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

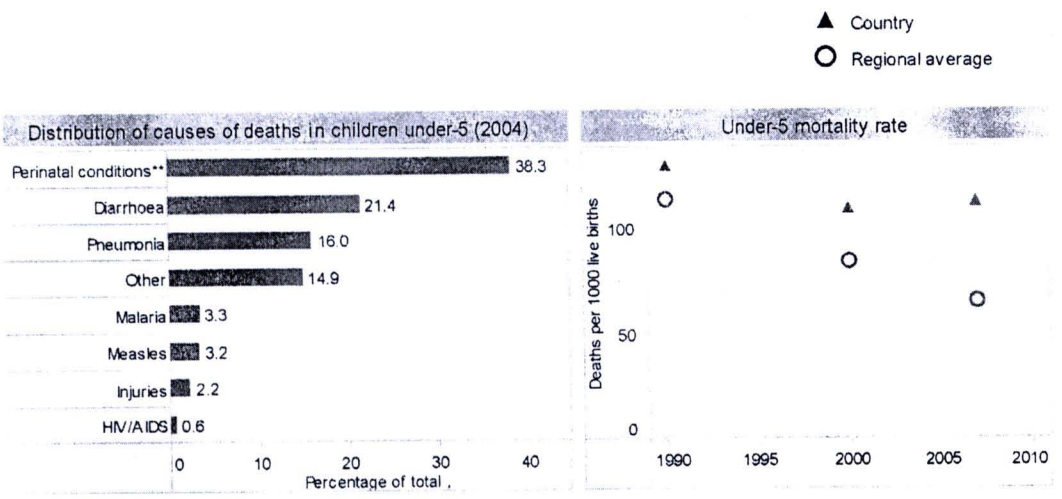
4.3 Proportion of 1 year-old children immunized against measles"

(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.