Conflict, Health Cooperation and COVID-19 in Myanmar

What's new? Amid a lull in fighting in much of the country, the Myanmar government and ethnic armed groups appear willing to put aside politics and work together to prevent the spread of COVID-19. The exception is Rakhine State, where conflict is escalating, putting medical workers at risk and exacerbating a potential health disaster.

Why does it matter? Conflict-affected areas of the country are highly vulnerable to COVID-19 but often outside state control. A successful response to the pandemic will require close coordination among the government, the military and ethnic armed groups, many of which have long run their own health systems.

What should be done? The government, military and ethnic armed groups should work together to combat the virus through prevention, surveillance, testing and referrals. In Rakhine, they should ensure the safety of health workers, enable access to displaced populations and strengthen COVID-19 prevention messaging.

I.   Overview

A major COVID-19 outbreak could have devastating consequences in a country as conflict-affected as Myanmar, where health spending is limited, governance is weak, hundreds of thousands of people are displaced by fighting, and the government cannot reach many areas held by ethnic armed groups. Reducing transmission as much as possible so that the health system can better cope will require cooperation with these groups, many of which run their own health systems. Promising discussions that have already begun between the government and various ethnic armed groups should continue in earnest to enable a holistic response in areas of the country where conflict is presently limited. The exception is Rakhine State, where fighting continues to escalate between the Myanmar military and Arakan Army, undermining prevention efforts and putting the lives of health workers at risk. Here, all sides should ensure the safety of medical personnel, allow humanitarian access to displaced and other vulnerable populations, and work to improve public adherence to mitigation measures.

Myanmar was one of the last countries in the world to confirm a case of COVID-19, announcing its first two positive tests on 23 March. So far, the spread of the virus appears to be limited, with fewer than 200 cases and just six deaths recorded, but low testing capacity and the geographic distribution of cases mean that the disease is

likely to be far more prevalent than reported. Even a modest outbreak would put considerable strain on resources, particularly hospital beds for severe and critical cases. A holistic response that includes cooperation with ethnic armed groups will be essential for containing the pandemic and avoiding a potentially catastrophic human toll.

Although Myanmar's military eventually announced a national ceasefire to support the response to COVID-19 in early May, it has excluded areas of Rakhine and southern Chin States where it remains engaged in fierce fighting with the Arakan Army. The Arakan Army, through its alliance with two other ethnic armed groups, has also announced a unilateral ceasefire, but the war shows no sign of abating. Hundreds of combatants and civilians have been killed since the start of the year, and the government's recent designation of the Arakan Army as a terrorist group has further diminished any prospect of de-escalation. The death of a World Health Organization (WHO) driver, whose vehicle was attacked on 20 April as it took novel coronavirus swabs to Yangon for testing, underscores the risks this conflict poses to health workers and to efforts to combat the virus. With no chance of a ceasefire in the near term, the government, the military and the Arakan Army should instead aim to reach an agreement that guarantees safe access for medical personnel and humanitarian workers.

Elsewhere, cooperation between the government and ethnic armed groups remains very much possible. The pandemic has surfaced in Myanmar at a time when the rest of the country is experiencing a lull in armed conflict. Although the peace process is largely stalled and the most powerful armed groups continue to resist signing the Nationwide Ceasefire Agreement (NCA), there have been few clashes reported in recent months in Kachin, Kayin and Shan States. Combined with this relative calm, the urgent need to respond to COVID-19 has created an opening for discussions. The government has already taken a number of positive steps, including forming a committee to coordinate with ethnic armed groups and developing a response plan that formally recognises the role of ethnic health providers. Tentative talks are now under way on how to take coronavirus cooperation forward.

Keeping discussions focused on technical aspects of health coordination, and avoiding linking the response to the peace process, will ensure the best opportunities for progress. It is of course possible that cooperation on COVID-19 could have benefits beyond the immediate response, including for the peace process. If the government, ethnic armed groups and ethnic health providers are able to work together to respond to the pandemic, this effort should, at a minimum, help build some trust. The most likely positive consequence is that it will prompt future coordination on health-related matters, something for which the NCA already provides but has not yet been pursued by either side. Generating dividends for the peace process should not be the primary objective, however, because it will politicise and thus complicate – even likely derail – collective efforts to respond to the virus. It is important that the focus remains on the pressing need to protect people across the country from contagion, whether they live in government-controlled areas or under an ethnic armed group's administration.

The government and ethnic armed groups need to find a way to work together, putting aside to the extent possible the political issues surrounding the peace process. The support of the Tatmadaw, as the Myanmar military is known, will be vital. Donors also have an important role to play in providing financing and technical support to facilitate this cooperation.

II.   A Late and Limited National Ceasefire

For months prior to the emergence of COVID-19, active conflict in Myanmar had been mostly limited to Rakhine State and neighbouring southern Chin State.[1] There, the Myanmar military has been locked in an intense struggle with the Arakan Army since late 2018 that shows no sign of de-escalating.[2] The fighting has cost hundreds, possibly thousands, of lives and forced at least 60,000 people into camps for internally displaced persons. According to civil society groups, up to 100,000 more are staying in monasteries, with relatives or in other communities, but they are not officially counted because they are not in recognised camps.[3] Since 2020 began, the number of civilian casualties has risen significantly as the Tatmadaw has resorted increasingly to air and artillery attacks, prompting some to accuse it of war crimes and crimes against humanity.[4]

Elsewhere in the country, however, fighting has been limited for some time, particularly over the past six months. The ten ethnic armed groups that have signed the NCA have clashed only very occasionally with the military, despite the fact that political negotiations have been stalled for several years.[5] Around ten other groups have only bilateral ceasefires with the government, or no agreement at all. Although some technically remain in conflict with Myanmar's military, its attention is focused almost entirely on Rakhine, leaving these conflicts to a slow simmer. An August 2019 joint attack by the Brotherhood Alliance – comprising the Arakan Army, Ta'ang National Liberation Army and Myanmar National Democratic Alliance Army – on police and military posts in northern Shan State was the last major flare-up outside of Rakhine.[6]

Pressure on all parties to announce a national ceasefire began to build from late March. On 23 March, the day Myanmar confirmed its first COVID-19 cases, UN Secretary-General António Guterres issued an appeal for a global ceasefire to "focus together on the true fight of our lives".[7] With conflict raging in Rakhine State and the peace process stalled, his statement – with its vision of "corridors for life-saving aid" and "precious windows for diplomacy" – seemed almost tailor-made for Myanmar.[8]

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[1] For Crisis Group reporting on Myanmar's peace process since the 2015 elections, see Asia Report N°287, *Building Critical Mass for Peace in Myanmar*, 29 June 2017; and Asia Briefings N°s 158, *Myanmar: A Violent Push to Shake Up Ceasefire Negotiations*, 24 September 2019; 157, *Peace and Electoral Democracy in Myanmar*, 6 August 2019; 154, *A New Dimension of Violence in Myanmar's Rakhine State*, 24 January 2019; 151, *Myanmar's Stalled Transition*, 28 August 2018; and 149, *Myanmar's Peace Process: Getting to a Political Dialogue*, 19 October 2016.

[2] See Crisis Group Briefing, *A New Dimension of Violence in Myanmar's Rakhine State*, op. cit.

[3] The Myanmar military does not release figures for the number of soldiers killed, but the severity of the fighting means that the death toll on both sides has been substantial. For numbers of internally displaced persons, see "Fresh fighting adds 1,000 to displaced population in Myanmar's Rakhine", Radio Free Asia, 25 March 2020.

[4] "Myanmar military may be committing new war crimes, says UN envoy", Reuters, 30 April 2020.

[5] For further details, see Crisis Group Asia Briefing, *Rebooting Myanmar's Stalled Peace Process*, forthcoming.

[6] See Crisis Group Briefing, *Myanmar: A Violent Push to Shake Up Ceasefire Negotiations*, op. cit.

[7] "Myanmar confirms first two coronavirus cases", Agence France-Presse, 24 March 2020. For further discussion of Guterres's appeal, see Crisis Group Commentary, "Global Ceasefire Call Deserves UN Security Council's Full Support", 9 April 2020.

[8] For the full text, see the UN Secretary-General's official website.

Several ethnic armed groups joined the appeal. On 26 March, the Karen National Union called on the Tatmadaw to announce an unconditional nationwide ceasefire to enable all sides to work together to fight the pandemic; the Chin National Front and Karenni National Progressive Party issued similar statements.[9] The Brotherhood Alliance also endorsed Guterres's call and extended its unilateral ceasefire to the end of April, although this measure did little to stop conflict in Rakhine State.[10] On 1 April, eighteen foreign ambassadors to Myanmar called on all parties to cease hostilities and ensure humanitarian access to conflict-affected areas, expressing concern at the growing toll in Rakhine and Chin States.[11] The following day, a Myanmar military spokesperson rejected the suggestion as "unrealistic".[12]

On 9 May, however, the Myanmar military announced a national ceasefire until 31 August so that COVID-19 containment, prevention and treatment activities could be carried out "effectively and rapidly".[13] The ceasefire applies to "all areas except where terrorist groups declared by the government take positions" – a caveat that refers exclusively to the Arakan Army, which the government had on 23 March formally designated as a terrorist organisation and an unlawful association.[14] Considering that fighting elsewhere is presently limited, the fact that the ceasefire de facto excludes Rakhine state makes it more of a political gesture than a meaningful attempt to halt conflict.

The ceasefire announcement did not represent a sudden about-face by the military. It came amid growing cooperation with the National League for Democracy government on the COVID-19 response, including using military facilities to test swabs from civilians and sending military medical staff to work at a new government health facility.[15] A looming closed-door UN Security Council meeting to discuss escalating violence in Rakhine and the effect of the pandemic likely also played a role.[16]

The nature of the conflict in Rakhine State makes a truly national ceasefire extremely unlikely. Despite sustaining heavy casualties, the Myanmar military refuses to countenance the prospect of a ceasefire that would recognise the Arakan Army's presence in the state, instead insisting that it withdraw to its base in northern Kachin State. For its part, the Arakan Army shows no sign of being worn down despite almost eighteen months of heavy fighting. Its supply lines remain intact and it continues to enjoy strong support among the Rakhine population. As government control weakens over

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[9] "Chin National Front joins call for truce", *Myanmar Times*, 6 April 2020. The Karen National Union statement is posted on its official website.

[10] "Emergency press release of the Three Brotherhood Alliance in the time of the spread of COVID-19", 1 April 2020.

[11] For the ambassadors' statement, see the official website of the U.S. embassy in Burma.

[12] "Tatmadaw rejects call for ceasefire during pandemic", *Myanmar Times*, 2 April 2020.

[13] "Tatmadaw releases statement on ceasefire and peace", *Global New Light of Myanmar*, 10 May 2020.

[14] "Myanmar govt declares Arakan Army a terrorist group", *The Irrawaddy*, 24 March 2020.

[15] The government's decision to create a second national-level response committee, the Coronavirus Disease 2019 Containment and Emergency Response Committee, on 30 March and appoint a former general to lead it has been important for building this cooperation. See, for example, "Myanmar military to lend state-of-the-art machines for public COVID-19 testing", *The Irrawaddy*, 27 April 2020; and "Inside Phaunggyi, Myanmar's ambitious response to COVID-19", *Frontier Myanmar*, 23 April 2020.

[16] "UN Security Council to discuss violence, coronavirus in Myanmar", Agence France-Presse, 12 May 2020.

large areas of central and northern Rakhine State, the Arakan Army is increasingly trying to fill the vacuum and take over basic administrative functions.[17] Its designation as a terrorist group has further reduced the chances for dialogue.

The conflict in Rakhine State has potentially severe consequences for the COVID-19 response, as the WHO driver's death on 20 April tragically underscored.[18] The fighting has inhibited the ability of health workers and civil society groups to undertake prevention, surveillance and testing, due to safety concerns and, in some cases, government restrictions on access. Apart from communities recently displaced by the conflict, some 130,000 people, nearly all Rohingya, have been living in squalid camps, with extremely limited access to sanitation and medical care, since communal violence erupted in 2012.[19] A mobile internet blackout introduced in June 2019 to curtail the Arakan Army's operational and intelligence capabilities has deprived more than one million people of access to potentially vital information about COVID-19.[20] The state's weak health system is already stretched and has little capacity to take on the pandemic response. Finally, lack of trust in the government appears to be undermining COVID-19 prevention efforts, with reports of people disregarding social distancing rules.[21]

In Rakhine State, neither a ceasefire nor cooperation with the Arakan Army on the COVID-19 response appears feasible. Instead, the priority for all sides should be on de-escalating the conflict to allow for more effective action against the virus. De-escalation could take the form of an agreement among the government, military and Arakan Army to ensure the safety of health workers in order to ramp up prevention activities. The government should review the restrictions on humanitarian access to strengthen the public health response – particularly in IDP camps – and lift the mobile internet ban to enable the people of Rakhine and Chin States to find information on the pandemic.

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[17] For a full discussion of the conflict, see Crisis Group Asia Report, *An Avoidable War: Politics and Armed Conflict in Myanmar's Rakhine State*, forthcoming.
[18] "Driver killed in WHO vehicle carrying virus swabs in Myanmar's Rakhine", Reuters, 21 April 2020.
[19] "Myanmar: IDP sites* in Rakhine State (As of 31 December 2019)", UN Office for the Coordination of Humanitarian Affairs, 12 February 2020.
[20] "UN experts concerned at surge in civilian casualties in northwest Myanmar after internet shutdown", UN Office of the High Commissioner of Human Rights, 18 February 2020.
[21] For further discussion of these issues, see "After WHO driver's death, fear and foreboding haunt Rakhine's COVID-19 response", *Frontier Myanmar*, 27 April 2020; and "In Myanmar's Rakhine State, conflict and internet blackout mar COVID-19 response", Devex International Development, 6 April 2020.

III. **Ethnic Health Systems: Putting Aside Politics**

Often described as the world's longest civil war, Myanmar's seven decades of conflict have left the country divided between areas under central government control and territory administered by ethnic armed groups.[22] Despite efforts since 2011 to reach a Nationwide Ceasefire Agreement with the country's twenty main ethnic armed groups, and launch negotiations over a power-sharing agreement that would end the fighting permanently, armed groups continue to control large swathes of territory, particularly along the borders with China and Thailand. In most cases territory is not officially or even clearly demarcated, and administrative structures often overlap. People are usually able to move between state-controlled areas and those under the control of ethnic armed groups with relative ease.

Administrative capacity varies significantly among ethnic armed groups. Some have almost no territory or soldiers, but the more established among them, such as the Karen National Union, United Wa State Army and Kachin Independence Organisation, have well-developed governance structures that include health departments, known as ethnic health organisations.[23] Working together with ethnic and community-based health organisations, they focus mostly on primary care at the community level and tend to refer more complex cases elsewhere. In the past, ethnic health providers sent patients only to Thailand or China, but over the past five years or so some have started informally referring them to public or private hospitals in Myanmar.[24] Some ethnic health officials have also begun developing links with government counterparts at the township and state level. There is very little institutional cooperation with the government health system, however, including on referrals, even in areas without recent fighting.[25] A long legacy of distrust means that there is little formal sharing of information or resources.[26]

In a country where the national health system is already weak, this legacy of mixed control further complicates Myanmar's ability to prepare for and respond to COVID-19. An effective response requires a holistic approach that covers areas under both government and non-government control. Such an approach is crucial given that ethnic armed groups control areas adjacent to international borders, which typically have high levels of outward economic migration. The economic impact of coronavirus in neighbouring countries has thrown many Myanmar migrant workers out of work. Tens of thousands have returned home, including to (or through) territory

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[22] See "Ethnic Armed Conflict and Territorial Administration in Myanmar", The Asia Foundation, July 2015. For a history of Myanmar's ethnic conflicts, see Martin Smith, *Burma: Insurgency and the Politics of Ethnicity*, 2nd edition (London, 1999).

[23] Most observers distinguish between the ethnic health organisations, which are the health departments of the ethnic armed groups, and the ethnic and community-based health organisations with which they work closely. Unless a distinction is necessary, this report refers to both sets of organisations collectively as "ethnic health providers".

[24] Crisis Group interview, expert on ethnic health systems, May 2020. For more information on the ethnic health system in south-eastern Myanmar, see "Achieving Health Equity in Contested Areas of Southeast Myanmar", The Asia Foundation, June 2016.

[25] Rare examples of cooperation include the response to a 2019 polio outbreak in Hpapun in Kayin State. Crisis Group interview, expert on ethnic health systems, May 2020. See also "Circulating Vaccine-derived Poliovirus Type 1 – Myanmar", World Health Organization, 22 August 2019.

[26] Crisis Group interviews, development expert, April 2020; ethnic armed group leader, May 2020.

controlled by ethnic armed groups, and many more are soon expected to follow when Thailand relaxes cross-border movement restrictions.[27]

Despite COVID-19 emerging in neighbouring China, the Myanmar government – like many others around the world – was initially slow to recognise the threat and put in place mechanisms to respond. Once the WHO declared a global pandemic on 11 March, the government formed a high-level committee, headed by Aung San Suu Kyi. It has since implemented strict mitigation measures, including the shutting of airports, cancellation of the annual Thingyan holiday in April and night-time curfews. But authorities have sought to avoid a lockdown-style response because of the grave socio-economic implications, which some have warned could result in more deaths than the disease itself.[28] With the WHO's support, the government finalised a response plan on 21 April that recommends continuation of social distancing measures, an expansion of testing and an upgrade for hospital facilities, particularly intensive care unit beds.[29] On 27 April, it also released an economic relief plan that officials say will cost $2.2 billion.[30]

Ethnic armed groups have also taken a range of steps to protect populations under their control from COVID-19 and prevent the spread of the virus. First, they have closed many illegal crossings, for both people and goods, along the borders with Thailand and China.[31] Secondly, most groups have conducted awareness campaigns, and some have enforced quarantine measures and introduced travel restrictions. Thirdly, they have set up checkpoints at which they check travellers' temperatures and provide them with health information.[32] When the Kachin Independence Organisation found one suspected COVID-19 case in April, it isolated the patient and sent a swab for testing to a laboratory in China's Yunnan province (the result was negative).[33] Overall, these measures have likely helped protect the country, at least to some degree, but the capacity of ethnic armed groups to respond to COVID-19 remains limited.

A response to the pandemic covering the entire country will require an unprecedented level of coordination between the government and ethnic armed groups, as well as the Myanmar military's support. So far, coordination has been limited to returning workers, with almost no cooperation on the broader health response. Despite the government's National Health Plan formally recognising the role of ethnic health providers for the first time in late 2016, describing them as a "key stakeholder", and the interim arrangements in the NCA creating a potential framework

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[27] Tens of thousands had been expected to return from 1 May, but most remain in Thailand after the Thai government extended movement restrictions between provinces. See "Myanmar migrant workers await Thai green light to return home", *The Irrawaddy*, 5 May 2020, and "Alarm as thousands of returning workers ignore quarantine orders", *Frontier Myanmar*, 27 March 2020.

[28] "Coronavirus policy response needs and options for Myanmar", International Growth Centre, April 2020.

[29] "Health Sector Contingency Plan: Outbreak Response on COVID-19 and Other Emerging Respiratory Diseases", Republic of the Union of Myanmar Ministry of Health and Sports, April 2020.

[30] "Govt expects COVID-19 response plan to cost $2 billion", *Myanmar Times*, 11 May 2020.

[31] Crisis Group interviews, political analyst, April 2020; and ethnic armed group leader, May 2020. "New Mon State party agrees to close Thai-Myanmar border crossings to curb COVID-19", *The Irrawaddy*, 27 April 2020.

[32] Crisis Group interview, ethnic armed group leader, May 2020. See also "From north to south, ethnic armies confront an unseen enemy", *Frontier Myanmar*, 15 April 2020.

[33] Ibid.

for cooperation on health, the deadlock in the peace process since 2017 has under-mined prospects for a closer working relationship.[34] Although there is some degree of informal interaction at the local level, health officials on both sides are reluctant to work together openly, partly out of fear that they could move faster than peace negotiators. As an expert on the ethnic health system said:

> Some government officials at the state and township level are nervous about work-ing with ethnic health providers because they don't know whether the central government will approve. If they step out of line, they might lose their promotion. That's actually one of the biggest obstacles in the day-to-day cooperation.[35]

Ethnic health providers also feel that some government officials do not sufficiently respect their expertise or contribution to ethnic communities, feeding concerns in the sector that working together will result in being subordinated under a highly cen-tralised state system.[36] Adding to tensions, the National League for Democracy gov-ernment has restricted donors from directly supporting ethnic health providers linked to ethnic armed groups. Donors are still able to provide support indirectly – such as through international NGOs – and may otherwise be reluctant to support unregis-tered organisations linked to ethnic armed groups, or have concerns about their capacity to manage grants. Nevertheless, these restrictions have undermined pro-spects for cooperation between ethnic armed groups and the government on health.[37]

Whatever the concerns and past grudges may be, if ever the situation demanded that the government and ethnic armed groups put aside politics and work together, it is now. There is an urgent need to share information and coordinate in a range of activities, including prevention messaging, surveillance and referral pathways. Myanmar is in the process of significantly scaling up COVID-19 testing, but unless some formal cooperation is in place, areas under ethnic armed group control will inevitably be overlooked.

Promisingly, both sides have begun positioning themselves to enable such coop-eration. Ethnic armed groups have been discussing a coordinated COVID-19 response among themselves and have raised the issue of cooperation during informal talks with government negotiators.[38] On 27 April, the President's Office formed a commit-tee led by chief peace negotiator Tin Myo Win to coordinate with armed groups, in-cluding sharing information on the return of migrant workers, suspected cases, treatment protocols and contact tracing.[39] This step has sent an important signal and potentially opened the door for a more comprehensive framework for technical coop-eration that will free local officials of some of the current political constraints. Signif-icantly, the government appears willing to work with both NCA signatories and non-

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[34] "Myanmar National Health Plan 2017-2021", Republic of the Union of Myanmar Ministry of Health and Sports, December 2016. The NCA specifies in its interim arrangements that signatories will coordinate on programs and projects related to "health, education and socio-economic development".
[35] Crisis Group interview, expert on ethnic health system, April 2020.
[36] Crisis Group interviews, expert on ethnic health systems, April 2020; ethnic armed group leader, May 2020.
[37] Crisis Group interviews, peace process analyst and ethnic health system expert, May 2020.
[38] Crisis Group interviews, government peace negotiator, ethnic armed group leader and development experts, April and May 2020.
[39] "Myanmar sets up COVID-19 committee with rebel armies", *The Irrawaddy*, 28 April 2020.

signatories, although there remain enormous obstacles to information sharing or coordination with the Arakan Army.[40]

Operationally, too, the government's position appears to have evolved significantly since March. Early versions of the Ministry of Health and Sports' COVID-19 response plan essentially ignored ethnic health providers, but the final version issued on 21 April stressed the importance of a "unified response" and "inclusive mechanisms and processes that encourage coordination" with these organisations. As a result, ethnic health providers have been included on proposed state and region level coordination bodies. The plan also proposed that government staff provide support in building their capacity and working with them to deploy rapid response teams and mobile clinics to treat vulnerable populations in conflict-affected areas.[41]

These are welcome steps, but it is not yet clear where they will lead. The committee held several meetings with ethnic armed groups since 8 May but no concrete agreement has emerged. Few if any of the coordination mechanisms or conflict area-focused activities in the government's response plan have been activated or undertaken. Cooperation at lower levels will likely depend on an agreement between government and ethnic armed group leaders, but neither side has quite shown the urgency that the situation dictates, and the political hurdles to working together remain significant on both sides. For ethnic armed groups in particular, the process will also inevitably raise deeper questions about what role ethnic health providers will play in any future federal system. These questions should be put aside for the time being in order to combat COVID-19.

All sides need to speed up the pace of engagement and focus on addressing the most critical issues. These include activating the coordination mechanisms in the government's response plan, and reaching agreements on information sharing, referral pathways, the provision of equipment (such as personal protective equipment) to ethnic health providers, training for ethnic health staff and a system for conducting tests in ethnic armed group areas.

For cooperation to proceed, government officials will need to be sensitive to the aspirations of ethnic health providers, who will expect to be treated as genuine partners, not merely community-based implementers. This will require a significant break with the past. The fact that the Ministry of Health and Sports specified a role for ethnic health providers in its COVID-19 response plan without seriously consulting them during the drafting process underscores the current imbalanced nature of the relationship.[42] One initiative that could help build trust would be for the government to provide support for an ethnic health organisation facility to conduct rapid tests that would be sent to government labs, and for that organisation to treat infected patients and refer them to government facilities through a formal pathway as necessary.

Although the declaration of a national ceasefire is a positive step, there remains a risk that the Myanmar military could undermine progress if it deems some aspects of the required cooperation a threat to its interests. It has already warned the Karen

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[40] Crisis Group interview, government peace negotiator, Yangon, May 2020.
[41] "Health Sector Contingency Plan: Outbreak Response on COVID-19 and Other Emerging Respiratory Diseases", Republic of the Union of Myanmar Ministry of Health and Sports, April 2020. All versions are on file with Crisis Group.
[42] Ibid.

National Union and Restoration Council of Shan State to cease COVID-19 prevention activities in some areas, claiming that they are encroaching on government-controlled territory. The Karen National Union has also accused the military of destroying several of its screening points.[43] Highlighting the initial disconnect between the government and military, the Karen National Union also received contradictory letters from the Kayin State government on the same day: one from the military-appointed security minister demanding that it remove some health checkpoints, and the other from the chief minister praising its prevention activities.[44] Now that the military has come on board with the ceasefire announcement, it should not only scrupulously respect it but also support government efforts to work with ethnic armed groups as much as possible.

Although the focus should remain on tackling the immediate threat of COVID-19, cooperation in the coming months could bring about significant benefits to the country's health capacities on the longer term. Fighting a common enemy could help break down barriers at the local level between health officials who have previously been reluctant to work together or even acknowledge each other's capabilities. Given that the scale and nature of the health response required for this virus differs significantly from earlier cooperation on polio and malaria, a joint response could build valuable personal relationships and set important precedents for the years ahead, once the pressing danger has passed. "There's an opportunity to test out working together from the bottom up", noted one source in the development sector.[45]

If such cooperation materialises, donors will have an important role to play, particularly given ethnic health providers' limited resources. Even a modest level of cooperation on COVID-19 – on referrals, for example – will require some degree of financial support. Due to the political sensitivity of government staff visiting areas under ethnic armed groups' control, international expertise will also be needed to assess the capacity of ethnic health providers and to identify gaps that can be addressed in their response. Donors should refrain, however, from linking coronavirus cooperation to the peace process, as politicising it will make negotiations only more difficult.

Government policy remains both a practical and political obstacle to the development of a positive working relationship. Ethnic health providers feel that the government's insistence that it approve grants to ethnic health providers runs counter to the NCA's interim arrangements, which emphasise coordination rather than control. Although some development actors will view the government's recent steps as a green light to scale up cooperation with ethnic health providers, there is also a risk that donors will remain wary of supporting them directly for fear of jeopardising relations with the government.[46] To avoid this problem, the government's new coordination committee should relax restrictions on provision of aid directly to ethnic health providers.

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[43] "Myanmar military increases coronavirus risk and threatens peace in ethnic minority communities", New Mandala, 30 April 2020.
[44] Crisis Group interviews, development expert, April 2020; ethnic armed group leader, May 2020.
[45] Crisis Group interview, April 2020.
[46] Ibid.

IV.　**Conclusion**

Although it has yet to experience a major COVID-19 outbreak, Myanmar remains highly vulnerable to the pandemic. It is crucial that the country's health response include coordination with the twenty ethnic armed groups that control territory, especially as most of them operate close to the country's borders with China and Thailand. A truly national ceasefire is unlikely, unfortunately, due to the conflict in Rakhine State, but in other parts of the country the barrier to cooperation in the health sector has less to do with conflict than with lack of political will and trust.

To date, efforts on such cooperation between the Ministry of Health and Sports and armed groups' health systems have been limited, but COVID-19 presents a concrete opportunity to work together more closely. Joint action against the virus could help overcome some of the mistrust and other obstacles that have hindered cooperation in the past. While it is encouraging that both the government and ethnic armed groups have started to position themselves to enable such cooperation, given the nature of the threat all sides now need to pursue these discussions with a greater sense of urgency. Donors have an important role to play in facilitating and supporting these initiatives, and should dispense with some of the caution they have previously shown to supporting ethnic health providers.

Such cooperation will not be possible in Rakhine State, where fighting continues to escalate between the Myanmar military and Arakan Army. The implications for the COVID-19 response could be grave. In many areas of the state, health workers and civil society groups are unable to work safely, as the WHO driver's tragic death in April clearly demonstrates. The mobile internet blackout has curtailed access to potentially life-saving information about the virus for over one million people, while humanitarian groups face difficulties getting access to vulnerable populations. The Arakan Army's recent designation as a terrorist organisation means that a ceasefire is almost certainly off the table, but all sides should pursue talks toward an agreement that would enable more effective action against contagion. The government could facilitate containment by lifting its restrictions on mobile internet use and ensuring humanitarian access to affected populations.

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