สภาวะสุขภาพอนามัยเจริญพันธุ์ของกลุ่มชาติพันธุ์ในบริเวณชายขอบของรัฐทหาร: กรณีศึกษา

กลุ่มผู้หญิงฉิ่นในหมู่บ้านแห่งหนึ่งที่ชายแดนอินเดีย-พม่า

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REPRODUCTIVE HEALTH OF AN ETHNIC GROUP ON THE MARGIN OF A MILITARIZED STATE: A CASE STUDY OF CHIN WOMEN IN A VILLAGE ON THE INDIA-BURMA BORDER

Mr. Ben Manser

A Thesis Submitted in Partial Fulfillment of the Requirements

for the Degree of Master of Arts Program in International Development Studies

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Thesis Title	REPRODUCTIVE HEALTH OF AN ETHNIC GROUP ON THE MARGIN OF A MILITARIZED STATE: A CASE STUDY OF CHIN WOMEN IN A VILLAGE ON THE INDIA-BURMA BORDER.
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Field of Study	International Development Studies
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เบน อเล็กซ์ แมนเซอร์: สภาวะสุขภาพอนามัยเจริญพันธุ์ของกลุ่มชาติพันธุ์ในบริเวณชายขอบของรัฐทหาร: กรณีศึกษากลุ่มผู้หญิงฉิ่นในหมู่บ้านแห่งหนึ่งที่ชายแดนอินเดีย-พม่า (REPRODUCTIVE HEALTH OF AN ETHNIC GROUP ON THE MARGIN OF A MILITARIZED STATE: A CASE STUDY OF CHIN WOMEN IN A VILLAGE ON THE INDIA-BURMA BORDER) อ. ที่ปรึกษาวิทยานิพนธ์หลัก : อาจารย์ ดร. พิชญ์ พงษ์สวัสดิ์, 148 หน้า.

งานวิจัยนี้ต้องการชี้ให้เห็นถึงผลกระทบของการปกครองภายใต้ระบอบทหารที่มีต่อสภาวะสุขภาพอนามัยเจริญพันธุ์ภายในพื้นที่ที่มีกลุ่มชาติพันธุ์ที่ไม่ใช่พม่าอยู่เป็นจำนวนมากดังเช่นกรณีของรัฐฉิ่น นับจนถึงปัจจุบันนี้แล้วนโยบายการสร้างเสริมสุขภาพและกลไกการให้บริการก็ยังมีลักษณะที่รวมศูนย์อยู่มากและถูกควบคุมโดยทหาร การบริหารและการควบคุมดังกล่าวนี้มีผลกระทบต่อสภาวะสุขภาพอนามัยเจริญพันธุ์

ด้วยการขาดซึ่งการมีส่วนร่วมของกลุ่มชาติพันธุ์ในการวางแผนและการนำนโยบายไปปฏิบัติ จะพบว่านโยบายการสร้างเสริมสุขภาพมีจุดเน้นอยู่ที่เมืองใหญ่ ทั้งที่ประชากรของประเทศร้อยละ 70 อยู่ในพื้นที่ชนบท นอกจากนี้ยังรวมไปถึงการกระจายงบประมาณของรัฐที่ผิดพลาดผ่านการจัดงบประมาณทางการทหารที่มากกว่าอย่างผิดสัดส่วนกับงบประมาณใช้จ่ายสาธารณะอาทิการสาธารณะสุขและการศึกษา งานวิจัยชิ้นนี้เสนอว่าหนึ่งในนโยบายแท้จริงที่ไม่ปรากฏในตัวเอกสารของรัฐพม่าก็คือการสร้างความมั่นใจว่าพื้นที่ของกลุ่มชาติพันธุ์จะไม่พัฒนาจนมีแนวโน้มที่จะสามารถเป็นอันตรายต่อการควบคุมของรัฐที่จะมีต่อประชากร

กรณีศึกษาของงานวิจัยชิ้นนี้มุ่งเน้นไปที่หมู่บ้านแห่งหนึ่งในบริเวิ้วชายแดนพม่ากับอินเดีย โดยมีการทำการสัมภาษณ์ผู้ให้ข้อมูล 25 คน ซึ่งได้แก่แม่ของเด็ก พยาบาล และ นางพยาบาลผดุงครรภ์ ข้อค้นพบของงานวิจัยชี้ให้เห็นถึงข้อจำกัดในด้านการบริหารและการปฏิบัติในการมุ่งเน้นเป้าหมายอย่างมีประสิทธิภาพในพื้นที่ที่ค่อนข้างถูกตัดขาดจากพื้นที่อื่นๆ และที่ตามมาในเรื่องของทรัพยากรในด้านสภาวะสุขอนามัยเจริญพันธุ์ที่มีอย่างจำกัดในหลายระดับ ทั้งจากรัฐ องค์กรพัฒนาเอกชน และกลุ่มต่างๆที่ทำงานในระดับชุมชน งานวิจัยนี้ยังชี้ให้เห็นถึงอัตราการตายของทารกที่อยู่ในระดับสูงซึ่งเป็นผลมาจากการขาดแคลนทรัพยกรทางด้านสาธารณสุข โครงสร้างพื้นฐาน ข้อจำกัดทางด้านเศรษฐกิจ และความไม่มั่นคงทางด้านอาหาร อย่างไรก็ตามงานวิจัยชิ้นนี้ก็ได้ชี้ให้เห็นถึงกลไกในการจัดการแก้ปัญหากับสถานการณ์ดังกล่าวที่เกิดจากการพัฒนาขึ้นในชุมชนนั้นเองเพื่อจัดหาซึ่งบริการทางด้านสุขอนามัยเจริญพันธุ์แต่ก็มีลักษณะจำกัด

งานวิจัยชิ้นนี้ได้เสนอว่าในระดับรากฐานแล้วนั้น การครองงำของทหารในการเมืองผ่านการเป็นรัฐทหารนั้นได้ทำให้เกิดวัฒนธรรมของการเพิกเฉยและไม่เห็นว่าตนมีความผิดใดๆในหมู่บุคลากรในกองทัพและเกิดการมีกลไกที่อ่อนแอในการบังคับให้นโยบายนั้นดำเนินไปได้จริง ซึ่งทำให้เกิดความล้มเหลวในการทำให้เกิดการพร้อมรับผิดของผู้ที่มีตำแหน่งรับผิดชอบ ผลของปัญหาในระดับรากฐานนี้ทำให้เกิดการที่ชาวฉิ่นนั้นมีทางเลือกที่จำกัดมากและต้องหันไปแสวงหาความปลอดภัยในประเทศอินเดียที่อยู่ติดกัน

สาขาวิชา การพัฒนาระหว่างประเทศ ลายมือชื่อนิสิต.....

ปีการศึกษา 2553 ลายมือชื่ออาจารย์ที่ปรึกษา.....

5281011824: MAJOR INTERNATIONAL DEVELOPMENT STUDIES
KEYWORDS: HEALTH / WOMEN/ CHIN / BURMA

BEN MANSER: REPRODUCTIVE HEALTH OF AN ETHNIC GROUP ON THE MARGIN OF A MILITARIZED STATE: A CASE STUDY OF CHIN WOMEN IN A VILLAGE ON THE INDIA-BURMA BORDER. THESIS ADVISOR: PITCH PONGSAWAT, 148 pp.

In the context of a militarized State such as Burma this research sheds light on the effects that military rule has had on reproductive health in ethnic areas such as Chin State. In 1997 the Burmese State ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and has specific obligations in terms of health care and family planning. However until the present time, health care policies and delivery mechanisms are highly centralized and controlled by the military, which has affected reproductive health, with infant mortality rates that are substantially higher than regional and international levels.

Moreover, with a lack of genuine ethnic participation in the planning and implementation of policies the existing health-care policies focus mainly on urban centers. Yet with over 70% of the population living in rural areas these policies do not reflect the needs of all the people. This is further compounded by a misallocation of State budgets which are allocated disproportionately to the military at the expense of public sectors such as health and education. The long-term ramifications of this in ethnic areas are sub-standard education systems, which restricts the number of potential students able to pursue higher education relating to public sector work. It is argued in this research that one of the unwritten policies of the State is to ensure ethnic areas do not become developed, which could potentially threaten the State's control over the population.

This research case study focuses on one village on the India-Burma border where 25 interviews were conducted with mothers, nurses and midwives. The findings highlight the logistical constraints on effectively targeting isolated areas and consequently the limited reproductive health resources available from various levels such as the State, NGO and community-based groups. The research also reveals a high rate of infant mortality through a lack of health resources, basic infrastructure, economic constraints and food insecurity. Yet it also reveals the coping mechanisms that the communities themselves have developed to provide limited reproductive health care.

Fundamentally, the research reveals that due to the State's prolonged militarization, there is a culture of impunity within the army and weak enforcement mechanisms which fail to hold accountable those in positions of authority. This has resulted in the Chin having little alternative but to seek safety in neighboring India.

Field of Study: International Development Studies
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Student's signature:.....

Advisor's signature:.....

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ABBREVIATIONS

AAPP	-	Assistance Association for Political Prisoners-Burma
ADB	-	Asian Development Bank
ARN	-	Arakan Rivers Network
ASSK	-	Aung San Suu Kyi
AIDS	-	Acquired immune deficiency syndrome
ASEAN	-	Association of South East Asian Nations
AIHCR	-	ASEAN Intergovernmental Commission on Human Rights
BPHWT	-	Backpack Health Working Team
BPL	-	Below Poverty Line
BGF	-	Border Guard Force
BMA	-	Burma Medical Association
BWU	-	Burmese Women's Union
CBO	-	Community-based organization
CEDAW	-	Convention on the Elimination of All Forms of Discrimination against Women
CHRO	-	Chin Human Rights Organization
CHW	-	Community Health Workers
CNF	-	Chin National Front
CNA	-	Chin National Army
CNP	-	Chin National Party
CPP	-	Chin Progressive Party
CRC	-	Convention on the Rights of the Child
DVB	-	Democratic Voice of Burma
EC	-	Election Commission
FBR	-	Free Burma Rangers
GDP	-	Gross Domestic Product
GHAP	-	Global Health Assistance Program
HAP	-	Health Assistance Project
HIV	-	Human immunodeficiency virus

HRW	-	Human Rights Watch
ICRC	-	International Committee of the Red Cross
IDP	-	Internally displaced person
INC	-	Indian National Congress
KWO	-	Karen Women's Organisation
MDG	-	Millennium Development Goals
MIMU	-	Myanmar Information Management Unit
MMR	-	Maternal mortality rate
MMCWA	-	Myanmar Maternal and Child Welfare Association
MOGE	-	Myanmar Oil and Gas Enterprise
MoH	-	Ministry of Health
MOM	-	Mobile Obstetrics Medics
MoU	-	Memorandum of Understanding
MTC	-	Mae Tao Clinic
NGO	-	Non-Governmental Organization
NLD	-	National League for Democracy
NHEC	-	National Health and Education Committee
OHCHR	-	Office of the High Commissioner for Human Rights
PHC	-	Primary health care
RH	-	Reproductive health
RHC	-	Rural Health Clinic
SPDC	-	State Peace and Development Council
SWAN	-	Shan Women's Action Network
TBA	-	Traditional Birth Attendant
UDHR	-	Universal Declaration of Human Rights
UN	-	United Nations
UNDP	-	United Nations Development Program
UNICEF	-	United Nations International Children's Emergency Fund
USDA	-	Union Solidarity and Development Association
USDP	-	Union Solidarity and Development Party
UPR	-	Universal Periodic Review
WFP	-	World Food Program

WHO	-	World Health Organization
WLB	-	Women's League of Burma
WLC	-	Women's League of Chinland
WRWAB	-	Women's Rights and Welfare Association of Burma

CHAPTER I

INTRODUCTION

1.1 Background of Study

Chin State is an isolated mountainous region of north-western Burma (Myanmar) bordering with Mizoram State, north-east India, (see Figure 1 for a map of Burma with states and divisions). Chin State lacks basic infrastructure development such as roads, bridges, electricity, hospitals and schools, which has also affected the currently available information on the Chin. This is further substantiated by the World Food Program (WFP) who describe Chin State as "*one of the poorest and most isolated states in Myanmar,"* (World Food Program, 2009). The Chin people are one of Burma's eight main ethnic groups and number some 1.4 million in total, of which Chin State has approximately 500,000. (Facts from Chin State, 2008) The Chin can be further subdivided into six primary tribes and over 69 sub-tribes (Sakhong, 2003: 19) with a shared culture and history, yet maintaining their distinct local dialects.

This thesis will focus predominately on the Chin people who originate from the Falam township of Chin State (nine townships in total) which border the case-study village, (see Figure 2 for a map of Chin State and major townships). The sub-tribes located in this area are the Lai and Lushai sub-tribes from Falam township, (see Figure 3 for an overview of the major Chin tribes and sub tribes). Due to security reasons this village has not been mentioned specifically by name, but is referred to as village X hereinafter.

Increasingly the Chin are migrating to both India and Malaysia due to human-security issues such as: food insecurity, access to healthcare, lack of sustainable livelihoods and human-rights abuses committed by the Burmese military regime (the State Peace and Development Council (SPDC). (CHRO, 2009: 13) These issues will

be discussed in-depth in this thesis in relation to accessing the relationship between development and reproductive health of the Chin along the Indo-Burma border.

There is an interconnected relationship between reproductive health and the wellbeing of the family; if a new born baby is not healthy then they cannot function effectively putting a strain on families, communities and society as a whole. In February 2010 with the help of foreign donors the case study village established a small medical clinic called ABC Clinic located on the India-Burma border. The clinic has been set up primarily to focus on providing limited primary health care to Chin people from Chin State. In addition it also caters for Chin and the local Mizo population located in Mizoram state.

1.2 Statement of the Problem

One of the main weaknesses that this thesis seeks to address is the lack of up-to-date research in regard to the ethnic Chin who live on the Indian-Burma border. Many studies concerned with the peripheries of Burma center predominately on the Thai-Burmese border, focusing on the Karen ethnic group, as they face ongoing gross human-rights abuses perpetrated by the Burmese military. This rightfully merits assistance and careful study in order to find appropriate strategies to alleviate the suffering of that people. However, the overemphasis on the Thai-Burma border has left a vacuum of a distinct lack of knowledge about the other borders surrounding Burma: the India-Burma border, Bangladesh-Burma border and China-Burma border.

Currently, the majority of up-to-date documents on the India-Burma border region and the Chin focus on the human-rights abuses they face both in Burma and once they migrate to India. There is, however, a lack of knowledge of the Chin reproductive health needs along the Indo-Burma border. This thesis seeks to shed light on this gap in knowledge and uses as sources of information both the case-study village and ABC clinic that have access to patients from Chin State, Burma.

1.3 Significance of Research

This research will help to provide a better understanding of the challenges of reproductive health for the Chin in relation to the larger issue of development in Burma. It will also provide insights into the current reproductive health support mechanisms which are being implemented at a grassroots level. Vitally this information can be used by various interest groups to develop improved reproductive health policies and strategies, which fit the needs of the local communities. The impact of this are it will help to make healthier; families, communities and a more sustainable society.

In its context, the socio-political significance of undertaking research in regard to the health of the Chin is the fact that the SPDC are pushing ahead with a seven-stage roadmap to disciplined democracy, and, as part of this process, held a national referendum to enshrine a constitution on 10 May 2008. (Lwin, 2008) Under number 367 of the Citizen, Fundamental Rights and Duties Chapter of the Constitution it states, *"Every citizen shall, in accord with the health policy laid down by the Union, have the right to health care."*(Ministry of Information, 2008: 152) A reliable indicator of a countries socio-political governance of a State is its provision of health care to its citizens. Yet the question must be asked: what is the level of health-care access in ethnic areas such as Chin State?

1.4 Research Questions

- The following questions must be answered: What is the reproductive health condition of the Chin along the Indo-Burma border?
- What causes this health condition in the context of development conditions in Burma?
- What local coping strategies do the Chin use relating to health issues?
- What are the development implementation recommendations for the State and NGOs?

- Which reproductive health mechanism is most effective in regard to isolated Chin communities?

1.5 Objectives

This thesis has the following aims:

- Assess the reproductive health condition of the Chin along the Indian-Burmese border.
- Identify what development conditions cause this reproductive health condition in Burma.
- Identify local coping strategies the Chin use as alternatives for reproductive health issues.
- Identify which reproductive health mechanism is most effective in regard to isolated Chin communities.

1.6 Hypothesis

The hypothesis of this research is that a combination of isolation in ethnic areas and increased militarization by the state has resulted in the SPDC implementing an unwritten policy of neglecting to develop ethnic groups such as the Chin. This can be substantiated through a lack of public services such as adequate healthcare, schools, electricity and other basic needs such as food security, water security and transportation. Within the whole of Chin State for a population of 500,000 there are only 12 hospitals, 56 doctors and just four viable roads (HRW, 2009). Such neglect could also be a direct consequence of a combination of being under military rule, increased potential danger to livelihoods, and poor access to goods and services. With little alternative options for basic survival, the Chin in Burma have little option but to relocate to India and Malaysia to escape the direct control from the Burmese State. Once in Mizoram state, India, the Chin can relatively easily meet their basic needs when compared to life in Burma.

The driving dynamics behind the state's unwritten policy are the following: Firstly, to increase military control over the ethnic peripheries, which are rich in natural resources. Secondly, the ethnic regions have a vital geopolitical significance, as they are strategically placed between India and China. Thirdly, with underdevelopment in Chin State, the military meet little local resistance with more of the population being forced to migrate to other areas or countries. Therefore they can easily further their own agenda of extending their sphere of influence and exploiting resources for their own personal gain. Finally, and significantly, this policy paves the way for the state to implement transnational development projects, for example in Chin State the newly undertaken transportation project entitled the Kaladan multi-modal transit transport project, which is a transnational development project between the SPDC and the Indian government. The project is estimated to cost $120 million and is due to be finished in 2013 (Arakan Rivers Network, 2009: 10). The purpose of the project is to allow ships and trucks to transport supplies to India's landlocked north east region. It also has geopolitical significance as India is trying to counter Chinas influence in the region. While this project could potentially benefit a limited amount of people, yet with the Burmese military's unwritten policy of neglecting the needs of its people, it is being carried out without any consultation with the locally affected population. These types of projects will also affect the health of the people along the project site in terms of food insecurity and increased forced labor.

Relating to accessing healthcare it could be more effective in certain cases for an increase in cross-border medical initiatives such as ABC's clinic healthcare model in order to meet the needs of Chins located in isolated rural areas of Chin State. This cross border mechanism could be relatively better placed to serve the needs of Chin communities both inside isolated areas of Chin State and along the border. This can complement the activities of International Non-Government Organization's (INGO's) operating from central Burma, which could be relatively more constrained by Memorandums of Understanding (MoU's) with SPDC and accessibility issues to reach isolated communities.

1.7 Research Methodology

- Primary research: qualitative and quantitative interviews with women in the case study village. Specifically targeting women in the reproductive age of approximately 16 years onwards due to the interviews focusing on their reproductive health condition.
- Primary research: qualitative interviews with medical staff at the ABC clinic and mobile medical clinic teams working inside Chin State to gather information about programs and activities relating to reproductive health.
- Secondary research: provided from ABC's Medical treatment records book and mobile clinic records books.
- Secondary research: data provided from Burma's Ministry of Health (MoH) and World Health Organization (WHO) relating to reproductive health.

1.8 Limitations

There are a number of limitations to this research: firstly the location of the case-study village. It is located in an isolated rural area of the India-Burma border, and as such access required extensive walking up to six miles to and from the village. The time constraint of field research at the clinic was limited to less than 10 days in total on site from July 2010, and therefore this study could at best only provide a limited snapshot of the targeted village, the clinic's activities and the patients attending the clinic. However this snapshot is an important point of gathering research information for future projects. Secondly, during the field research period, many of the families were busy with the rice planting season and were working and living away from the village, often inside Burma in paddy fields, interviews were therefore unable to be undertaken with such families.

Personally I also needed to recognize my own personal limitations including a lack of fluency in speaking the local Chin dialect, and my limited knowledge of health issues, as I am not I a trained medic. I therefore travelled to the field with a trained nurse whom I had met previously who was one of the nurses in the village, which

helped build up trust and relationships in a short period. I tried to address some of these limitations however. having lived before with the Chin for over a year, I have learnt basic phrases in various Chin dialects and can also happily embrace food and cultural customs. This helped to a certain extent to break down some of the perceived barriers when foreigners embark on field research. Having local women translators who I have previously built up a strong personal relationship with also helped to reinforce relationship building in the community with effective translations appropriate to the women we were interviewing. I had previously already visited the field research village two times in 2009 and had been able to establish good relationships with some of the community members and well-respected figures in the community, so making questionnaires on my visit this time was a viable option.

Relating to the limitations in secondary medical data gathered at ABC clinic, while the dedication of the nurses at the clinic is unquestionable there are some important limitations relating to the health diagnosis they give in medical records because of their limited training and experience. Each of the ABC nurses has one to two years' health-related practical and theoretical experience. Therefore specifically relating to their diagnosis in the medical-record book and the mobile clinic book, it was considered necessary that a secondary experienced Western doctor helped to look through the data and compile the various diagnoses the nurses had offered into logical types of diseases. Recognizing this limitation should not mean however that we disregard the findings presented from this valuable rich source of data findings. Sadly it also serves to further highlight the desperate lack of investment in educating and developing the health professionals in the region.

1.9 Ethical Issues

Before any interviews were undertaken, informed consent was asked for, to ensure all interviewees were aware of the purpose of the project and what it entailed. All of the respondents were informed that their names would be kept confidential, which helped to ease any security concerns for them. Importantly also, I had to recognize my own limitations of being a male foreigner -- this could potentially have been very

uncomfortable for some female respondents and inappropriate especially relating to describing in-depth their maternal health issues. Therefore I worked closely with local women translators who had sufficient experience and could gauge the situation, identifying the appropriate course of action i.e. for me to not be present during certain interviews. This was sometimes needed specifically relating to asking sensitive questions relating to miscarriages. It was also important in some cases to provide words of encouragement and positive words to respondents who have had to experience traumatic times we in their lives and for whom retelling their stories can be painful.

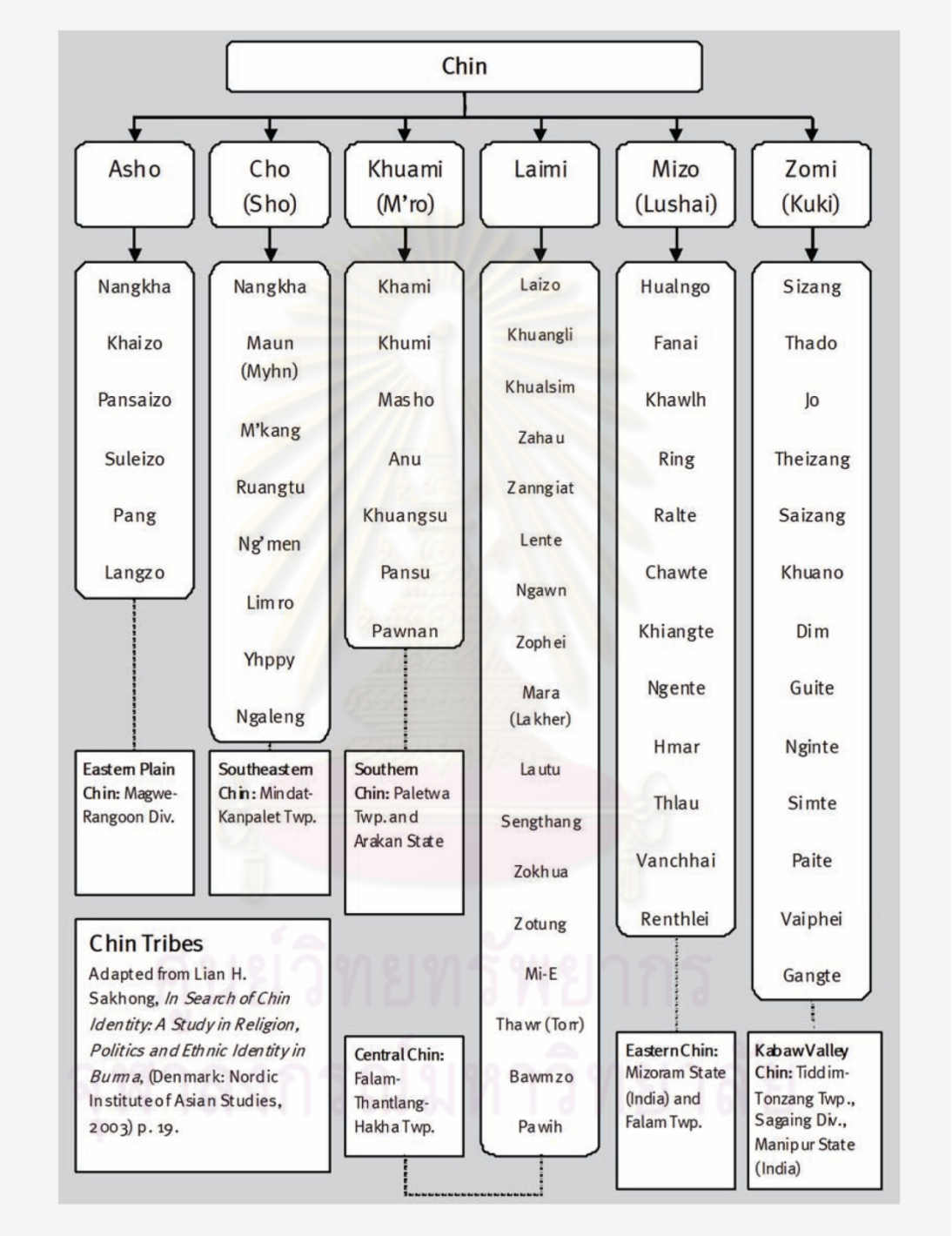
Figure 1 Map of Burma with States and Divisions

Note: (MIMU, 2009)

Figure 2 Map of Chin State with Major Townships

Note: (MIMU, 2009)

Figure 3 Major Chin Tribes and Sub-tribes



Note: (Sakhong, 2003: 19)

CHAPTER II

LITERATURE REVIEW

This chapter is split broadly into 2 main sections. Firstly it focuses on health and development and the impact on reproductive health through the implementation of the Millennium Development Goals (MDG's). Secondly different models of health care are explored including the medical health care approach and primary health care approach. The advantages and disadvantages of these models are critiqued in the context of how they are implemented in Burma.

2.1 Health and Development

At the turn of a new millennium the importance of health in a society can be seen by a global survey at the Millennium Summit of the United Nations where health was ranked consistently as number one priority amongst the world's population. (Nations, 2000) Broadly healthcare can be organized into mainly 3 different segments including public, private or a combination such as public-private partnership. Public Health can be defined as, *"the art and science of preventing disease, promoting health, and prolonging life through the organised efforts of society."* (Beadkehole, 1996: 372) It is important that health care encompasses a multifaceted approach, whereby all sections of society are involved from the government level of the relevant ministries such as Ministry of health, labor, medical professionals and also community based groups.

Health is an integral pillar to a development of a country; if healthcare is overlooked in development of individuals, communities and states then it is not a sustainable model of development to a country. Effective health care will not only enhance the quality of life of an individual, but also make them potentially a more productive person in society rather than a hindrance. Further supporting this argument is the following, *"as with the economic well-being of individual households, good*

population health is a critical input into poverty reduction, economic growth, and long-term economic development at the scale of whole societies."(WHO, 2001: 21) Therefore it has a direct link to economic development with less disease burden a workforce has less labour turnaround making it more efficient and productive.

2.1.1 Millennium Development Goals (MDGs)

One of the most current significant set of internationally recognized targets are the Millennium Development Goals (MDGs). The MDG's consist of 8 targets which have been vitally agreed by all 192 United Nations member states to be met by 2015. (Nations, 2010) Within the 8 goals there are 2 which specifically focus on health issues MDG 4: *"Reduce child mortality"* and MDG 5 *"improve maternal health."* (Nations, 2010) Further details and sub targets of MDG 4 are outlined as, *"Target 4a: Reduce by two thirds the mortality rate among children under five.*

4.1 Under-five mortality rate

4.2 Infant mortality rate

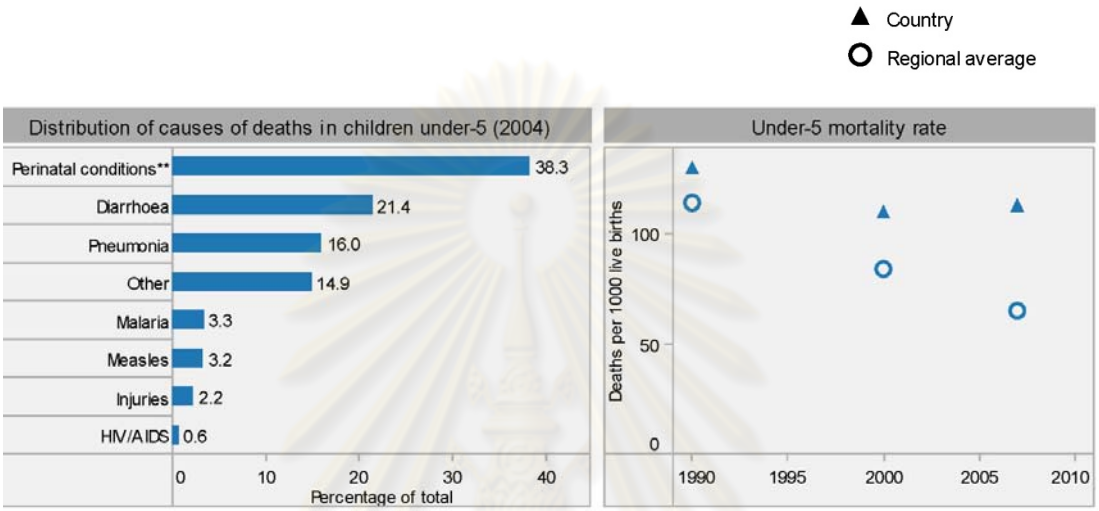
4.3 Proportion of 1 year-old children immunized against measles"

(Goals, 2010)

Under-five mortality is an important indicator which can more broadly access the performance of a government. It is measured against the probability of children aged below 5 years dying per 1000 live births. 2007 figures indicate Burma has 113 deaths, with a regional average of 65 and global average of 67. (WHO, 2007) These figures demonstrate that the SPDC is failing to respond effectively to the basic needs: further evidence of this is the fact that Burma is placed 138 out of 182 countries in the 2009 UNDP Human Development Report (UNDP, 2009: 145) It is estimated that annually 3 million of under 5 deaths are attributed to diarrhea and pneumonia (WHO, 2010) so it is essential to focus on setting up health care strategies to target these conditions. This is further substantiated within Burma with diarrhea and pneumonia being the second and third most common causes of deaths in children under 5. The major cause of death is perinatal conditions which are interlinked with complications during pregnancy and childbirth. These could be avoided with appropriate care in

prenatal stages such as increased nutritional intake, regular checkups and essential care of the baby during the postnatal period after giving birth.

Figure 4 Distribution of causes of Deaths in Children Under-5 (2004)



Note: (UNICEF, 2008)

Within MDG5, which focuses on improving maternal health, there are 2 main targets and sub targets which include: *"TARGET 5.A Reduce the maternal mortality ratio by three quarters between 1990 & 2015.* It states, *giving birth is especially risky in Southern Asia…where most women deliver without skilled care."* (Goals U. N., 2010) This will be undertaken by focusing on the maternal mortality ratio and universal access to reproductive health. *TARGET 5.B Achieve, by 2015, universal access to reproductive health.* (Goals U. N., 2010) This will be achieved by targeting areas such as: contraceptive prevalence rate, adolescent birth rate, antenatal care coverage and unmet need for family planning. While the principle MDG's and their targets are worthy in principle and all UN members have agreed to implement them, there needs to be some critical points raised about the process of designing these goals in the first place. It could be argued that these goals appear to be top down rather than at a local level. It is a 'one size fits all' policy and seem to be overly optimistic to be achieved by the self-imposed deadline of 2015.

2.1.2 Reproductive Health

Reproductive health is essential not only to ensure a mother and child are healthy before, during and after pregnancy. In the 1990's reproductive health was integrated by policy makers in the wider context of population control. However more recently there has been a shift illustrated in the following, *"prominence to reproductive health and the empowerment of women while downplaying the demographic rationale for population policy."* (Merson, 2008: 71) The approximate physical reproductive age for women is defined within the ages of starting of puberty 15-45 years, although many of the world's countries set different legal minimum age of consent for sexual activities for example both the UK and India has 16 as the minimum, while Burma's law states 14 years old (Hall, 2010). On average it takes approximately 38 weeks - 40 weeks for a baby to be fully formed and ready to be born. (News, 2004)

During this time it is critical to have an effective reproductive health program to help ensure the health and development of both a mother and child, *"Reproductive health is a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity."* (Nations, 1994) Therefore to ensure this, reproductive health can be broken down into various sections including antenatal care, postnatal care and family planning services. All of these areas help to reduce maternal mortality rates, miscarriages, low infant birth weights and associated problems. These various areas are outlined below:

2.1.2.1 Antenatal and Postnatal Care

Antenatal care is an essential part of ensuring that both a mother and baby are healthy and developing correctly during pregnancy. This can be done in several ways by going for regular check-ups, ensuring a balanced food diet with vitamins and where possible being in an environment free from e.g. smoking or alcohol. It is such a vital stage and can help to proactively identify possible problems early on in the pregnancy. Antenatal checkups ensure that the baby is in the right position. Ultra scans are also important to check the baby's development in terms of spinal cord and

internal organs. In the context of antenatal care in Burma, especially in rural areas an ultra scan is not practical or possible. A different technique employed is using a medical instrument to monitor the baby's breathing. MDG 5 also stipulates the provision of support during reproductive health as cited in the following: 5.5 Antenatal care coverage (at least one visit) (UNDP, 2010)

Another important stage of reproductive health is postnatal care which is ensuring that both the mother and new born baby are healthy after the pregnancy. This stage usually last approximately 6-8 weeks after giving birth. (National Institute for Health and Clinical Excellence, 2010) It is also a vital stage of equipping the mother with information about knowledge of the importance of breastfeeding, reproductive health and the use of contraception.

2.1.2.2 Miscarriages

On average 1 in 5 pregnancies will end in a miscarriage. (Kids Health, 2010) This occurs usually within the first 3 months of pregnancy. Late miscarriages can be defined after this initial 3 month period until 24 weeks (approximately 6 months). After this period the foetus is large enough to be classed as a stillbirth from 6 months onwards until the baby is born. If the baby is born and has its first breath but dies, this is classified as an infant mortality death. The loss of a pregnancy can not only cause physical health problems relating to a woman's reproductive organs; it can also have a psychological impact which is known as clinical depression.

2.1.2.3 Skilled Birth Attendant and Family Planning

One of the ways infant mortality can be minimized is through the use of a skilled birth attendant. These can include doctors, nurses or midwives. Yet one third of woman worldwide deliver at home without a skilled birth attendant present. (Organization, 2008) This could potentially increase the likelihood of both mother and child mortality rates through the use of sub standard equipment, limited knowledge and the untrained birth attendant maybe less likely to foresee complications which

could warrant a referral. While Traditional Birth Attendants (TBA) are not classified as skilled birth attendants due to not being formally trained, however in many parts of the world the TBA or informal midwife are an essential pillar to provide care before, during and after pregnancies. Contraception is an essential part of family planning, defined as *"the means used to prevent a women becoming pregnant."* (Minister for Education, 2001: 9) Yet it may not always be available or accessible due to financial, cultural barriers or logistical constraints.

2.2 Medical Health Care Delivery

The medical health care delivery often referred to as the "medical model" of health care fundamentally focuses on doctors, nurses and health professionals treating the sick once they have already become ill, which is reactive rather than preventative. This Westernized-orientated health model can be a combination of both public and private health care and is often very expensive creating a huge barrier, which many poor people cannot afford. Therefore some governments initiated a policy of health insurance for its citizens, to provide medical services. The limitations of this are that in most developing countries they do not have access to this type of initiative as the public health care system are relatively underdeveloped. It also requires a relatively good tax system to function properly, something which in a country like Burma would not be feasible given indiscriminate arbitrary taxation which goes into corrupt officials' pockets instead of providing legitimate public services.

This type of medical model is predominately implemented in urban areas in hospitals, clinics or health centers. With the advancement of sophisticated technology surgeons can now conduct operations such as brain surgery with specialist equipment, which in certain cases would cost an entire health budget allocated for a single village. Therefore in terms of numbers there is a clear imbalance in the sharing of health resources and priorities of the medical model in focusing on funding for research and development into sophisticated equipment. Although it is a sign of development that complex operations are now able to save lives, yet the vast majority of poor people do not need this type of health care, requiring more rudimentary health

care. For example, the basic health needs of a community might be a improving sanitation, clean water or implementing an immunization program, which in some area of the world have still not been met. WHO state due to a lack of these basic needs, "*About 2 million people die every year due to diarrhoeal diseases, most of them are children less than 5 years of age.*" (WHO, 2010)

While it is undeniable that this type of medical health care model is needed and helping certain people of a society in achieving better health, however often it is not realistic or economically viable for a country to have enough doctors and nurses to take care of the entire population. Also, while medicine may be a quick fix, it may not be a sustainable solution for a more inclusive approach to healthcare factoring in the whole community and not just the immediate ill patient. Additionally there are the constraints of the health professionals, who are often too busy and unable to visit the sick patient's community to look at some of the underlining root causes as to why health problems are occurring in the first place. Potentially medicine and the health professional can also create dependency on this type of curing through the buying of expensive Western medicines, so reinforcing the power imbalance of people feeling powerless about their own health and dependency of medical professionals. This is supported by the following, "*Control resides firmly with professionals; choices for the individual are limited to the options provided and approved by the 'helping' expert.*" (University, 2006)

With all of these key points in mind, it is essential to prioritize a more decentralized community based approach, which addresses the inequalities posed by the medical model of predominately the only people with power and money gaining access to adequate health care. In the context of isolated rural areas such as the India-Burma border that do not have the access or resources to this type of medical model, an alternative is needed.

2.3 Primary Health Care Delivery

Outlined below is the context of the formation of the primary health care delivery model.

2.3.1 Alma-Ata Declaration

The formal beginnings of an alternative to the medical model were during a WHO conference which formed the Declaration of Alma-Ata in 1978 in USSR. (World Health Organization, 1978) Underpinning the conference was the principle that healthcare was not just for the rich or powerful in society, but was fundamentally a basic human right for all. Representatives from 134 countries attended, sharing comments and experiences on providing effective alternative decentralized health care approaches with the goal of making people healthier. During this conference key issues were discussed, such as how existing health models could be adapted to provide better health care for those who could not previously access them, and empowering communities to take ownership and seek preventative rather than reactive approaches to health care. These outlines were formalized to become what is now known as Primary Health Care (PHC). As part of the declaration a target of Health for All (HFA) using PHC approach was announced.

2.3.2 Primary Health Care

The primary health care (PHC) model of health care was a shifting to a more affordable holistic approach to health care focusing on a multifaceted stakeholder approach including different sectors such as health, education, farming, local community leaders, medical professionals and even businesses. It helped to promote health in a community through food, clean water, sanitation and immunizations. *“Address main health problems in community by promoting preventative, curative and rehabilitative services.”* (World Health Organisation, 1978) PHC focuses more broadly on the needs of the community and is preventative in nature rather than reactive. This type of heath care focuses on trying to reduce some of the root causes

of poverty and illness such as communicable diseases and mortality rates. Helping communities improve their health through activities could result in preventing illnesses before they occurred. PHC can work well in isolated remote areas, which may not have access to a nearby medical facility, doctors or other health professionals. Yet it is important to recognize that PHC also needs a flexible approach in that it must be reactive as well as proactive in the case of injuries or illnesses which do occur. The health care support mechanism should be able to effectively respond, yet it should be focused on limiting and reducing these numbers before they happen.

2.3.3 Community Health Workers

An integral element of PHC is the use of Community Health Workers (CHW) who are selected by communities and have important knowledge and have already established relationships in a community. They are trained to support communities to know their own health needs and work with them to help solve their own problems. CHW will often be from the local communities which is also another reason they work quite effectively as they are often highly motivated to improve and develop their local communities. It is the act of caring for the community that they often do home visits to families in a community, which is proactive in trying to solve potential problems before they arise and become potentially more serious.

This holistic approach to health care does not focus solely on the individual illness, but more broadly on the entire body, family and the community's way of life. With the CHW's local knowledge of communities, culture and needs they can identify the root causes of illnesses in a community. Often these root causes are difficult to change as they are is embedded into culture and daily life. Yet with CHW subtle understanding of the local context combined with maintaining a long-term perspective to healthcare, they are focused on gradual behavioral changes of the community's way of life which can improve their overall health. CHW can be defined as someone, "*who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language,*

socioeconomic status and life experiences with the community members they serve." (Administration, 2007)

It is this transformational change of communities being empowered from the grassroots level to help themselves which is different from the medical model of health care, which is predominantly centralized and top-down. It is often the first level of contact that local communities have with the wider national system and is a continual process where local communities feel ownership in the whole medical process from planning to implementation of strategies to improving health as they are also the agents of change, such as working together to improve the water and sanitation in a community which can help to reduce diarrhea and cholera. However it is important to recognize the limitations of PHC which may be ill equipped to diagnose and cure more complex illnesses, injuries or long term conditions. Therefore a referral system is an integral element for a more complete health care service. Referral is the process of sending a patient to a better placed hospital/clinic which may have more facilities, resources and knowledge to help deal with the health problems of a patient. There may be barriers to the referral system such as the logistics of moving a patient from A to B especially if the patient's condition is serious and they are located in an isolated area. Other potential barriers could include expenses, the requirement of identification/insurance or language barriers. Therefore the medical model of health care should not be discounted and is interconnected between the overall national health system including rural and urban areas through this referral mechanism.

CHAPTER III

POLITICAL AND DEVELOPMENT CONTEXT OF BURMA IN RELATION TO THE HEALTH SITUATION

This chapter is divided broadly into 2 different sections; political and development. Firstly in the political section, issues surrounding the militarization, ethnic groups and the rise of the women's movement in Burma are discussed. Then these issues are linked within regional political ties such as ASEAN, India and China. Secondly these link with the second section focusing more specifically on development issues relating to livelihoods and economic disparity which consequently leaves areas of Chin state food insecure. The above will help to conceptualize the current situation in Burma, in relation to the current health situation which will be discussed in detail in the next chapter.

3.1 Politics

The dire political situation in Burma has also severely affected the development of the country, especially in ethnic areas. The last democratic elections were held in 1990 with Aung San Suu Kyi's party, the National League for Democracy (NLD) winning over 82% of the votes (Irrawaddy, 2009). However, these results were not honored and instead severe restrictions have been placed on political parties in Burma. Such restrictions go against the *"fundamental freedoms, promotion and protection of human rights, and promotion of social justice,"* which are fundamental rights of the Universal Declaration on Human Rights (UDHR). This declaration was adopted during the United Nations General Assembly in 1948. While the UDHR is not legally binding, the importance of this declaration is that it is an obligation for all countries belonging to the United Nations (UN) to uphold the declaration's fundamental rights. The declaration also has provisions for health care related to: article 25. "(1) *Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and*

medical care and necessary social services," (UNDHR, 2010). It also specifically highlights mothers and their children as stipulated in, *"(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection."* (UNDHR, 2010)

3.1.1 Militarization

The SPDC is a deep-rooted military-orientated institution within Burma and has been in power in one form or another for nearly five decades since a military coup in 1962. The current strength of military is believed to number up to 500,000 soldiers (Burma Campaign UK, 2010) and has been headed by Senior General Than Shwe since 1992, who is also the commander-in-chief of the armed forces. The disparity of the SPDC in allocating the national budgets on the military is highlighted in the fact that it is estimated by the World Bank to spend more than 40% of the country's total GDP on defense. (Women of Burma, 2008: 30) This fact has resulted in a dire lack of investment in key public sectors such as health and education which, combined, only account for 1.4% of GDP. (Turnell, 2008: 3)

One of the main reasons that the military has remained in power for so long is the recruitment of child soldiers, evidence of which can be found in the following, *"Despite national legislation which prohibits the recruitment of children below 18 years of age into armed forces or groups, minors continue to be recruited in the armed forces of all parties including non-state groups."* (UNICEF, 2008) Within the SPDC military it is estimated that there are up to 70,000 child soldiers, (Cary, 2005: 8) making it the largest user of child soldiers in the world. Child soldiers are easy to target, vulnerable and can be systematically brainwashed to fit in with the ideology of the military. This ideology centers on instilling extreme nationalist feelings and the beliefs that they are protecting the sovereignty of the country. State propaganda also helps to drive these nationalist sentiments through disseminating slogans such as "*crush all internal and external destructive elements as the common enemy."* (New Light of Myanmar, 2004) These types of slogans are common throughout the country,

which are often referring negatively to pro-democracy groups both domestically and internationally.

Another factor in the drive for the recruitment of child soldiers is partly a result of high desertion rates amongst the Burmese army. In the process of the recruitment of child soldiers, battalion commanders are offered incentives such as money, leave from work and promotion. Equally, they face the potential threat of considerable disciplinary pressures if they fail to meet the increasingly demanding recruitment quotas set by military generals. A clear indication of the recruitment drive can be seen in the fact that from 2006 recruitment levels increased fourfold to monthly targets of up to 7000 soldiers. (HRW, 2007: 7) These incentives and pressures combined with weak enforcement of domestic laws, which prohibit the recruitment of anyone less than 18 years old, ensures that recruiters face insignificant penalties. This only helps to perpetuate further the widespread abuse of power and impunity within the system. Importantly, even though the SPDC have signed the International Child Rights Convention (CRC) in 1991, they have failed in their obligations to protect the basic rights of a child under the age of 18: there are specific articles relating to *"protection from harmful influences, abuse and exploitation."* (UNICEF, 2010) Therefore the SPDC should be held accountable for these state-sanctioned policies and distinct lack of progress in regard to specifically safeguarding children under the age of 18.

Unfortunately often these child soldiers are placed on the front lines in ethnic conflict areas in a policy by SPDC called the Self Reliance Program. This results in army personnel having to fend for themselves purposely with little supplies. They are also faced with the harsh dilemma of having to meet their basic survival needs such as water, food and shelter, but having to commit human rights abuses in the process. In terms of the impact militarization has had on health, this cycle further perpetuates the deterioration of the physical wellbeing of the civilians who are affected. However, more long-term and of great concern is the psychological and mental condition of these victims of prolonged militarization which also includes the soldiers themselves.

3.1.2 Militarization in Ethnic Areas, With Emphasis in Chin State

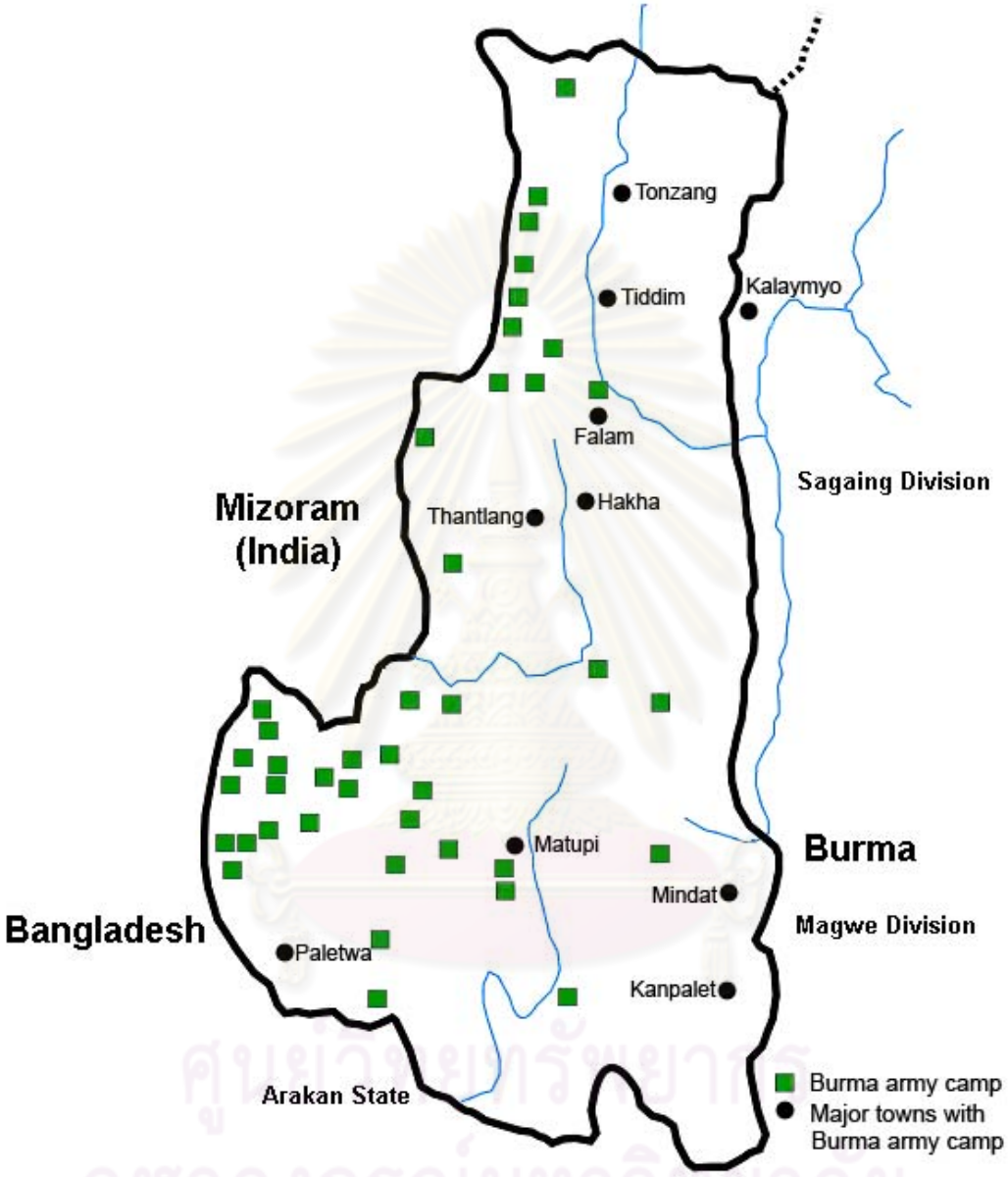
Within Burma there are approximately several dozen main ethnic armed groups. These groups have arisen for a number of reasons such as: historically, as an outcome of increased militarization by SPDC in ethnic areas and fundamentally due to a lack of genuine political inclusiveness which respects the rights and semi-autonomy of ethnic groups. Civil war has been long and protracted for over 60 years in ethnic areas of Burma. Approximately 27 of the armed ethnic forces, have signed ceasefire agreements with the SPDC since 1989 (Global Justice Centre, 2004). However, these ceasefire agreements (which on paper can look an impressive feat), benefit only a small population within the ceasefire groups' designated areas, which permits them to collect taxes and conduct business. The SPDC has used strategies akin to the British colonial tactics of "divide and rule," which has helped to segregate similar ethnic groups along religious lines. Any potential coalition of opposition forces therefore becomes weaker through such disunity. Additionally, the ceasefire agreements can mask the hidden agendas of the SPDC to Burmanise and assimilate ethnic areas in a process of state building. Evidence of this process of Burmanization can be further substantiated by referring to Figure 5: Map of Chin state with Burma army camps. In 1988 there were no Burmese army camps present, which contrasts completely with today's situation with currently over 50 camps. (HRW, 2009: 22)

With the increased militarization of Chin State, there has been a substantial increase in human-rights abuses perpetrated by the SPDC including widespread forced labor, arbitrary taxation, land confiscation, rape and killings. Another dynamic in terms of militarization in the context of Chin State is the Chin ethnic resistance in the form of the Chin National Front (CNF) and its military armed wing, the Chin National Army (CNA). The CNF was formed in March 1988 (CNF, 2010) as an open response to opposing the rule of the Burmese military over ethnic areas of Burma. At presently the CNA's armed resistance has been completely overwhelmed with the increased militarization of Chin State and the Burmese military soldiers heavily outnumbering CNA's. With the Burmese military having permanent army camps it is extremely dangerous for locals to show any support for the CNF and CNA as this is

met with harsh punishments. Until today the CNF and CNA have not signed any ceasefire agreement with the Burmese military.

The large number of camps in Chin State also helps the military maintain control over the general population and resistance movement. This is similar to the military tactic used in other ethnic areas such as Karen State in their four cuts policy of cutting revenue, information, recruits and food. (Tharckabaw, 2003) While the situation in Chin State may not be so pronounced when compared to the horrific conflict situation in Karen state, nevertheless the human tragedy of prolonged increased militarization should not be discounted as it affects every sphere of society including the link to poor health with the people's basic survival under threat.

Figure 5 Map of Chin State with Burmese Army Camps



Note: (Human Rights Watch, 2008)

3.1.3 Border Guard Force

More recent strategies by the SPDC to control armed ethnic groups center on assimilating and integrating these groups into a Border Guard Force (BGF), ahead of the proposed elections in November 2010. The SPDC have issued various deadlines for these groups to adhere to the State ruling of coming under the premise of forming a National Army, fundamentally which will be controlled by the president, Than Shwe. Moreover there has been a lot of criticism and resistance from many of the larger non-ceasefire ethnic armed resistance such as Wa and the Kachin who have openly defied the deadlines imposed by SPDC. The situation remains very much a potential for renewed fighting which will again have a knock-on effect in regard to a humanitarian disaster with victims of conflict, food and water security and refugee overflows to neighboring countries. This can be substantiated by the fact that in August 2009 over 37,000 Kokang ethnic population and Chinese (Irrawaddy, 2009) fled over the Chinese border as fighting broke out between SPDC and Myanmar National Democratic Alliance Army (MNDAA) within the Kokang region of north-east Shan state.

With the potential of a renewal of widespread civil war, it remains to be seen how this very sensitive issue of BGF will be dealt with by the present SPDC. They will want at all costs to avoid any potential mass conflict ahead of their proposed election, especially as it could damage relations with China and neighboring countries.

3.1.4 The National Referendum in 2008

More recently, the SPDC are in the process of legitimizing their authority through a proposed seven-stage roadmap to disciplined democracy. The dynamics behind this move towards disciplined democracy is part of the military's strategy of wanting to be perceived as a legitimate government in the eyes of the international community and especially the Association of South East Asian Nations (ASEAN). It is also a key exit strategy for the top military generals of the military such as Than

Shwe who is currently 77 years old. He is reported to be in increasingly poor health with numerous visits to private hospitals in Rangoon and Singapore. The proposed roadmap will help to safeguard retiring military generals and their families, while still maintaining the power of key institutions from behind the scenes. As part of the roadmap in 2008 a national referendum was held to enshrine a new constitution which perpetuates military rule with such articles as: *"The military's power to veto constitutional amendments provides blanket immunity for past atrocities."* (Burma Elections 2010: 2) In addition, the constitution also stipulates that, *"amendments to the constitution need at least a 75% vote."* (Burma Elections 2010: 2) Therefore with the military automatically given a share of the seats and the presence of their civilian proxy Union Solidarity and Development Party (USDP), it will be impossible for ethnic groups to amend this one-sided pro-military constitution in the future without the consent from the military. The constitution lacks any form of a genuine inclusive process that includes the voices of other ethnic groups. Further, the president is not elected by popular vote; it is therefore highly likely that a pro-military backed person such as Than Shwe will remain in a position of absolute power and impunity.

Moreover, specifically relating to health care article 367, the constitution stipulates, *"Every citizen shall, in accord with the health policy laid down by the Union, have the right to health care."* (Ministry of Information, 2008: 152) However, even during the time of voting for the referendum in May 2008, Burma saw its worst natural disaster ever when Cyclone Nargis struck the Ayeyarwady Delta region. The death toll alone was over 100,000 deaths (BBC, 2008). It was during this period that the military kept back emergency aid and much-needed humanitarian assistance, including medical treatment from the victims who needed such help, which goes against their own proposed constitution's article 367 which refers to every citizen's right to healthcare. Sadly and ironically, days later the SPDC announced the adoption of the constitution with a turnout of over 99% countrywide and over 92.4% of citizens voting "yes" (BBC, 2008). However, given the context of the referendum taking place during Cyclone Nargis, which caused widespread displacement, these figures remain highly dubious and only further highlights the gross negligence of the SPDC in consolidating their own future instead of that of their citizens.

3.1.5 Elections in 2010

The SPDC have recently announced that democratic elections will be held on November 7th 2010. This will be the first time that elections will be held in over 2 decades, since the national 1990's elections were not recognized by the military. There are currently 47 different parties in total that are registered from each of the 7 states and 7 divisions for the upcoming elections. Currently 42 parties have been approved including 9 state backed parties and the main civilian proxy of the military such as: USDP (Altsean, 2010) In the context of the 2010 elections within Chin State, 2 parties has registered with the election commission (EC) and are planning to contest including: Chin National Party (CNP) and Chin Progressive Party (CPP) who represent the entire Chin State consisting of the 9 townships and various Chin sub-tribes. However, it is important that they also have, where possible, representation and active participation from women; otherwise their rights and voices may not be represented specifically relating to women's rights. CPP has recently released a statement regarding their main policy, *"to create opportunities in Chin State for peace, health care, education and economic development, as well as promoting equal rights for Chin people within the Union and the right to preserve their natural resources, literature and cultural heritage."* (Weng, 2010) However one of the main problems ethnic political parties face are the high registration fees which have been outlined by the EC: this is having an effect on creating a barrier to enter the political frame. The formation of the EC itself is also contentious as it does not include representation from pro-democracy ethnic groups, and instead is headed by a former major-general Thein Soe who is appointed as chairman. (Burma Elections, 2010: 1) He was also responsible for drafting the 2008 Constitution, which fundamentally lacks inclusion of other ethnic groups in the process.

The previous 1990 democratically elected party, the National League for Democracy (NLD), who won 392 seats (Burma Campaign UK, 2010) has now had little choice but to have been forced to dissolve their party. Since May 2010 they have chosen not to contest in the November election due to the fundamental fact that over 1200 political prisoners are in prison or under house arrest including key people such

as Aung San Suu Kyi and Min Ko Naing. Some of the political prisoners are serving extended life sentences of up to 106 years. (Burma Elections, 2010: 3) In order for genuine free and fair elections to take place, pro- democracy coalition groups have called on 3 fundamental conditions to be met; these include:

- *"The release of all political prisoners.*
- *Cessation of hostilities against ethnic groups and pro-democracy forces.*
- *An inclusive dialogue with key stakeholders from democracy and ethnic groups, including a review of the 2008 Constitution."*
  (Burma Partnership, 2010: 5)

In order to have credible elections, these above fundamental conditions as well as freedom of assembly, association, speech, expression and movement should also be adhered to. Presently the proposed elections on 7th November 2010 which will activate the SPDC's new constitution will as a well-known Burma expert Lintner argues, *"establish a structure designed to perpetuate military rule, not to change it."* (Lintner, 2010) This highlights the importance of politics as this will in turn affect how policies are shaped relating to the delivery of health in the public and private sector within Chin State.

3.1.6 Ethnic Groups

Historically an agreement between ethnic groups and General Aung San was reached in 1947 with the signing of the Panglong Agreement which was fundamental for negotiating independence from the British in 1948. (Tinker, 1984: 404) However, it was during this timeframe that General Aung San was assassinated, which only further disunited an already fragile agreement and country. Over the next decade ethnic groups ratified the federal constitution, allowing them to secede after a decade of independence. This paved the way for the 1962 military coup and various military backed governments who propagated the Burmese Way to Socialism. This new ideology instilled strong nationalistic feelings and fundamentally pro military which still remain until this day, sidelining ethnic groups in the process.

As previously touched upon, the process of Burmanization is deep-rooted and can impact on all elements of society, not just increased militarization, as seen for example in ethnic areas where in the educational system outlawing the use of Chin language at schools and in the workplace is banned in Chin State and installing Burmese as the only language permitted. (BF-UPR, 2010: 9) This was indirectly achieved by the state through their policy of teachers from urban areas such as Mandalay and Rangoon being sent to Chin State to teach who are unable to speak the local Chin dialects. Teachers from these areas often feel isolated and homesick due to being unable to effectively communicate with the Chin in their own language, unfamiliar foods, lack of development and harsh living conditions. As a consequence, in some cases this causes teachers' attendance to plummet and also to seek a transfer to other more developed areas. In the longer term this directly affects the level of education that future generations of Chin will receive and thus the potential pool for much needed services such as education, health and politics.

3.1.7 Women's Movement

The women's movement in Burma has strengthened considerably over the decades, especially with the country's iconic pro-democracy leader Aung San Suu Kyi (ASSK). ASSK is the daughter of General Aung San who is deeply revered as a national Burmese hero for negotiating independence from the British. Comparatively, ASSK is equally perceived as a national hero for her role in fighting for the people of Burma- this time opposing the policies of SPDC. During her role in politics she became the Secretary-General of NLD, but this has come at a huge personal cost as she has had to spend in total over 15 years under house arrest since 1989. Significantly, her position as a prominent leader has given rise to a new generation of Burmese women to take to the stage in domestic, regional and international forums. Women groups in Burma and in exile have been able to mobilize themselves successfully into both community based ethnic organizations such as Karen Women's Organisation (KWO), Shan Women's Action Network (SWAN) and Women's League of Chinland (WLC). Additionally these groups are also part of umbrella

organizations such as the Women's League of Burma (WLB) representing the voices of women from Burma.

3.1.7.1 CEDAW

The value of this growing rise of women's voices being heard has importantly been a vital catalyst for pressuring the SPDC into signing the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1997. Another factor in this respect is that SPDC desires to improve their international image by signing this convention. The convention has specific safeguards for women and actively promotes gender equality. This convention has been ratified by SPDC, meaning that the state has a legal obligation to implement the convention into domestic laws. As such, it is a powerful tool for women organizations to mobilize advocacy campaigns and press for policies which reduce violence against women and promote greater gender equality.

Within Burma there is a direct connection between increased militarization by the State and violence against women, particularly in ethnic areas. In Chin State alone given the limitations of accessibility and also the difficulties of finding out information, 38 cases of violence and sexual crimes against Chin women that had been perpetrated by the SPDC were documented. (Women's League of Chinland, 2007: 1) WLC believes the actual number of cases is much higher, yet due to the difficulties posed with the sensitive subject and access to information remained limited. These shameless acts by the SPDC are often carried out by higher ranking officers in front of their fellow soldiers, which only further indoctrinate a culture of impunity and lack of rule of law, furthering perpetuating these types of atrocities. (Women of Burma, 2008: 60) Rape as a weapon is used as an unwritten policy by the state to sanction sexual violence by military personnel not just in Chin State, but all over Burma. Rape not only undermines rape survivors causing horrific psychological damage to them, but also destroys families and communities. The social stigma borne by rape survivors only helps to further destroy communities. Therefore the CEDAW

convention is an essential tool to hold the state more accountable and to stop the culture of impunity relating to discrimination and violence against women.

If we consider article 12 of the CEDAW convention: *"health care and family planning"* (United Nations, 2010), this also provides specific safeguards to maternal health issues facing the general women population of Burma,

"1 State Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2 *State Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."*
(Women of Burma, 2008: 39)

3.1.8 ASEAN

ASEAN was first established in 1967, bringing in 10 countries located geographically in South-East Asia. More recently due to a severe economic crisis gripping the region this has resulted in the impetus to forge closer ties amongst members similar to a European Union system. This bought about the establishment of the ASEAN Charter in December 2008, which became a legally binding agreement amongst the 10 members. The basis of this strengthening of relationship is heavily weighted towards economic interests which as a group within the ASEAN region amounts to USD $1.5 trillion GDP in 2009 alone (Union, 2010). Burma ratified the charter on July 21 2008 which is essential, in that the charter's articles, for example article 1.11 mentions *"equitable access to opportunities for human development, social welfare and justice;"* (ASEAN, 2007: 4). It is therefore a mandatory obligation of the state to actively address social welfare issues such as providing health and education public services.

3.1.8.1 ASEAN Human Rights Body

In addition to the ASEAN charter is the establishment of the ASEAN Intergovernmental Commission on Human Rights (AICHR). It is the first mechanism in which ASEAN has tried to focus exclusively on human rights. All 10 ASEAN governments have agreed to implement the AICHR as part of article 14 in the ASEAN charter. The mechanism was made under the strong leadership of the ASEAN Secretary General Surin Pitsuwan, who has helped to a certain extent to promote growth of democracy and human rights in the region. It will however be a test to see how the mechanism is implemented in reality, especially with the current chair of ASEAN presiding over by Vietnam. Within this mechanism there is also a strong potential for a conflict of interpretation of articles as can be seen by asking which has a higher priority, for example in the ASEAN charter and AICHR in regards to article 2e ASEAN charter: *"non-interference in the internal affairs of ASEAN Member States;"* (ASEAN, 2007: 5) which can conflict directly with *"respect for fundamental freedoms, the promotion and protection of human rights, and the promotion and protection of social justice,"* (ASEAN, 2007: 6) especially in the case of Burma.

It is easy to criticize AIHCR and its terms of reference, which are more focused on constructive engagement essentially advisory, coordinating and consultative rather than any independent enforcement powers. Yet the fact that the AIHCR could act as a trigger for further discussion on human rights using other additional tools is a positive first step. Therefore a combination of international conventions, regional bodies and domestic laws are essential tools to hold the SPDC accountable and this can directly link to human rights and the right to health care.

3.1.9 India's Look East Policy and impact on Burma

As previously touched upon in the hypothesis, India's involvement in Burma is growing with increased interests in development projects since the initiation of India's Look East Policy in 1991. (Kuppuswamy, 2010) The primary aims of the policy are to counter China's influence in the region and move towards closer ties with ASEAN. Burma is fundamental to this policy as it serves as the main corridor by land for India into the mainland south-east Asia region.

Previously the SPDC relied heavily on China for political, economic and security issues, yet more recent events illustrate a calculated shift of policy by SPDC, for example as mentioned in the Border Guard Force section regarding 37,000 Kokang and Chinese fleeing to China due to fighting. The SPDC does not appear to feel threatened or fear reprisals from the Chinese government - something which previously they would have been very cautious about, given the sensitivities along the China-Burma border. This could be due to SPDC being very calculating in shifting their overreliance on China in favor of India and as a result strategically playing off the 2 countries' growing geopolitical importance that Burma represents.

In April 2008 a Memorandum of Understanding (MoU) was signed between India and Burma for the Kaladan project with a view to increasing transport links between Burma, India and the region, which will provide river access, road access and increased trade routes from South-east Asia to India's landlocked north-east states. Over 1 million people are at risk of food insecurity in the project areas along the coast of Arakan State, Burma and also along the project site of the Kaladan River which is in Chin State. (Arakan Rivers Network, 2009: 7) Communities use this river for fishing and paddy field cultivation. Yet no Environmental Impact Assessment (EIA) has been carried out and made public. Over 225km of the Kaladan River will be dredged to make the waterway passable by ships; such dredging is carried out through excavating sediment from the bottom of the water bed. This process can result in toxic chemicals being released from bottom sediments; also the disposal of the dredging material is a key issue. This is a major concern for the health situation of the Chin and

people of Arakan State who are likely to face a depletion of food sources along the river, risk of increased exposure to toxic chemicals and forced labor.

As a continuation of the Look East Policy, on 26th July 2010 Than Shwe visited India's Prime Minister Manmohan Singh on a 5 day state visit (Irrawaddy, 2010) focusing on strengthening ties between the 2 countries specifically relating to economic and security issues in the north-east of India bordering with Burma. This directly affects Chin State for security issues along the Indo-Burma border, which will become only stricter and also could affect the attempts at humanitarian assistance operating along the India-Burma border. Significantly in the context of this historic meeting, the Indian Prime Minister indirectly showed to the international community that he recognizes and legitimizes the Senior General ahead of the November 2010 elections.

3.2 Development Issues

The next section focuses on development related issues and the impact it has had on the health situation.

3.2.1 Economy

Another key element of SPDC remaining in power for so long is the exploitation of Burma's rich natural resources for their own self-interest. Systematic militarization in ethnic areas has given rise to large-scale resource extraction and infrastructure building. This has had the effect of destroying the natural environment and threatens the local management systems of communities. (Burma Environmental Working Group, 2009: 1) The consequences of this resource extraction are long-term with food insecurity becoming a major issue linked to the process of extraction often with no Environmental Impact Assessment (EIA) carried out prior to operation.

Related to resource extraction we can specifically consider gas. Burma has consistently ranked extremely low in the Corruption Perceptions Index since 2003

when Burma was first included; currently it is ranked 178 out of 180 countries (Transparency International, 2009) The corruption stems from economic mismanagement and distortion of money generated by natural resources such as gas. For example the SPDC has earned approximately US$4.83 billion since 2000 (Earth Rights International, 2009: 18) on just one of its gas pipeline projects entitled Yadana gas pipeline. The lack of accurate financial information which fails to show correctly the revenues generated by this project consequently affects the national budget allocated for education and health. It is clear that the vast majority of the civilian population sees little benefit from the extraction and selling of gas with only a small amount of labor generated during the initiation of the projects and fewer skills are transferred from the company to the local population.

In terms of an analysis of Burma's economy structure by sectors, it can be shown that the primary sector of agriculture, livestock, fishing and forestry accounts for the highest amount with over 47%, (ADB, 2007). This implies that Burma's economy is heavily reliant on the extractive industry. Secondary industries, which include manufacturing and processing, account for 13% (ADB, 2007) and the tertiary service industry including: trade, communications and finance account for 27%. (ADB, 2007). The secondary and tertiary sectors are a key indicator of a country's transformational growth, yet these figures remain relatively low, which creates a potential vulnerability to the fragile economy, especially with natural disasters such as Cyclone Nargis.

In relation to the current political-economy, the SPDC and its business partners are privatizing many sectors, buying strategic locations and buildings within urban centers of Burma. This is in anticipation of a more open market-based economy after the elections. These include the privatization of over 300 natural gas stations in Burma, buying strategic sea harbors, government buildings and the issuing of privatized licensees for hospitals and clinics. However, the real beneficiaries in this process are not the general population of Burma but the SPDC and the people who have enough money to afford the luxuries of private health care.

3.2.2 Livelihoods

There is an interconnected relationship between health and livelihoods which can be further substantiated in the following, "*labour conditions play a critical role in determining the health of employees, families, and communities. Labour conditions influence health in these three spheres, but in different ways- by how work is structured, by the physical environment at the work site, and by the social and policy environment at work, among others.*" (Chantal, 2007: 170) Relating to livelihoods within Burma, almost 70% (Asia, 2010) of the population rely on agriculture as their basic livelihood and for food security. Yet external factors relating to the policies of the SPDC affect livelihoods and health through arbitrary taxation, hindering basic survival of families. Arbitrary taxation is often in the form of land confiscation, cattle, crops or forced labor. (Network for Human Rights Documentation-Burma, 2010) When families are required to undertake forced labor, it takes them away from their livelihoods in the rice fields, often at critical times within the cycle of rice cultivation. The lack of benefits these taxes have is further substantiated in the following, "*People are paying large amounts of tax yet are receiving very limited public services and in some areas extremely limited access to health services, electricity and water.*" (Network for Human Rights Documentation-Burma, 2010: 13) This system of taxes on livelihoods has a long-term impact on food security and overall health as families become more malnourished and financially poorer.

3.2.3 Food Insecurity

Another key impact on the health condition in Burma is a combination of external factors such as global world prices of rice increasing by 50% (Dr Cynthia Maung, 2008: 1) and also internal factors inside Burma such as Cyclone Nargis which has devastated the delta region of Burma. This area was the main area for growing rice, which has increased food insecurity to people in Burma. Climate change has also resulted in a lack of rains and late monsoon rains affecting the planting seasons.

3.2.4 Food Crisis in Chin State

Food security concerns have only been further exacerbated in Chin State with a severe food crisis caused by a plague of rats in a natural phenomenon traditionally called "*mautam*" by local Chin meaning "*dying bamboo.*" This phenomenon occurs every 48 years in Chin State, Burma and Mizoram State in north-east India. In Chin State alone, over 20% of the population has been affected by the mautam crisis. (Chin Human Rights Organisation, 2008: 3) During this freak phenomenon, vast forests of bamboo covered with jungle flower produce a type of bamboo fruit called *"maurai,"* which attracts the local rat population. These rats, which are usually moderate in numbers, consume this new abundant food resource. Locals believe this fruit has aphrodisiac properties, causing the rat numbers to rise exponentially.

In a twisted tale of bad luck, once the bamboo fruit surplus has been exhausted, the hungry plague of rats turn on villagers' crops, causing a widespread food crisis. In certain areas of Chin state this food insecurity is causing malnutrition of the population. The situation in Chin state could be compared to the global health situation as cited in the following, *"the persistence of approximately 850 million persons suffering from malnutrition (marginally higher than the estimated 820 million at the turn of the century) may partly reflect the erosion of agro-ecosystem resources, and the occurrence of crop pests and diseases- and the persistence of unequal access to food supplies."* (Robert Beadlehole, 2009)

Village elders who experienced first-hand the last mautam in 1958 explained that this time the situation is much worse. Unusually strong winds damaging crops and bamboo forests dying at different times have caused the rats to shift unpredictably from one area to another. The combination of this food crisis and militarization of their land has only compounded further their plight as argued in the following, *"Some forms of extraction from peasants are acceptable to them, while other forms are not. Peasants withstand exploitation, but not all kinds of exploitation, especially forms that put them consistently below a minimum line of subsistence, exposing them to undue risk."* (Robbins, 2004: 56)

This exploitation by SPDC as previously mentioned is in huge contrast to neighboring Mizoram State, India which is also experiencing the crisis. Here the local government has a number of programs such as a Below Poverty Line (BPL) ration card which entitles families who are deemed to be most needy in a community to obtain rice at subsidized prices. Additionally, the proactive provisions by the State through crop substitution such as coffee, ginger or garlic which are not susceptible to the plague of rodents have been appropriate response mechanisms. The mautam food crisis is expected to end in 2010, but is having such an effect on the Chin that they are faced with little alternative but to migrate to India or other areas of Burma. It is reported that up to 4000 Chin have left due to the food crisis and compounding militarization. (Chin Human Rights Organisation, 2009: 1).

CHAPTER IV

HEALTHCARE SYSTEM AND POLICY IN BURMA

This chapter focuses on different healthcare systems and health initiatives in Burma, including public healthcare from the State, private healthcare from various providers, International groups and community based organizations (CBOs). It will identify the main systems and responses to provide health care.

4.1 Public Health System

When we examine the underlining structure of the health system within Burma, we can see that health related issues and policies have been integrated into the National Health Committee (NHC) since 1989 which, significantly, is under the chairmanship of the SPDC. Within the NHC, the Ministry of Health (MoH) is also included as one of the key policy decision makers. The MoH states it has two main objectives,

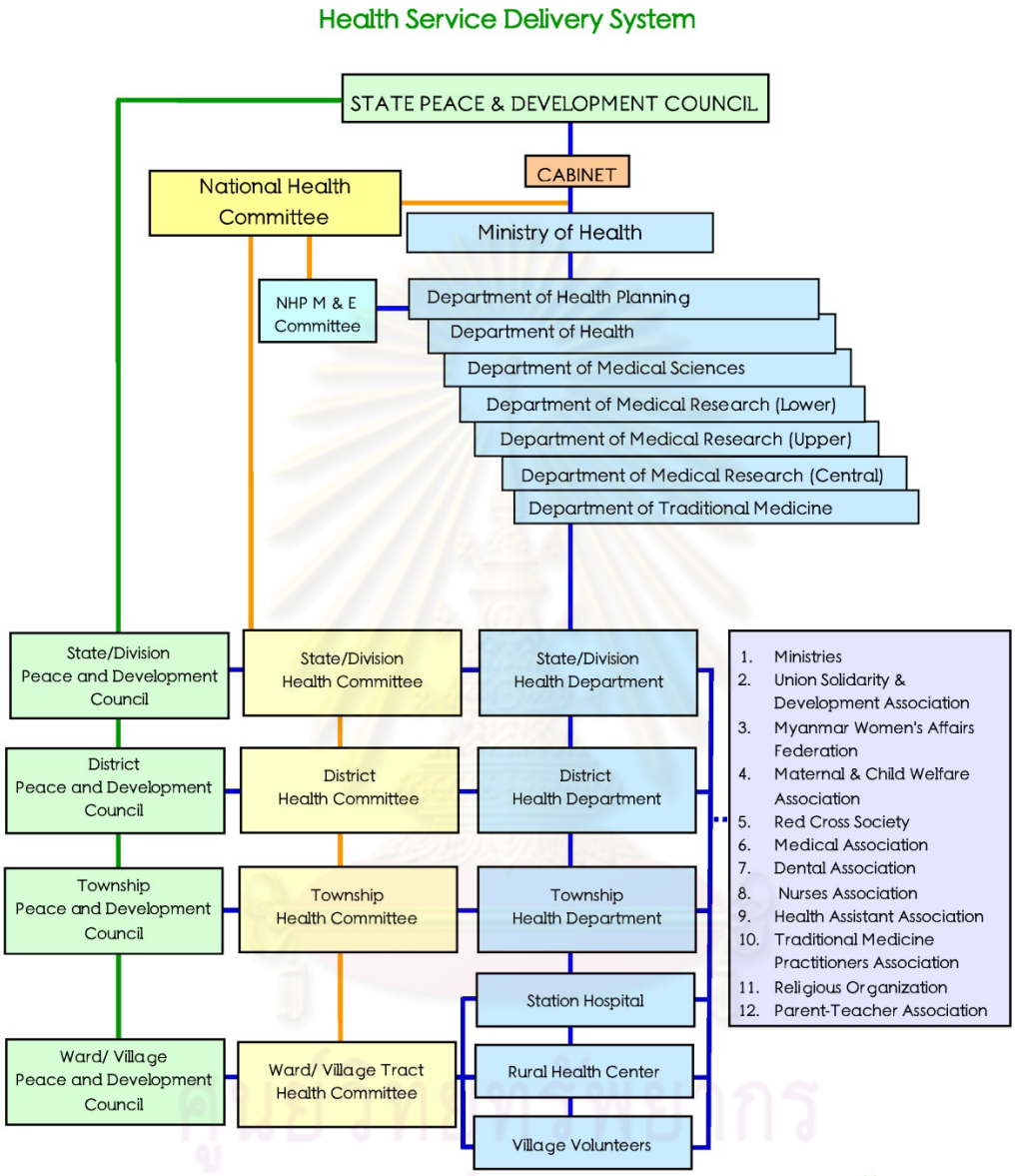
- *"To enable every citizen to attain full life expectancy and enjoy longevity of life.*
- *To ensure that every citizen is free from diseases."*

(Ministry of Health Myanmar, 2010)

The MoH has 7 departments under it to administer healthcare policies including the Department of Health planning. (Ministry of Heath Myanmar, 2009) The MoH follows a Primary Health Care PHC approach which it states to have been implementing since 1978. (Myanmar, 2009: 42)

The overall distribution of healthcare infrastructure in Burma can be categorized into 4 main target locations: state/division, district, township and village levels. March 2009 figures state the total number of public government hospitals in Burma is 846 (820 under MoH and 26 under various other ministries). (Myanmar, 2009: 37)

Figure 6 The Structure of the Health Care Delivery System in Burma 2009



Note: (Myanmar, 2009: 11)

Noting the overall structure of health care delivery system, it is significant that it is extremely centralized through a top down approach. This is due to the NHC being under the chairmanship of the Prime Minister and the SPDC, which are placed at the top of the delivery system. At every level the SPDC are included from the national policies, State/Division, district, township and village. This has resulted in highly centralized decision making and policies which do not address the needs of the people

especially in rural ethnic areas. There is no room for the people who are at the community level to be part of creating the right type of policies which are more appropriate and effective for them. This is further substantiated by the UN Working Group findings during implementation of NHC policies, *"The Government follows a highly centralized system, with central commands that do not adequately take account of people's needs."* (UN Working Group, 1998)

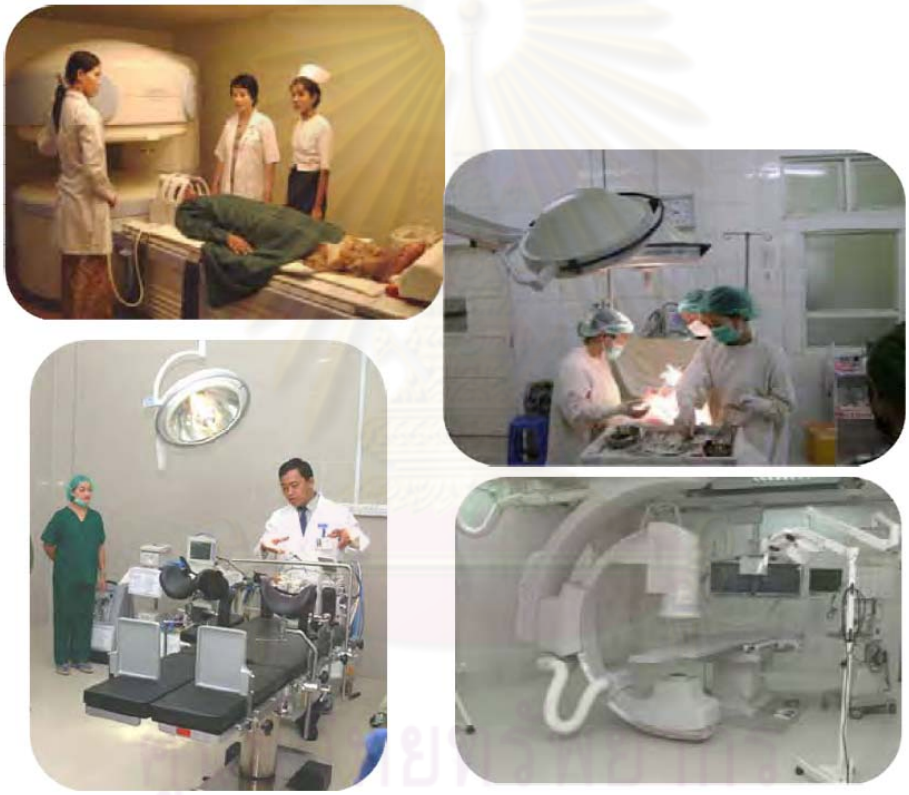
The dire health needs in ethnic areas which are not fundamentally under the direct controlled by the SPDC are often referred to as white areas (under the control of SPDC) brown areas (under limited control by SPDC and ethnic groups) or black areas (under control by opposition armed groups). Often these brown and black areas are in ethnic areas where health care delivery systems for vulnerable civilians are most needed. However, it seems highly unlikely that there will be a substantial shift to focus on the ethnic areas due to the overriding centralized health care delivery system. The MoH view of border regions is thus followed, *"With prevalence of tranquility, law and order in the border regions, social sector development can be expanded throughout the country."* (Myanmar, 2009: 8) How they achieve this prevalence of tranquility, law and order is another question, whether through dialogue, coercion or outright military attacks. The significance of the time when the NHC was created in 1989 also illustrates the era then with the Burmese army controlling the country using extreme martial law measures- 1988 saw the Burmese army brutally massacre thousands of students (Burma Campaign UK, 2010), which was also just before the 1990 elections. During this time it was important for the SPDC to maintain their control on key sectors.

4.1.1 State

At the State level healthcare policy is planned and coordinated through the State/Divisional Health Department who are responsible for, *"State/ Divisional planning, coordination, training and technical support, close supervision, monitoring and evaluation of health services*." (Myanmar, 2009: 34) This centralized health delivery system model diverts funds for example towards the SPDC's new capital

Naypyitaw, which translated as: seat of kings (Pedrosa, 2006), which has completed in 2008 establishing a 1000-bed general hospital aiming to cater for those living in “middle Myanmar.” (Myanmar, 2009: 37) In terms of health care coverage in Burma the MoH policy with SPDC at the head is centered on establishing adequate coverage of hospitals within the rapidly developing socioeconomic zones such as Naypyitaw.

Figure 7 1000-Bed General Hospital in Naypyitaw



Note: (Myanmar, 2009: 37)

It is highly questionable who is benefiting from this kind of general hospital located in the new capital which is inaccessible to the vast majority of the 70 % of Burma’s population who are living in rural areas. Additionally it highlights the lack of genuine participation in the planning and implementation of policies from ethnic groups living in other states and divisions outside Naypyidaw’s Mandalay Division. This only reiterates further the centralized policy and priorities shown by the SPDC.

Therefore there needs to be much more public participation and monitoring of the system to ensure accountability.

4.1.2 Township

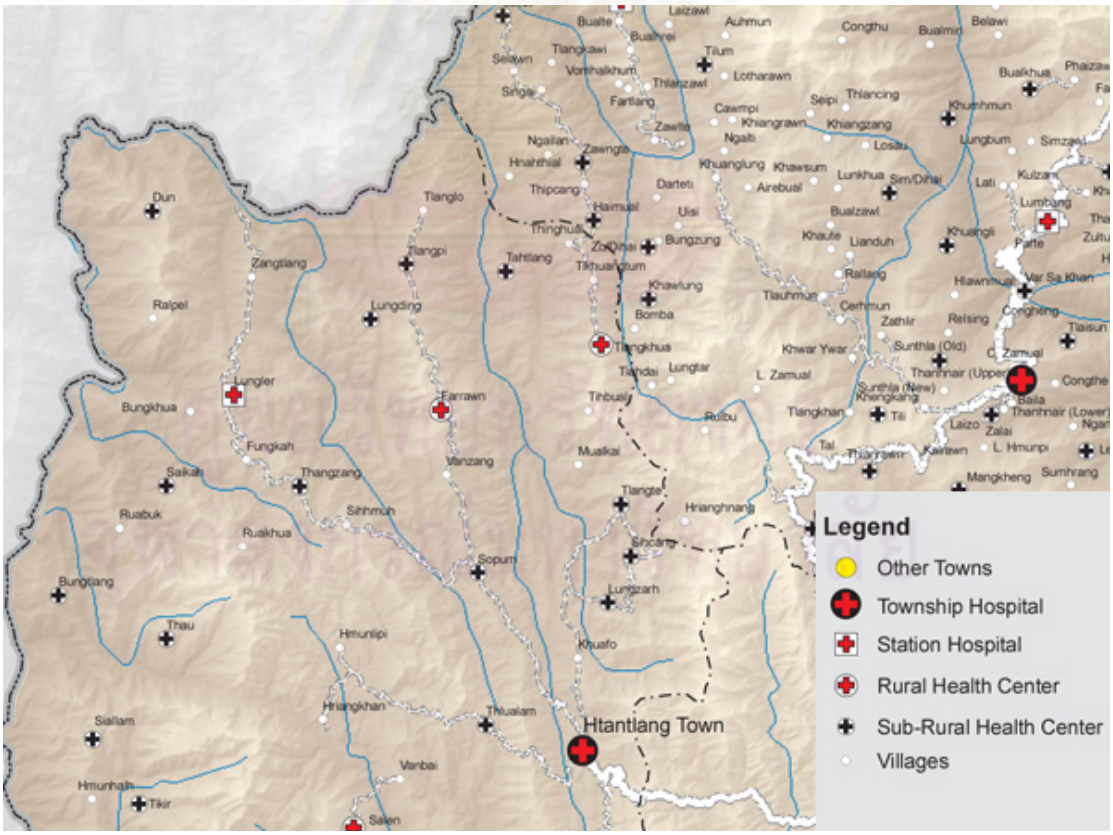
It is from the township level that the actual provisions of health care and implementation of state policies are carried out. Within the township level health care is provided at a township hospital and 1-2 station hospitals. In terms of beds the township hospitals have between 16-50 beds, depending on the size of the population. Rural Health Clinics (RHC) also forms an important part of the delivery of healthcare to the rural populations who fall under the jurisdiction of the township level. There are between 4-7 RHC per township. (Ministry of Health Myanmar, 2010)

In co-ordination with the Ministry for the Development of National Races and Border Area it is claimed that in border areas of Burma, *"since 1989 and up to March of 2009, 100 hospitals, 106 dispensaries, 62 rural health centres and 140 sub-rural health centres have been established and functioning."* (Myanmar, 2009: 38) Unfortunately there is also a disconnection between these types of statements from the Health in Myanmar reports and the reality of established and functioning health services importantly with health personnel. For example, in the year 2000 a sub-rural health center was constructed in Chin State near the research village by the government/villagers, but has been empty for over 10 years, only having a wooden bed and no medicines or personnel to implement any health service. See following figure 8 and figure 9 for more details:

Figure 8 Sub-Rural Health Facility in Chin State

Note: (Author photo, 2009)

Figure 9 Map of Chin State with Health Facilities



Note: (Myanmar Information Management Unit, 2009)

The map shows a cropped section of Chin State with township hospitals, station hospitals, rural health center and sub-rural health center villages. Although there are many sub-rural health centers, and limited Rural Health centers and township hospitals, there is often a lack of health resources and personnel.

4.1.3 Village

With 70% of the population residing in rural areas the MoH policy states, *"Access to health care for 70% of country population residing in rural areas has been improved through the expansion of health manpower in terms of basic health staffs and voluntary health workers, i.e. community health workers and auxiliary midwives."* (Planning, 2009) The term; *voluntary health workers,* needs careful consideration in the context on Burma, firstly due to the method in which volunteers are recruited. Secondly, the extent of training they are provided with and finally, the level of provisions and mechanisms in place to support them when they are working in the field. It is dubious how much positive impact this stated policy of improved health care has had in ethnic areas of Burma which are not directly under control from SPDC.

Moreover, within the policy outlined above the voluntary health workers have also been designated as been responsible for collecting data on health, followed by monthly reporting for monitoring, supervision and mid-year and yearly evaluation. (Planning, 2009) The collection of data is an extremely important element and rightfully should be prioritized within policies in order to ascertain the health needs of the community which will in turn shape future policy decisions, planning and implementation. Yet given the strategy of employing voluntary staff this would be extremely difficult to implement given the limitations of the voluntary CHW and auxiliary midwives trying to meet their own basic family survival needs. For example, having to work a secondary job for basic survival in rice fields limits how sustainable this policy of volunteer CHW and auxiliary midwifes is. If it is not their primary job for survival and with no financial incentives, then there may need to be a review of

the strategy employed to achieve the goals of the national health policy and other initiatives, or more holistically a review of government spending on healthcare.

The challenges of targeting the 70% of rural populations in Burma at the village level are huge as outlined earlier. Currently the MoH has a PHC approach focused on channeling health services through Rural Health Clinics (RHC) targeting the village level. Each RHC can be further subdivided into four sub clinics which are staffed by a midwife and public health supervisor grade 2. It is stated by the MoH that the advantages of having these health personnel directly in the field are they have good knowledge of the community and their needs. However, the reality is that many of the voluntary health workers are under resourced, and have no effective mechanism and provision of medical resources.

At each level of healthcare delivery and implementation are committees, *"These committees at each level are headed by the chairman or responsible person of the organs of power concern and include heads of related government departments and representatives from the social organizations as members."* (Ministry of Health Myanmar, 2010: 2) Reading further into the above extract; responsible person of the organs of power, unfortunately within communities this are usually corrupt military backed officials, who abuse their power and lack any accountability of the implementation of health care related projects.

4.1.4 National Health Policy and Planning

There have been a number of policies set up to implement health care in Burma by the state outlined below:

4.1.4.1 Country Health Program

This was initiated from 1978-82 and outlined official commitment by the state to achieving Health For All goals by the year 2000. The HFA program started from 1978 as part of the Alma-Ata Declaration applies that everyone "*by the year 2000 of a level*

of health care that will permit them to lead a socially and economically productive life." (World Health Organisation, 1978: 1) Within the context of Burma the HFA goals would be carried out through volunteers in communities such as auxiliary midwifes and community health workers, especially recognizing that these groups played an essential role in providing primary health care to remote isolated areas. It was stated that these plans would be reviewed every 4 years. HFA by definition should be focused on health for all not just one particular ethnic group, class, religion or specific location.

4.1.4.2 National Health Policy

As part of National Health Policy from 1993-1996 a National Health Plan (NHP) was set up under the guidance from NHC. Again it focused on achieving HFA goals using PHC approach. One of the stated goals of the NHP was by the year 2000 *"To reduce the infant death rate from 94 to not more than 50 per 1000 live births."* (Education, 2000: 29) Yet more recent figures from 2008 state infant mortality rates are 71 per 1000 live births (UNICEF, 2008), meaning that Burma still has a long way to go to fulfilling basic health needs of its people.

From 1996-2001 and 2001-2006 there has been a continuation of the NHP with 5 year cycles. The Department of Health Planning is responsible for planning the National Health. The National health policy stated, *"Further, the policy envisaged enhancement of border areas and rural health development for all-round development."* (Asia, 2007)

4.1.4.3 Myanmar Health Vision 2030

More holistically within the above national health strategies of the State is integration of these as part of a more long-term approach to healthcare through the establishment of the Health Vision 2030. These more long term plans will be used as a guideline for short term national health plans. The indicators that these plans are based on relate to such matters as infant and under-5 mortality rates. However, the

quoted amounts outlined by the MoH below in figure 10 are inaccurate when compared to UNICEF findings. For example the MoH state that infant mortality rate figures in 2001-2003 was 59.7 per 1000 live births compared with UNICEF figures of a rate of 71 for 2008 as stated previously in the chapter. This clearly demonstrates discrepancies in the quoted MoH mortality rates which are under-representing the true extent of the health crisis which may not account for rural areas.

Figure 10 Myanmar Heath Vision 2030

Indicator	Existing (2001-2002)	2011	2021	2031
Life expectancy at birth	60 – 64	-	-	75 – 80
Infant Mortality Rate/1000 LB	59.7	40	30	22
Under five Mortality Rate/1000 LB	77.77	52	39	29
Maternal Mortality Ratio/1000 LB	2.55	1.7	1.3	0.9

Note: (Myanmar, 2009: 17)

The MoH states, "*Ministry of Health, plays a major role in providing comprehensive healthcare throughout the country including remote and hard to reach border areas*". (MOH 2009: 1) Regretfully this is to a certain extent just rhetoric especially in the claim of comprehensive healthcare to *remote and hard to reach border areas*, which have a continuing health crisis due to the SPDC's military operations and neglect from them in regards to health, education and sanitation. As part of these health policies relating to poverty reduction, such MDG 1 the eradication of extreme poverty and hunger by 2015 is still very much an unrealistic target evidence of which can be clearly demonstrated below:

Figure 11 Malnourished Child

Note: (Author, 2008)

Figure 12 Boy with Worm Infestation

Note: (Author, 2008)

Malnourishment amongst children is a problem relating to food security and also lack of health facilities. In the whole of Chin State there are only 12 hospitals, 56 doctors, and 128 nurses (Chin Development Initiative, 2008) for a population of approximately 500,000. As a sign of the communities' basic needs not being met by the state, very common throughout Chin state is worm infestations which directly affects vulnerable children. In many of the Chin villages there is a lack of basic sanitation such as closed toilets or closed water systems for the community. Through contaminated drinking water and bad hygiene a number of children living in Chin State have worm infestations which can cause severe discomfort, vomiting and weakness that affect a child's growth. Important ways to minimize the potential for infections relate to improving the sanitation of communities such as their toilets and the community's water system. The Environmental Sanitation Division (ESD) assumes responsibility for improving these fundamental needs of a community stating its aims, "*to attain universal coverage of safe water supply and sanitation and to reduce the incidence of water and excreta –related diseases.*" (Myanmar, 2009: 52) The ESD have also been promoting initiatives such as the National Sanitation Week

(NSW) since 1998, and has claimed that sanitation coverage in rural areas amounts to 78%.

Figure 13 Coverage of Urban and Rural Water Supply and Sanitation

Sanitation Coverage	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Rural	39	53	57	56.5	85.3	91.9	90.7	77.9	81.0	80.7	78.0
Urban	65	72	73	83.6	90.4	87.1	88.9	83.5	87.6	92.2	87.4
Union	45	60	62	63.1	86.6	88.4	90.3	82.4	82.7	83.6	80.2

Note: (Myanmar, 2009: 53)

Figure 14 Open Water Source

Note: (Author, 2008)

Without improving this basic infrastructure such as the water source, this leads to other waterborne infections such as cholera and dysentery. Poor sanitation, lack of preventative health education, inadequate footwear and de-worming pills compound the situation. Even with CHW support it will take a long time and involves more than one voluntary CHW. To start tackling the problem, education also needs to be undertaken in the community to make them more aware of some of the precautions they can actively take to minimize the risks of worm infestations- such as cleaning

children's hands before eating, wearing footwear outside or going to the toilet in designated places. This involves multi-disciplinary approach including CHW, community, local NGO'S and the appropriate authorities.

Figure 15 Chin Women with Goiter

Note: (Author, 2009)

Goiter is one of the conditions which affect many of the ethnic groups in Burma, especially women in Chin State. It is caused by a lack of iodized salt, which is not readily available in isolated rural areas. Within the PHC approach also involves not only local CHW and local communities but also the involvement of businesses, for example within Burma there are over 130 iodized salt companies licensed to produce iodized salt. This could directly improve and reduce the occurrence of goiter in mountainous regions if appropriate logistics are worked out in regard to storing and transporting supplies. The MoH has stated it has initiated an iodine deficiency disorders control programme in 1968, yet 40 years later in Chin state there is a lack of basic infrastructure and implementation of outreach iodine control programs to these areas.

4.1.4.4 Responding to Natural Disasters

One of the main responsibilities of the NHC is in responding adequately to natural disasters. In regards to the devastating Cyclone Nargis in 2008 they state that, *"Under the leadership of the Head of State and with collaborative and coordinated efforts of the international and national organizations, adequate health care could be provided for the victims and disease out breaks could be prevented. The emergency relief, rehabilitation and reconstruction tasks were smooth and successful."*
(Ministry of Health Myanmar, 2010: 3)

Figure 16 Supplies for Nargis Cyclone victims Red Cross warehouse, Rangoon

Note: (Author, May 2008)

However in reality even after over 2 weeks following the cyclone hit, the above photos depict a Red Cross supply warehouse, loaded with emergency relief supplies such as water purifying machines, shelter kits and medicines. Red Cross workers are unable to deliver the supplies due to being refused permission by the authorities to take much needed emergency relief equipment inside to affected areas. This a clear indication of how the current NHC is ineffective with the restrictions imposed by the SPDC who control every level of the health delivery system. The consequences of this are that the general population receives limited or no emergency relief assistance and much needed medical attention.

4.1.4.5 Monitoring

There is a critical question over who is monitoring the effectiveness, accountability and transparency of the NHC and its activities. The MoH states, *"For the monitoring and evaluation purpose, National Health Plan Monitoring and Evaluation Committee has been formed at the central level. Built-in monitoring and evaluation process is undertaken at State/Division and Township level on a regular basis."* (Myanmar, 2009: 14) Yet with this built-in monitoring and evaluation process the questions must be asked: how transparent is it and does it meet international standards of accountability and transparency such as the previous mentioned Transparency International where Burma ranks so poorly 178 out of 180 countries (Transparency International, 2009)

4.1.4.6 Health Personnel

Figure 17 below highlights the total number of health personnel within Burma who are servicing in public sector or co-operative private. It is important to see the trend of co-operative and private figures which are vastly outnumbering public, for example in the total number of provisional doctors for 2008-2009 figures, co-operative private outnumber by approximately 30% the public service doctors. An analysis further down the list of who is responsible for targeting over 70% of the population through PHC approach to rural areas falls on the responsibility of midwives, lady health visitors and health assistants which combined account for 23,612 for 2008-2009. The main problem is these 3 types of health personnel represent 31% of the total number of health personnel in the entire country, yet are having to work voluntarily.

Figure 17 Health Personnel in Burma

Health Manpower	1988-89	2004-05	2005-06	2006-07	2007-08	2008-09*
Total No. of Doctors	12268	17564	18584	20501	21799	23709
- Public	4377	6473	6941	7250	7976	9593
- Co-operative & Private	7891	11091	11643	13251	13823	14116
Dental Surgeon	857	1365	1594	1732	1867	2305
- Public	328	580	625	707	793	777
- Co-operative & Private	529	785	969	1025	1074	1528
Nurses	8349	18123	19776	21075	22027	22881
Dental Nurses	96	159	162	165	177	244
Health Assistants	1238	1771	1771	1778	1788	1822
Lady Health Visitors	1557	2796	3025	3137	3197	3247
Midwives	8121	16201	16745	17703	18098	18543
Health Supervisor (1)	487	529	529	529	529	529
Health Supervisor (2)	674	1339	1359	1394	1444	1484
Traditional Medicine Practitioners	290	819	819	889	945	950

* *Provisional actual*

Note: (Myanmar, 2009: 2)

4.1.4.7 Training of Health Personnel

Under the MoH, the Department of Medical Science is responsible for training and technical support of health services, "*for training and producing all categories of human resources for health in accordance with the needs of the country.*" (Myanmar, 2009: 80) There are 14 medical and health related universities within Burma in addition to 46 nursing and midwifery and related training schools across the country. (Ministry of Health Myanmar, 2010) Statistics released by the MoH state that such universities and training schools enrollment levels are annually:

Figure 18 Health Related Higher Education Student Numbers

University/ Training School	No. of Intake each Year
University of Medicine	2400
University of Dental Medicine	300
University of Pharmacy	300
University of Medical technology	300
University of Nursing	300
University of Community Health	180
Nursing Training Schools	1200
Midwifery Training Schools	1050

Note: (Myanmar, 2009: 90)

It is difficult to obtain specific data such as an ethnic breakdown of these students or how many of them go to ethnic areas after completing their study and if so for how long. The lack of health facilities in medical universities, the quality of the curriculum, laboratory facilities and equipment do not meet the minimum standards to learn about diseases and treatment procedures. This lack of investment has inadvertently compounded the dire health situation. Moreover, the SPDC military are extremely suspicious of any international and domestic organizations offering help even relating to soft sectors such as education and health sectors, as they perceive them as sectors which could be used as a way to mobilize people and challenge the state through the establishment of institutions. Evidence of this is the fact that 12 of the 14 medical universities are located within Rangoon and Mandalay with the remaining 2 in another central area of Burma, revealing the lack of willingness from SPDC to expand higher education programs to the other 7 ethnic states. The impact of this on the population results in health conditions in ethnic areas deteriorating. Another problem is accessing higher education in these urban areas as ethnic groups from rural areas of Burma may not have the qualifications, finances or resources needed to gaining access to these higher education facilities in central areas of Burma. In Chin state there are no universities for a population of approximately 500,000 inside Chin state. (Chin Development Initiative, 2008)

Figure 19 Chin Primary School Teacher Figure 20 Primary School Students

Source: Chin Civil Society 2008 Source: Author 2009

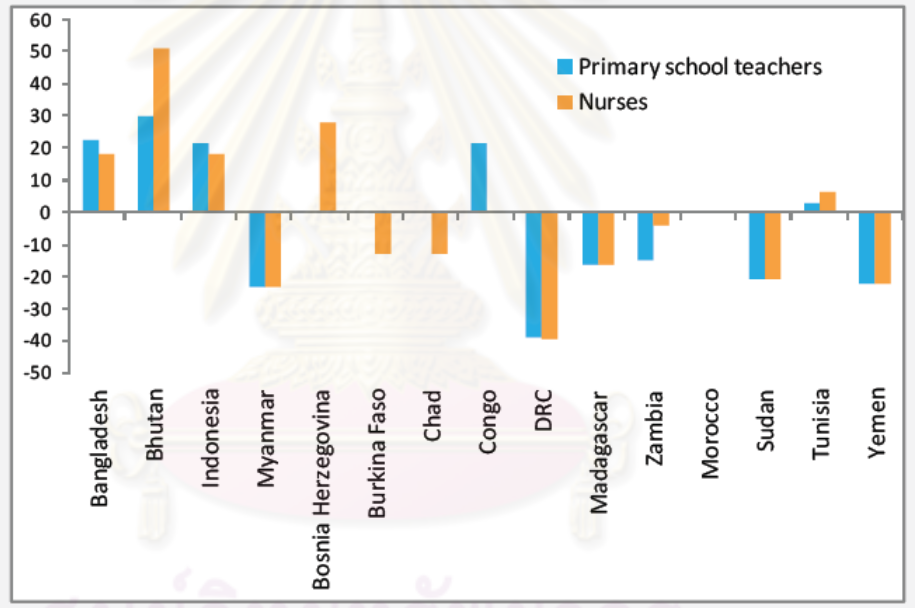
Primary school teaching is the foundation platform in nurturing the next generations of potential public sector personnel such as teachers, doctors and nurses. In the above photos one depicts a primary school teacher in Chin state who has to teach with her child on her back demonstrating the hardship of the state's neglect in the public sector. In the corresponding photo students wait patiently for their teacher who is having to teach 4 classes separately singlehandedly. This contrasts with what the MoH states, "*Expenditure for health and education have risen considerably, equity and access to education and health and social services have been ensured all over the country.*" (Myanmar, 2009: 8) Yet clearly this is not the case with under resourced and underfunded services which will affect the potential pool of future health personnel from ethnic areas.

4.1.4.8 Health Personnel, Retention and Salaries

One of the major challenges facing the operation of public health care services is retaining trained health personnel in the public sector, predominately due to low salaries being paid. In Burma with basic commodity prices increasing and inflation being high, such foodstuffs as rice which is so fundamental to daily survival has dramatically increased in price. During the recent global financial crisis, across

Burma rice prices increased over 14% in less than 1 week from 22,000 kyat to 25,000 kyat (US $19.80-$22.50) for a 38 kg bag. (Irrawaddy, 2008) Further evidence of the dire lack of sufficient salaries given to nurses and primary school teachers is highlighted in the below chart which depicts various countries including Burma between the 2007-2009 period. It states the estimated changes in annual salaries within Burma have actually decreased in real terms by up to 40% resulting in nurse's purchasing power being lower for buying basic food and the added impact of an increase in commodity prices only exasperates the situation.

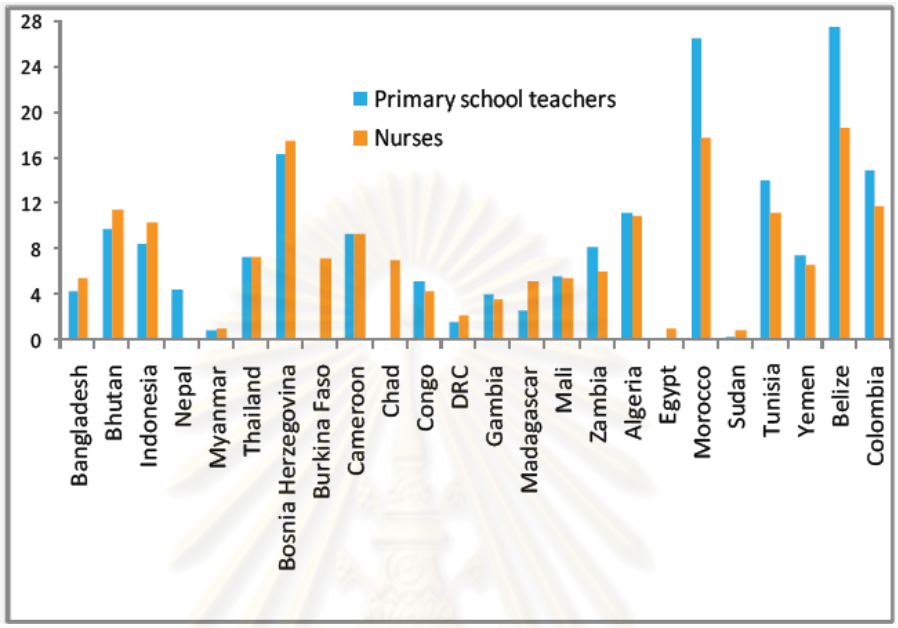
Figure 21 Estimated Changes in Annual Salaries, 2007-2009



Note: (UNICEF, 2010: 3)

The consequences of the misallocation of state budgets are that many health personnel in the public sector have little alternative but to start charging informal fees, supplement their income with an additional livelihood or seek work in the private sector. Moreover this can lead to school teachers having to informally charge pupils. This particularly impacts rural and high poverty areas such as Chin State, where there is a lack of infrastructure and frontline health and education personal are essential to delivering worthwhile services to communities.

Figure 22 Annual Salaries Compared to $2 A Day Poverty Line, PPP adjusted, 2009 or Latest



Note: (UNICEF, 2010: 3)

The above chart highlights further the lack of sufficient salary for trained nurses and school teachers in Burma's position within the region of the $2 poverty line. When compared to other countries such as Thailand, Bangladesh or even the Democratic Republic of Congo, Burma's salaries are dramatically less.

4.1.4.9 Challenges

In the health policy plan and legislation the MoH identified its key country's health problems, including, "*Need for improvement in rural health care coverage and public health services. Persistence of maternal, infant and child mortality that needs further reduction*" (Myanmar, 2009: 6) While it is constructive that these problems have been identified, under the current delivery mechanism of the NHC which is controlled at all levels by the SPDC's own agenda and policies there does not seem to be a substantial opening for addressing the much needed rural health care coverage.

4.2 Private

Since the 1962 military coup and the establishment of the Burmese Way to Socialism, the one party state prohibited private hospitals with only general clinics permitted to operate officially in what could be defined as the private sector. With the sub-standard healthcare service offered by the public health sector, many of the unofficial private hospitals were effectively operating underground in a grey area with a temporary license. In 2007 a new law was established entitled Private Health Care Services in which private hospitals would be regulated in accordance with this new law. This has allowed private healthcare to operate legally and is monitored by the Central Private Healthcare Department. With the provision of this new law the MoH states that private practitioners now have the opportunity to update and exchange with fellow practitioners. While this could be seen as a positive step in creating set standards and legal legitimacy for hospitals and clinics to run, in the context of the lead-up to the 2010 elections the SPDC are also issuing licenses to private hospitals and clinics in the health sectors. Additionally the main target areas of private healthcare services are in more urban areas such as Rangoon, Mandalay and larger cities. In the 2008-2009 provisional figures the MoH state that there are 14, 116 cooperative-private doctors as compared to 9,593 public doctors. It is difficult to quote a figure for the number of private facilities, but in the former capital Rangoon there are over 50 private hospitals, 300 special healthcare centers and over 1,800 clinics operating. (People's Daily Beijing, 2009) However with the vast majority of ordinary citizens living below the poverty line and public health access limited, it is questionable if they will indeed see any of the health benefits that the MoH is so keen to public state in their material.

4.3 UN, NGO, INGO Responses to Health

Organizations such as the UN, INGO’S and NGO are wanting to implement socio-economic development projects in Burma have to obtain a MoU or agreement. The stated objectives of the MoU are:

- To enhance and safeguard the national interest
- To prevent the infringement of the sovereignty of the State
- To cooperate without any string to the State (Development, 2006: 3)

Included in the MoU's are guidelines on coordination, project implementation, opening and registration of field offices, appointments of field staff, internal travel, management and equipment purchases, coordination at the States, Divisions and townships levels. (Development, 2006: 3) Moreover the MoU's have to be signed by the Ministry of National Planning and Economic Development (MNPED) or a similar ministry dependent on the type of project. With the MoU's stated objectives and guidelines outlined above this clearly demonstrates that the SPDC and implementing ministries are focused on restricting organizations involvement in developing the general population.

For example, the restrictions and impairments by MoU's have also affected access to basic heath of over 1200 political prisoners inside numerous prisons in Burma. The International Committee of the Red Cross (ICRC), the only international agency that has managed to gain access to Burma's political prisoners, suspended their visits to prisons due to strict supervision by the SPDC. This is a tactic used by SPDC to increase the hardships on political dissent by poor conditions for prisoners and will also impact upon potential resistance in the future from potential opposition groups. It also sent a clear message to international NGO's that SPDC are in control and "national security issues" will always take a higher priority over humanitarian interventions, with them trying to control information.

4.3.1 Global Fund Initiative

According to WHO's millennium assessments on health care systems, Burma ranked 190th out of 191 Nations in 2000. (World Health Organisation, 2000: 163) With the huge need to tackle the major diseases affecting the public health crisis in Burma, in 2004, a Global Fund initiative was launched to combat AIDS, TB and Malaria through UN agencies, INGO's and NGO's. Its allocated budget was US$ 98.4

million over a 5 year period. (Fund, 2005) The decision was made because in Burma malaria caused morbidity and mortality, epidemics of TB were uncontrollably fast and the spread of HIV/AIDS was severe. However, later the Global Fund faced a difficult dilemma to put additional safeguards to their Burma grants as the United Nations Secretary General Kofi Annan raised concerns about human rights violations by the SPDC and restrictions set out by the junta on humanitarian agencies working inside Burma. With little success in negotiating on the performances and implementation of the grants between the Global Fund and the SPDC, the Global Fund announced its termination of the grants on 18 August 2005. This was due to the grants not been implemented effectively under restrictions such as travelling to affected areas, *"The Global Fund has now concluded that the grants cannot be implemented in a way that ensures effective programme implementation."* (Fund, 2005)

The withdrawal of the Global Fund dealt a severe blow to patients and implementing staff on the ground, who needed vital support. Yet at the same time the operations of these groups had been compromised to breaking point, that is was felt that withdrawal was regrettably the only temporary solution - this highlights again the restrictions of the NHC under the control of the SPDC

4.3.2 3 Disease Fund

With these regulations and restriction imposed by the SPDC it has been difficult to strategize the best tactics to approach Burma's health crises. As has been documented, some of the major donors have pulled out. After Global Fund's withdrawal, the executive director of World Food Programme (WFP) also visited Burma/Myanmar. (BBC, 2005) During his visit, he called upon the relaxation of the SPDC on their policies on health and other humanitarian services. The WFP reported that one in three Burmese children was chronically malnourished or stunted, and that 15% of the 2005 population of 53 million was food-insecure. (WFP, 2005)

During this time the European Commission called to increase humanitarian aid to Burma, with the establishment of the 3-disease fund (3DF) in October 2006 in the

wake of the termination of the Global Fund aimed again to target a reduction in mortality and morbidity rates relating to HIV/AIDS, TB and malaria. This was while maintaining that no money should go through the military and restrictions should not be in place. To ensure this monitoring is provided through WHO, UNAIDS and UNFPA. It is a 5 year program and allocates a budget of approximately $100 million. The fund has 31 implementing partners including international NGO's, MoH in Burma and local partners to reach remote areas of Burma. Relating to the current HIV/AIDS program during the first six months of 2009, 144,255 beneficiaries from the highest priority groups have been able to get treatment for HIV/AIDS. (3dfund, 2009)

4.3.3 Organizations Operating in Chin State

Currently there are officially 12 organizations working in Chin state focusing on health. (Unit, 2010) The below figure 23 highlights the specific activities that the various organizations are carrying out with many of them focused on combating malaria, HIVAIDS and TB with many of the organizations receiving funds from the 3Df amongst other donors. Other areas include women's health such as reproductive health care and child health. The coordinating body of NGO activities within Chin State is being handled by the UN office OCHA (Office for the Coordination of Humanitarian Affairs) which is also pushing indirectly with the SPDC in Chin state for a relaxation of restrictions in terms of local authorities and line departments. Yet given the current context prior to elections, the next steps is likely to take place after the November elections.

Figure 23 Who, What and Where in Chin State Health June 2010

Sector	Sub Sector	Organisation	Township								
			Falam	Hakha	Htantlang	Kanpetlet	Madupi	Mindat	Paletwa	Tiddim	Tonzang
Health	Basic Health Care	CARE								■	
		Merlin			■						
	Community Home Based Care	CARE								■	
	Control of Communicable Diseases	CARE	■			■		■		■	
		PSI		■	■		■				
	Health Assessment	CARE				■					
	Health Education	CARE	■	■		■	■	■		■	
		PSI	■	■	■	■	■	■	■	■	■
		UNDP		■	■	■	■	■			
	HIV/AIDS Prevention and Control	MCC	■								
		MoH		■							
		PSI	■	■	■	■	■	■		■	
		UNDP						■			
	Malaria Prevention and Control	CARE	■			■		■		■	
		MCC	■								
		Merlin		■	■						
		PSI	■	■	■	■	■	■	■	■	■
		WHO	■	■						■	
		WV								■	
Health	Reproductive Health Care	CARE								■	
		PSI		■						■	
		UNFPA	■	■							
	Revitalization of existing HS - Infrastructure	UNDP	■		■					■	
	Revitalization of existing HS- Equipment&Supplies	iLM	■								
		UNDP						■			
	TB surveillance and programs	CARE	■			■		■		■	
	Women and Child Health	Merlin			■						
		UNICEF	■	■	■	■	■	■	■	■	■
	Not Specified	IRC							■		
		UNDP	■	■	■		■		■	■	■
		WV								■	

Note: (Unit, 2010)

4.4 CBOs Policy and Response to Health

4.4.1 Community Based Approaches

While it is important to not totally dismiss the information and services provided by MoH and International organizations focusing on the health situation in Burma, it is important to recognize the limitations and constraints of the information gathered from these sources particularly in accessing the neediest in remote areas or operating restrictions under the MoU. Within Chin State there are a number of Community Based Organizations (CBO's) from the India-Burmese border operating which focus on capacity building programs within communities such as women empowerment, health and sanitation. They are also an important tool which can monitor the checks and balances of NGO's, INGO's who may not be able to monitor effectively the implementation of projects under the MoU's from the SPDC.

4.4.2 Programs and Services

A comparison of the most common health care needs on the Thai-Burmese border focus on the most commonly treated illnesses such as acute respiratory inflections, malaria and anemia. Within ethnic areas there is a chronic emergency developing with approximately 12% of the population infected with the worse strain of malaria at any given time and 15% of children suffer at least mild malnutrition levels. (Back Pack Health Working Team, 2006: 13) CBO's health projects based along the borders focusing on maternal health care in ethnic areas, which is a pilot project focusing on community based approaches to maternal health entitled: MOM (Mobile Obstetrics Medics) *"The MOM Project's focus on task-shifting, capacity building, and empowerment at the community level might serve as a model approach for similarly constrained settings."* (PLOS Medicine, 2010: 2) Fundamentally it is a mechanism which seeks to directly go to communities proactively in inaccessible and potentially volatile situations.

Therefore in Burma's rural ethnic areas, it is apparent that cross-border back-pack programs are more effective to combat these health problems, as Chin, Karen, Shan and Kachin States back-pack health workers have been mobilizing and provide basic health training programs, health education, health assistance and data collection. Within Chin State there are also a number of small CBO's providing limited backpack medic support to areas of Chin state located along the border. However from a public health perspective, the health of the country needs to be addressed from both a local and also a national level with a proper public health policy. Yet unfortunately this is currently unviable, given the current political turmoil with restrictions in place and the SPDC actually causing ethnic conflict.

4.4.3 Documentation and Advocacy

Various CBO's focus on human rights abuses perpetrated by the SPDC which affects the communities daily lives. The CBO's can also be used as a tool to monitor relief and development projects by INGO's, NGO's and the state. For example in

Chin State, Food For Work (FFW) programs have been initiated through implementing partners under the World Food Program. In an attempt to help alleviate poverty in communities in Chin state which have been experiencing a food crisis and lack basic infrastructure such as road, these implementing partners have provided FFW. However in certain cases this has inadvertently caused the use of child labour. This is one of the major concerns with no proper monitoring in place to minimize potential negative consequences by well intended international donors. With abject poverty, families who are already having to work long hours in rice fields to barely meet their basic needs have little alternative but to send their own young children on road construction projects instead of going to school.

Figure 24 Child Labour during Food For Work Programs

Note: (Chin CBO, May 2009)

CHAPTER V

RESEARCH FINDINGS AND ANALYSIS ON THE HEALTH CARE NEEDS OF CHIN WOMEN

Field research was undertaken in order to validate the arguments presented in this thesis, which focus on the State's failure to meet the basic health needs of women in ethnic areas due to; a misallocation of national budgets focusing on increased militarization in ethnic areas, combined with underdevelopment creating logistical constraints of reaching remote isolate areas. This deliberate prolonged militarization seeks to keep ethnic groups such as the Chin at the margins, making it easier for the military to maintain control over the population.

In order to justify the various aspects of reproductive health covered in this chapter, key internationally recognized essential elements of an effective women's reproductive health service include ensuring a trained birth attendant is present during delivery, use of sterilized equipment and also an effective postnatal care system. They will be assessed in comparison to international standards such as the Millennium Development Goal relating to reducing infant/under 5 mortality and improving maternal health.

This field research focuses specifically on village X located in Mizoram State, India less than 4 miles from Chin State, Burma. Initial information gathered from the village head during the field research period revealed that as of July 2010 the village has over 50 households and a population of approximately 210, of which approximately 45 households have migrated from Chin State, Burma since the 1990's.

Some of the most insightful research findings were found during formal, informal interviews and group discussions. A total of 25 formal interviews were conducted during the field research period with approximately 10 days spent in the actual case study village. A total of 20 of the interviewees were mothers who were

either expecting or had already given birth before. Their interviews highlighted the challenges and local coping mechanisms related to reproductive health. Out of the 20 mothers interviewed 4 were born in Mizoram State from 3 different villages in addition to 16 of the mothers born in Chin State, Burma from 7 different villages. They have all migrated to the case study village for a number of reasons such as; a lack of development, human rights abuses, marriage or having land within the village. Additionally there were also a total of 4 ABC clinic nurses from Burma interviewed and their testimonies helped to provide rich personal insights into the background motivation into becoming involved in providing health care. Lastly 1 Traditional Birth Attendant (TBA) with over 32 years experience was invaluable in providing detailed midwifery experience and a more holistic view of the health situation.

Each of the interviewees quoted has remained anonymous for security reasons and is denoted by an interviewee number followed by type e.g. Interview 1 mother, additionally location names have been altered and are denoted by a letter and xxx e.g. Lxxx. Importantly while a large proportion on the key findings have been included either in the overall survey data or interviews, not all of the interviews have been included. This was due to some of the interviewee's testimonies being similarly repeated by other interviewees. The survey data and interviews have been presented and categorized into various topics and subtopics which also include an analysis which became apparent during the interviews. While some of the in-depth-interviews overlap into more than one category, an attempt has been made to present these in a logical manner and not break the flow of the interviews.

5.1 Reproductive Healthcare along the India-Burma Border

As testament to the overall reproductive health situation in Chin state is the following interview with the experienced TBA,

"We are very poor in Chin state and the mountainous area, so when a pregnant mother comes to me I know how many months pregnant they are and how big the baby should be, yet many mothers simply have a lack of vitamins. I want to

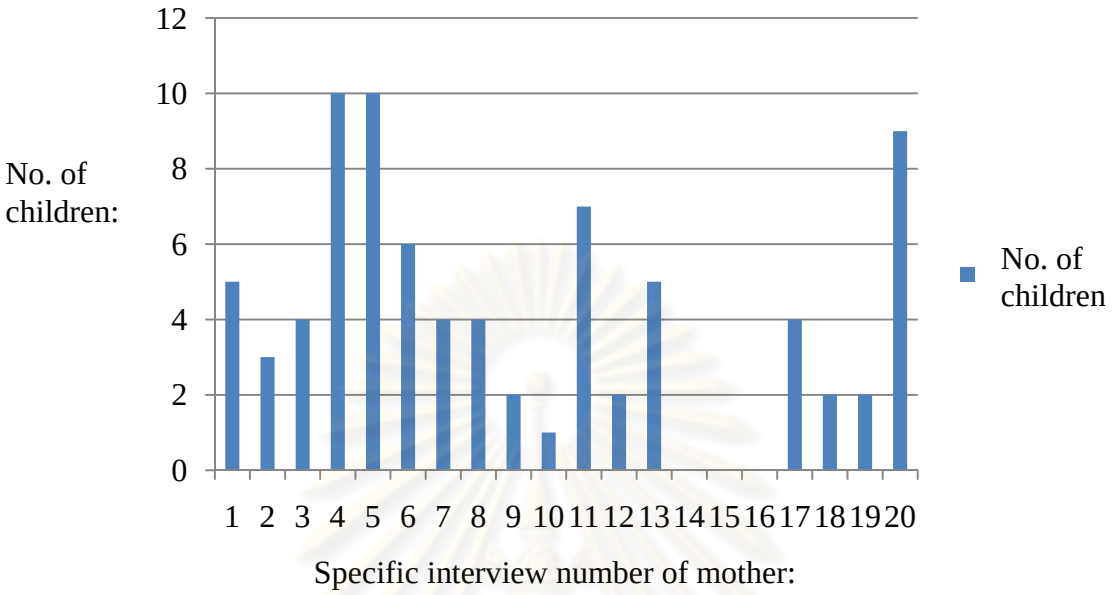
give them, but I cannot provide them freely. With that lack of vitamins and lack of nutrition some babies are born with health problems. Over time when I touch a pregnant mother's stomach I know if the baby is healthy or not."
(Interview 25 Traditional Birth Attendant, 2010)

Chin state lacks adequate healthcare facilities and basic nutrition during the important prenatal period of a mother's pregnancy; this can severely affect the development of a newborn and increase the likelihood of an unhealthy new born baby with the higher potential of being vulnerable to diseases. Information gathered during interviewing the 20 mothers revealed that the total number of children born was 80, excluding currently 6 pregnant women. Note this number does not include miscarriages.

Figure 25 Pregnant Women Visit ABC Clinic for Prenatal Check-up

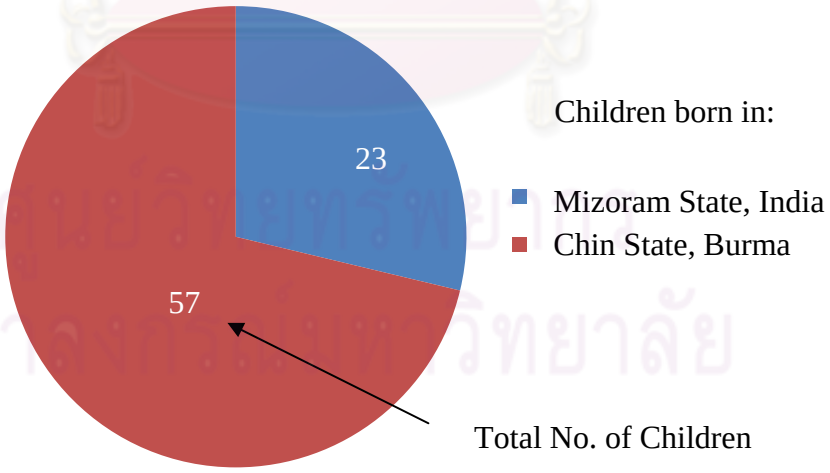
Note: (Author, July 2010)

Figure 26 Number of Children Per Mother Interviewed



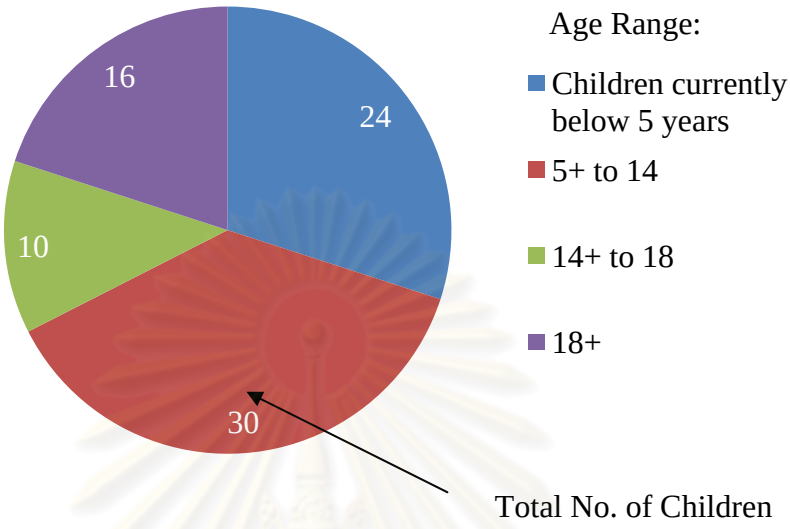
Note: (Author, July 2010)

Figure 27 Number of Children Born in India and Burma



Note: (Author, July 2010)

Figure 28 Current Age Range of Mother's Children



Note: (Author, July 2010)

Within the number of children born the current number of high risk children below 5 years amounts to 30%. A clear indication of the health care situation is the fact that out of the 16 mothers interviewed from the 7 villages in Chin State, Burma, 100% of them stated that there were no regular health care facilities in their native village. Necessities such as the following were lacking: a clinic, medicine, nurse, doctor, or even a basic first aid kit. The consequence of this is that mothers have to travel to other villages or a larger town to receive health care. Due to a chronic shortage of investment in health care in Chin State, this is often the impetus behind why some the current ABC nurses wanted to become involved in health care, as highlighted in the following interviews with the current ABC nurses,

Case 1:

"The main reason why I wanted to become a medical person is due to my mother's death. My mother died of womb cancer when I was 13 years old. I kept asking questions to myself why my mother had such cancer. I kept thinking the cause of the problem and what could have been done to save her life? I have a goal now to

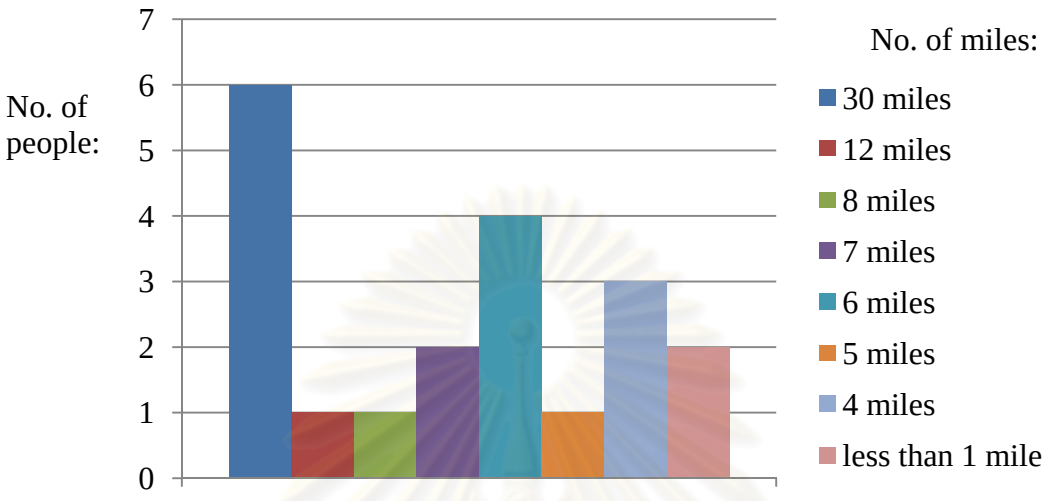
become a surgeon specializing on women's reproductive health." (Interview 21 ABC Nurse, 2010)

Case 2:

"When I was a little girl, one man from our village died of some serious sickness. The villagers mourned that he could have been saved if there was a hospital or a medical person. I cried a lot even though he was not our relative. I felt so sad that someone had to lose their life just because they are poor or there is no access to health care facilities. Now I am determined to become a medic and contribute to my community. I want to study further on women's health since these problems are the most common ones in our community." (Interview 22 ABC Nurse, 2010)

The Chin villages are extremely isolated and up to 10 miles apart from one village to the next. In terms of the nearest healthcare facility this can be much further for many of these villages. From the 20 mothers interviewed the distance villagers have to travel from their native villages in Chin State or Mizoram State to the nearest health facility with appropriate health care personal such as a trained nurse or doctor varied considerably.

Figure 29 Distance to the Nearest Healthcare Facility in Chin State



Note: (Author, July 2010)

For 2 of the interviewees their native villages in Mizoram state had medical facilities so therefore the distance they had to travel to seek medical treatment was less than 1 mile. For others mothers 30% had to travel over 30 miles to the township hospital to seek medical treatment for more serious conditions. The long distance along narrow footpaths in mountainous terrain can be extremely difficult especially if the villagers themselves are sick,

Mother aged 35 with 5 children:

"If any of my family members became ill we would go to Lxxx (7 miles away in Chin State) to buy medicines, treat ourselves or see a nurse. We would have to walk in the morning and come back in the evening. During the rainy season it was a lot more difficult. Sometimes if traders came to our village they would sell us medicine." (Interview 1 mother, 2010)

Mother aged 35 with 4 children:

"Even in the rainy season we had to travel to get medicines or get someone such as a traders to buy for us. In the worst case scenario we had to carry the sick to the nearest health facility." (Interview 3 mother, 2010)

Mother aged 30 with 6 children:

"Previously in the past I bought such things as paracetamol or vitamins from travelling traders at a higher cost. There is no fixed price and their service is not regular." (Interview 6 mother, 2010)

Although traders to a certain extent offer a legitimate service to remote villages providing them with much needed medicines, it also opens up the possibility of exploitation of the villagers who given the limited opportunity of any health care are faced with little alternative but to buy medicines at inflated prices. It also became apparent during interviews that occasionally these medicines would be substandard in quality or out of date. The most concerning limitation of this kind of service is the trader's themselves who have inadequate health knowledge and subsequently often cannot provide a comprehensive diagnosis of a villager's condition and appropriate prescription. Therefore it could potentially be more damaging to a sick patient if an incorrect medicine is prescribed only to compound further the health problems of the sick person. This clearly throws a light on the gap of the lack of health care personnel in the region. As mentioned in Chapter 2 PHC approach centers on looking more holistically at the root causes of health problems rather than solely on the immediate health care needs, therefore sometimes medicines are at best only a short-term solution.

5.1.1 Government Nurses

There is a distinct lack of regular government nurses providing health care in the region. Out of all of the 16 mothers from the 7 villages in Chin State they reported that there were no regular government nurses who came to their village or the neighboring villages. One of the main problems is that; if government nurses are sent to rural areas of Chin State, there is a policy of sending government nurses who are predominately from urban areas of Burma. Often they cannot speak the local Chin dialects of the area or are not accustomed to the challenging living conditions, so creating further potential barriers between the local community and the government nurse. The TBA for the area highlights further this issue,

"The previous nurses in Burma never stay long in the villages; they cannot survive or eat our food." (Interview 25 Traditional Birth Attendant, 2010)

As a sign of the desperate health situation and needs of communities to have some form of health care; in the past communities collected money to take to the local health department to try and pay for a government nurse to come to the village as cited in the following,

"When I was young the government sent a nurse to our village, however it was only temporary and she left shortly afterwards. Then our village council collected 2000 kyat from each household and went to the Chin State Health Department office in Falam and asked to send another nurse, but they did not send one. We kept asking and giving money, but no nurse has been sent until now. In Burma, nurses and doctors care more about money instead of the patients. It is very painful to see this." (Interview 22 ABC Nurse, 2010)

These testimony contrasts with what the MoH report on its outreach border programs relating to health, *"The services are free and other costs for outreach services were borne by NGOs and other individual donors."* (Myanmar, 2009, p. 38) Sadly reading the finer details from this statement, in this case of *other individual*

donors; these are the marginalized communities who are contributing and yet receive nothing in return. The underlining reasons behind this are due to low government salaries in the public health system, and often nurses and doctors are left with little alternative, but to focus on the private sector. This comes at the expense of the vast majority of the population in Chin State, who do not have the capital to obtain these services. Also worryingly is the fact that some of the government nurses are stationed in remote areas which are in themselves already challenging, yet compounding further to the health problems is the lack of sufficient health knowledge and practical experience.

"One mother from Ixxx village before they came to me they went to one nurse and the nurse injected an IV for one labour to speed up the labour. But it didn't work and the mother didn't deliver the baby so in the end they came to me. I was scared due to the injection if something could go wrong so I advised them to go to a better hospital and the mother and baby were fine." (Interview 25 Traditional Birth Attendant, 2010)

Another concern is that government nurses are sometimes inconsistent with their duties and are absent from hospital. This could be partially due to the lack of investment by the government which is overstretching an already limited workforce or relating to the misfit policy of recruiting urban nurses to be stationed in rural areas. The potential negative impact this could have especially for expecting mothers who have to travel extremely long distances on foot to seek medical attention is highlighted below,

Mother aged 29 with 5 children:

"During one of my pregnancies I had typhoid and got help from Mxxx (6 miles away) from my village in a private clinic. In Lxxx (8miles away) they have larger health facilities, the problem is the nurses are not regular and I have walked there before, but no nurses were there." (Interview 7 mother, 2010)

5.1.2 Immunizations

The one area which 44% (7 of the 16 mother interviewees) from Burma said that the Burmese state was assisting to a certain extent was relating to a limited immunization program. These mothers stated that their children received one or more immunizations such as measles or polio for free whilst living in Burma. When families have come to Mizoram, India similarly there is an immunization program focusing on measles and polio. 16 of the 20 mothers interviewed (80%) now residing in India said their families had had immunizations once in India provided freely.

Mother aged 35 with 5 children:

"I received immunizations for 3 of my children from the Mizoram government 2 times such as measles (injection) and polio (tablet) which were provided for free. In Burma also a similar limited immunization program was set up freely coming from a government nurse. Yet there is no clinic or medical assistance." (Interview 1 mother, 2010)

It is a welcomed development in Burma that there is at least a limited immunization program being carried out. However the main potential barrier is the remote locations of the villages. In certain cases families have to travel long distances to get the immunizations and especially for young children this can be problematic. The other main challenge is effective communication as villagers rely on travelers to pass messages such as immunization program dates between different locations. This is essential as families may need to plan ahead especially if they have to take time off cultivating their crops to walk long distances to reach the immunization programs.

Mother aged 28 with 3 children:

"My children have been immunized for both polio and measles in our village in Mizoram. In Burma we didn't have to pay for injections, which were provided by

the governments nurse, but we have to travel to Lxxx to get them which is 7 miles away." (Interview 2 mother, 2010)

What could be more effective is a mobile immunization program which specifically focuses on going to do outreach immunizations in these isolated villages.

5.1.3 Traditional Birth Attendant

Within close proximately of the ABC clinic there is one extremely experienced TBA with over 32 years practical experience who serves over 9 villages in Chin State alone. However it is not her fulltime job as she cannot earn enough money for basic survival since she undertakes the TBA work predominately as a volunteer. Therefore she has to manage; working in the rice fields to support her family, personal household duties as well as trying as best as possible to serve the community through midwifery activities. In the following she accounts her experiences as a midwife,

"*Mostly I look after the patients on Sundays. I request most of the patients to come on Sunday as I am working in the rice fields during the week days, and as a mother I have to look after the household. When I am taking care of the pregnant women, sometimes they pay me in the form of gifts or sometimes I do not get anything, so it's not a regular income. Sometimes I have to stay up 2 nights or wait the whole day to deliver a baby and I didn't receive anything. In our Chin tradition people believe that if someone delivers a baby we receive a chicken as a gift in return and some families cannot afford to pay me anything. However that is ok with me, because we learn how to treat our patients based on love and service. The other reason is I know many people are poor and don't have any extra money. Sometimes I refer the patients to hospital. There are some people that I recommend them to go to hospital and they survived.*

I have helped to deliver 6 twin babies. One time during a twin baby birth the babies wanted to come out feet first, it was very difficult and we had to deliver one of

the babies first and then wait and deliver one later. Another time in Mxxx village, one mother had twin babies and the first one had come out already, but the next one was stuck in her stomach and the mother almost died. She fainted and couldn't respond when I spoke to her. I had to think how to give the mother energy. I asked the family if they had milk, sugar and eggs to give her energy. Unless the mother had energy she would not be able to do anything. After hours of trying to get the baby out I took out the womb, and it appeared to me that the mother would die, so in order to have her breathing properly again, I asked her to turn on her side and slowly she was able to start recovering.

Figure 30 TBA for the 9 Villages Inside Burma Outside ABC Clinic

Note: (Author July, 2010)

There are so many stories I am missing because there are so many of them, although we have a nurse in the village they didn't call them, they always call me when delivering. I cannot remember how many babies I delivered as it is so many. Now the first child I delivered is over 30 years old." (Interview 25 Traditional Birth Attendant, 2010)

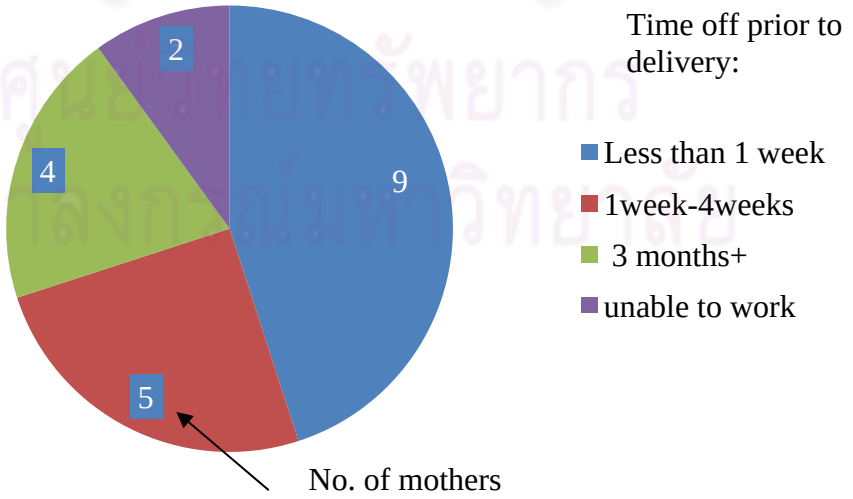
After the interview was finished with the TBA, though informal conversions it was discovered that the TBA had helped to deliver over 300 babies along the India-Burma border. Under the circumstances it could seem that this TBA service is

unsustainable given the lack of financial support and next to no resources provided by the state for reproductive health care. Yet it clearly demonstrates firstly the TBA's dedication to helping others through voluntary services, in only receiving limited financial returns to cover the cost of equipment. Secondly this only highlights further the demand and need for this kind of service in this area. This TBA is very much the local coping strategy for the Chin people in this area with her 32 years experience.

5.1.4 Labour Period

With the increased hardships of daily survival 45% of the mother interviewees have experienced at least once during their pregnancies the necessity of having to work until the last week prior to delivery. This is predominately due to the fact that a family's very survival is dependent on their manual labour in the fields so they can ill afford to have one less laborer. However this is a precarious period for an expecting mother as it could affect the chances of having a miscarriage/still born or babies can become positioned awkwardly prior to delivery.

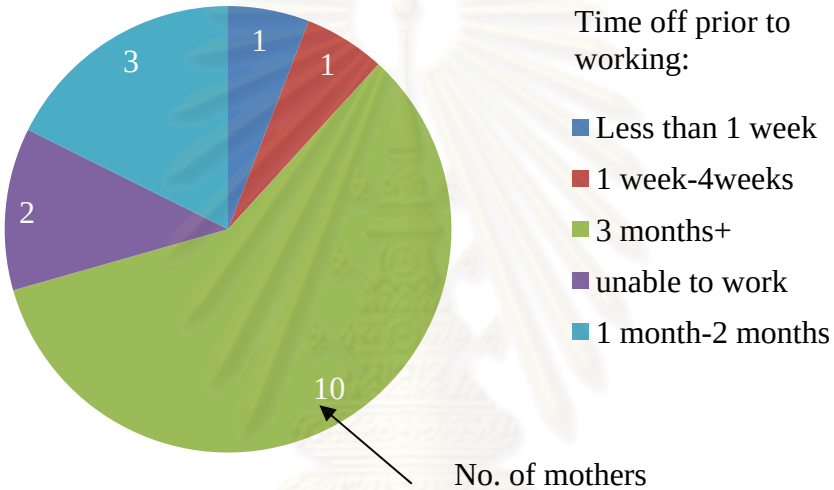
Figure 31 Breakdown of how long before giving birth does a mother stop working in the rice fields



Note: (Author, July 2010)

Note 2 out of the 20 mothers are unable to work in the fields due to long-term health conditions, *"Now during my 3rd pregnancy I feel very weak. I cannot go too far, and haven't been working this year in the fields. I just do household work such as cleaning and cooking."* (Interview 18 mother, 2010)

Figure 32 Breakdown of how long after giving birth did a mother start working in the fields



Note: (Author, July 2010)

Note: For 3 of the 20 mothers they are still pregnant with their first child so they are not included in the above chart.

Mother aged 35 with 5 children who has experienced 1 miscarriage:

"I am always working in the farm and carrying wood, depending on my health situation. I usually take 2 days off prior to delivering. To make my pregnancy easier I would like vitamins, nutritious food and to not work so hard during and after pregnancy." (Interview 1 mother, 2010)

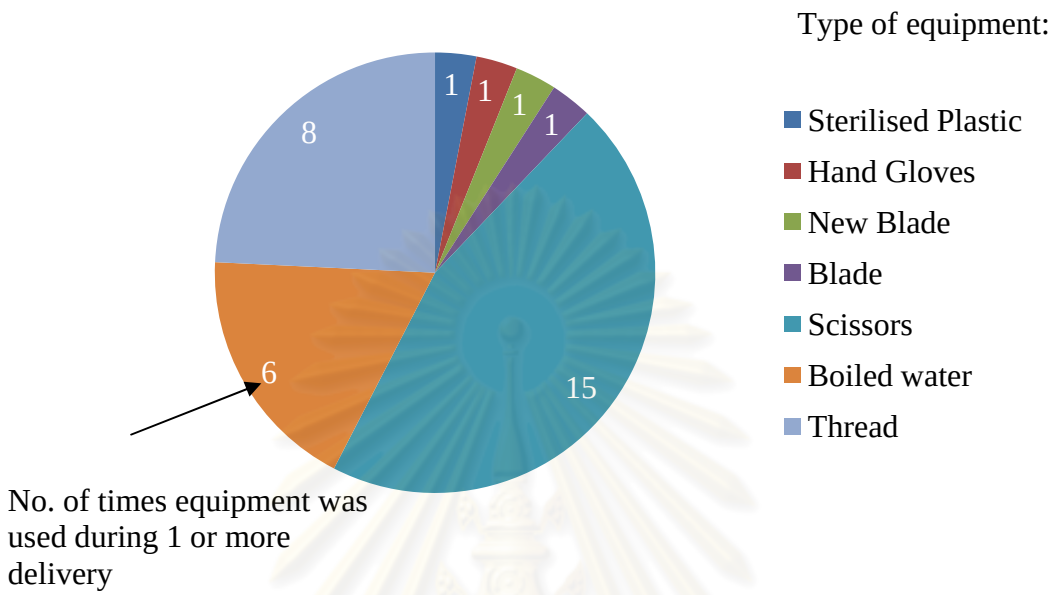
The TBA also highlights an increase in the number of expecting mothers with their babies positioned awkwardly in their wombs. The TBA provides informal antenatal checkups to ensure the baby is in the right position prior to delivery.

"In the past when I started working as a traditional birth attendant, the women didn't have so many problems in regards to the baby position. Now I think more and more pregnant women have a problem with their womb and baby position. This is especially when the mothers get closer to delivering their baby. The mothers come to me when they are about to deliver but they are unable to give birth. So I have to reposition the baby slightly up and the mothers feel better." (Interview 25 Traditional Birth Attendant, 2010)

5.1.5 Equipment used during pregnancy

Facilities and equipment are limited in the area. Many of the villagers use basic and rudimentary equipment for their deliveries; these include old scissors which are sometimes put in boiling water along with a thread for the umbilical cord. 35 % of the mothers said that during their newborn deliveries they usually boiled old scissors as a precaution before using, however some did not. Astonishingly only 1 of the 17 mothers to have delivered stated that plastic gloves and a sterilized plastic sheet were used representing just 6%.

Figure 33 Equipment Used by Mothers during Delivery



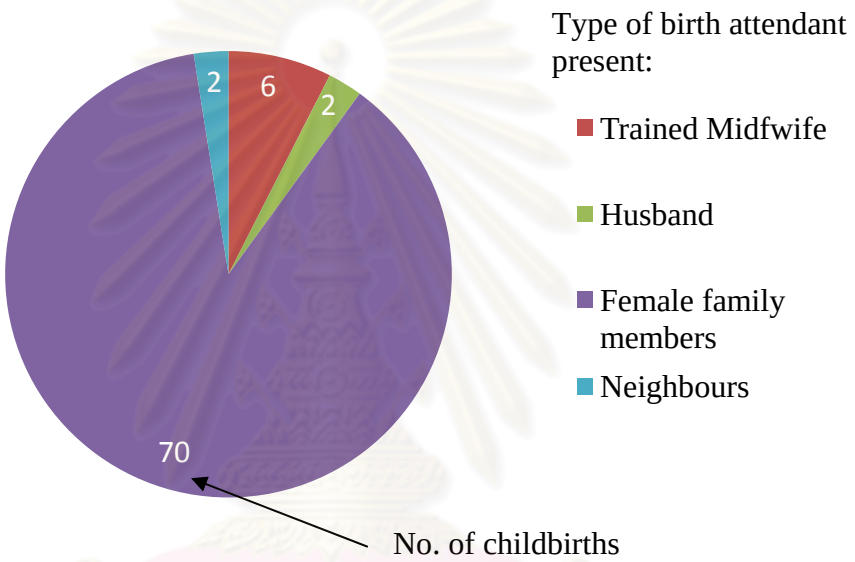
Note: (Author, July 2010)

It is difficult to get a 100% accurate account of each of the specific 80 child births from the 17 mothers as long term memories of the mothers often cannot remember the exact equipment used during every birth. This is especially true if they have large family sizes, yet this figure provides an important snapshot of what resources are generally available during most births.

There is a clear lack of equipment appropriate resources and finance to help ease the burden of health personnel such as TBA's helping to deliver babies. The MoH states one of its objectives of its National Health Policy is, *"To explore and develop alternative health care financing system."* (Myanmar, 2009, p. 15) Yet in reality this is implemented at the expense of already overstretched voluntary health personnel on the ground. It is unrealistic and the alternative health care financing system results in TBA's having to work less thoroughly than is completely safe, for example by reusing old equipment which increases the potential health risks to both the mother and child,

"I don't have many problems with home deliveries. My problem is I have to buy hand gloves myself. When the baby is born sometimes we need a pipe to clean all the dirty parts of the child's mouth etc, but now my pipe is very dirty and old." (Interview 25 Traditional Birth Attendant, 2010)

Figure 34 Personnel Helping to Deliver Baby



Note: (Author, July 2010)

According to a recent Save the Children report, in Burma 57% of births are attended by skilled health personnel (Children, 2010), yet within the case study village this clearly is not the case. The vast majority of the 80 childbirths were delivered by a pregnant mother's family members including mother, mother-in-law, aunties and sisters accounting for approximately 88% of the deliveries. TBA's who are trained were the 2nd highest accounting for 8% of the births. In all of the 80 childbirths there were no government nurses present to help deliver newborns either in Chin State or Mizoram state. Testimony to the importance of the TBA is one of the mother's experiences of directly benefiting from the TBA midwife based along the region.

Mother aged 24 with 2 children:

"When I was living in Burma I sometimes bought medicines from other villages, or we have to carry someone to Falam town (30 miles away) or Lxxx (10 miles) along the footpaths as there is no road. Since 2003 I have lived in X (India) so if I am ill, I would go to Ixxx (in India 4 miles away) for dysentery and coughing problems. During one of my pregnancies in India my womb got stuck- it was very dangerous and I had a swollen body, I went to the mid wife in Txxx (in Burma 2miles away) who helped by taking out my womb. For delivery she used a new blade, thread in hot boiling water, and free sterilized plastic sheet from an Indian sub-centre." (Interview 12 mother, 2010)

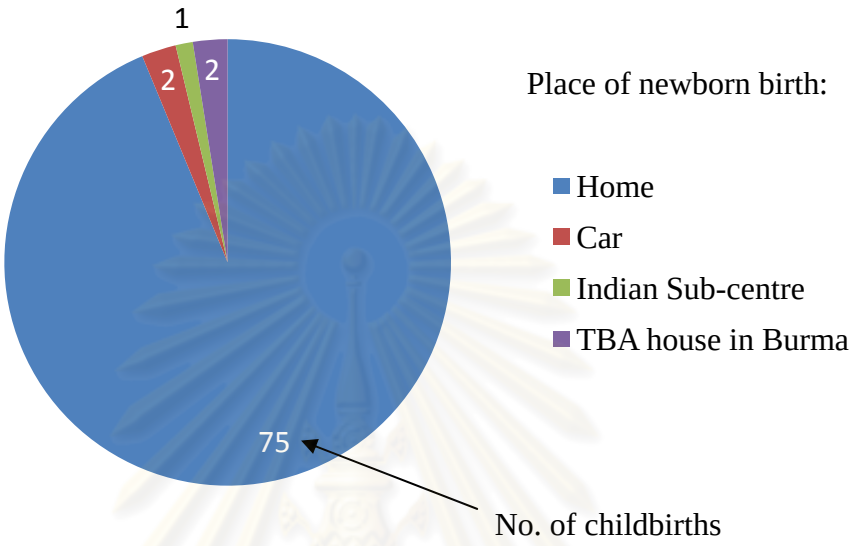
With a lack of a trained midwife some families just have Another coping mechanism for reproductive health; their husbands helping to deliver on 2 separate occasions. This also highlights the lack of reproductive health care in the Chin State.

Mother aged 28 with 4 children:

"In my village in Chin State there is no medical assistance. Three of my children were born at my home while I was living in Burma. My mother helped with the first 2 births. With the 3rd delivery my husband helped deliver. We used old scissors which were not boiled. With my last delivery I got help from Ixxx sub-centre in India, so it was a little bit easier in terms of delivery. Also here in X, India the village gives vitamins for pregnant women freely.

Most of the time during pregnancy I am working until about 8 months, now I have 4 children so I was very busy looking after the young children while I was pregnant with the last baby. Sometimes my other family members helped so I am able to work in the rice field." (Interview 17 mother, 2010)

Figure 35 Place of Baby Delivery



Note: (Author, July 2010)

The vast majority of births are traditional home births rather than at a hospital. Out of the 17 mothers to have delivered 80 babies 94% of them were traditional home births. It is customary in Chin society to have home births; this fact is further compounded due to the isolated area and inadequate health facilities available in villages and therefore the situation remains much the same. Highlighted below are some extremely powerful testimonies of both mothers and TBA experiences during pregnancies:

Mother aged 35 with 5 children:

"I was 22 years old when I had my first child. All of my 5 children were traditional home births with my mother in law as the birth attendant. In terms of equipment used during giving birth scissors were put in the boiling water for a long time, and my womb was cleaned by my mother in law. Previously the first pregnancy labour was difficult and for 3 days and nights I experienced pain so a nurse came from Kxxx village over 8 miles away." (Interview 1 mother, 2010)

TBA:

"One time from a neighboring village, villagers carried an expecting mother and she gave birth on the way. They asked me to run to her, but it was up a mountainous area so I ran but couldn't run fast so villagers carried me one by one. I had to prepare boiled water, scissors and the thread to help tidy up the umbilical cord to take care of the baby on the way." (Interview 25 Traditional Birth Attendant, 2010)

Mother aged 46 years with 5 children:

"During the first pregnancy I was very unlucky as my husband was away from my village. I had malaria and a fever and at the end I passed out. I went to Lxxx (in Burma 12 miles away), but it was during Christmas time and difficult to find medical care. I ended up having to go back to my village and deliver the baby, but the baby was suffering from a fever. I managed to get some medicine for my malaria (I took 7 pills at 1 time and felt very dizzy.) I gave birth prematurely during my 2nd pregnancy; I had to work in the farm and suddenly I realized blood was coming out, I ended up giving birth in Lxxx, with the help of a midwife and teacher. Initially the baby was not moving, but luckily the baby was given a number of injections and amazingly recovered afterwards. My 3rd child my husband was very helpful and I didn't have to go work in the farm, but even during my 3rd and 4th child births, just before giving birth the babies became out of position and blocked my main nerve. I had to call a midwife from Txxx to arrange the baby in the correct position. The final one (5th) was a very difficult birth again, suffering the same pain, and I ended up calling the midwife and relatives. I didn't have to pay the midwife, but I gave her a chicken as a token of my gratitude. When the midwife helped with delivery I was fine as she had her own equipment, but during other times we have limited to no equipment." (Interview 13 mother, 2010)

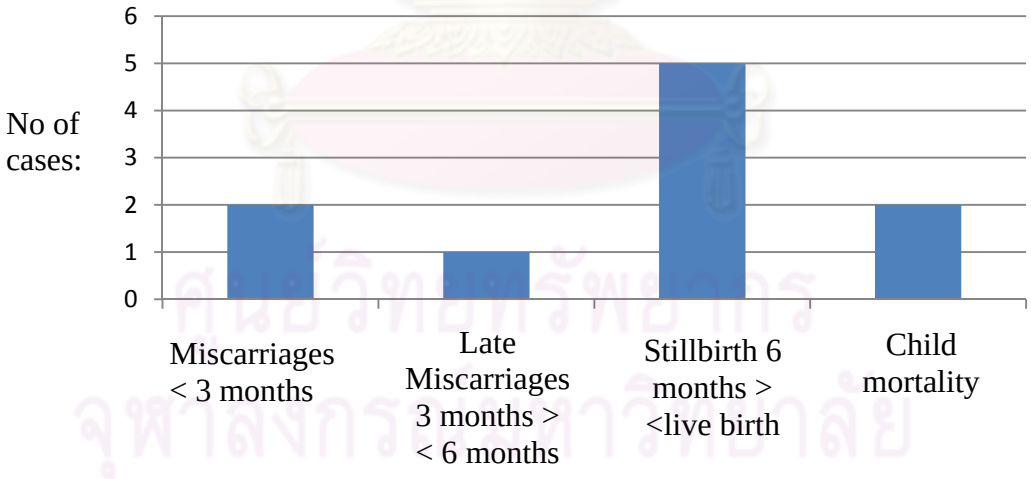
Other mothers are luckier with no major health problems reported. Many of the villagers rely on informal nurses or TBA to help with any complications during the pregnancy or postnatal period.

Mother aged 39 with 7 children:

"Personally I had no problems relating to delivery, after 3 days I manage well. My first child had a problem initially with his bladder so I had to get a nurse from another village. The nurse did it for free and I offered her some food in return." (Interview 11 mother, 2010)

5.1.6 Miscarriage, Stillbirth and Child Mortality

Figure 36 Miscarriages, Stillbirth and Child Mortality within India Burma Border Case Study Area



Note: (Author, July 2010)

Out of the 20 mother interviews there were a total of 4 miscarriages which includes early miscarriages (less than 3 months) and late miscarriage up until 24

weeks (6months). This number is common worldwide with 1 in 4 women usually experiencing a miscarriage. However shockingly there are an extremely high number of stillbirths (from 6 months to live birth) amounting to 6 in total. The Infant Mortality Rate (IMR) is an important indicator which can also indicate the health and development of a country or territory Burma is ranked 178 out of 224. (CIA, 2009)

While it is difficult to diagnose exactly why the specific miscarriages or stillbirths occurred, outlined below are some of the possible determining factors from the mothers themselves,

Mother aged 35 with 5 children, who has experienced 2 miscarriages:

"I have had 2 miscarriages (one in Burma and one in India). This was during my first pregnancy and one before my current 9 year old child. It was from working too hard after about 3 months I suffered a miscarriage. It was so painful and I had to call for my parents in law in X. During that time we didn't have any medics. Many women face the same problem, due to labour in the fields we cannot afford to take time off to rest as we need to earn for our daily survival working in the fields. If women have a miscarriage on their 1st pregnancy during the 2nd pregnancy they have to be extremely careful. Usually before giving birth the main problem is a loss of appetite about 3 months prior to delivery. I coughed and vomited a lot so I ate sour fruit such as lemons and also cherry's which helped. Comparing giving birth in Burma, India is was not much different at that time." (Interview 1 mother, 2010)

Mother aged 28 with 3 children, who has experienced 2 miscarriages:

"During all of my pregnancies I was sick and had intestine ulcer. When I was in Burma 2 of my children were delivered at my home, with my auntie attending to help with delivery. We used scissors dipped in hot water and thread. During my first pregnancy I bought medicines from Lxxx (7miles) and went to Mxxx village (5miles) to seek a medic.

My other child was born in X, India. Here I received vitamins and nutritious food once a month from the authorities. I also went to Champai hospital (7 hours drive away in India), I had to pay a lot of money but my health improved. I borrowed money from the villagers which they gave me interest free as they took pity on my situation. I have had 2 miscarriages, the first after 6 months and the 2nd after working again after 4 months. My youngest child also had malaria." (Interview 2 mother, 2010)

Mother aged 35 with 4 children, who has experienced 1 stillbirth:

"When I was pregnant with my second oldest (now 9 years old) I had typhoid and malaria, and had to walk 30 miles to go to Falam town to get medicines and injection. In 2006 I suffered a stillbirth after 6 months and I could not work or walk. I suffered from chronic back pain and stomach pain." (Interview 3 mother, 2010)

Further highlighting the need of the area not only inside Burma but also in India is the fact that one of the mothers has experienced 2 stillbirths while living on the India-Burma border.

Mother aged 28 who has experienced 2 stillbirths:

"I have had 2 stillbirths, the first one in 2003 just before giving birth and second in 2008. During my first pregnancy I was 9 months pregnant and I tried to deliver, but I had complications so went to Champai (in India 7 hours by car). I was able to get a free ride from a politician from Champai who came to our village in India, but my baby was already dead. The 2nd time I had to rent a hired vehicle at a cost of 4,000 rupees from X to Champai, I had to borrow money and it was very expensive in Champai hospital. My breath stopped on the way but I was able to recover. After the second stillborn I decided to have an operation for permanent contraception operation in Champai, after I couldn't walk for 2 months. Now I am very weak and my nerves are stained from working in the fields. I am unaware of any health initiatives from the Burmese state. There private medicines are also very

expensive. We need a proper road to make health care more accessible." (Interview Mother 9, 2010)

Figure 37 Reproductive Health Group Discussions

Note: (Author, July 2010)

One of the most extreme tragic testimonies of infant mortality was from one of the mother interviewees.

Mother aged 48 with 9 children of which 5 have died:

"I have given birth to 7 children in Zxxx (Burma) and 2 in X (India), yet 5 of them have died in Burma. Two of my children died after only about 2 weeks of being born, both from fever. After this the midwife of the area advised me not to go to the farm, but I had to go to the farm to work as we didn't have enough food. My next pregnancy the midwife had all the equipment and came 2 nights before giving birth. I had to pay 2,300 kyat for her help, but my baby girl died in my stomach. She was positioned horizontally wrongly and was stillborn, I almost died too.

In 1997 just before moving to India 2 of my other children died in our village in Burma, they were 8 and 6 years old. One day my 8 year old daughter felt dizzy on Saturday and then suddenly on Sunday died; we didn't know why. My 6 year old had swollen lungs and there was no medical care. I was unable to take care of them or

take them to a hospital as it was too far away. These experiences combined with my children's deaths have really affected me. If I was here in India when I delivered my first 2 children they would not have died. I could have taken them to hospital. Here in India at least we can ask for assistance or go to town hospital, which is better than in my village in Burma." (Interview 20 mother, 2010)

It may be difficult to diagnose the exact health problems resulting in the young children and infant mortalities. Yet what it clearly highlights is the urgent need for regular healthcare services to the region to help minimize these unnecessary deaths which can deeply psychologically affect mothers. This can also help to share some of the burden that the local TBA already has as they are severely overstretched to respond to all the needs,

"When the mothers have a very difficult time delivering the babies they become very weak and unhealthy. One time a pregnant woman had a problem but I was having a meal during that time, so the baby was delivered but died, the family prepared a burial for the baby." (Interview 25 Traditional Birth Attendant, 2010)

5.1.7 Mother Mortality

The following interview illustrates the tragic situation of living in a remote area with limited resources. During a difficult labour a family is reluctant to send the expecting mother to hospital, due to their own financial constraints and long distance to an appropriate healthcare facility.

"One time one of my patients in my village suddenly had a stomach problem. I thought that the baby and mother were ok as I had seen them previously regularly. So I went to the house and I didn't think that the mother would deliver immediately so I went around the house taking care of other children, but then suddenly her water broke. When I checked for the position of the baby it was not in the correct place it was higher. I panicked as I never experienced that before. After some time the mother became ok, I asked them to send the mother to hospital. The mother wanted to go to

hospital but the rest of the family didn't want to send as they would have to spend money. So the family told me that I along with another village nurse should take care of the mother instead of sending her to hospital, but I told them I didn't want to because I was afraid.

On that night the mother really got sick and there were another 2 voluntary nurses from surrounding villages. I didn't want to touch her at all as I knew things weren't right with her. The next day the family members carried her to Lxxx hospital (Chin State) and they also told them to go to Falam hospital (Chin State). Just as the family cross to go to Falam she died." (Interview 25 Traditional Birth Attendant, 2010)

One of the most important aspects of PHC is to recognize the limitations of working directly in the field as highlighted in the above case by the TBA. Although the experienced TBA recognized the seriousness of the mother's condition which could warrant a referral to a better equipped health facility, yet sadly this tragic story highlights the poverty that is prevalent in the region.

5.1.8 Referral System

Given the limitations of limited facilities in rural areas, as outlined above sometimes referrals to a better equipped health facility is essential,

"One mother from our village had a very large stomach and her stomach was very hard so I couldn't find where the baby was. The mother's skin also had a red rash. So I told them that it was not a twin birth and her stomach was too hard, so it may be better to deliver the baby in the hospital. Upon delivering in the hospital the baby and mother were both fine.

Another case was a mother's water hadn't broken yet and she was in great pain. I told them that this was a difficult situation and I advised her to go to hospital and they did. I heard later that during the birth in hospital she almost died with the baby as the baby was upside down. I'm not trying to glorify myself, there are cases I

cannot do and then I refer them to a hospital. Usually when I refer expecting mothers to a hospital they also find it difficult cases to deal with." (Interview 25 Traditional Birth Attendant, 2010)

5.1.9 Postnatal Care

Postnatal care and support is essential with the below interview highlighting the essential lactation stage where a new born baby needs appropriate nutrients from breast feeding which also helps to build the immune system of the newborn.

Mother aged 46 with 10 children:

"There were no health care facilities in our village in Burma. During labour I would usually work until the night of delivery. My mother in law and sisters helped with delivering my children. They had no proper supplies or equipment using only hot water, unclean scissors and clean clothes. After giving birth I would usually take care of the baby for 3-4 months before working again. After my 6th child was born I felt dizzy and weak. Also this particular baby's health was not so good and my breast feeding was not good at that time. I couldn't take care of myself and didn't know what to feed my child." (Interview 4 mother, 2010)

Sometimes births coincide with the low season of work and therefore provide mothers with a chance to rejuvenate and attend to their newborn children, *"In the past when I have given birth I usually didn't work for 3 months, due to the off season in the cultivation of rice paddy. I only went to the field when no one else is available."* (Interview 1 mother, 2010)

5.1.10 Family Planning

Within the case study village in both Mizoram and Chin states there is no formal family planning services or literature available for families to make informed decision about their families. However, informally advice and experiences are shared between relatives and friends and contraception is available limitedly in the region. There is a distinct difference in the cost of contraception between India and Burma as highlighted in the following:

Mother aged 46 years with 5 children:

"From my 4th child I used contraception from a sub-centre from Ixxx (India) on a 1 month's course provided freely. But in the Chin villages in Burma this costs, it has gone up rapidly from 25 Kyat to at least 100 Kyats.($0.1)" (Interview 13 mother, 2010)

Mother aged 35 years with 4 children: "*Contraception pills are available, but I felt sick afterwards. Additionally I loose my appetite and my milk for breastfeeding is not enough. So when we want a baby I stop taking."* (Interview 1 mother, 2010)

In other areas of Chin state contraception is not available, Mother aged 39 years with 7 children: *"In Burma there were no contraception pills, here in X, India if I have the pill I feel weak. I have had an operation in Nxxx, India (approximately 15miles) from here for free."* (Interview 11 mother, 2010)

Mother aged 23 with 2 children and is 9 months pregnant: *"I haven't used any contraception pills, but they are available here in India. I don't need them yet, and besides I'm worried of overdosing or the side effects."* (Interview 18 mother, 2010)

With no social-security net offered by SPDC, parents often have large families to increase their potential productivity in crop cultivation and also acts as a social

security net in old age. Yet this can have unintended ramifications with a large amount of crops being taxed by SPDC.

5.2 Cost of Healthcare

One of the mothers who has delivered 2 of her children in Burma and 2 in India briefly discusses the differences in pricing when she had a TBA help to deliver her children.

Mother aged 29 with 4 children: *"It is easier to deliver here in India, as I don't have to pay money to deliver. In Burma I had to pay 3,000 kyat per delivery. So here I can save money."* (Interview 7 mother, 2010)

The cost of health care is a major barrier to access essential health services, as demonstrated when one ABC nurse had to travel over 30 miles to seek medical care in the Falam township hospital, only to be charged extortionate rates,

"In 2004, I had a hearing problem and I went to Falam hospital. At that time, the doctors there were Burmans. Not only did they charge us a huge amount of money but also my hearing got worse. It was unfair. I decided then to become a doctor." (Interview 22 ABC Nurse, 2010)

Often due to discrimination against ethnic groups and the corruption within the public health system due to health personnel being underpaid, they will charge unusually high fees. Many of the ABC nurses have experienced first-hand this inequality in the health system. Astonishingly they use this negative experience as a motivational factor to help change this inequality towards their people.

"My goal is to set up a clinic inside Burma one day because medical check-ups and medicines are too expensive for poor people. I have seen many people suffering just because they don't have money. I don't think the Burmese government is

doing enough, as healthcare access is almost impossible to access for most of the people in Burma who are poor." (Interview 23 ABC Nurse, 2010)

One of the main problems is the poverty that is prevalent, with the high costs that are associated with health care in Burma. This has dire consequences with villagers waiting until their health conditions reach a critical point before seeking proper medical treatment. In the case of delivery of newborns if there are complications which warrant a referral to a health facility many families are left with little alternatives due to a lack of liquid cash.

Mother aged 42 with 10 children, 2 of whom have died:

"My sisters helped with delivery of my children, I didn't want to call a nurse due to the cost. Many of my births have been on a Sunday so luckily I'm not working in the farm. If we were sick we would wait until their condition was critical, and would buy from a travelling traders at a higher cost. After my 3rd pregnancy my health started to decline. I developed a heart condition, stomach problem and fever. I have also gone for treatment of typhoid and malaria at L xx (over 8 miles away). I have 10 children but 2 of them have died- one died at about 8 months old, they were very ill and spent 8 months in hospital and 2 months after being released died." (Interview 5 mother, 2010)

5.3 Corruption and Discrimination

Inter-connected to the cost of healthcare is the issue of widespread corruption and discrimination at all levels in Burma. This can also apply to even health education institutes. These types of abuses should be addressed with a proper monitoring and enforcement mechanism, yet due to the centralized structure of the NHC and the monitoring group National Health Plan Monitoring and Evaluation Committee (which has its own built-in monitoring and evaluation process) there is no independent 3rd party, to file cases in a manner which would not endanger the individual.

Case 1:

"In my school exams I got 357 score out of 500 in total. If I was from a privileged family, I could attend medical university. But I wasn't and instead I focused on trying to become a nurse. I applied for the nursing entrance and they took a 300,000 kyat ($300) bribe from us. There were two seats available; the Burman girl whose father was an education department officer in Chin State, got the seat although her scores were lower than mine. Yet I was very happy to get a chance to go to a separate NHEC (National Health Education Committee) training." (Interview 22 ABC Nurse, 2010)

Another ABC nurse who had to travel to different parts of central Burma to seek medical learning also elaborates on discrimination in daily life against ethnic groups,

Case 2:

"*I don't see the Burmese government caring for the people especially the poor and unhealthy. Being ethnic groups and poor people, we are neglected and we are looked down upon. Many times I've had arguments with some Burman people on the train. Once they know we are Chin, they think they can exploit us. They don't want to give us seats that we had paid for."* (Interview 21 ABC Nurse, 2010)

5.4 Human Rights Abuses

Linked to discrimination and exploitation, human rights abuses often occur in ethnic areas such as Chin State. Out of the 16 mothers who were born in Chin state, the following information was gathered in regards to human right abuses suffered at their household. At least 3 of the mothers (19%) interviewed had to personally carry out forced labour when their husbands were absent from the village.

Figure 38 Number of Households Who have Experienced Human Rights Abuses by SPDC in Chin State

Note: (Author, July 2010)

These abuses deeply affect health conditions both physically and mentally. Basic daily living of the communities residing in Chin State becomes unbearable and is often the impetus for why families seek a safer life in Mizoram State, India. The human rights abuses are often perpetrated by the Burmese army, but within Chin state with the presence of the CNA insurgency group there is a complex indirect connection between the CNA, SPDC and the villagers. Often village communities will be in an uncompromising position between both groups as highlighted in the following interviews from both nurses and mothers, leading to human rights abuses:

Mother aged 48 with 9 children, 5 of whom have died:

"My husband was the village head in our village. During that time CNA asked our village for rice supplies. The SPDC heard about this and thought he was a sympathizer with the CNA and he ended up having to runaway for about 2 years, due to SPDC wanting to catch him. We Chin have to show our love and support for the

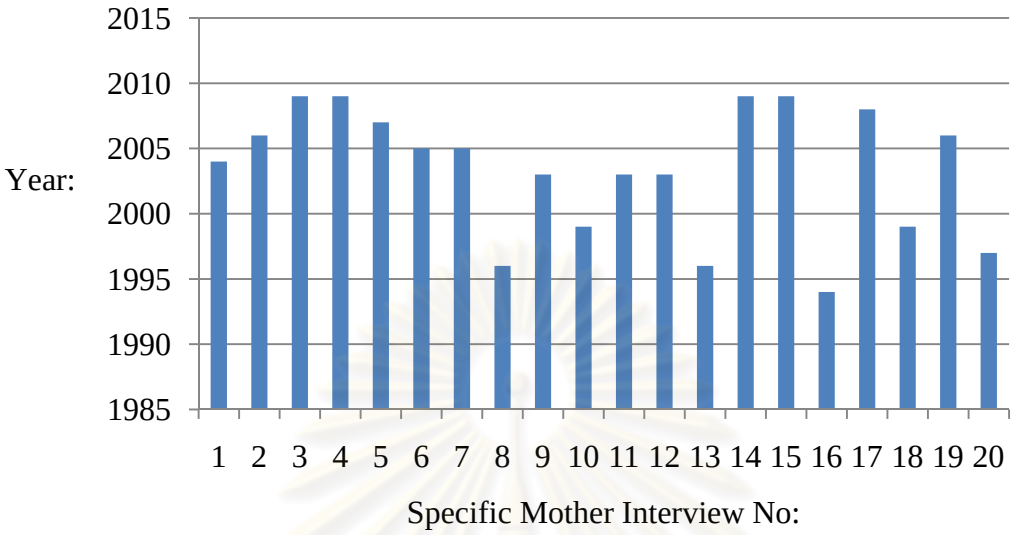
CNF/CNA who are at least doing something for our country. One night the SPDC came at 1am and kicked in the door, waking up my children looking for my husband, they even looked in our rice storage basket. The SPDC always called me for forced labour, sometimes I had to borrow money from the other villagers for food or paying the army." (Interview 20 mother, 2010)

Widowed mother aged 42 with 10 children:

"In 1999 CNA kidnapped 1 Burmese soldier in our village. The Burmese army came to our village and threatened us saying they would burn the village if we cooperated with the CNA. Due to my husband being a village committee member, the Burmese army sent us a letter saying they will kill us, so he had to flee for his safety. They would come to our village very often demanding us to collect fire wood for them. They introduced a curfew during the 1999 incident, stating that no-one could go out of their house after 7pm, this lasted for 2 months. We were not allowed to use any fire during the night (which was used as touch lights). More recently in 2005 CNA invaded the Burmese army camp Lxxx. The SPDC collected money and we had to contribute labour to building the army camps. In the past, 3 times my husband was not present so I had to do forced labour." (Interview 5 mother, 2010)

The above cases highlight the human rights abuses such as arbitrary taxation and the fact that women are also forced to do labour, which is particularly of concern especially if they are taken away from their young children or are pregnant.

Figure 39 Chart depicting date when mother first migrated to village X



Note: (Author, July 2010)

The above chart highlights the movement of families from their native villages in Burma. Much of the period of movement is done after the year 2000 which could be directly linked to the increases in military presence of both SPDC and CAN during that period as highlighted in the above testimonies. Note interviews 10, 16, 18, 19 the mother interviewees are from Mizoram.

In the interview below a member of the ABC clinic staff highlights the complex relationship between prolonged military rule and trying to focus on further health education in order to better serve the community.

"Before I attended health training, I was a volunteer teacher at our village school. Our village has many experiences of human rights abuses and problems from the Burma army because the insurgency groups (CNA) use our village as their mobile base and temporary shelter. The Burma army always targets us whenever they hear that the insurgency groups came to the village. Therefore, the villagers are fearful of both Burmese soldiers and insurgency groups. When we got the invitation for health training, my other friends didn't want to go and cancelled because they were afraid.

But I insisted my family to let me go because I knew that this was my call. After 3 months of the health training program, I did self-study in my village and helped the patients since we don't have a proper doctor and medics. My mother is a trained mid-wife nurse, which also helped me to learn more about medical knowledge." (Interview 22 ABC Nurse, 2010)

The following interviews highlight further the difficulties living under repressive conditions in Burma. As part of the exploitive arbitrary taxation policies which are not based on the proportion of income made (in the case of rural Chin state income is largely based on crop yields). However if a particular harvest is unusually poor due to freak weather conditions these types of "*one size fits all taxations"* do not account for such adverse conditions severely affecting food security. Moreover, given the seasonality of crops in terms of harvesting and planting seasons these types of taxations do not offer any flexibility. They are carried out on a random indiscriminate bases, which has dire implications if it is not the harvesting season and income is low, further compounding difficulties in basic survival needs.

A mother aged 35 with 5 children noted:

"Things are very difficult in Burma, in X, India it is easier. In Burma there is so much tax such as land tax from the government on our own land. We have to feed the army if they come to our village. There is an army camp which uses forced labour and if a family cannot send someone per household they have to pay a penalty. So many times we have had to carry weapons and food supplies for the Burmese army. For the forest department we also had to help build the roof of the army camp with bamboo trees. Having to carry and collect cement, sand and rope. (Interview 1 mother, 2010)

The fact that it is not just the army, but also government departments, who indiscriminately use forced labour too are a sign of the widespread mentality in the authorities of a culture of impunity and abuse of their powers. An indication of the desperation of families wanting to escape living in Burma is in the following

interview; in which a mother left Chin State in 2006 to come to Mizoram State. However, even once her family relocated, life is extremely difficult as there is no land free for cultivating. So she is therefore forced with having to travel everyday to work back in Burma, while having to leave her 3 children at home in India.

Mother aged 38 with 3 children:

"In Burma it is difficult to survive, in X India it is easier to earn money. We had land in Lxx (Burma), but we had to do forced labor such as portoring and paying taxes to the army. My husband has also been forced to build army defense walls and also make a road to the camp. I was pregnant during this time. Now in India I have to find work in Mxx (Burma) which is 1 1/2 hours walk away from X (India) the daily work begins from 8:30-4:30. My eldest son (6 years) has to take care of my other children while I am in the rice fields in order to get food. I get paid about 100 INR or 2,000 kyat per day ($2), our biggest needs are job opportunities and a hospital." (Interview 2 mother, 2010)

Mother aged 35 with 4 children:

"It is difficult to survive with taxation and forced labour by the army, many times my husband has experienced forced labour for example he has had to carry 10 pieces of wood for the roofing of the main army camp Lxxx, about 10 miles away. If it was a bad army commander on duty it could be as often as 2 times a month that he would be forced to work freely for the army, also constructing a road to the camp. I am not well so cannot do the labour, yet even still I have had to feed the army freely with chickens." (Interview 3 mother, 2010)

While it may first appear insignificant that livestock such as chickens are forcibly taken without any financial compensation, it is highly detrimental to the health of a family as the eggs from the chickens are an important source of protein and nutritional intake for families. Road construction is also one of the most needed things in Chin State which have the potential to help link to more urban centers that

can have a vast impact on transportation, health, education and communication to isolated villages. Yet in the context of Chin State, inadvertently road construction projects have led to negative effects on villages, becoming more accessible to army camps and consequently increased forced labour and exploitation of local resources.

Mother aged 46 with 10 children:

"We are very poor and suffered taxation from the army. Also my husband had to do forced labour and portoring for them. The army collected food so it's very difficult. They come randomly sometimes only 2 times a year to our village yet other times 2 times a month, it's very difficult. The water security is also a problem in the summer it is very hard as there is no tank for storage. We have no NGO's to help assistance us." (Interview 4 mother, 2010)

The above interview is testament to taxes collected not being put into the development of communities, with the mother's village lacking a basic water storage facility. In the community, water is a necessity for basic survival and cooking which families need for boiling their rice and vegetables. Especially in the dry season water scarcity can have dire effects on the health of communities and their domestic livestock. Moreover community cohesion as may disintegrate as villagers become more agitated fighting over limited water supplies.

5.5 Healthcare in India

After families have moved to India, they feel much safer in terms of security as highlighted in the following, *"After moving I can sleep freely and easily without the Burmese army."* (Interview 8 mother, 2010) Yet even when families settle in India and have access to health facilities within transportation distance, sometimes the logistical constraints of getting to a health care facility to deliver newborns can prove too difficult. In the following interview a mother with 9 children, even the husband in an urgent case can assist with delivering their newborn,

Mother aged 48 with 9 children:

"In late 1997 we arrived in X, India, but we had no food or land, we stayed in a tent. At this time there were only 5 households with no roads, from house to house we had to make paths. In India I have given birth to 2 children. I took a lot of vitamins and eggs. During labor I tried to go to a sub-centre in YXX, India (4 miles away) we had to take a vehicle, but there was a landslide and the vehicle got stuck. I ended up having to give birth in the vehicle with my husband helping to deliver our baby." (Interview 20 mother, 2010)

It is extremely fortunate that the child born in the vehicle survived and it was not a particularly complicated birth, as this could have potentially been very serious for both the mother and child. The above interview highlights the remoteness not only in Chin state but also in Mizoram, lack of trained midwives, the vulnerabilities during the rainy season with landslides and the need for a locally based health facility for the region.

5.5.1 Local Government Initiatives

One of the most notable differences in policies between Burma and India relates to food security with the local Mizoram government implementing a Below Poverty Line (BPL) rationing system so that vulnerable families who are experiencing increased hardship can gain access to subsidized rice. This in turn has a positive effect on increased food security and can reduce the likelihood of health conditions such as malnourishment.

Mother aged 28 with 3 children who has experienced 2 miscarriages:

"In Mizoram they have Below Poverty Line (BPL) initiative and I can get about 30 kg of rice per month every month at subsidized prices which are cheaper than normal prices. 1kg =6.5 Indian rupees. The village committee decides who is the poorest families, in the village there are about 3-4 families on this program.

During the rainy season I have to go to Ixx (India) to collect which is about 4 miles away." (Interview 2 mother, 2010)

While there may be limitation in terms of the number of families the BPL initiative can target only certain families due to financial constraints. The importance of a decentralized approach, letting local village communities decide whom is most vulnerable and needy in a community is a relatively effective and transparent initiative. Evidence of this is demonstrated in the above case of the mother who is unable to work due to 2 miscarriages and stomach problems who is classified as needy. Yet the BPL does not target everyone in a community,

Expecting mother aged 19 and 9 months pregnant:

"Here in India we would like to be more food/financially secure, as we don't have adequate rice stocks. We are not included in Below Poverty Line as the village committee decides and priorities families with many children so they can buy rice at subsided prices- 6.5 Indian Rupees for BPL or 10 Indian Rupees at normal rates." (Interview 14 mother, 2010)

5.6 Healthcare at ABC

The importance of the establishment of the first health clinic in this region will have extremely significant health implications not only in the short-term, but also in the long-term. Vitally the clinic not only supports the local village, but serves needy communities inside Chin State. According to the ABC medical records which have been recorded since ABC clinic began operations in mid April 2010 there have been a total of 428 patients coming directly to the clinic as of 23rd July 2010 from 9 villages inside Burma and 4 villages inside Mizoram State, India. (Nurses, 2010) The importance of which is highlighted in the following interview,

Figure 40 ABC nurses checking through medical records

Note: (Author, July 2010)

"Our villages are very grateful for this ABC clinic, even when the project was first started other villages wanted to have it located in Burma. This entire region not only these villages are very happy because we have never had this kind of health facility. In every village we pray for this clinic, some families even have a church gathering or private gathering and pray for this village. Some of the patients the pregnant women who come to me, I ask them to go to ABC clinic to get vitamins. Now 2 pregnant women in my village in Burma asked me to get vitamins from ABC." (Interview 25 Traditional Birth Attendant, 2010)

Figure 41 Mother carries her baby to ABC clinic for check-up

Note: (Author, July 2010)

Mother aged 35 with 5 children who has experienced 1 miscarriage:

"The clinic is great for my family and especially my eldest son as he gets weak and dizzy but now he is completely fine. I also had a kidney problem and women issues but now I am fine." (Interview 1 mother, 2010)

Mother aged 28 with 3 children who has experienced 2 miscarriages:

"Before ABC clinic was open we went to Mxxx village in Chin State (5 miles away) Mxxx has 1 medic who learned from a doctor in a private clinic, but is not formally trained. Since ABC has been setup all my family has come here, I have been for my stomach problems. It's very good and I can get cheap medicine and buy on credit. I was very afraid that this clinic would not be established." (Interview 2 mother, 2010)

5.6.1 Mobile Medical Clinic

ABC also operates mobile clinic projects which have been run in 3 villages inside Chin State seeing a total of 143 patients as of 23rd July 2010. (Records, 2010) The mobile clinics are essential as in the region there are over 9 villages from within Chin State that need urgent medical care. This outreach medical assistance is also one of the essential aspects of PHC approach. With some of the sick unable to travel long distances these mobile clinics help to reach the most vulnerable in communities.

Figure 42 ABC medics performing outreach mobile medical services

Note: (Author, July 2010)

5.6.2 Current Pregnant Women

At the time of writing, there are currently 6 mothers in the field research village who are between 5-9 months pregnant. 3 of the mothers are between the ages of 16-19 and it is potentially very risky for these young ladies with their firstborn baby. Therefore it is imperative to minimize the risks through prenatal care. In several of the interviews below the expecting young mothers would prefer to have home births, therefore it is important that the ABC nurses are flexible to their wishes and could possibly go to the home of the mother prior to delivery. During the birth ABC nurses should be present to firstly guarantee a safe birth through the use of sterilized safe equipment. Secondly with their previous midwifery experiences they can ensure a safer birth and help smooth possible complications. Finally as a precaution the ABC nurses can make an informed decision prior to labour if a referral to a larger facility is needed.

Expecting mother aged 16 and 8 months pregnant:

"I am currently 8 months pregnant and not sure where whether to deliver at home or at the clinic. In the past when we were sick with Malaria or high fever we had to be carried to Ixx, India (4 miles away). ABC clinic has helped our village by supplying mosquito nets. Currently I am still working but not sure when I will stop working. I have to cross the river to go work in Burma from 9am- 4:30pm. Our family does not own any land, we are daily laborers and I have only about 30 minutes break during work." (Interview 16 mother, 2010)

The above interview really highlights the struggle of even expecting pregnant women coping with little rest prior to delivery. It is imperative through outreach checkups that the ABC nurses monitor her condition prior to delivery. There are also some initiatives to provide pregnant women in the case study village with extra vitamins and other nutrients,

Expecting mother aged 19 and 9 months pregnant:

"Here in India I am able to get calcium from the pre-school teacher for virtually free. After initially paying 10 Indian Rupees per year I can get a 1 month's course. I am currently 9 months pregnant and I have stopped working in the rice fields about 3 months ago. I plan to deliver my baby at home, due to less cost. But it depends on my situation, if it's free I would prefer to go to ABC. I have come to ABC clinic for support during my pregnancy and I am seeking advice from my friends and arranging new clothes for my baby." (Interview 14 mother, 2010)

Expecting mother aged 17 and 6 months pregnant:

"In my village in Burma we had no supplies or health facilities so we had to go to Falam township hospital or Lxx. I have come to ABC clinic to check that the baby is in the right position and I have also had a lot of advice from my family. I think I would like to deliver my baby at home." (Interview 15 mother, 2010)

Figure 43 Pregnant mother comes for prenatal checkup

Note: (Author, July 2010)

Mother aged 24 with 2 children and is currently 5 months pregnant:

In Burma we have no free health care support, but on the Indian side from Ixx Sub centre I got given iron. I am currently 5 months pregnant and I feel the pain. My husband is staying in the farm so I still have to do work around the house cleaning and seeing to the pigs, sometimes I also go to the farm to work. Yet I feel secure knowing ABC clinic is here for health issues." (Interview 12 mother, 2010)

The above interviews highlight the importance of having ABC Clinic available and accessible to pregnant women helping to reassure and ease any anxieties.

Mother aged 23, with 2 children and is 9 months pregnant:

"My first child, my mother helped me give birth and with my second child a neighbor helped. The neighbor had some practical experience following a sub-centre worker in Ixxx India. They also helped by giving me knowledge about giving birth. We used old scissors which were boiled in hot water. After giving birth to my first child after 5 months they had typhoid and got sick. During my 2nd child I was also sick. Now I am currently 9 months pregnant and I haven't decided where I will give birth.

But I think it is better to deliver with a nurse from ABC." (Interview 18 mother, 2010)

Mother aged 23 with 2 children, currently 8 months pregnant:

During my previous pregnancies I had no vitamins or no health education. One of my pregnancies my baby was not in the right position so I went to see a midwife in Txxx (2 miles away in Burma) having to walk there. After my 1st baby was born I had pieces of the womb stuck inside of me and I got sick. I went to Kobm village hospital (approx 30 miles away in Chin State) and the doctor advised me not to have any more babies so I had an operation to stop having children.

I didn't do field work during my pregnancy, instead I worked at home and in the garden, it was the same after giving birth but I had a lot of back pain for 3 months. And now I am pregnant again. Now I have managed to get some iron tablets in 1 month supply doses at a good price from ABC at 10 rupees supply. (Interview 19 mother, 2010)

5.6.3 Referral System

With ABC being a limited primary health care facility for more complicated or severe health conditions one of the most important aspects is the establishment of the referral system. The nearest hospital from the clinic is approximately 7 hours drive. Sometimes even at the Champai hospital they do not have sufficient resources or specialist equipment therefore with the assistance of an ABC medic, patients are transferred to Mizoram's State capital Aizawl which is over 8 hours by vehicle. Below the elderly woman has suspected throat cancer and is undergoing a biopsy with the results having to be sent to Mumbai. In the end it turned out that she did not have cancer and had a severe throat infection.

Figure 44 Champai Hospital, Mizoram State

Note: (Author, July 2010)

Figure 45 Aizawl Hospital, Mizoram State

Note: (Author, July 2010)

Figure 46 Elderly woman with suspected throat Cancer, Aizawl Hospital, Mizoram State

Note: (Author, July 2010)

5.7 Health Education

Health education can be split broadly into two main different health education target groups. Firstly, health education directed towards health personnel in order to develop their health knowledge, practical skills and health education training to use in the field. Secondly, health education directed specifically towards communities or individuals to promote awareness on health related issues.

5.7.1 Health Education for Health Personnel

Investment in training and further educating health personnel is essential in order for a comprehensive sustainable health care system. While health education does take place in Burma, it is often sporadic, limited or very expensive. This is further substantiated in the following interview of a local TBA who received 6 months medical training in total prior to serving in the community for the last 32 years.

"In 1978 my father was a village head there was an invitation to do nursing training from the government, we didn't have any other educated people in our

village only myself and one other. My father asked me to go to the training but I would not receive any money and I would have to go as a volunteer. For 6 months I learned about medical training at Falam hospital. Since then I have been working as a medic for 32 years until now." (Interview 25 Traditional Birth Attendant, 2010)

It is significant that the health care system is historically under resourced and even in 1978 there was a lack of prioritizing state budgets for health care; with the TBA having to pay her own expenses during the 6 months training period. This is extremely difficult given the limited income of Chin families in rural areas. Yet the fact she attended the training is also recognition of the importance of health education to the community. It also provides a valuable insight into the low level of investment in regular health education programs with only a 6 months training period and then a return to serve communities for over 32 years with no periodic training. Significantly, this training initiative took place during the context of 1978, which was also the same period that the WHO conference in Russia had agreed on the declaration promoting PHC (mentioned in chapter 2) which was to be implemented into national health policies such as in Burma, which was beginning to focus on PHC.

A more recent picture of the current state of health education for health personnel in Burma relating to ethnic groups can be drawn upon through the background health education of the ABC clinic nurses. Given the limitations of health care facilities in Chin State all 4 of the ABC nurses have had to travel to different areas of Burma, India and even Thailand to seek further knowledge on healthcare.

"I went to a clinic in Mizoram, India-Burma border to learn more closely with a doctor from Burma. After this I went to Sagaing Division (Burma) to work with Dr. Xxx private clinic. I was assisting him and other nurses for patients care and minor treatment. Since I could speak Falam, Hakha and Mizo dialects, Dr. Xxx and the other doctors/nurses needed my help for patient's treatment. It was a great experience for me." (Interview 22 ABC Nurse, 2010)

In a separate interview another ABC nurse who was working closely with WLC based in Mizoram was selected to get more practical health education along the Thai-Burmese border,

"Since I attended a health training program, I took a more serious interest in health issues, as we the participants had to discuss issues relating to motherhood, childhood and reproductive health of men and women. For our first activity, we had to distribute educational leaflets among the Burmese migrant communities in Mizoram and some Mizo families.

During this time, I got involved with WLC and attended further training programs on human rights and women's rights issues. I was working as an AIDS public educator for 10 months. In 2007, I was selected by WLC to go to Mae Tao clinic on the Thai-Burma border. We could not begin our training program straight away as we were late for the first round. We had to wait for several months. Sometimes, I cried because I was afraid to speak with many strangers who are from different parts of Burma. However, after gaining intensive training over a year, I worked as a mid-wife nurse for 8 months. I helped deliver over 50 babies and I was also a supervisor for new medics with a small team at Mae Tao clinic. After this, I was in the emergency ward for 3 months. I gained many experiences dealing with different types of health problems and patients.

During my training and practical works at Mae Tao clinic, I prayed to God to let me help deliver babies as much as possible. Many nights, I lacked enough sleep, which was difficult for me sometimes. I had experienced one particular bitter experience. One night, there were 12 babies born in one night alone. My supervisor did not allow me to deliver the babies; instead I had to clean everything from the 12 mothers and babies. It was the most painful experience for me as I wanted to improve the skills and gain experiences as much as possible." (Interview 21 ABC Nurse, 2010)

The personal hardships that these nurses have had to endure in foreign countries have really highlighted their personal sacrifice and love towards their own people. They are faced with a steep learning curve sometimes in environments in which their native language is not spoken, so making learning about health more challenging. Yet despite these hardships they recognize that in order to address the lack of health care in Chin State they have to become more educated through theory and practice. Another of the more senior ABC nurses has had some limited training in 1982 in public health by the government of Burma, with further study on mid-wife nursing, before working at a civil hospital in Shan State. She recalls her past experiences delivering babies,

"I cannot count how many babies I delivered in my past experience. When the babies came out upside down or covered face, I am nervous. Luckily, they survived." (Interview 24 ABC Nurse, 2010)

In terms of formal education the most educated ABC nurse already possesses a master's degree from India. She has also undergone training with the Free Burma Rangers (FBR) in Karen State for 2 months and then went to seek further training along the Thai-Burmese border.

"I was interested in medicines so I joined the medical team during a FBR training program. I was in Karen State, Burma for two months for practical work and I learnt general health education at Mae Tao clinic. We learnt preventive health education, mid-wife nurse, medical treatment, pharmacy, trauma and counseling." (Interview 23 ABC Nurse, 2010)

Figure 47 ABC Nurse proactively doing self-study of health issues

Note: (Author, July 2010)

It is deeply concerning that there is a lack of government supported health training programs especially for ethnic rural areas as there is such a need. The MoH states, *"regionally administered workshops and training sessions are regularly given to these workers for updating their technical know-how and work."* (Ministry of Health Myanmar, 2010) Instead, as has clearly been demonstrated through the above cases, health personnel from Burma have to travel outside of Burma to different countries to seek more knowledge and practical skills relating to health, to implement in their own country. It is similar to the brain drain effect with many of Burma's most bright and talented people actually now living outside the country.

5.7.2 Health Education for Communities

In terms of medical personnel providing health education to communities this has been carried out informally by the TBA and ABC staff for example,

"I have been promoting awareness about pregnancy education a lot amongst pregnant women. Now they are improving, even hygiene for mothers, usually in the past they would leave their hair very dry and dirty it's not healthy for them. I think we are progressing a lot more comparing with the past, although we don't have health facilities like the city." (Interview 25 Traditional Birth Attendant, 2010)

Clearly, health education is an essential ingredient to promoting a healthier community and given the limitations of health personnel it is crucial to provide education to the community which can empower them to minimize diseases through improved sanitation further supported in the following,

"The root-cause of the health problem in our community is lack of knowledge about hygiene. The government does not invest enough on healthcare. I have seen many poor people; I asked myself how I can help them. The most effective way I can help is by helping them through their health problems. I am determined to become a medic. I would like to study more about health." (Interview 23 ABC Nurse, 2010)

5.8 ABC Model Constraints

ABC clinic's model of health care focuses on providing PHC grassroots services. However there are some key limitations with this ABC model mainly due to the political economy constraints of India's Look East Policy and the strengthening of ties with the Burmese SPDC military regime. Fundamentally the clinic is located in India and therefore has to abide by Indian law. This poses a serious risk for the ABC clinic operations as potentially more barriers are set up by India's ruling party; Indian National Congress (INC) and Mizoram National Congress against providing any support to ethnic groups from Burma even if it is humanitarian assistance. Relating to

legal constraints the Mizoram State laws and regulations restrict foreigners from travelling outside the state capital of Aizawl. Only if foreigners apply for and receive a permit which grants them permission are they allowed to travel to other parts of Mizoram. Therefore for example any medical training undertaken by foreign doctors wanting to provide health training at the clinic area could be potentially very difficult and dependent on the local authority's decision to issue permits. It is therefore imperative to win the hearts and minds of local Mizo communities and authorities based in Mizoram state, India. Especially within the local area of the clinic through providing health services, so they too can directly benefit from the clinic and feel part of the process of positive development for the area.

Importantly, India is not a signatory member of the 1951 UN Convention Relating to the Status of Refugees. This affects Chins residing permanently or temporarily in Mizoram State as there is also no UNHCR presence to determine the status of the Chin along the border. This results in Chin from Burma in Mizoram with no legal status i.e. they are unregistered refugees and undocumented migrants. This has ramifications for the operations of the clinic as the ABC nurses are from Burma and effectively their legal status operating on Indian soil remains at the mercy of the local authorities who could effectively close down the clinic and send ABC nurses back to Burma.

ABC has only recently been established and as such it is still in its early growing stages and consolidating what has already been achieved as a primary health facility. It has been able to provide limited health services to 9 villages from inside Burma and also 4 villages inside India. Given the remoteness of the clinic, access and communications constraints, the clinic is still developing in terms of logistical support such as improving medical supplies to the clinic and its referral process to larger medical facilities in India for more complicated health conditions. During the rainy season accessing the clinic is also a major challenge not only for the resupplying of medicines, but for sick patients having to travel over the river to the clinic. Another challenge is developing the medical knowledge and skills of the ABC medical personnel with regular training programs. Given the remote location, the management

is responding as best as possible to the needs of ABC nurses by sending them on short-term training programs in other areas of Mizoram. During these training programs temporary replacement nurses from other areas of Mizoram have been drafted in to cover while they are away. It is with this long-term approach to health care that not only the ABC nurses will benefit from further honing their skills, but also communities will see first-hand the tangible outcomes through increased health care.

A definite strength of the clinic is trying to increase directly reaching communities inside Burma by running mobile medical clinics to villages inside Burma; it is this proactive initiative rather than a reactive approach which in the long-term will help to improve the entire region's health and is fundamental to a PHC approach. Moreover related to PHC and CHW approaches when the mobile clinics operate informal health education, training is also conducted in their local native languages. This is an essential advantage which in the state lead model is often overlooked with sending nurses who cannot speak local dialects; therefore training in areas such as maternal health and sanitation can be conducted. However trying to change the mindset of villagers in their habitual daily behavior is a long-term objective. With appropriate practical training and mentoring from professional doctors the facility is finding its feet to respond to the needs of the region and is maintaining a long term approach. In regards to the mobile clinic programs, security is a potential concern, given the past track record of human rights abuses by the SPDC in the same areas. Although the medics are focusing solely on health there is always a risk of what will happen if or when SPDC soldiers find out they are operating. This could not only put the ABC staff and clinic in danger but also the villagers themselves. Therefore the medics have set up a support mechanism to ensure security is clear before going and during running mobile clinics in a village to try and minimize any security concerns.

5.9 Summary of Research Findings

Although a detailed analysis has been ongoing through each section and sub-section of this chapter, we can summarize as follows: it is amazing to think that with all the logistical constraints, cost issues, limited health and education facilities, ethnic discrimination, insurgencies/SPDC human rights abuses blighting the region that a functional health care service could emerge. A vital point is the motivation and dedication of the TBA, ABC nurses, the community and international donors showing towards their own people. The experience and care of the TBA and ABC nurse in particular was extremely humbling. With the TBA having helped to deliver over 300 babies, it is remarkable that the first children she delivered are now over 30 years old. The ABC clinic nurse's stationed onsite in remote areas are increasingly diversifying their roles in the community not only providing health services to patients, but increasingly fulfilling the role of CHW and to a certain extent providing limited counseling services to villagers who may not have a physical health problem, but more deep-rooted physiological conditions.

With ABC Clinic just beginning operations this year already they have achieved so much. Yet the ABC nurses are not complacent and on the contrary are highly enthusiastic and determined with setting ambitious goals for the future of health care at the clinic:

"I also would like to see ABC clinic growing with professional doctors and nurses with proper equipment, so that we will be able to do medical operations when serious health problems happen." (Interview 23 ABC Nurse, 2010)

Figure 48 ABC Nurses doing general check-up

Note: (Author, July 2010)

CHAPTER VI

CONCLUSION

6.1 Summary of Key Findings

In answering the fundamental questions presented at the start of this thesis, firstly *what is the reproductive health condition of the Chin along the Indo-Burma border?* The reproductive condition of the Chin along the Indo-Burma border relating to the field research area, historically Chin women have experienced increased hardship during their pregnancy due to a lack of nutrition support, there is increase pressure prior to delivery through having little alternative but to work in the fields to support their family prior to giving birth leading to more potential miscarriages. Additionally human rights abuses touch everyday life with some of the interviewees having to do forced labour while pregnant. However since the 1990's they have been faced with little alternative but to leave their communities in Chin state, Burma for Mizoram State India, things have gradually been improving in terms of access and especially with the establishment of ABC clinic in 2010. This will help to minimize potential health risks to both mothers and babies through support during antenatal, delivery, postnatal and newborn care.

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More broadly, the fact that many of the Chin migrating to different countries around the world has helped to shed light on the plight of the Chin through advocacy and lobbying with governments and international donors. As a result INGO's, NGO's and GONGO's have been shifting some of their resources to operate in Chin State focusing on improving food security, water, sanitation, health and education which all have an interrelated effect on the health of mothers, newborns and the community as a whole.

Secondly, *what causes this health condition in the context of development conditions in Burma?* Fundamentally while the problems in Burma are deep, complex

and protracted which have been discussed in detail in this thesis, at its core it comes down to one root cause: prolonged military rule. Health is affected not only by a lack of access to services, but by the environment that a person is living in. Military rule affects all areas of life, society and development in Burma: this is an inescapable fact. Even if more hospitals were built now in ethnic areas, people would continue to become sick due to their unhealthy environments and power over them in all facets of life be it arbitrary taxation, lack of clean water, sanitation, military development projects or human rights abuses. Therefore unless the environment is changed in Burma, or the process of solving it is genuinely begun which includes ethnic groups then all of the other possible remedies outlined are comparable to applying sticking plasters on a spreading cancer. This is further highlighted in the following:

"I don't see the Burmese government caring for the people especially the poor and unhealthy. Being ethnic groups and poor people, we are neglected and we are looked down upon...The main reason why I wanted to become a medical person is due to my mother's death. My mother died of womb cancer when I was 13 years old. I kept asking the questions to myself why my mother had such cancer. I kept thinking the cause of the problem and what could have been done to save her life? I have a goal now to become a surgeon specializing on women's reproductive health." (Interview 21 ABC Nurse, 2010)

Thirdly, *what local coping strategies do the Chin use relating to health issues?* Due to a lack of health facilities provided by the state, local communities have through their personal practical experiences learned to a certain extent about reproductive health especially given the relatively large family sizes (up to 10 children). The vast majority of birth attendants are family members such as mother in laws, aunties or in certain cases even a husband has assisted with delivery. For more complicated deliveries the Chin along this border rely heavily on the local Chin TBA who has served informally for over 32 years and has extensive experience, skills and dedication for her people. There is widespread knowledge of traditional medicines evolving from knowledge of local plants in the forest which have healing properties for minor cuts, diarrhea or women's pre-menstrual pains involving boiling cherries

and sugar cane. Yet these treat only minor health conditions and for more serious conditions proper medical treatment is needed. Also the local merchants who travel from rural villages to urban areas where medical supplies are available are another coping mechanism. However the limitations apart from cost or lack of supplies is the fact that merchants are not trained medics and may not know the right prescriptions which could potentially put villagers in a worse health condition. More recently with significant developments in health care in Mizoram state many of the Chin who have migrated over to Mizoram State or even those who are located still in Chin State seek medical treatment in Mizoram state. However barriers such as cost, language and lack of identification results in only a few can have the means to access these alternative services.

Finally, *what reproductive health mechanism is most effective in regards to isolated Chin communities?* In the specific research area already there were noticeable improvements in the health of not only expecting mothers, but also the whole community due to villagers using ABC clinics health services. This was further highlighted by some of the mothers and TBA:

Mother aged 35 with 4 children:

"Now with this clinic for basic medicines we don't have to go to other villages. Over 10 villages from Burma side rely on this clinic and more will come. It has just opened now but if there is a proper doctor more will come. Now it is a lot of relief to the villagers, before we had to carry people when we got very sick to Ixx (India) and now we just need to take them to the clinic and the medical treatment is good and we recover quickly. Our biggest needs are a clinic due to health problems, electric and job opportunities. In the future we would like to see ABC have a proper doctor and facilities for operations." (Interview mother 3, 2010)

The main limitation of the state model is accessibility to hospitals located in urban areas, which are often too far from the villagers. Especially in the rainy season it

becomes increasingly inaccessible combined with pregnant ladies having to walk to the hospitals makes it near impossible,

"Before the main problem was there was no nearby hospital it was too far. We had to go to Champai (India 6 hours drive) to see a professional doctor or Falam town (in Burma). From Txx to Falam we have to walk about 2 days (45miles), but now that we have this clinic many of our problems are solved."
(Interview 25 Traditional Birth Attendant, 2010)

The fact that the vast majority of health professionals in Burma have to focus on private health care due to inadequate salaries in public health sector work also reinforces the dire need for there to be some reforming of the entire policy of the government including better facilities and salaries. Although there are limitations and constraints currently with ABC clinic operating from India, yet the alternative of operating from Burma under the current conditions of prolonged military rule does not permit an effective and realistic health care service to take root. The struggle for PHC community lead health development in rural areas continues through this clinic, the nurses and community. Although the challenges may be many they remain committed to improving the situation for the people of Burma. All they need now is a government which would do the same.

6.2 Analysis of State Healthcare

Although PHC is one of the chosen health care strategies used by the state since 1978 in actual implementation it has been absent. Firstly this may be due to a lack of understanding about what PHC actually is from the various implementing groups. Secondly, the fundamental principle of PHC is empowering communities, giving them a platform for decision making, which could be a direct threat on the centralized power control that the SPDC needs in order to remain in power. The fact that SPDC holds power in all ministries, including the ministry of health, also results in health programs which are highly centralized and do not involve local communities and to a large extent neglect rural ethnic areas. Within the NHC there is a clear lack of transparency and accountability at all levels which breeds corruption, for example at

the state level, budget allocations are distributed unevenly proportionally towards SPDC urban areas such as Naypidaw, and at the local level there are overpriced medicine prices, expensive treatment, availability of medicines or sub standard medicine supplies.

The hierarchical centralized model of health care delivery with every major policy decision having to be channel through SPDC is also highly restrictive, with the SPDC being superstitious of any outsiders wanting to assist in supporting the general population and ethnic groups. This is further substantiated though the recent announcement from SPDC that they have stopped issuing humanitarian visas to Cyclone Nargis affected areas ahead of the 7th November elections. (Irrawaddy, 2010) There is still very much a need to help rebuild the devastated areas which are still underdeveloped. The SPDC lacks any regards for the wellbeing of the general population and it serves them well to keep them in power and the people powerless. Referring to Professor Dr Kyaw Myint who is the Minister for Health, he paints a dubious picture of the Cyclone Nargis affected area, *"adequate health care could be provided for the victims and disease out breaks could be prevented. The emergency relief, rehabilitation and reconstruction tasks were smooth and successful."* (WHO Myanmar, 2009: 4) Yet social workers in the Cyclone Nargis affected areas report even 2 years on in 2010 there has still been a lack of reconstruction and socio economic conditions remain dire. The consequences of this are in local communities they are left vulnerable with no adequate social welfare net to help support them especially young women who are left with little choice and are becoming easy targets of exploitation and trafficking. However this type of information has not been mentioned by the Minister of Health and it is this failing on all levels which is so ingrained into the positions of power within the ministries and SPDC. From their point of view, even if they did want to speak out about the true situation or criticize in public they are in real danger of losing not only their prestigious position, but also their family's security. Therefore fundamentally under this military system they keep silent and oblivious at the expense of their own people.

6.3 Recommendations

6.3.1 Recommendations for ABC Short-term

- Consolidate and improve PHC support in ABC clinic village through running more outreach home visits to the community to strengthen reproductive health care, village/clinic relationships and minimize health problems before they arise. Areas of reproductive health care include increasing the level of support of antenatal care, safe delivery and postnatal care for mothers. Also providing the option of ABC nurses helping mothers wanting a home birth to minimize potential health risks through the use of clean sterilized equipment. Postnatal care visits should be carried out to monitor health of baby and mother.
- Run short day clinics in neighboring Mizo villages in Mizoram India, to help build trust and a good working relationship with the local village council which is essential for the long-term stability of ABC operations along the Indo-Burma border.
- Run more frequent mobile clinics inside Chin State to the 9 surrounding villages with TBA and ABC clinic staff so the TBA can transfer her knowledge to the next generation.
- Gather census data, health related data, health related photos and GPS positions from neighboring mobile clinic villages for future planning of health care strategies.
- Improve logistics relating to the referral system setting up contact lists for medical supplies and emergency transport.
- Provide more community health education training through working with the international doctors, TBA, ABC clinic staff and villagers to promote PHC goals of communities finding solutions to health problems.

6.3.2 Recommendations for ABC Medium/Long-term

- Have professional doctor’s onsite to oversee and work with the local ABC medics in improving their medical diagnosis and healthcare to patients.

- Use ABC clinic as a launch pad where various international/regional/local organizations can run health education programs and practical mobile medic courses.

6.3.3 Recommendations for SPDC Short-term

With the elections commencing in November 2010 it is uncertain how this process will affect key policy making decisions in Burma. However with this in mind there are some clear tangible steps SPDC could be taking both in the short-term and long-term to help improve the overall health and development of the country.

- Increase mobile health teams and immunization programs to specifically focus on isolated ethnic areas.
- Increase the number of higher education and health scholarships to ethnics located in rural areas.
- Review of NHC focusing on alternative decentralized structures which are inclusive, transparent, accountable and independent groups are able to monitor.
- Initiate a PHC practical medical mentoring training program between public, private, grassroots and international health care organizations. With the outcome to train CHW's practical knowledge of health in various locations as well as health professionals from urban areas learning more practically about a communities health needs with the view of them returning to their community with more knowledge and confidence about health related issues.
- Comply with the obligations of the state in effective implementation of CEDAW article 12 at all levels of health related planning, policy making, implementation and monitoring.
- Develop a Below Poverty Line (BPL) system in coordination with international groups, national and local groups which will help to support the most vulnerable people in each community. This scheme should eventually be decentralized and administered through each local village who define the neediest in each community

- Establish a quota for women's genuine involvement in the decision making and policy making of key health ministries, departments and institutions in the new government.
- Reduce the size of the army-through outlawing new recruits especially anyone under the age of 18 as per CRC. This will also help to cut spending on the military and divert military spending more equally into key public sectors such as health and education with appropriate transparency and accountability.
- Cease all conflict hostilities in ethnic areas with the view of allowing humanitarian groups access to rural isolated areas of Burma.
- Stop arbitrary taxation which is only further exasperating the health situation of the people.
- Allow INGO's and NGO's unrestricted access to ethnic areas with the view of providing PHC.

6.3.4 Recommendations for SPDC Long-term

- Establish health related universities/institution in ethnic states (currently all 7 ethnic states do not have a health related university) with all state specific ethnic groups involved in the participation in planning and implementation of the project.
- Set up bilateral agreements with India to allow purely humanitarian assistance unrestricted access to people along the India-Burma border-provided they are also accountable and transparent with their activities so as to not harm national security.
- Construct roads and bridges with local communities active participation in decision making in planning and implementation, ensuring that an independent monitoring commission is able to monitor the labour rights of villagers are being respected.

6.3.5 Recommendations for Local and National NGO'S

- Increase coordination with local groups based in border areas to minimize overlap and increase effectiveness. This could be done through the use of online electronic documentation of target areas and sharing of data and lessons learned.
- Actively target training local ethnic health personnel.
- Independent monitoring, transparency and accountability mechanism relating to the distribution, quality of aid to the targeted communities. This should be carried out with full participation from the local communities.

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APPENDICES

APPENDIX A

QUESTIONS FOR REPRODUCTIVE HEALTH ASSESSMENT FOR WOMEN IN CASESTUDY VILLAGE

Name: Place of Birth: Status:

Number of people in house hold and age: Family Livelihood(s):

1. Before ABC clinic what did you do if one of your family members got ill?
2. How many of your children were born in India?
3. How many of your children were born in Burma?
4. Where did you deliver your baby?/babies (E.g. at the clinic? At home?)
5. Who was the assistant when you gave birth?
6. What supplies did the birth attendants carry?
7. Did you receive care during pregnancy? If so, what kinds of services were provided? (e.g. maternal health care)
8. Did you have any health problems during your pregnancy (s)?
9. Are any family planning services available in your village? If so, what are they?
10. Did you work during your pregnancy (s)? (how many days prior to giving birth?)
11. How long after giving birth did you return to work? (e.g. after 1 week)
12. What contraception is available in your village/area?
13. What village are you from in Burma?..... Township..... HH..... People.....
14. When did you leave your village?
15. How far is it from this village .....miles ..... hours walk
16. Why did you leave your village in Burma?
17. What health resources did you have in your village? (Tick below list)
18. Clinic Medicines Nurse Doctor Immunizations Medical training First aid kit
19. What state support have you had for health related things?
20. What do you do if someone is seriously ill in your village in Burma?
21. What are the differences between your village in Burma and here in regards to health care during pregnancy/after?

APPENDIX B

QUESTIONS FOR REPRODUCTIVE HEALTH ASSESSMENT FOR NURSES

1) Who is the assistant at most births? (A health worker? A traditional birth attendant?)
2) Who trains birth attendants? How often do these trainings occur?
3) What supplies do birth attendants carry?
4) Do women traditionally receive care during pregnancy? If so, what kinds of services are provided?
5) What is the payment policy for births?
6) Where do women usually deliver? (At the clinic? At home?)
7) Does the clinic or birth attendant record information on deliveries?
8) Are any family planning services available? If so, what are they?
9) What contraception is available and used in the area?
10) Is there an abortion system/related problems in the area?
11) What NGO/government support has there been in the Chin villages relating to women's health?
12) What types of reproductive health training or supplies do you think are most needed?

APPENDIX C

KEY INFORMANTS

Below is a list of all the key informants interviewed during field-research along the India-Burma border in the case study village in July 2010. Please note for security reasons the names of the informants have remained anonymous.

Interview No	Type	Date
1	Mother	Jul-10
2	Mother	Jul-10
3	Mother	Jul-10
4	Mother	Jul-10
5	Mother	Jul-10
6	Mother	Jul-10
7	Mother	Jul-10
8	Mother	Jul-10
9	Mother	Jul-10
10	Mother	Jul-10
11	Mother	Jul-10
12	Mother	Jul-10
13	Mother	Jul-10
14	Mother	Jul-10
15	Mother	Jul-10
16	Mother	Jul-10
17	Mother	Jul-10
18	Mother	Jul-10
19	Mother	Jul-10
20	Mother	Jul-10
21	Nurse	Jul-10
22	Nurse	Jul-10
23	Nurse	Jul-10
24	Nurse	Jul-10
25	Tradtional Birth Attendant	Jul-10

BIOGRAPHY

Ben has a 1st class honours undergraduate degree in Computer Animation, from Bradford University UK. He focused his final year there on working with Karen refugees from Burma producing media projects. It was during this time that he wanted to develop a firmer understanding of the underlining challenges of development and therefore undertook a Masters in International Development at Chulalongkorn University, Thailand. On a personal level, what motivates him to try and make a change in this world comes from his roots. Although born in UK his mother is from Burma. In the future he is focused on working with grassroots communities and partners on improving the situation in Burma.