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,

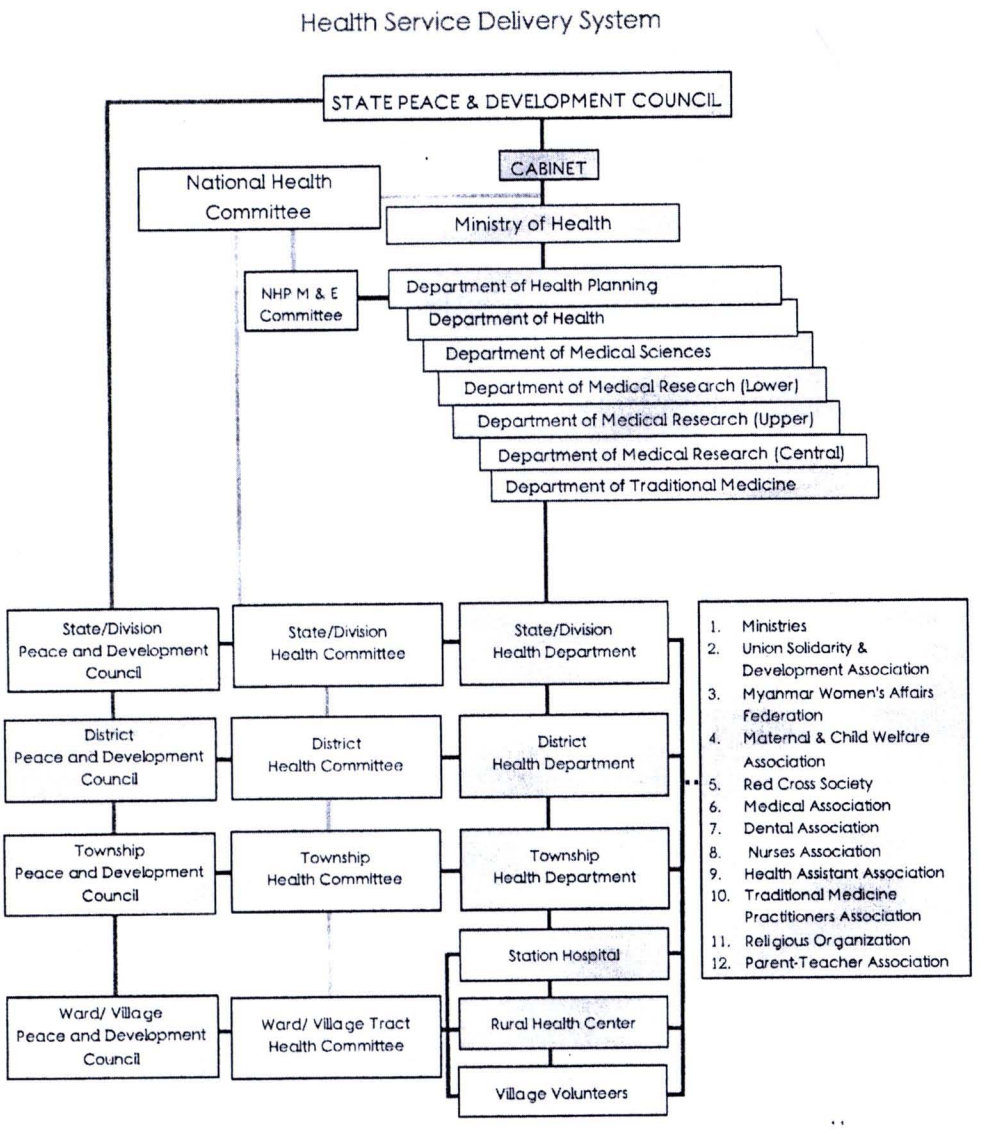
- *"To enable every citizen to attain full life expectancy and enjoy longevity of life.*
- *To ensure that every citizen is free from diseases."*

  (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)

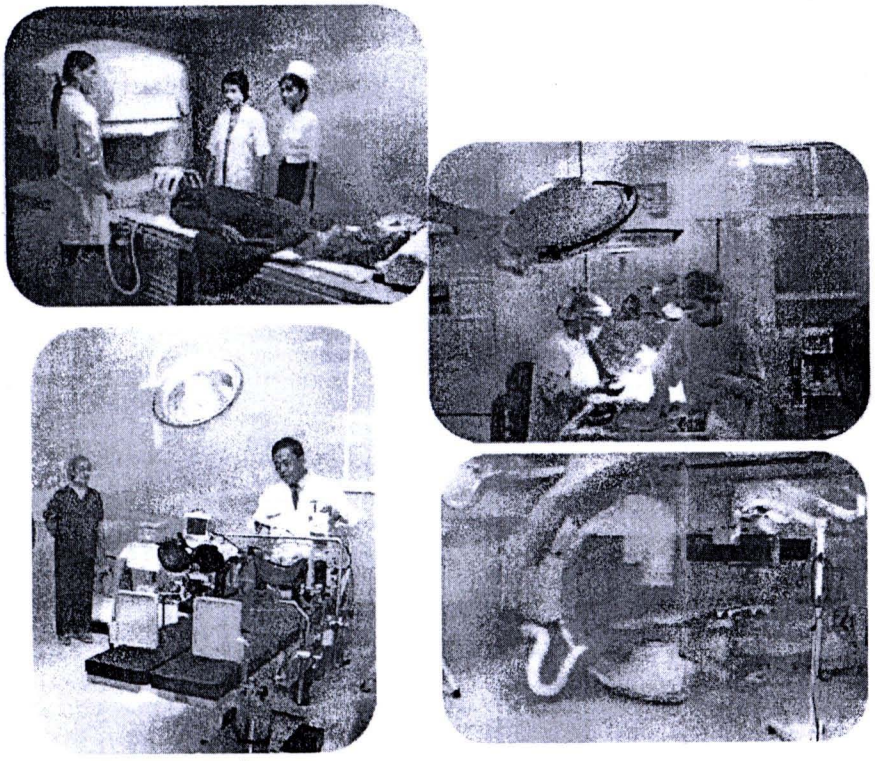
The dire health needs in ethnic areas which are not fundamentally under the direct controlled by the SPDC are often referred to as white areas (under the control of SPDC) brown areas (under limited control by SPDC and ethnic groups) or black areas (under control by opposition armed groups). Often these 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

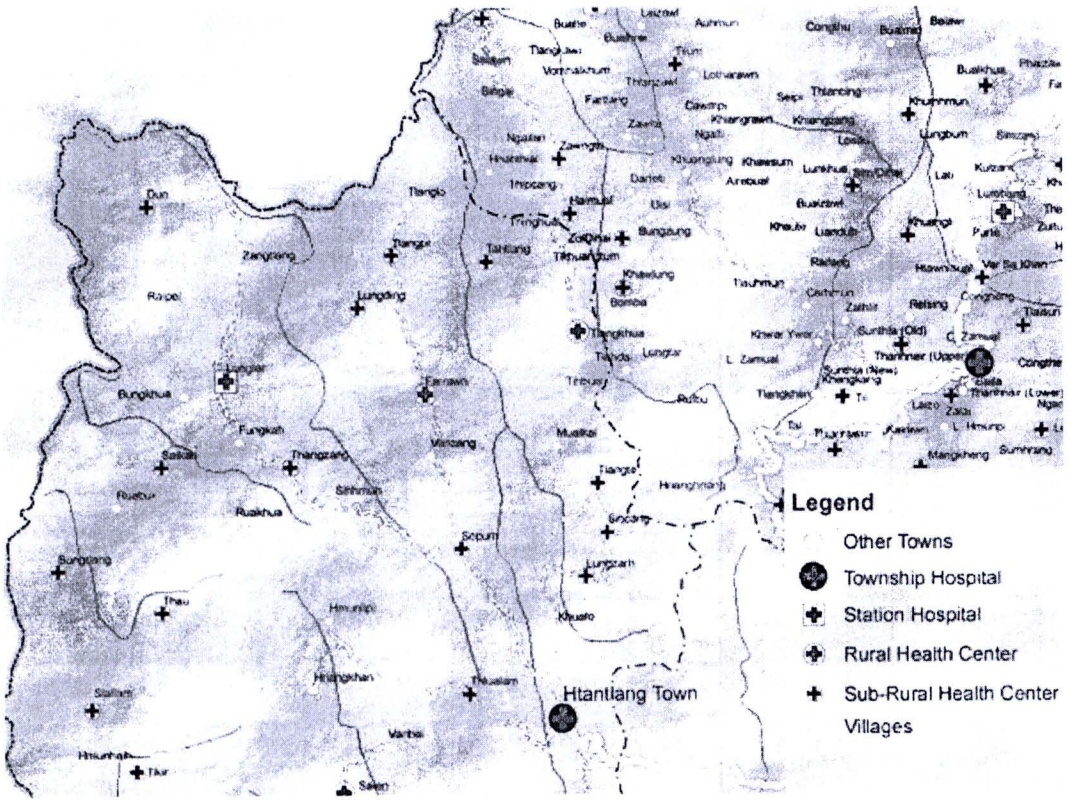
It is from the township level that the actual provisions of health care and implementation of state policies are carried out. Within the township level health care is provided at a township hospital and 1-2 station hospitals. In terms of beds the township hospitals have between 16-50 beds, depending 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.

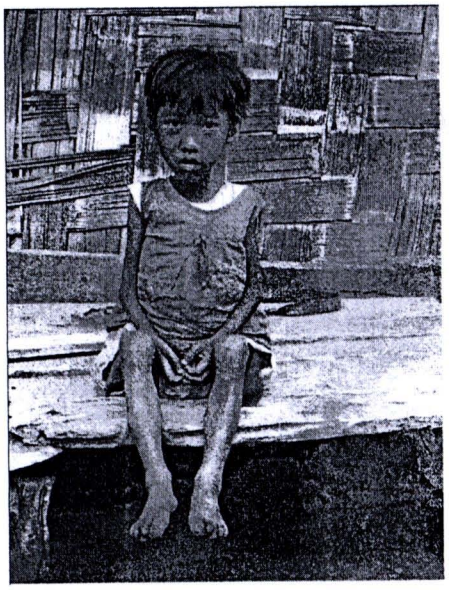
Figure 10 Myanmar Heath Vision 2030

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)

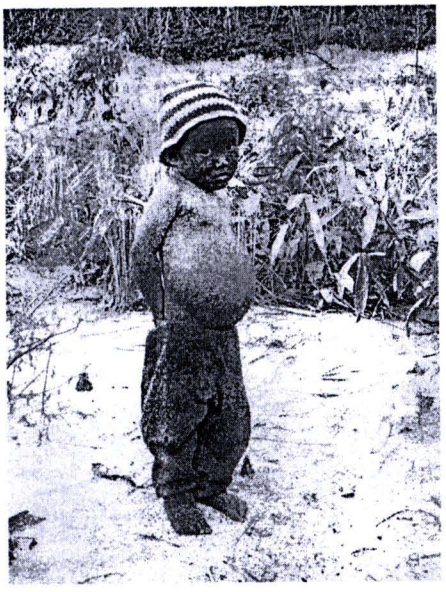
The MoH states, "*Ministry of Health, plays a major role in providing comprehensive healthcare throughout the country including remote and hard to reach border areas*". (MOH 2009: 1) Regretfully this is to a certain extent just rhetoric especially in the claim of comprehensive healthcare to *remote and 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

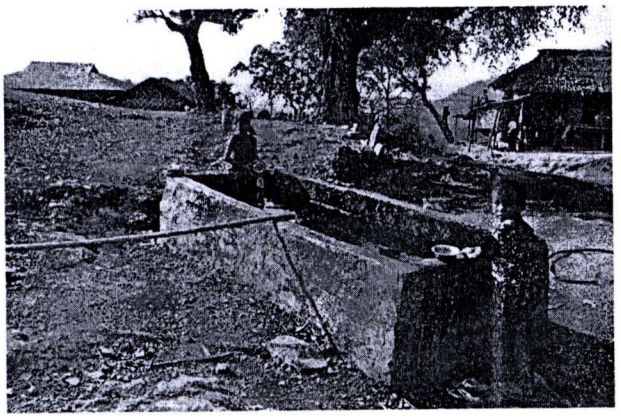
(NSW) since 1998, and has claimed that sanitation coverage in rural areas amounts to 78%.

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

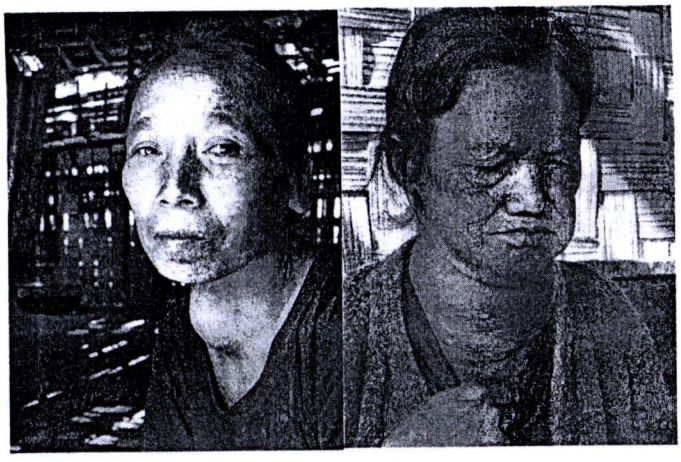


Note: (Author, 2008)

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



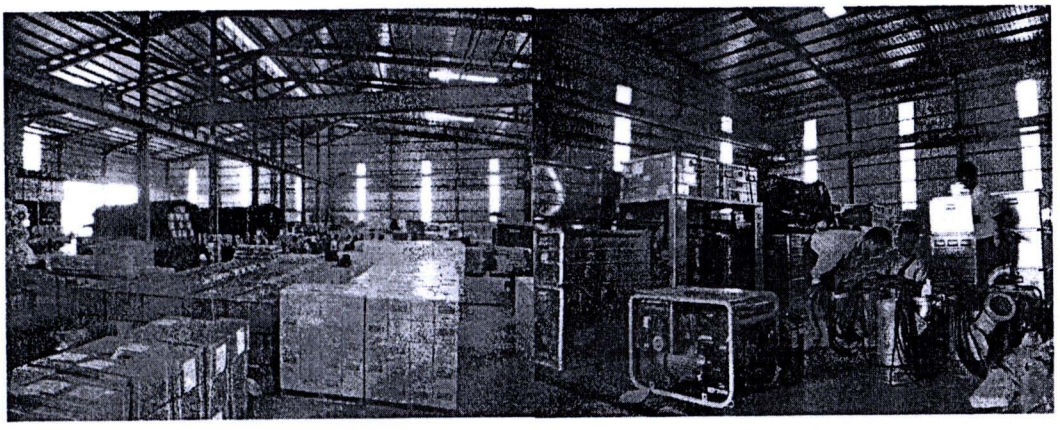
Note: (Author, 2009)

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

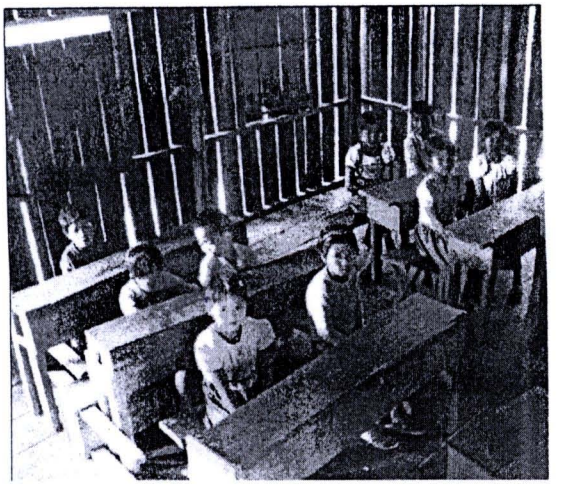
University/ Training School	No. of Intake each Year
University of Medicine	2400
University of Dental Medicine	300
University of Pharmacy	300
University of Medical technology	300
University of Nursing	300
University of Community Health	180
Nursing Training Schools	1200
Midwifery Training Schools	1050

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

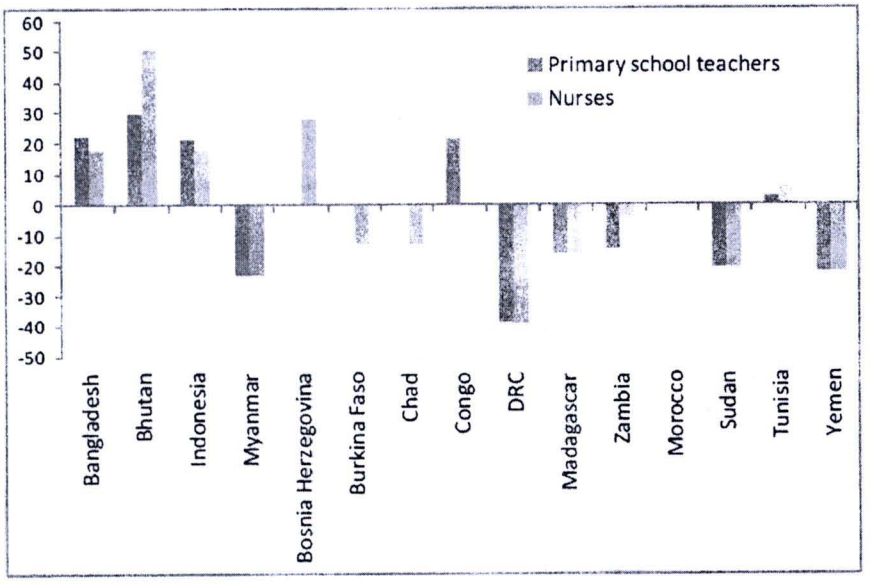
Primary school teaching is the foundation platform in nurturing the next generations of potential public sector personnel such as teachers, doctors and nurses. In the above photos one depicts a primary school teacher in Chin state who has to teach with her child on her back demonstrating the hardship 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.

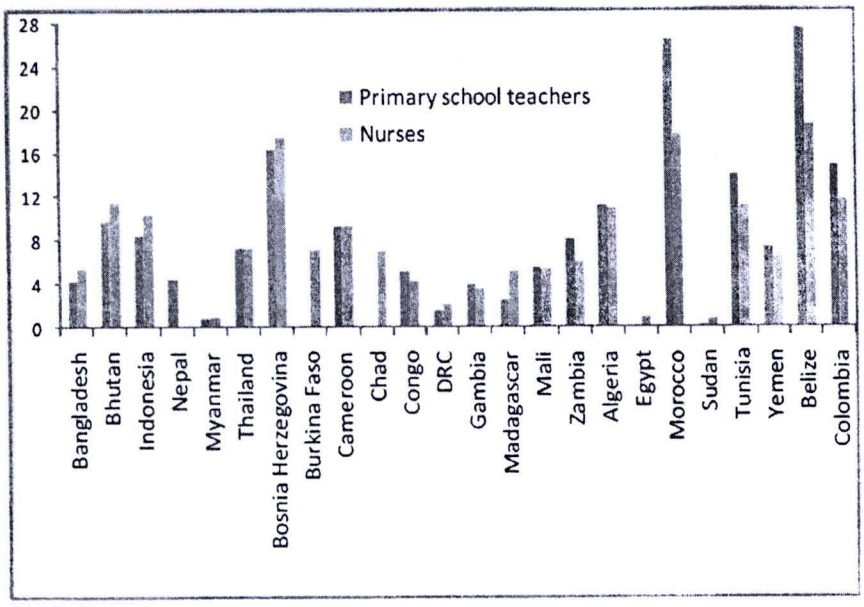
Figure 21 Estimated Changes in Annual Salaries, 2007-2009



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)