CHAPTER VI

CONCLUSION

6.1 Summary of Key Findings

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

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

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

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

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

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

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

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

Mother aged 35 with 4 children:

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

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

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

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

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

6.2 Analysis of State Healthcare

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

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

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

6.3 Recommendations

6.3.1 Recommendations for ABC Short-term

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

6.3.2 Recommendations for ABC Medium/Long-term

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

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

6.3.3 Recommendations for SPDC Short-term

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

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

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

6.3.4 Recommendations for SPDC Long-term

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

6.3.5 Recommendations for Local and National NGO'S

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