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

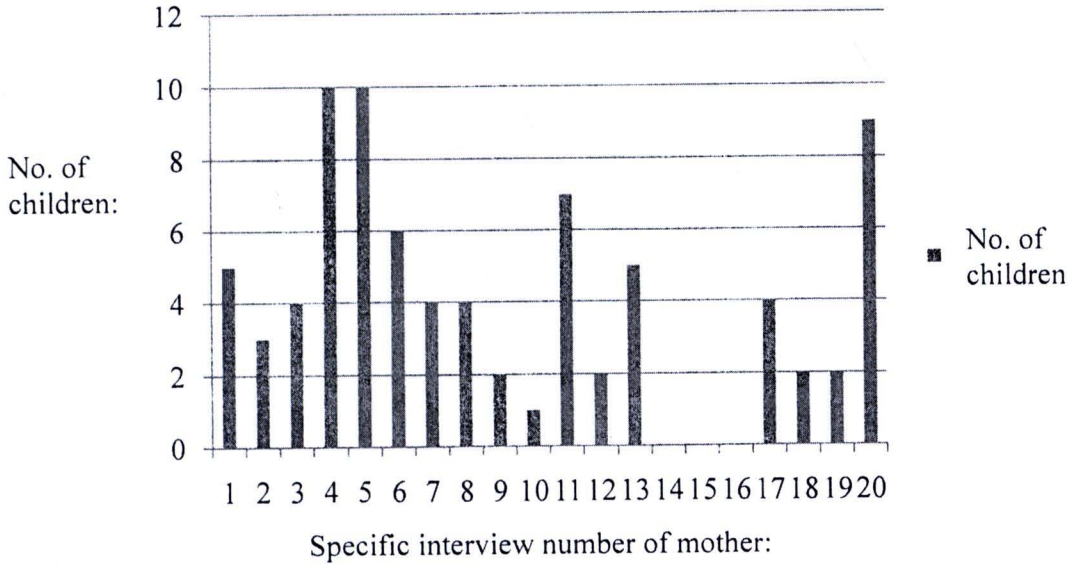
give them, but I cannot provide them freely. With that lack of vitamins and lack of nutrition some babies are born with health problems. Over time when I touch a pregnant mother's stomach I know if the baby is healthy or not."
(Interview 25 Traditional Birth Attendant, 2010)

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

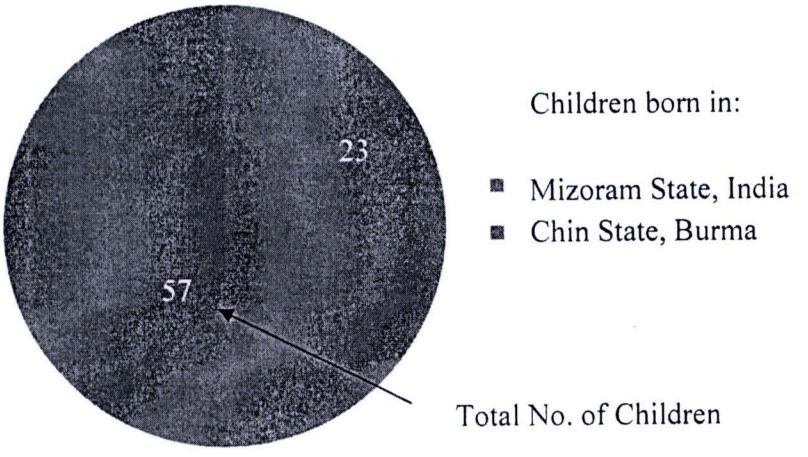
Note: (Author, July 2010)

Figure 26 Number of Children Per Mother Interviewed



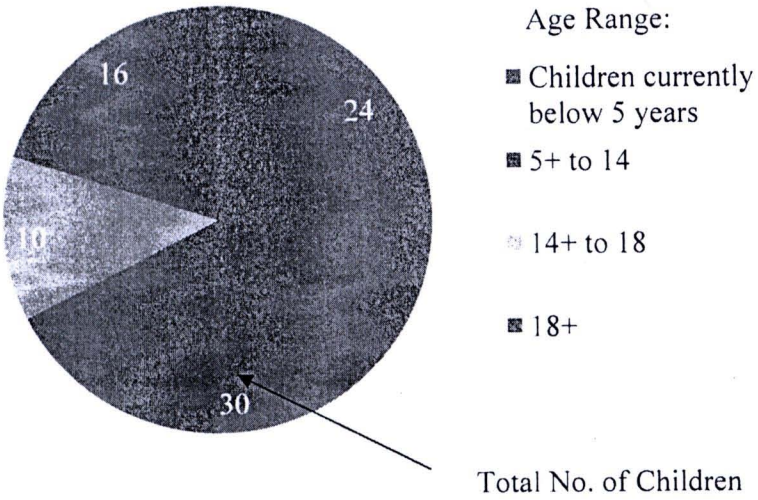
Note: (Author, July 2010)

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

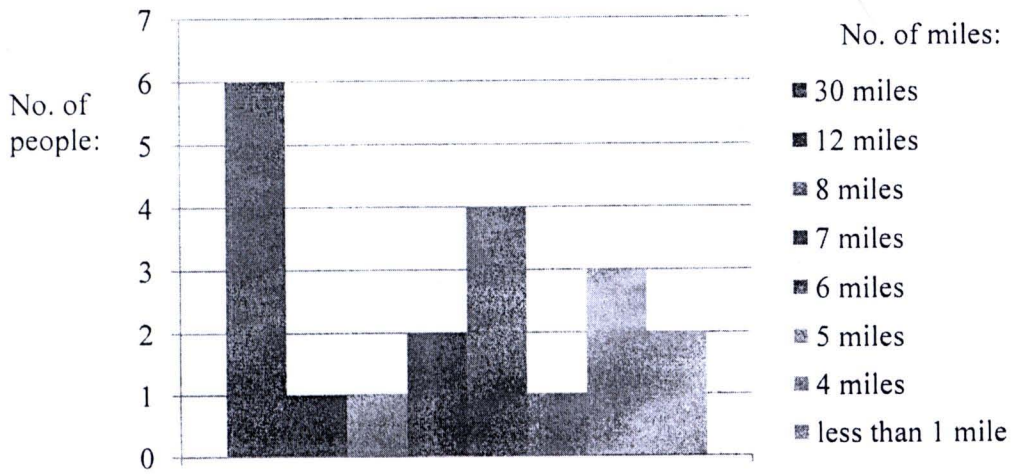
become a surgeon specializing on women's reproductive health." (Interview 21 ABC Nurse, 2010)

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)

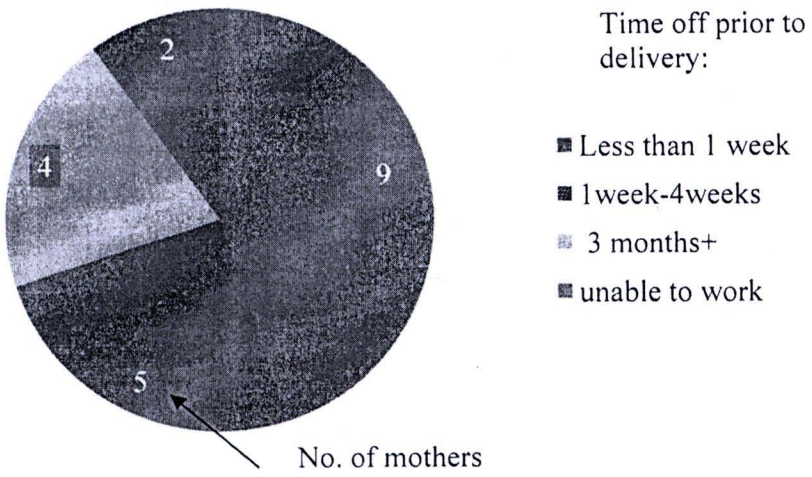
After the interview was finished with the TBA, though informal conversions it was discovered that the TBA had helped to deliver over 300 babies along the India-Burma border. Under the circumstances it could seem that this TBA service is

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.

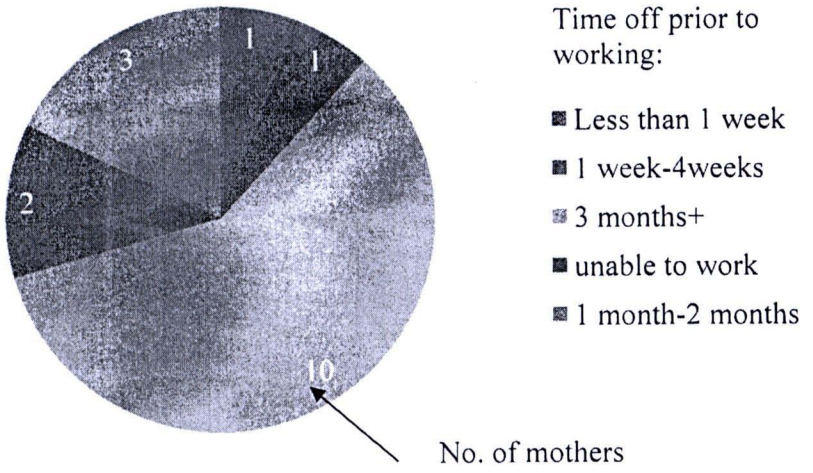
Figure 31 Breakdown of how long before giving birth does a mother stop working in the rice fields



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)

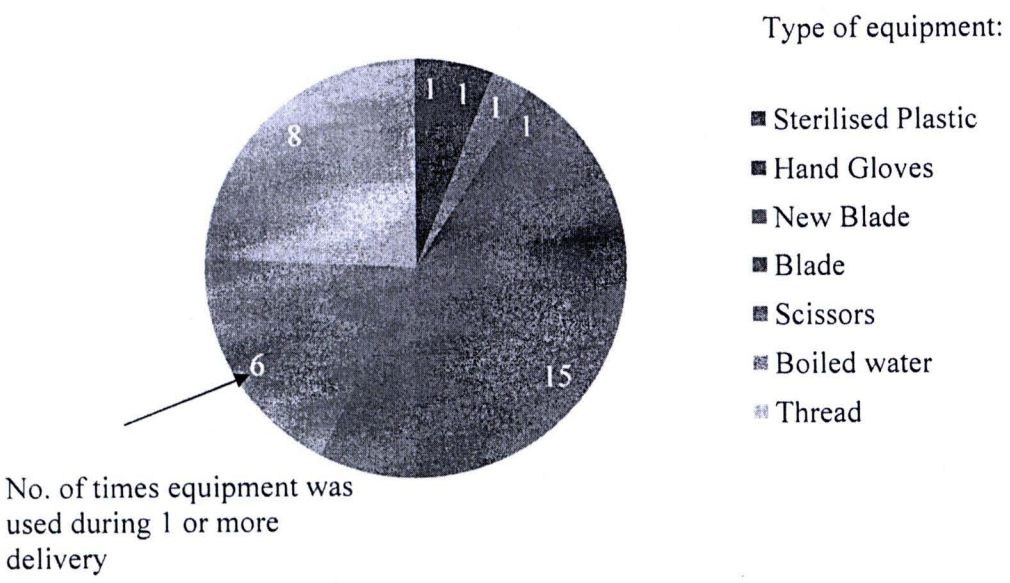
The TBA also highlights an increase in the number of expecting mothers with their babies positioned awkwardly in their wombs. The TBA provides informal antenatal checkups to ensure the baby is in the right position prior to delivery.

"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



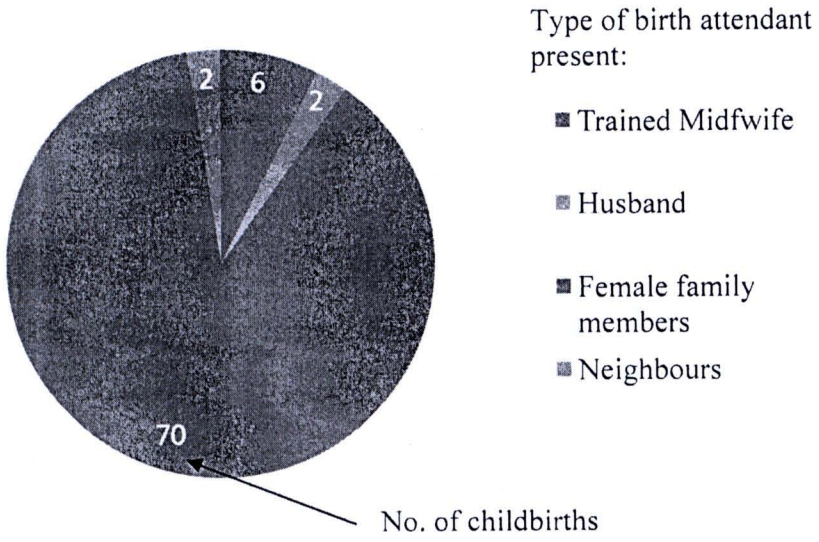
Note: (Author, July 2010)

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)

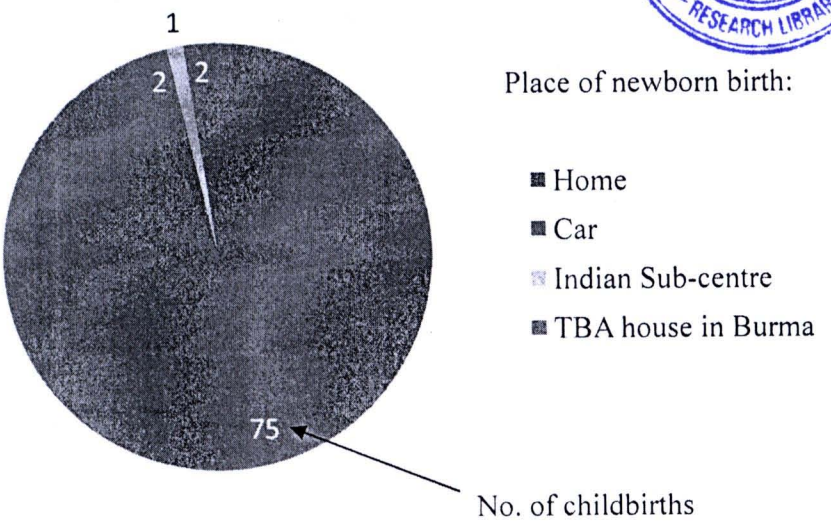
With a lack of a trained midwife some families just have Another coping mechanism for reproductive health; their husbands helping to deliver on 2 separate occasions. This also highlights the lack of reproductive health care in the Chin State.

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)

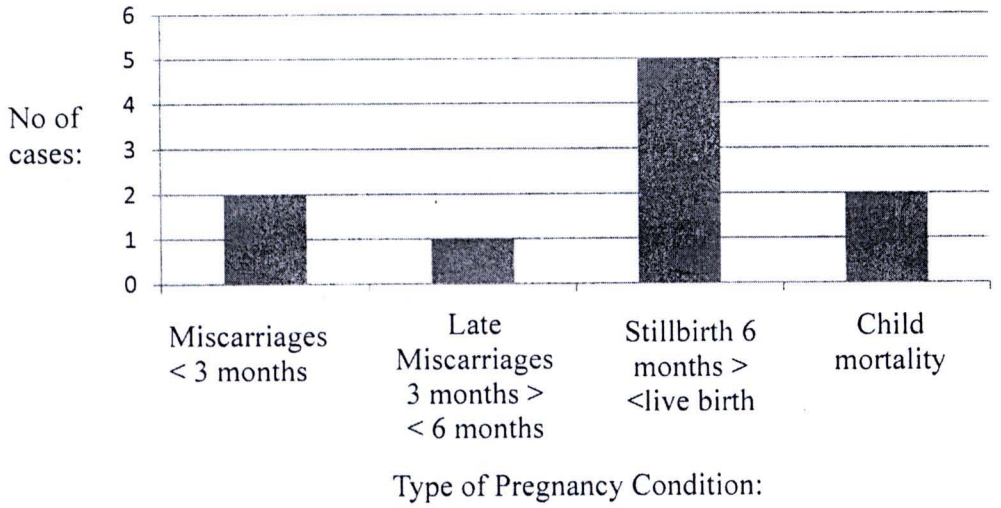
Other mothers are luckier with no major health problems reported. Many of the villagers rely on informal nurses or TBA to help with any complications during the pregnancy or postnatal period.

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,

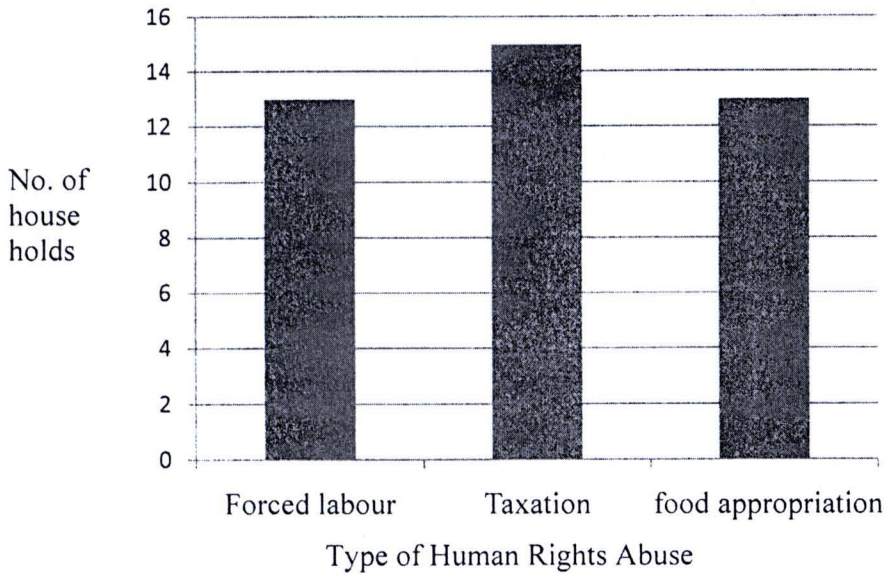
Case 2:

"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

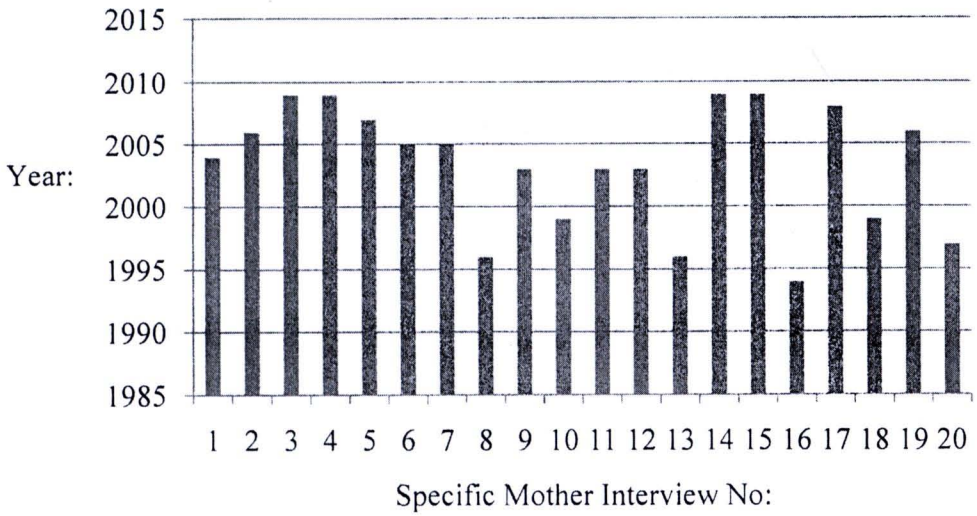
CNF/CNA who are at least doing something for our country. One night the SPDC came at 1am and kicked in the door, waking up my children looking for my husband, they even looked in our rice storage basket. The SPDC always called me for forced labour, sometimes I had to borrow money from the other villagers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

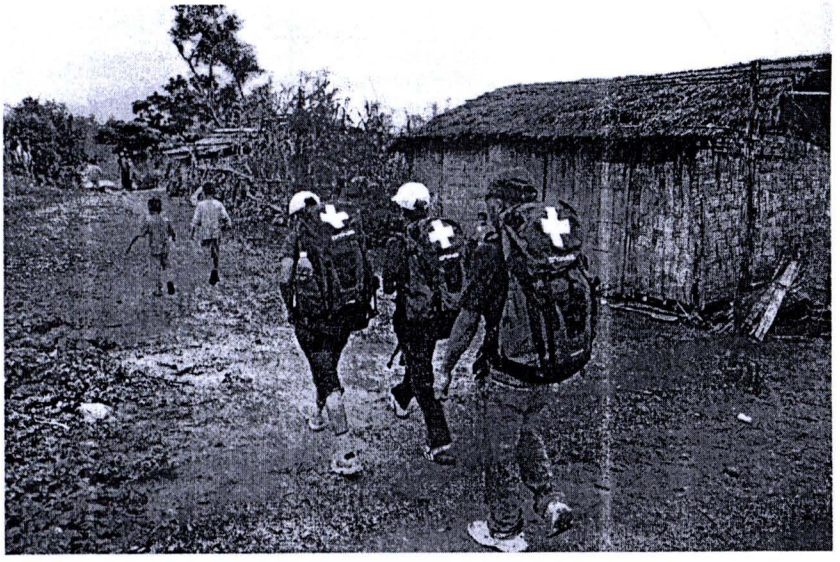
Mother aged 28 with 3 children who has experienced 2 miscarriages:

"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:

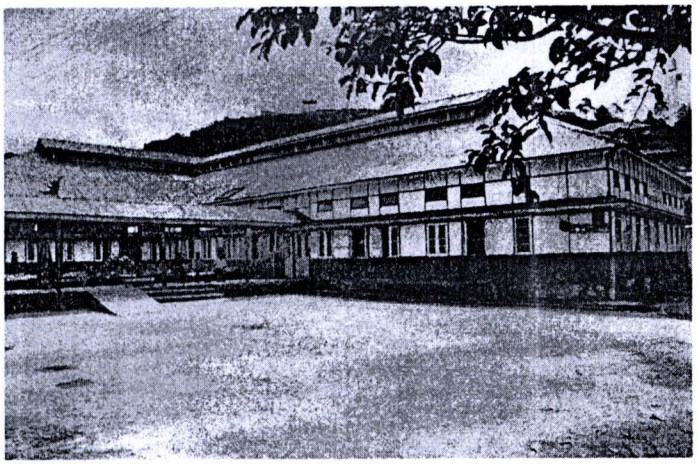
During my previous pregnancies I had no vitamins or no health education. One of my pregnancies my baby was not in the right position so I went to see a midwife in Txxx (2 miles away in Burma) having to walk there. After my 1st baby was born I had pieces of the womb stuck inside of me and I got sick. 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

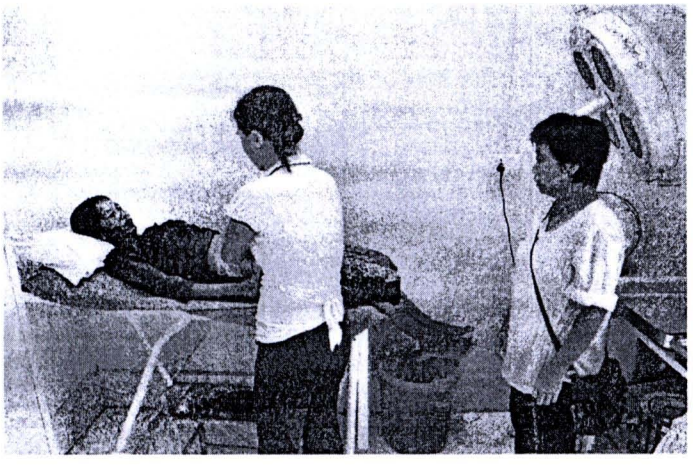
With ABC being a limited primary health care facility for more complicated or severe health conditions one of the most important aspects is the establishment of the referral system. The nearest hospital from the clinic is approximately 7 hours drive. Sometimes even at the Champai hospital they do not 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



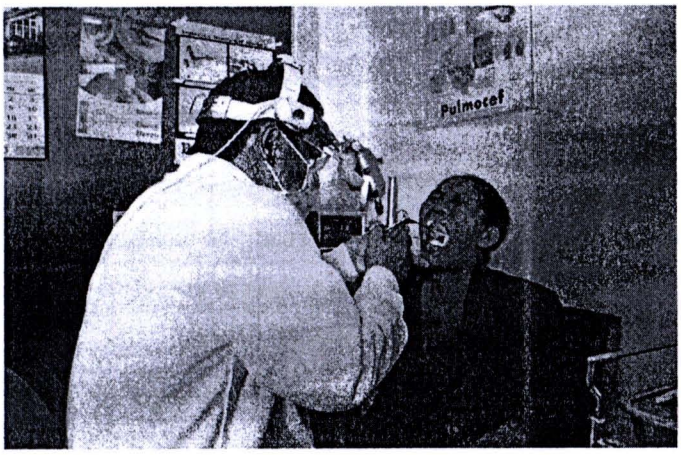
Note: (Author, July 2010)

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)

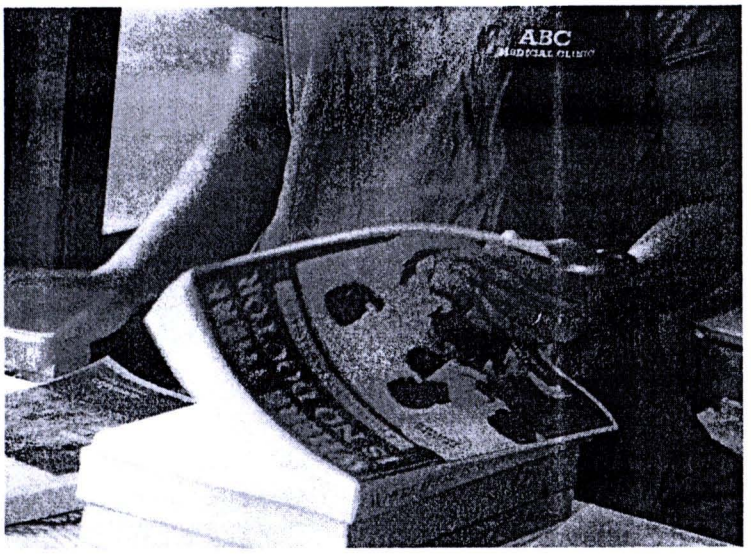
The personal hardships that these nurses have had to endure in foreign countries have really highlighted their personal sacrifice and love towards their own people. They are faced with a steep learning curve sometimes in environments in which their native language is not spoken, so making learning about 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.

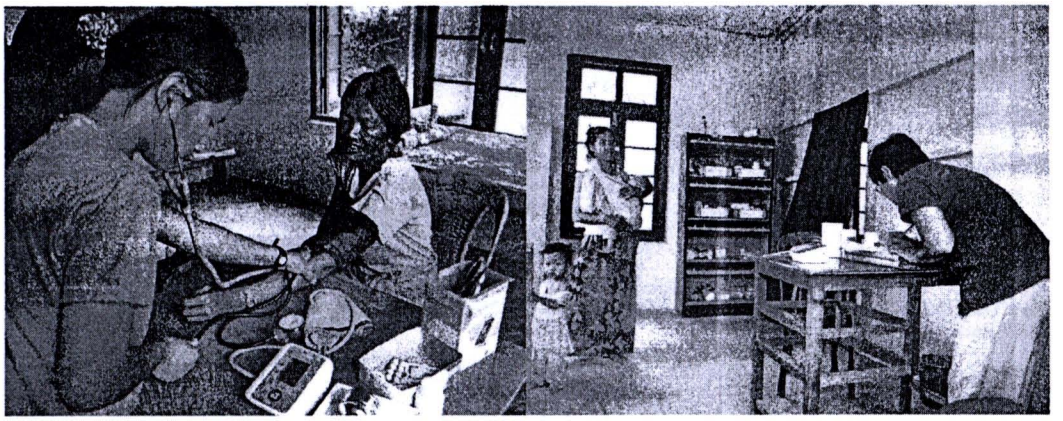
5.9 Summary of Research Findings

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)