cooperation with international and local NGOs, will have to be modified in conflict-affected areas, as there are other key stakeholders that need to be consulted prior to the design and delivery of any interventions. This includes representatives from relevant government agencies (the Ministry of Health at national, regional and local level, as well as the General Administration Department which will handle communication with relevant security forces), relevant armed opposition groups (especially health departments where these exist), as well as other health providers and civil society organisations. Existing health providers should be consulted about if, where, how and what kind of interventions are to take place, and included in programming and activities where it is possible and ethically sound. Engagement with ethnic armed groups - and relevant health organisations affiliated with them - in conflict-affected areas is crucial. 3MDG will conduct visits to States/Regions and some of the townships to assess the best model(s) of implementation in the selected intervention areas, and to develop and update the 3MDG conflict analysis.

Coordination and cooperation in these areas between all stakeholders may not be easy, and it may thus not be possible to develop a comprehensive township health plan with the involvement of all stakeholders. In such cases it is important to have a flexible and pragmatic approach, and allow for the development of different interventions models. It is also important to note that the government township boundaries and names usually do not correspond with those of ethnic armed groups. 3MDG should not push for joint township health plans and convergence of health providers, and should only support such efforts if all relevant conflict actors aspire to do so. It is important to keep progress in the peace process in view, and avoid pushing interventions ahead of the peace process or presuming outcomes that have not been realized. Regular reviews will ensure adherence to this.

The involvement of civil society organisations (CSOs) in conflict-affected areas is crucial for several reasons. Local NGOs and community-based networks play a significant role in crossing military and political frontlines in conflict-affected areas. CSOs tend to have a better understanding of changing conflict realities on the ground, which is dynamic, and it is important to consult with them about where, how and with whom to work in conflict-affected areas. CSOs often have trust of local communities and conflict actors, and are well placed to advice to ensure interventions are conflict sensitive. Working with and hiring local people reflecting the ethnic groups in the area is important to ensure inclusiveness and equity. It is important to engage with civil society organisations representing ethnic and religious groups in the area of an intervention. There are also isolated and underserved areas in the country where neither MOH nor ethnic armed groups have a strong presence. It would also be important to ensure these populations groups also benefit from 3MDG interventions. In areas and townships affected by active fighting, where new ceasefires are not in place, access for MOH as well as International NGOs will be limited. In such areas the only service providers often are civil society organisations. In selecting CSOs to work with, it is important to identify relevant and appropriate CSOs for each area who can fulfil these roles.
Selection of intervention areas
(States/Regions and Townships)

Prior to the selection of townships, it will be essential for 3MDG to identify the townships that are conflict-affected (or contested), and be aware that this may change over time. The selection of townships within conflict-affected states needs to reflect the principle of balancing beneficiary groups. The selection of intervention areas by 3MDG will ensure fair representation of population groups and ethnicity; areas under government as well as under ethnic armed opposition groups control; and urban areas (often under control of or served by government) versus rural areas (underserved and remote areas often affected by conflict). These principles apply to the selection of states/regions, townships, as well as within townships.

Before the final selection of townships, pre-engagement and consultation with key stakeholders including government (MOH), ethnic armed opposition groups and civil society organisations is crucial. In particular, it will be important to informally consult with the major ethnic armed groups in the state. It is essential to ensure that they do not have any objections to proceeding in townships where these groups may have significant influence.

In the final selection, it is important to ensure a good balance between townships under government control as well as with presence of ethnic armed groups. These selection criteria will lead to 3MDG supported interventions in hard to reach and isolated areas, with often lower population density, as areas under control or influence of ethnic armed opposition groups tend to have greater health risks and significantly more challenges accessing even basic medical care.

3MDG conducts visits to States/Regions and the selected townships affected by conflict to consult with all key stakeholders in the implementation areas, including the government (MOH), ethnic armed opposition groups and civil society organisations, about if, how, where and with whom 3MDG interventions should be implemented.

Call for Proposals (CFP)

When issuing Call for Proposals for conflict affected areas, the following questions should be included:

- How the applicant will work in conflict affected areas;
- How the applicant will support to Health Departments and health staff outside of Ministry of Health;
- How the applicant will ensure inclusion of CBOs/CSOs and other community based groups in service delivery, including VHC committees;
- What is the approach to working in areas where the Union Government has limited access;
- What is the approach to work in conflict affected areas.

When evaluating proposals from prospective implementing organizations, it will be essential to ensure that they meet a basic standard of ‘do no harm’. The conflict advisor of the 3MDG together with conflict advisors of 3MDG donors will assess the proposals based on criteria agreed by the panel. They will rank the proposals on conflict sensitivity and indicate any red flags for part of or for entire proposals when these do not meet the threshold. The conflict advisors can also make recommendations for follow-up, including where there are any issues in proposals that should be addressed. In the final selection of the proposals, the advice from the conflict advisors will be weighed in as one of the criteria. Proposals that do not meet basic criteria and deemed unfit by them will not be further considered for support.

Preparing for implementation

During the preparation for implementation final decisions will be made about the implementation models in each township and whom to work with. This will consist of assessing, planning and making an agreement with relevant stakeholders, resulting in an agreement on how to operate in the township, which may differ from area to area. This will include a decision on whether it is possible to develop a comprehensive township health plan or opt for a different approach. This will require an analysis of the non-state health system at township level to understand the scope and capacity of the non-state health systems in each township where 3MDG will be supporting programs. In particular, this analysis should demarcate areas covered by non-state
health systems; areas covered by government systems; and areas with a mixture of both. This analysis will help to ensure that 3MDG does not support an expansion of areas serviced by different stakeholders where this would lead to increased potential of conflict. It will be important for programs to effectively accept the de facto geographic division of services, and work with the existing health system in all areas. In areas where both state and non-state systems are functioning, it will be important to negotiate cooperation in advance.

Planning and implementation begins with an inception phase during which implementing partners are required to conduct in-depth analysis of local conflict and political dynamics for each township where they plan to implement 3MDG activities. This analysis will involve extensive conversations with township government health officials, local representatives of ethnic armed groups, CSOs and INGOs involved in health provision, and ethnic health system leaders. This should only be done in places where there is clearly support, and after the purpose is explained to key local actors on all sides.

The analysis could focus on the following issues:

- Establish the geographic coverage of the state and non-state systems, based on de facto coverage of current health activities. This could include a spatial analysis of all of the population centres (over 100 people) in the township to determine which systems currently provide services, and how frequent they access the areas.
- Analysis of relations between state and non-state systems, which would include level of coordination, any existing disputes, and channels for communication. This analysis would particularly focus on areas of mixed control, and areas under ethnic armed group control.
- Analysis of foreign-funded health services to date, and their impact on conflict dynamics in the area. This analysis would particularly focus on INGO activities in the area, with close attention to areas where there have been complaints by ethnic leaders.
- Analysis of potential for armed violence and displacement in the township, including status of ceasefire (if any), and possible impact on 3MDG operations.
- Identify indicators for monitoring the level of conflict risk, to enable more systematic monitoring during implementation, and develop mitigating measures.
- Provide specific recommendations for 3MDG processes at the township level to manage conflict risk.
- Assess whether any part of the population of the township is excluded from services and why this is the case, and make recommendations to address this.

During the preparation for implementation, 3MDG will conduct follow-up advocacy visits at the state/region level and where necessary to certain townships and to ensure interventions adhere to the 3MDG principles for engagement in conflict affected areas. These visits also serve to explain the overall purpose of 3MDG and discuss links to the local situation, identify areas of collaboration, and where necessary facilitate linkages between different actors.

3MDG realises that working in conflict affected areas is more complicated, and the process of how this is done is very important. Therefore, during the ‘preparing for implementation phase’, which can take some time, a start can already be made by some activities when requested and based upon local acceptance and feasibility, including referrals, capacity building of health providers, outreach activities (where possible and agreed), and training of Auxiliary Midwives (AMWs) and Community Health Workers (CHWs). Showing willingness to work together and start some basic activities practising common work will contribute to trust building, and also prevent delays in getting activities started.

**Implementation**

As the peace process is still fragile and in initial stage, 3MDG FMO should constantly monitor that its implementation strategy is still relevant and appropriate. During implementation 3MDG FMO will ensure that its supported interventions in townships adhere to the 3MDG principles for engagement in conflict affected areas and make recommendations where this is not the case. All programmes can be adapted and amended as need arises, and contingency lines are provided to be able to react to emergence needs.
The speed of the implementation for a large part depends on local conflict dynamics, and is determined by access, finding suitable partners, and willingness of parties to cooperate and coordinate. Apart from the political situation, trust building clearly is also a key factor. This needs to be done before any large scale implementation happens. The ambition of 3MDG is to provide healthcare for all people in selected areas, but this should be carried out in the context of ‘do no harm’.

Implementation models and partners will vary greatly in conflict affected areas. Each township has different conflict dynamics, conflict actors and health providers. The guiding principle is to try to bring health services to all people in selected areas. However, it is important to find the right balance between process and achieving health results. Working in conflict affected areas with different conflict actors requires a lot of investment in building trust and understanding by the 3MDG and its implementing partners. In such volatile and contested areas, in the initial phase of 3MDG involvement priority should be given to ensure the process of intervention is sound, and accepted by all parties. In this process, implementing partners also have an important role to place as facilitator between the different parties.

3MDG FMO will also collect evidence, including data and reports from the field, in cooperation with our implementing partners, on challenges the 3MDG and its implementing partners have encountered and how these have been addressed. As the situation is very sensitive, the details of these stories may not be shared with a wider audience. However, 3MDG will facilitate opportunities for implementing partners and 3MDG to share experiences and collect lessons learned.

3MDG FMO will demonstrate where and how the FMO and implementing partners have made adjustments in their programming in their efforts to ‘do no harm’.

3MDG will also reflect on lessons learned and best practices at local level. To ensure sustainability and success, it will be important to develop practical tools and activities from the 3MDG experience. This can be supported by reflections on lessons learned and best practices at the field level, discussions about these with the implementing partners, and bringing these results up to the state/region and national levels. Such deliberations and conclusions should also link with current initiatives on conflict resolution with other international donors and programmes.

**Monitoring & Evaluation and Continuous Learning**

3MDG FMO will carry out monitoring and evaluation activities during the implementation phase to ensure adherence to the 3MDG principles for engagement in conflict affected areas as well as capture lessons learned and build on those. 3MDG recognises the lack of existing reliable data in many conflict affected areas, and that data and data collection there is sensitive. Therefore, great care will be taken to ensure such efforts only take place after discussions with key stakeholders. 3MDG also recognises that some exceptions on data collection and data sharing may need to be made in this regard. Measuring success will not just focus on health results but also on the process of implementation and levels of cooperation and trust built by the interventions.

3MDG FMO will closely monitor and evaluate lessons learned from its first effort to implement the 3MDG strategy to operate in conflict affected areas, and where necessary make adaptions.