

HEALTH POLICY AND PRACTICE IN MYANMAR: A CIVIL SOCIETY PERSPECTIVE

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Abstract:

The quality of health care available to a population is considered a robust measure of the effectiveness or otherwise of a nation's governance. In transitional states with a legacy of authoritarian governance, the provision of health care may be hostage to other priorities, leading to sub-optimal outcomes for vulnerable groups. In Myanmar where the private sector accounts for over seventy per cent of expenditure on health care, the civil society sector has taken significant responsibility for provision of health care services in a policy framework which has often been deficient. This article explores the quality of health care available to Myanmar's vulnerable populations, the resources and outcomes fostered by civil society initiatives in a context where the state is seeking to 'catch up' with others in the region.

INTRODUCTION

Everything about Myanmar is contested, from the country's name¹ to the way aid is received and distributed, whether it is reaching those in need, and how much might be siphoned off into the hands of officials, a foregone conclusion in some minds for a country where Transparency International in 2006 cited Myanmar on its corruption index at 1.9, just above Haiti.² Before Cyclone Nargis wreaked its path of destruction across the Ayeyarwaddy delta, Yangon, Bago and Magwe divisions on 2-3 May 2008, the provision of humanitarian assistance to Myanmar by the international community was a controversial issue, despite numerous calls from international NGOs such as UNICEF that considerable assistance was required to avert a humanitarian disaster in the country. In 1997, Rolf Carriere, former head of UNICEF, Yangon, had called for

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[Formerly known as the Union of Burma, the country was re-named Myanmar by the military junta in 1989 after the dissolution of the Burma Socialist Program Party. Myanmar is the official name of the country as registered with the United Nations. Activist supporters of pro-democracy leader Aung San Suu Kyi however, continue to use the name, Burma. This paper uses the new official name for the post-1989 period, and the name of 'Burma' for the country as it was prior to 1989.](#)

² [Transparency International Corruption Perceptions Index 2006.](#) By comparison, Zimbabwe was accorded a 2.41, and Thailand 3.63. Myanmar is thus in the second bottom slot, ranked with Iraq and Guinea at Number 160 on the chart. Finland, was accorded 9.6 and ranked at Number 1; Australia was accorded 8.7 and ranked at Number 8 along with The Netherlands. See www.transparencyinternational.org Accessed 4 September 2008.

the urgent resumption of humanitarian relief and development assistance to Myanmar as the ‘hallmark of a civilized and sophisticated global community’ that does not need to vent its spleen on children, the vulnerable, the elderly and infirm, and those suffering from serious health problems.³

Carriere’s perspective was seconded by the heads of the UN relief and development agencies in Myanmar; on 30 June 2001 they issued a public statement calling for an increase in foreign aid to pull the country back from the brink of serious humanitarian crisis. These calls went largely unheeded, although some countries such as Japan, Germany, Thailand, China, India and Australia did increase their assistance for certain programs especially in the health and education sectors. In 2005, the Global Fund withdrew, citing operational difficulties; subsequently, the Three Diseases Fund (3DF) was established on 12 October 2006 with funding from Australia, Norway, Sweden the UK, the Netherlands, and the European Commission for prevention and treatment of malaria, tuberculosis and HIV/AIDS.⁴ This excellent international initiative, whilst of critical importance, does not address the general

³ R. C. Carriere, (1997) ‘Responding to Myanmar’s silent emergency: the urgent case for international humanitarian relief and development assistance,’ in P. Carey (ed.) (1997) *Burma: the challenge of change in a divided society*, (Basingstoke and New York: Macmillan Press and St Martin’s Press) pp. 209-34.

⁴ Initial pledged contributions of USD100million over five years have effectively increased to USD106million in 2008 with fluctuations of the US dollar. All pledged contributions have been honored. These are: Australia (AusAID) USD13,111,014million over five years; UK (DFID) USD40,247,936million over five years; European Commission USD25,246,101million over four years; The Netherlands USD7,036,157million over five years; Norway USD2,488,070million; and Sweden (SIDA) USD 16,515,105 over five years. The Three Diseases Fund management board has a zero tolerance policy on corruption and fraud. In 2007/2008 grants of over USD21million were made through 34 agreements with 23 implementing partners from UN agencies and International NGOs who work with domestic community-based NGOs and professional associations to improve provision of health services focussed on these three diseases. Some of these are: the Francois-Xavier Bagnoud Association which provides HIV comprehensive care for 1000 patients in 42 townships in Yangon Division, Mon State, Ayeyarwaddy and Mandalay Divisions; the Myanmar NGO consortium on HIV/AIDS (comprised of Save the Children UK, Care Myanmar, Marie Stopes International and the Myanmar Nurses and Midwives Association); Myanmar Medical Association(MMA)/WHO involved in quality diagnosis and treatment of malaria in 150 clinics in 39 townships; Population Services International/WHO/MMA for the detection and early treatment of TB in 107 townships. Some eight partner agencies have contracted with 3DF to provide services for the detection and treatment of TB. The 3DF is also deeply involved in assisting victims of Cyclone Nargis; 19 of its partner agencies are providing relief aid in the five affected States/Divisions. See www.3dfund.org (Accessed 3 September 2008).

issue of overwhelming poverty, maternal and child malnutrition, and a social fabric under considerable distress.⁵ In June 2007, Charles Petrie, the former head of the UN Development Program (UNDP) in Myanmar warned of a looming humanitarian crisis, unless international assistance was forthcoming to tackle acute poverty, AIDS, malaria and tuberculosis. Petrie had noted the worrying evolution of these three diseases as a cause for major concern in view of the increasingly significant percentage of the population which has difficulty earning a livelihood. Operating in 57 townships (out of a total of 325 nationwide) in Myanmar, UNDP focuses its assistance at grass-roots level, in primary health care, environmental issues, HIV/AIDS prevention and food security.⁶ However, it took the disaster of Cyclone Nargis, which claimed over 130,000 lives, before such calls were heeded in the wider international community.

When the cyclone hit the four most heavily populated southern divisions of Myanmar, it destroyed over 800,000 homes and 75 per cent of the health facilities. Despite initial fears that the region would then be ravaged by epidemics of serious diseases such as cholera, typhoid and dengue fever, these fears proved unfounded, largely owing to the combined efforts of both the international community and the domestic civil society sector in Myanmar which saw Burmese citizens living abroad rally to assist their compatriots inside the country. Whilst the international community focussed its efforts on organizing large scale donations for relief and later, reconstruction, and neighbouring countries (Thailand and China) in the Asian region

⁵ On 21 August 2008, for example, *The Irrawaddy Magazine* broke the story of 30 children in Chin State, western Myanmar, dying of hunger as a consequence of a rat plague which has eaten the rice stores in some villages. According to Amartya Sen's theory, if Myanmar were a functioning democracy the institutional capacity would have been present to prevent such a tragedy, by rapid mobilization of alternate sources of sustenance and medical care. See Amartya Sen, and Jean Dreze, (eds.) (1999) *Omnibus*, New Delhi and New York: Oxford University Press, including *Poverty and Famines* and *Hunger and Public Action*.

⁶ *The Irrawaddy Magazine*, 20 June 2007.

sent in medical teams, small scale domestic NGO operations also sprang up to assist in building houses, providing food, clothing and medical supplies to those in need, often taken into the devastated delta areas by boat or private cars which ran the gauntlet of the authorities' road blocks. One group, the Handy Myanmar Youths, left their day jobs to build low cost shelters for those who had lost their homes. Another, the Cape Negrais Committee, formed from Myanmar business people and wealthy expatriates living in the United States, hired an aircraft and flew in one thousand shelter boxes for the homeless. Medical NGO Merlin was provided with a cruise ship donated through clients of a local tourism company, which was used as a floating hospital in the devastated Laputta area.⁷ The Turkish NGO Kimse Yok Mu (which means, 'Can anyone help?') provided funds to build 100 homes at a cost of US\$1000 each, plus two schools costing \$50,850 each, in Ayeyarwaddy Division.⁸ The Saudi Government sent five planeloads of medical supplies, construction equipment, tents and food, plus a ship with 100 tons of rice, pesticides, ambulances, Land Rovers and heavy construction equipment.⁹ National governments and Myanmar Relief Funds in many countries saw ordinary citizens reach out to assist the cyclone survivors in a situation where initially the government of Myanmar gave the unfortunate impression that it was perplexed and unable to organize effective immediate assistance for those victims in dire need.¹⁰ Dozens of private foundations and NGOs in both the US and

⁷ *Myanmar Times*, 14-29 July 2008. This is an area which has suffered widespread destruction of the mangrove forests, used by very poor people for cooking and heating. It is possible that this environmental issue contributed to the severity with which Cyclone Nargis impacted on the area. See Helen James, (2005) *Governance and Civil Society in Myanmar: Education, Health and Environment*, (London and New York: RoutledgeCurzon).

⁸ *Myanmar Times*, 30 June – 6 July 2008.

⁹ *Myanmar Times*, 2-8 June 2008.

¹⁰ The devastating earthquake in Sichuan province, Southwest China occurred soon after Cyclone Nargis. The contrasting responses by the government of the People's Republic of China and that of the Myanmar government were widely commented on in the international media. It took considerable diplomatic skill by the new UN Secretary-General, Ban Ki-moon, and several visits to Myanmar to hold discussions with senior figures in the Myanmar government before official approval was granted for substantial international assistance and relief teams to be able to enter the country to work with the victims of the cyclone disaster.

the UK also contributed their resources to this relief effort.

Speaking after the tripartite assessment team comprised of the UN, ASEAN and Myanmar government agencies had released the results of their first assessment on 24 June, Dr Surin Pitsuwan, ASEAN Secretary-General (and former Thai foreign minister in the Democrat government of Chuan Leekpai, 1997-2000) said it was time to speed up the humanitarian relief effort. He called for more support for the NGOs and the international organizations to expand their activities and to adopt the stance that providing humanitarian assistance to Myanmar is a long term commitment. Noting that this is a high priority for ASEAN, Dr Pitsuwan said: 'We certainly would like to maintain that humanitarian space and deepen it and expand on it so that we can continue to help, because they do need help.' His views were echoed by Daniel B. Baker, UN Population Fund (UNFPA) representative. Whilst people are now rebuilding slowly and planting crops, they are still living precariously, Baker said. 'We still have a lot of humanitarian relief work to do in the future. That is the big issue, how do we keep it going?' At UN headquarters in New York to attend the second fundraising appeal to raise international donations for the relief effort, Baker praised the UN Secretary-General Ban Ki-moon in conducting his successful discussions with Senior General Than Shwe and the Myanmar government, which resulted in permission being granted for the international relief teams to gain access to the cyclone-affected areas. Baker noted that it was these combined efforts – those of the international community, Myanmar's citizens and domestic NGOs, together with Myanmar's public health system - which prevented a disease epidemic and further loss of life.¹¹ In the event, the UN Under-Secretary General for Humanitarian Affairs, John Holmes, called for an additional \$481million over and above the \$201million

¹¹ *The Irrawaddy Magazine*, 14 July 2008.

pledged during the first appeal, to fund a further 100 projects for vulnerable people. These would include projects to assure food supplies, restore agricultural activity, water and sanitation, health, schooling and shelter.¹² Mr Holmes said the funding would be mostly for the agricultural sector and for providing food for the more than 1.2 million people directly impacted by the cyclone. In a notable departure from previous policy, *The Myanmar Times* for 18-24 August 2008 carried the story that the UK based INGO, Action-Aid, in cooperation with the Myanmar Fisheries Federation, had committed to providing USD10million over four years to assist the revival of Myanmar's fishing industry which was devastated by the cyclone, and that discussions were ongoing with OXFAM for a further USD2million in assistance. These efforts have run in parallel with those of international civil society – World Vision, Care, ADRA, the International Federation of Red Cross and Red Crescent Societies – who have all responded to the overwhelming need evident in the wake of the disaster. By August 2008, World Vision Australia had raised over AUD5.8million for the relief operations.¹³

CIVIL SOCIETY – HOW CAN IT HELP THE NEEDY?

In this paper, I employ the definition of civil society expounded by Cohen and Arato (1992)¹⁴ that it refers to the level of governance existing between the state and the governed. It includes, but is not limited to, non-government organizations involved in service-delivery and advocacy activities, charitable organizations, religious organizations, private foundations, professional associations, social

¹² *Myanmar Times*, 14-20 July 2008.

¹³ [Personal communication with Mr Tim Costello, AO, Chief Executive, World Vision Australia.](#)

¹⁴ J. Cohen and A. Arato, (1992) *Civil Society and Political Theory*, (Cambridge, MA: MIT Press)

movements, and activist networks. The key common denominator with all these groups is that they be 'not for profit', and seek to achieve their objectives through non-violent methods. This definition is consistent with the criteria of Muthiah Alagappa (2004).¹⁵ Since the resurgence of scholarly interest in civil society after 1989, when various Eastern European countries overthrew their communist governments and embraced democracy, the most common paradigm of civil society envisions it as a sector working in antagonistic mode against the state in order to increase the space for licit political protest and citizen activism. Exponents of this perspective (amongst many others) include John Keane, Ernest Gellner and Adam Seligman¹⁶ The concept that a vibrant civil society sector fosters good government underpins the seminal work of Robert Putnam.¹⁷ However Judith Tendler's work on Brazil has a different perspective to Putnam's 'bottom up' approach; Tendler's research proposes a 'top down' theory that good government fosters and deliberately makes space for civil society.¹⁸ Both these approaches however may be too simplistic, too schematic. Philip Oxhorn's groundbreaking research in Latin America demonstrates that civil society, in states where a neo-liberal politico-economic order has replaced a previously authoritarian one, is often co-opted and deliberately weakened by the newly emerging elites who control the processes of democratic governance.¹⁹ A similar development has been observed in Thailand where, since

¹⁵ Muthiah Alagappa, (ed.) (2004) *Civil Society and Political Change in Asia*, (Stanford: Stanford University Press), —p. 35.

¹⁶ Ernest Gellner, (1994), *Conditions of Liberty: Civil Society and its Rivals*, (London: Hamish Hamilton); — John Keane, (1998) *Civil Society: Old Images, New Visions*, (Cambridge: Polity Press).

—Adam Seligman (1992), *The Idea of Civil Society*, (New York: The Free Press).

¹⁷ Robert Putnam (1993), *Making Democracy Work: Civic Traditions in Modern Italy*. (Princeton: Princeton University Press).

¹⁸ Judith Tendler, (1997) *Good Government in the Tropics*. (Baltimore and London: Johns Hopkins University Press).

¹⁹ See Philip Oxhorn, (2006a) "Conceptualizing Civil Society from the Bottom Up: A Political Economy Perspective." In *Civil Society and Democracy in Latin America*, (ed.) R. Feinberg.

1997, democratically elected governments of both the Chuan Leekpai (Democrat Party – 1997-2000) and Thaksin Shinawatra (Thai Rak Thai Party – 2001-2006) regimes sought to suppress and minimize the influence of the civil society sector.²⁰

A somewhat different approach is taken by Julie Fisher. In her work on civil society in Third World countries, she proposes the theory that civil society in non-democratic states expands in inverse proportion to the political and social space permitted; in effect civil society expands its operations and influence in response to demonstrable ‘need.’²¹ An oppressive political culture strengthens the resistance of the civil society sector, parts of which may go underground to conceal their anti-state objectives. In this type of environment, those NGOs which focus on socio-economic issues, as distinct from overtly political ones, may expand their operations in partnership with, or at least in apparent cooperation with, the state, to deliver necessary social services. Were they to operate in antagonistic mode against the state, this latter style would result in their being either totally suppressed, or at best marginalized. Either way, civil society’s capacity to assist those in need would be considerably reduced. Much depends, however, on the membership base, funding sources and leadership of the NGOs, whether they are grassroots-focussed in their

W. C. H. and L. Zamosc. (New York: Palgrave Macmillan), pp. 59-84.

———. (2006b) "Neopluralism and the Challenges for Citizenship in Latin America." In *Citizenship in Latin America*, (ed.) J. S. Tulchin and M. Ruthenberg. (Boulder: Lynne Rienner Publishers), pp. 123-47.

———. (2007) "Citizenship as consumption or citizenship as agency? The challenge for civil society in Latin America." In *Civil Society, Religion and Global Governance*, (ed.) Helen James. (London and New York: Routledge), pp. 100-29.

²⁰ Duncan McCargo, (ed.) (2002) *Reforming Thai Politics*, (Copenhagen: Nordic Institute of Asian Studies).

²¹ See Fisher, J. (1993) *The Road from Rio: Sustainable Development and the nongovernmental Movement in the Third World*, (West Hartford, CT: Kumarian Press).

———. (1998) *Nongovernments: NGOs and the Political Development of the Third World*, (West Hartford, Ct: Kumarian Press).

———. (2003) "Local and Global: International Governance and Civil Society", *Journal of International Affairs*, 57(1): 19-39.

charter and operating style, or whether they are essentially ‘elite civil society’, created by governing elites to promote their own interests and in particular, the appearance of democratization. In this latter situation, civil society is essentially co-opted by government, or ‘corporatised.’²² Grassroots NGOs on the other hand, often have to resist government efforts to control them through funding or providing members to their management committees.

Fisher’s view may be relevant to the civil society sector in Myanmar. Certainly the traditional notion that civil society fosters good government would be of dubious applicability to this military state; equally, the notion that good government fosters civil society would be considered of doubtful provenance, since good government is so obviously lacking; and although the country officially embraced the market economy in 1989, it has not yet adopted a full neo-liberal politico-economic framework with a recognized democratically elected government responsible for the processes of governance. On the other hand, though still weak, and in some situations, co-opted, a steadily growing civil society sector is apparent, responding to the demonstrable needs of the majority impoverished population. Indeed, Burmese academic Kyaw Yin Hlaing has argued that the associational life in Burma/Myanmar never died out, even during the severe repression of the Ne Win military government (1962-1988). In some cases - that is, the political NGOs – went underground,

²² For an insightful discussion on corporatised civil society, see Somchai Phatharathananunth, ‘Civil Society and Democratization in Thailand: a critique of elite democracy’, in D. McCargo, (ed.) (2002) *Reforming Thai Politics*, (Copenhagen: Nordic Institute of Asian Studies), pp. 125-142. Somchai notes that in many cases in Thailand, governments have co-opted civil society organizations, sought to make them quiescent and to serve the national ideology of state unity. The rhetoric of ‘partnership’ may serve to enable the state to dominate, and foster state corporatism. He states that ‘Cooptation has already begun to appear among some social organizations that receive funds from the government. Because of their reliance on government funds, some existing organizations have given up their anti-government activities, and new ones have refrained from involvement in such activities.’ See Somchai Phatharathananunth, (2002), p. 137.

became ‘book clubs’ where students could still meet to discuss political ideas.²³ Since the mid-1990s when some legal space was made for non-political domestic NGOs, the civil society sector in Myanmar has been increasing. When, in 1997 the National Commission for Environmental Affairs (NCEA) released its diagnostic document, *Myanmar Agenda 21*, it called for national renewal in cooperation with the civil society sector.²⁴ This was clearly a function of the government’s need to draw on all available resources especially in the social sectors, and in view of continuing economic constraints at the time arising from the regime of internationally imposed sanctions after the violent suppression of democracy protesters in 1988. Nevertheless, a report by UNICEF in 1998 was able to identify over 50 domestic NGOs and International NGOs operating in Myanmar.²⁵ Since that time, many new service-delivery, professional associations, charitable associations, religious associations, and ethnic communities development associations have come into existence. Their activities often appear in *The Myanmar Times*, particularly when giving alms or assistance to the needy. At the present time, it is possible to estimate that several thousand such organizations are operating throughout Myanmar, mostly in the health, health education, and welfare sectors. They play a vital role in providing social services to the vulnerable populations.

Some of these domestic NGOs, such as the professional associations – the Myanmar Medical Association, Myanmar Red Cross and Red Crescent Societies, the Myanmar Nurses Association, the Myanmar Dentists Association, the Myanmar Marine Engineers Association (established 1986), the Myanmar Construction

²³ See Kyaw Yin Hlaing, (2007) ‘Associational Life in Myanmar: Past and Present’ in N Ganesan, and Kyaw Yin Hlaing (eds) *Myanmar State, Society and Ethnicity*. (Hiroshima: Hiroshima Peace Institute), pp. 143-171.

²⁴ NCEA, (1997) *Myanmar Agenda 21*. (Yangon: Aung Din and Associates).

²⁵ UNICEF, (1998) *National and International NGOs in Myanmar*. (Yangon: UNICEF).

Entrepreneurs Association, the Myanmar Overseas Seafarers Association, the Myanmar Engineering Society, the Myanmar Ceramic Society, the Myanmar Physically Handicapped Association, the Myanmar Musical Asiaayone (Association), the Myanmar Maternal and Child Welfare Association (MMCWA) and the Myanmar Women's Federation – are well known for their social and charitable work. Some work closely with major UN agencies and International NGOs. Some are more closely aligned to the state than others.²⁶ The MMCWA with over two million voluntary members, plays a major role in maternal and child health care, national immunization programmes, and health education programmes. Originally a small organization of less than 200,000 members, under the presidency of Professor Kyu Kyu Shwe (a medical doctor and widow of a former minister for health), it was co-opted in the mid-1990s to assist the government's health programmes when the advantages of such an organization with its nation-wide network of units were realized. Almost every village now has its MMCWA group whose members usually wear the distinctive yellow blouses and brown longyis (ie long Myanmar skirts), 'colour-coded' to distinguish them from the nurses, health assistants and lady health visitors also attached to each rural health centre. Others, such as the Shalom Peace Foundation, Byamaso, Free Funeral Association, Charity-Oriented Myanmar (which supports Monastic Schools), the Myanmar Handy Youths, the Mandalay Traders, Brokers and Industrialists Association are perhaps less well-known. Some have sprung up in response to the needs of the cyclone victims; others such as Shalom and Byamaso have been long established and devoted to assisting the needy in a variety of

²⁶ [The \(re\)-emergence of some of these professional associations in the mid-1990s is reminiscent of the state-initiated construction of professional and business associations in Thailand in the mid-1980s as the Thai government was also seeking to create a more democratic image internationally. See James Ockey, 'Civil Society and Street Politics in Historical Perspective', in Duncan McCargo, \(ed.\) \(2002\) *Reforming Thai Politics*, \(Copenhagen: Nordic Institute of Asian Studies\), pp. 107-123.](#)

situations, especially needy students who may require hospital services, youth training programs, and conflict resolution seminars. The Shalom Peace Foundation acted as go-between to broker peace between the military government and the Kachin Independence Organization. Their networking skills brought together UN officials and diplomats to foster development in the ethnic nationalities special regions.²⁷ Through the Shalom initiative, the Myanmar Ethnic Nationalities Mediators' Fellowship (MENMF), several Karen development organizations are participating to enhance community mediation and reconciliation programs.²⁸ Byamaso, a private foundation operating in Upper Myanmar, especially Mandalay, focuses on the medical needs of poor patients in hospitals (where, by government policy, patients have to supply their own medicines and other medical equipment); it provides funeral cars and related services where necessary.²⁹ Other private foundations such as the Tun Foundation and many informal citizen networks also provide social welfare services and educational funds to assist children from poor families in both rural areas and urban areas. More than 15 such foundations are said to be operative in Myanmar.³⁰ A new NGO, the Myanmar Business Executive Group, provides Grameen style microfinance for farmers in the delta affected by the cyclone. Eco-Dev, established by former Forestry Department workers, focuses on environmental conservation issues. The work of these domestic NGOs and private foundations is complemented by that of numerous religious organizations based on all the faiths

²⁷ Ja Nan Lahtaw, (2007) 'Peace Initiatives among Ethnic Nationalities,' in N. Ganesan and Kyaw Yin Hlaing (eds) *Myanmar State, Society and Ethnicity*, (Hiroshima: Hiroshima Peace Institute), p. 254.

²⁸ Alan Saw U, (2007) 'Reflections on Confidence-building and Cooperation Among Ethnic Groups in Myanmar: A Karen Case Study,' in N. Ganesan and Kyaw Yin Hlaing (eds) *Myanmar State, Society and Ethnicity*, (Hiroshima: Hiroshima Peace Institute), p. 228.

²⁹ Kyaw Yin Hlaing (2007) notes that the military government took control of older cemeteries located within city limits and opened new ones some 50-60kilometres out of town thus increasing the cost burden for the poor in organizing and attending funerals. Byamaso's social welfare services meet this need. Its refusal to be co-opted by the regional commander in Mandalay led to its accounts being audited on several occasions.

³⁰ Kyaw Yin Hlaing (2007), p. 164.

present in the country: Buddhism, Christianity, Hinduism, Islam, Judaism. Some of these – the Karen Baptist Convention, the Kachin Baptist Convention, the Chin Baptist Convention, the Myanmar Council of Churches, the Kachin Development Committee, the Karen Development Network (KDN), for example - function as both development and education organizations, as well as charitable associations. Together with the Metta Development Foundation and the Cetena Foundation, they provide a substantial portion of the poverty alleviation and social welfare services in the country. The KDN for example has a charter which prioritizes peace-making and peace-building, education and training efforts, social reconstruction (resettlement and rehabilitation of internally displaced persons), healthcare, HIV/AIDS and health education initiatives, inter-faith dialogue, conflict management and media and information dissemination.³¹ Like the Byamaso Foundation, it is imperative that they avoid all semblance of political activities and function solely on their social charters. Despite these limitations, and they are very real limitations, as Alan Saw U states, ‘the resurgence of civil society organizations continues’ in Myanmar, in response to a clearly perceived need.³² Thus, the domestic civil society sector plays a major role in poverty alleviation programs, national immunization days, national sanitation programs, health education and disease prevention, educational services, and social welfare services. Perhaps Julie Fisher’s thesis is applicable to Myanmar; in a society where ‘good governance’ is often wanting, ordinary people have organized themselves to attend to the needs of their fellow citizens. It is true to say civil society organizations are tolerated as long as they do not challenge the state.³³ However, in

³¹ [Alan Saw U, \(2007\), p. 229.](#)

³² [Alan Saw U, \(2007\), p. 234.](#)

³³ [The fine line which must be walked by NGOs is apparent in the deregistration in May 2007 of the Free Funeral Service Association and the Myanmar Engineers’ Association, on the grounds that their activities were considered to be political rather than social, and constituted a challenge to the state. However, they were later permitted to re-register. Some 22 other NGOs were denied registration. The chairman of the Free Funeral Service Association, Kyaw Thu was forced to resign after he participated in the September 2007 anti-government demonstrations. See Ardeth Maung Thawngmung and](#)

one way this fails to recognize the symbiotic relationship between the state and the civil society sector; from a purely resource perspective, the state in Myanmar needs the civil society sector to deliver the services which its bureaucracy is unable to do solely on its own. In the absence of effective policy development and implementation the civil society sector often provides the services and public goods the people need. This is no more apparent than in the health sector where, according to government sources, some 73 per cent of health services are funded by the private sector, less than 17 per cent by government, and the remaining 10 per cent come from international sources.³⁴

HEALTH POLICY AND PRACTICE: GOVERNANCE ISSUES

Health care, as Ahlburg and Flint (2001) have argued, is a robust measure of development and the effectiveness of state governance.³⁵ Whilst majority populations in states emerging from authoritarian structures may have less than optimal access to quality health care provision, their minority populations often experience health care deprivation owing to social, cultural and political factors which inhibit their capacity for inclusion in the wider socio-political discourse of the state. Such deprivation can result in epidemics (HIV/AIDS, tuberculosis, STIs) which can spread both through the majority populations and across borders into the international community. Health care is also positively correlated with educational access and economic opportunities,

Maung Aung Myoe, 'Myanmar in 2007: A Turning Point in the "Roadmap"?', *Asian Survey*, 48(1): 13-19. The perils of political activism may be seen in the fate of Ashin Gambira, the leader of the All Burma Monks' Alliance (ABMA), who was disrobed by the authorities and charged with multiple criminal offenses as a consequence of his role in the September 2007 demonstrations; and the imprisonment and trial of the leaders of the 88 Generation Students, a political NGO which initially had sought to foster social welfare type services. See *The Irrawaddy Magazine*, 22 August 2008.

³⁴ Myanmar Ministry of Health (2007), *Health in Myanmar 2007*, (Yangon: Ministry of Health).

³⁵ Dennis Ahlburg, and D. Flint (2001) 'Public health conditions and policies in the Asia Pacific region,' *Journal of Asian Pacific Economic Literature*, (15)2: 1-17.

especially for women, both of which may be lacking in many marginal communities and among indigenous populations. Moreover, studies of adult health in developing countries have also shown a positive correlation between maternal mortality and child and infant mortality. Research in Bangladesh in the mid-1980s, for instance, showed that a maternal death produced a 200 per cent increase in the mortality of the deceased's sons and a more than 300 per cent increase in the mortality of daughters. The consequences of adult ill-health in developing countries have been demonstrated to be more serious and wide-ranging in terms of consequences for the community than is the case for non-adults.³⁶ Where state governance may be deficient, the civil society sector often takes the responsibility to respond to demonstrable need, especially for vulnerable populations, often indigenous communities or ethnic minority groups. Civil society groups which operate at the grassroots level may offer more effective health care interventions than those of state healthcare facilities, because they may be more closely aligned with cultural norms or socio-political collectivities.

Myanmar Demographics

More than 50 percent of Myanmar's estimated 55.4million people³⁷ live in the four southern divisions: Yangon, Ayeyarwaddy, Bago, Magway. Of the country's 14 administrative areas (seven states and seven divisions) these four have the highest population density ranging from 595 in Yangon division to 14 in the western Chin State.³⁸ Health care policy, administration, and service delivery for the country's officially recognized 135 ethnic groups (c.68 per cent Burman, c.8 per cent Shan, c.

³⁶ [M. Over, R Ellis, J Huber and O. Solon, \(1992\) 'The Consequences of Adult Ill-health,' in Richard Feachem et als, *The Health of Adults in the Developing World*, \(New York: Oxford University Press\), pp. 161-207.](#)

³⁷ [World Health Organization, \(005\) , *Wld Health Statistics*, \(Geneva: WHO\).](#)

³⁸ [Myanmar Ministry of Health, \(2007\) *Health in Myanmar*, \(Yangon: Ministry of Health\).](#)

6.8 per cent Karen, c. 2 per cent each of Kachin, Chin, Mon, Kayah; 10 per cent in total for the remaining 128 groups) is based on the state's administrative divisions: 65 districts, 325 townships, 13,762 village tracts, 65,235 villages.³⁹ Since the country's last census was in 1983, much of the population data is estimated from international sources or various government ministries, each of which has its own statistical unit operating in parallel with the government's Central Statistical Organization, whose outcomes need to be treated with caution. The country appears to be preparing for a new census, as *The Myanmar Times*, 4 June 2007 announced the acquisition of new GIS software through the sponsorship of UNFPA to enable the maps to be produced on which a new census would be based. It quoted U Sein Myo Aung, assistant director of the Department of Population under the Ministry of Immigration and Population as stating that infrastructure and computer systems had been upgraded, and new GIS GeoMedia software installed in preparation for a new nationwide census. Instructors from the Department of Geography at Yangon University were providing intensive training on the software to staff in the Department of Population. However, so far, no further sign of the census has been observed. In its absence, therefore, this paper utilizes data drawn from several international organizations, and from domestic Myanmar sources, as well as field work undertaken by the author in the course of 17 visits to the country since 1996.

Since independence from Britain in 1948, a significant portion of the country's resources were consumed in a forty year civil war during which time government control of much of the country, especially outside the major towns, was precarious. This situation only started to change in 1989 when cease-fire arrangements with 16 of the insurgent groups were negotiated. Although the country's foreign currency

³⁹ [Myanmar Ministry of Health, \(2007\) *Health in Myanmar*, \(Yangon: Ministry of Health\).](#)

reserves have considerably improved since 2001 when they were estimated at around USD300million⁴⁰ and gross national income has increased as a result of revenues from gas and oil sales, reputedly around USD3billion in 2007/2008, only a very small percentage finds its way into social sector improvement policies. In 2003, for instance, the national health budget was set at 2.8 per cent of GDP; nevertheless, this was an increase from the .8 per cent in 2001.⁴¹ The health budget has been slowly increasing, up from 8,000 million kyats in 2001 to 23,411.8 million kyats in 2007.⁴² Bearing in mind that this represents only 17 per cent of total expenditure on health and that the private sector accounts for around 73 per cent of total health expenditure, it is an understatement to say that the government health budget suffers severe constraints. Myanmar Ministry of Health estimated that per capita expenditure from all sources – private, government, and international - was less than 500 kyats in 2007. If we compute this at the official rate of 6 kyats to the USD1, we have an annual expenditure of around USD83 per person; however, if computed at the market rate of 1,120 kyat per USD1, then the per capita expenditure from all sources is less than 50 cents. In a country suffering from such virulent diseases as HIV/AIDS, malaria and tuberculosis, and where leprosy can still be found in at least 27 villages, it is easy to envisage a health care sector under severe stress. In 2000, WHO rated Myanmar 192 out of 192 countries in terms of the quality of the health care provided to its population, a result which caused great consternation and extreme distress in official quarters.

[insert figure 1. Increase in Myanmar Government Health Budget 1988-2001]

⁴⁰ [*The Irrawaddy Magazine*, 22 August 2008, quotes an estimate by Sean Turrell, Macquarie University, that the country's foreign exchange reserves are likely to be in the region of USD4bn owing to gas and oil sales. But since movements in the energy sector are rather opaque, this could be only a guesstimate.](#)

⁴¹ [*This may be compared with 8.2 per cent of GDP allotted to Defence according to the World Bank \(2002\).*](#)

⁴² [*Myanmar Ministry of Health, \(2007\) Health in Myanmar. \(Yangon: Ministry of Health\).*](#)

Like most other Asian countries, Myanmar has an ageing population as a result of declining fertility and mortality. In 2007, the UN Economic and Social Affairs Population Division estimated that around 60 per cent of Myanmar's population is aged between 15 and 59⁴³ with around 32 per cent being under 15 years old, and only eight per cent over 60 years (2004-05 figures). Myanmar's total fertility rate (TFR) varies from 2.01 (UN 2007) to 2.8 (Asian Development Bank 2005). Myanmar's Ministry of Health estimates the TFR at 2.2.⁴⁴ In 2001, the Department of Population within Myanmar's Ministry of Immigration and Population, in conjunction with UNDP, estimated the TFR at 2.4; this was derived from a Fertility and Reproductive Health Survey (FRHS) based on face to face interviews with 36,808 households conducted in nine domains covering all 14 administrative regions and is likely to be more accurate than other estimates.⁴⁵ The objective of the survey was to obtain information on levels and trends of fertility, knowledge and use of contraception, infant and child mortality, maternal and child health, and knowledge of sexually transmitted diseases (STDs) and HIV/AIDS.

Despite Myanmar's high adult literacy rate (where 'adult' refers to those over 15 years of age), agreed by World Bank (2006), Asian Development Bank (ADB 2005) and Myanmar Ministry of Education (2002) to be around 92 per cent,

⁴³ [United Nations \(2007\) *World Population Ageing*. \(New York: UN Economic and Social Affairs Population Division\).](#)

⁴⁴ [Myanmar Ministry of Health, *Health in Myanmar 2007*. \(Yangon: Ministry of Health\).](#)

⁴⁵ [The domains for the survey were 1. Kachin/Kayah/Shan; 2. Kayin/Mon/Taninthari; 3. Chin/Sagaing; 4. Bago; 5. Magway; 6. Mandalay; 7. Rakhine; 8. Yangon; 9. Ayeyarwaddy. During fieldwork in October to mid November 2001, the survey interviewed 8288 ever-married women aged 15-19 with a sub-sample of 4,648 never-married women aged 15-34. See Ministry of Immigration and Population/UNDP \(2003\) *Fertility and Reproductive Health Survey* \(Yangon: Ministry of Immigration and Population\).](#)

somewhere between 26.6 and 50 per cent of the rural population lives below the UN designated poverty line of USD1 per day (World Bank 2001). WHO in 2005 estimated that 30 per cent of children under five years of age were malnourished (compared to AusAID 2002 estimate of 46 per cent). In 2005, WHO estimated the per capita Gross National Income at less than USD875 (purchasing power parity). Despite the income from oil and gas revenues therefore, the average income for the ordinary person appears to be going backwards; in 2001, it was estimated at USD1000 (James 2003). The apparently high literacy rate, is at odds with a high basic education attrition rate: somewhere around 50 per cent of school age children drop out between middle school and high school, particularly in rural areas. This is a function of poverty and the need to assist in agricultural work.⁴⁶ Around 70 per cent of Myanmar's total population lives in rural areas; around 64 per cent of the labour force works in the agricultural sector. Most of the 30 per cent urban population is dispersed between Yangon (around 5million people) and the 10 other cities along the Ayeyarwaddy River corridor between Yangon and Mandalay. In 1995, the International Fund for Agricultural Development (IFAD) noted that Myanmar had 'moderate' levels of poverty, but was not a food deficit country. Even when Cyclone Nargis devastated the main rice producing areas in the delta, rice was brought south to those in need from the central and northern rice growing areas around Kyaukse (traditionally one of the main agricultural areas) and Mandalay, often by ordinary citizens acting on their own initiative. The IFAD noted that the average landholding of small farmers had decreased and the number of landless rural workers had increased. Though farmers may inherit small holdings, they are often too small to be farmed economically and indebtedness may force small farmers to assign land rights to other farmers. In the main rice growing areas of the delta, up to 25 per cent of rural

⁴⁶ [James \(2005\). Data is drawn from the Myanmar Ministry of Education \(2002\).](#)

families are landless; the corresponding figures in the hill areas are 10 to 15 per cent, and 20 per cent in the central dry zone. In 1995, in Ayeyarwaddy and Bago divisions, some 33 per cent of land holdings were less than 0.8 hectares; some 29 per cent were between 0.8 and 2 hectares. Poverty in these areas is considered endemic. A similar situation exists in Sagaing, Mandalay and Magway divisions in Upper Myanmar and in Shan State. The IFAD identified land reform, particularly security of tenure, as the fundamental issue to create an enabling macro-economic and institutional framework for poverty alleviation.⁴⁷ Prior to the vast increase in national revenue derived from the gas and oil sales, the agricultural sector accounted for around 50 per cent of total foreign export earnings. However, the ADB in 2007 revised this downwards to 43 per cent; with industry now providing around 20 per cent; gas and oil some 37 per cent.⁴⁸ Despite the achievement of modest rates of growth in recent years based on these gas and oil revenues, and some market-oriented reforms in the agriculture and finance sectors, poverty remains the overwhelming life experience for the majority of the population, as they seek to cope with double-digit inflation arising from the government's 'money creation' and extensive public expenditures related to the construction of the new capital at Naypyidaw.

Health Administration in Myanmar

⁴⁷ [Hugh Tinker \(1957\) *The Union of Burma: a study of the first years of independence*. \(London: Oxford University Press\), p. 226 states that at independence in 1948 some 50 per cent of farmers in the delta were tenant farmers on one year leases. Pre-war problems of absentee landlords and Chettyiar moneylenders were behind the U Nu government's enacting the Land Nationalization Act 1953 under which all land belongs to the state; farmers have usufruct rights and only citizens may lease land. The related Forest Law 1992-95 confirmed state ownership of land. Agricultural statistics for 2002 showed that 3,005,000 farmers worked holdings of less than 5 hectares, accounting for 7,544,000 hectares under cultivation; 1,180,000 farmers were on holdings of 5-10 hectares. In the past ten years some large agribusinesses have developed to meet the export market. Ministry of Agriculture, 2002. \[www.e-application.com.mm/Agriculture/statistics.htm\]\(http://www.e-application.com.mm/Agriculture/statistics.htm\)](#)

⁴⁸ [Asian Development Bank, \(2008\) *Asian Development Outlook 2008*. \(Manila: Asian Development Bank\), p. 213.](#)

Myanmar is currently in the second of its five year health plans (2001-2006; 2006-2011). Its 'Health for All' policy is co-ordinated by a National Health Committee (NHC) chaired by Secretary-1 of the State Peace and Development Committee (SPDC), currently Lt General Thiha Thura Aung Myint Oo.⁴⁹ The Minister of Health, Professor Dr Kyaw Myint, a medical doctor by training, was previously one of the Directors-General in the Ministry of Health; he has also been elected to Chair the Board of WHO. To him report seven departments: Health, Health Planning, Medical Sciences, Medical Research (Lower Myanmar); Medical Research (Upper Myanmar); Medical Research (Central Myanmar); and Traditional Medicine. A Director-General manages each department. The Department of Health Planning compiles the health statistics and manages the Health Education Division. The Department of Health is responsible for the public health division and manages primary health care, nutrition promotion and research, environmental sanitation, maternal and child health services and school health services. This civilian administrative structure encompasses district, township and village health committees which run in parallel with the government's military structure or State Peace and Development Committees at all levels: from district, to township to village tract.

To implement its 'Health for All' goal, the National Health Plan follows the primary health care approach based on state/division, and township administrative levels. The township health departments (325) are responsible for the delivery of both urban and rural health care services. Urban areas have township hospitals of 16, 25 or 50 beds to which are attached urban health centres, school health teams and maternal

⁴⁹ Members of the NHC are: the Ministers of Health, National Planning and Economic Development, Home Affairs, Progress of Border Areas and National Races and Development Affairs, Social Welfare, Relief and Resettlement, Science and Technology, Education, Sports, Immigration and Population; the Mayor of Naypyitaw; the Director of Medical Services, Ministry of Defence; the Deputy Minister of Health; and the Director-General of the Department of Health Planning.

and child health centres (currently numbering 348). There are also some larger 100, 200 and 250 bed ‘specialist’ hospitals.⁵⁰ Rural areas (districts) are served by one to two station hospitals attached to each township hospital, and four to seven Rural Health Centres (RHC). Each RHC has four sub-centres and many outreach centres, each served by a midwife and public health supervisor grade 2, plus community health workers and voluntary health workers. Myanmar’s health resources in 2007 were in the order of 832 hospitals, 35,544 hospital beds, 442 dispensaries, 86 primary and secondary health teams in urban areas, 1463 Rural Health Centres, and 80 school health teams. Traditional medicine is highly favoured in Myanmar and has a separate set of resources including 14 traditional medicine hospitals, 237 township clinics, and 5000 licensed private traditional medicine practitioners. According to the Ministry of Health, the total number of doctors was 20,501 (public: 7250; private 13, 251); nurses numbered 21,075; dentists, 1732 (public: 702; private 1025); dental nurses 165; health assistants 1778; Lady Health Visitors 3137; midwives 17,703.⁵¹ Many newly trained medical practitioners leave the profession owing to poor career structures and remuneration, and requirements to serve at least three years in distant ethnic minority areas where personal safety may be compromised. Many take up other professions in the commercial sector, or go overseas as soon as they can.

Under the primary health care approach, Myanmar’s official health priorities are: (1) the three major diseases, malaria, tuberculosis and HIV/AIDS; (2) maternal and child health and reproductive health (women and children are 60 per cent of the

⁵⁰ In 1998, France provided funding to establish a new hospital in Mandalay which was officially opened in December that year. The Ministry of Labour also runs two Workers Hospitals: a 250 bed hospital in Yangon and a 150 bed hospital in Mandalay as well as a 100 bed TB hospital in Hlaingtharyar for those eligible under the 1954 Social Security Act which provides free medical treatment, cash benefits and occupational injury benefit. Under this law, factories, workshops and enterprises with more than five employees have to provide social security benefits for their employees at a rate of 2.5 per cent by the employer, 1.5 per cent by the employee and the remaining being the government’s capital (or in-kind) contribution.

⁵¹ Myanmar Ministry of Health, (2007) *Health in Myanmar* (Yangon: Ministry of Health), p. 78.

population); and (3) rural health care. Modern approaches to mental health care and aged care are still in their infancy; aged care is mostly considered a family responsibility.⁵² Malaria is the greatest scourge, claiming over 3,000 lives annually. In addition, glaucoma, trachoma and leprosy remain prevalent in Myanmar.⁵³ WHO considers leprosy, the Biblical disease, to be eliminated if there is fewer than one case per 10,000 people. By 2003 the nationwide prevalence was reduced to 0.51 per 10,000 and by 2005 the prevalence had been further reduced to 0.44. But in February 2006, it was reported that there were still 27 townships where the prevalence of leprosy remained above one case per 10,000.⁵⁴

[insert Figure 2 Myanmar Government Health Statistics]

In 2005, WHO reported that the Myanmar population was served by 30 doctors per 100,000; 40 nurses per 100,000; 60 midwives per 100,000; and 90 community health workers per 100,000. There were an estimated six hospital beds per 10,000 population. Myanmar's health administration is struggling to increase the health resources available to the population and to improve the efficiency of health care. On 26 August 2008, *The Irrawaddy Magazine* reported the death of a Yangon University student from snake bite when the anti-venom vaccine was not administered in time and the case was incorrectly handled. Two hospital administrators were sacked over the case. Myanmar has one of the highest incidences of snake bite in the world, and although it manufactures anti-venom serum locally, such tragedies still occur. Clearly both the quality of health care and the resources applied to it need to be improved and

⁵² [The Myanmar Ministry of Health, perhaps in recognition of the ageing of the population, in 2007-2009 introduced a volunteer-based home care service for the elderly based on the Korean Help Age program. The Myanmar program is to be implemented in 28 townships by the MMCWA, the Myanmar Women's Affairs Federation, World Vision Myanmar and the National YMCA.](#)

⁵³ [For the past five years, teams of Australian eye surgeons have been going to Myanmar to assist Myanmar doctors and to teach them current techniques of dealing with these illnesses.](#)

⁵⁴ [The Myanmar Times, 14 February 2006.](#)

increased. Below is the new Institute of Medicine I, in Yangon, where much of the medical education is carried out.⁵⁵ It is a very modern facility with both internet and intranet connection to the nearby Institute of Nursing. In 2001 I took a team from several Australian universities to join with Myanmar colleagues from the Institute of Medicine I and from other health policy and administration units in Yangon for a joint conference on Basic Health Science and Research, as part of a project to assist in the development of Myanmar's health sector.

[insert Figure 3 Institute of Medicine 1 Yangon]

My team visited a Rural Health Centre at Bago, just 50km from Yangon. Here the midwives walked seven kilometers across the fields to their patients in the villages the RHC served. A UNICEF official accompanied us on this visit. The staff at the centre comprised MMCWA members, midwives, Lady Health Visitors and Community Health officers. Since there was no equipment evident for health education purposes, on our return to Australia we organized to collect funds from which video equipment was purchased, and arrangements made to have it delivered to the RHC together with a motorized scooter which the midwives could use to visit their patients.

[insert figure 5 Bago Rural Health Centre]

The upper photo shows members of the team with the UNICEF officer, relaxing near Inya Lake in Yangon on our return from the Bago Rural Health Centre. The lower photo shows the UNICEF officer talking with some of the health staff at the RHC, and on the side are two officials of the Ministry of Health.

⁵⁵ There is a second Institute of Medicine in Yangon, another in Mandalay, and a separate facility for the Defence services. In addition, a new University of Public Health is being established.

In 2004, because I wanted to see the health infrastructure available in some of the ethnic minority areas, I arranged to visit 10 of the former opium poppy growing areas in Northern Shan States, the Wa Special Region No. 1 and Wa Special Region No. 2, and the Kokang region which borders China. This is the famed, or infamous, area known as the Golden Triangle, through which the Salween and Mekong Rivers flow. Together with 37 other researchers, we flew in two Russian helicopters over densely jungled mountainous areas to the sites. Our group included two American missionary couples and a Swiss NGO representative, a French journalist, a Singaporean businessman and a Yangon-based Swiss travel agent. At Mong Pauk, close to the Myanmar-China border, we visited a 50-bed township hospital which had been funded by China. It catered mostly for former drug addicts undergoing rehabilitation. I had the opportunity to speak with some of the patients who were Shan.

[insert figure 5 Hospital Mong Pauk]

This hospital so close to the Chinese border, had Chinese writing on it, not surprising since the people in this area mostly speak Chinese; moreover, the Kokangese are ethnic Chinese stock.

At another site a little further south, Yong Kha, our group was welcomed by the Wa official in charge. He made a welcoming speech to us in Chinese which was then translated for us by the Singaporean businessman. At Yong Kha, we visited a 16-bed station hospital which had been funded by Thailand. It was very new and gave the appearance of not yet having had the privilege of being able to attend to any patients. I wondered if the people of this village preferred traditional medicine, or if

there were language difficulties for the Burmese nurses. The village was beautifully set out, with market gardens and fruit trees surrounding an area of mixed farming.

[insert figure 6 Hospital Yong Kha]

[insert figure 7 Nurses and Casualty Room Yong Kha Hospital]

Nearby was a primary school, also very new, which was part of the integrated health/education program here at this former opium growing site. The leader of the group explained that since the children spoke Chinese as their mother tongue, the school children learnt Burmese as a unit of study within the school curriculum.

[insert figure 8 School Yong Kha]

A third site, Wan Hong, produced a full welcome band, staffed by young soldiers, 14 – 16 years old, both female and male, who were part of the 20,000 person strong United Wa State Army.

[insert figure 9 Wan Hong Children and Fruit Orchard]

The children at Wan Hong seemed to me to be in good health, well-fed and adequately clothed. What struck me was the number of sets of twins, because I had read that among some of the ethnic minority groups twins were traditionally considered very bad luck and were usually put to death at birth. However, that was not the case in this village. At another site, Mong Pyan, which had electricity and trucks to carry the produce to market, the large numbers of children were also remarkable. The children thronged around us, curious, and friendly, happy to see us, and quite natural in their behaviour.

[insert figure 10 Wan Hong Welcome Band]

[insert figure 11 Mong Pyan Truck and Welcome]

Myanmar Health Statistics

Since its 2000 report which rated Myanmar 191 out of 192 countries in terms of the quality of its health care, WHO has worked closely in cooperation with the Myanmar Ministry of Health to achieve better overall outcomes. In 2005, WHO accorded the following statistics to Myanmar:

Figure 12:

<u>Mortality:</u>	
Life Expectancy at Birth (2003 data) – 63 years	Males – 56 years; Females
Under 5 years per 1000 live births (2003 data)	106
Neonatal deaths per 1000 live births (2000 data)	40
Maternal deaths per 100,000 live births (2000 data)	360

Source: WHO 2005

Figure 13:

<u>Morbidity:</u>	
Adult rate living with HIV (2003 data)	1.2%
Adults (15-49 years) and children living with HIV (2003 data)	330,000
No. of polio cases (2004 data)	0

TB – new smear cases per 100,000 (2003 data)	76
Low birth weight new borns (2000-2002 data)	15%
Children under 5 years stunted for age (2003 data)	32%
Children under 5 years underweight for age (2003 data)	32%

Source: WHO 2005

Domestic NGOs in Myanmar, particularly the MMCWA, have established 17 feeding centres for children at risk. In January 2000 I visited some of these in Upper Myanmar, in Sagaing division and Taunggyi, the capital of Shan State. Nutrition promotion especially for children, pregnant and lactating women is a major program of both the Ministry of Health and the civil society sector with special programs to address iron deficiency anemia, vitamin A deficiency, vitamin B deficiency, protein energy malnutrition, and iodine deficiency.

These statistics need to be read in conjunction with those provided by the Central Statistical Organization (CSO) for 2003 which provides the MMR rate per 1000 live births at 1.9 rural and 1.1 urban; and corresponding IMR rate per 1000 live births of 50.7 rural, and 48.4 urban. Death rates for TB per 100,000 is given as 26.7; while for malaria is 30.8. CSO figures are likely to be more favourable than those of WHO.

In December 2004, WHO estimated that less than 10 per cent of people with HIV/AIDS were on antiretroviral therapy. In mid-2008, Medecins sans Frontieres stated that its five clinics in Yangon treat 8000 out of an estimated 10,000 in need of antiretroviral therapy. Figures provided by 3DF however are much higher with an estimated 6000 children said to have contracted HIV, and 13,000 new infections per year. The 3DF estimates some 75,000 adults and 1600 children were in need of

antiretroviral treatment in mid-2008. Around 60 per cent of 3DF funds for 2007-2008 are expended on HIV/AIDS treatment programmes.⁵⁶

Immunization coverage among infants (less than one year old) according to WHO, was 75 per cent for Measles; 73 per cent for DPT-3; 73 per cent for Polio-3; 76 per cent for BCG; and 0 per cent for HepB. These immunization rates need to be improved and immunization programs need to be extended to all the ethnic minority areas. By comparison, when I was in the ethnic minority areas of North Vietnam in 1998-2000, the White T'ai village 150km north-west of Hanoi in which I stayed could prove a 100 per cent immunization rate for its infants and young children. The statistics showing when the children in each family were immunized and which immunizations each had received, were kept on boards in the nearby health centre.

Amongst the most serious health conditions affecting Myanmar's populations are Malaria, TB, HIV/AIDS, Dengue fever, Diabetes, Trachoma, Glaucoma, Leprosy, Snake Bite, Acute Respiratory Infection (ARI), and Waterborne Diseases. ARI is a major childhood illness, especially in the mountainous areas where heating is usually provided by wood fires. Trachoma has been a major cause of blindness in the central dry zone in Myanmar. Programmes to address this disease, launched with assistance from WHO, UNICEF and other international NGOs, have reportedly reduced its incidence from 43 per cent to 1.2 per cent in 2005⁵⁷ so that attention has now focused on cataracts as the major cause of blindness.

WHO estimates the TB detection rate under the Directly Observed Treatment Scheme (DOTS) (2003 data) at only 73 per cent; and TB treatment success rate under DOTS (2002 data) at 81 per cent. The Myanmar Ministry of Health, 2007, states that

⁵⁶ [See www.3dfund.org/programme](http://www.3dfund.org/programme) (Accessed 3 September 2008).

⁵⁷ [Myanmar Ministry of Health \(2007\), p. 59.](#)

4.7 per cent of TB cases are HIV positive; and 80 per cent of AIDS cases have TB. In conjunction with 3DF and WHO, the MWAF, MMCWA and Myanmar Red Cross Society the DOTS strategy has been extended to all 325 townships in an effort to improve these statistics. A nationwide survey is about to be launched to determine the efficacy of the TB control programmes.

A number of behavioural and environmental risk factors impinge on Myanmar's health statistics. Since waterborne diseases play a significant role in both morbidity and mortality statistics, Myanmar has regular mass National Sanitation Days as well as mass National Immunization Days when NGOs, domestic and international, and ordinary citizens join together to install latrines and protected water wells in rural areas.⁵⁸ In 2000 WHO/UNICEF stated that 95 per cent of the urban population and 74 per cent of the rural population had access to improved water sources, whilst 96 per cent of the urban population and 63 per cent of the rural population had access to improved sanitation. However, around 95 per cent of the total population still uses solid fuels for heating and cooking, a clear poverty indicator, which underpins the high incidence of ARI, particularly among infants and primary school children.⁵⁹ WHO (2005) also estimated that some 37 per cent of male adolescents (13 to 15 years old) but only 5 per cent of female adolescents use tobacco, surprising in a country where in earlier times smoking a large cheroot was a favourite pastime including for women. On the other hand, per capita alcohol consumption for both male and female was estimated at only 0.4litres.

⁵⁸ [The Ministry of Health is trying to establish ways of dealing with the danger of arsenic seepage into water wells from rocks over which the water flows.](#)

⁵⁹ [WHO and UNICEF, \(2000\) Global Water Supply and Sanitation Assessment 2000 Report, \(Geneva: WHO and UNICEF\).](#)

In recent years, the Myanmar Ministry of Health, working in cooperation with WHO, has sought to improve the quality of the health services delivered to the population. It has instituted school health education programmes, de-worming programmes for school children, and adolescent sex education programmes in an effort to stem the tide of HIV/AIDS infections. Commencing in 30 townships, this programme, known as SHAPE, the School-based Healthy Living and HIV/AIDS Prevention Education Programme, with the assistance of UNICEF has been extended to 137 townships. To improve access to information on health issues, a new e-health programme is being trialled in areas where the technology to access it is available, mostly urban areas.⁶⁰

Maternal and Child Health

Since over 60 per cent of Myanmar's population are women and children, and over 1.3million women in Myanmar are said to give birth annually, maternal and child health and reproductive health are a very important aspect of the governance of the country's health policy and practice.⁶¹ In the nine domains and 36,808 households where the 2001 Fertility and Reproductive Health Survey (FRHS) was conducted, only 26 per cent owned a radio, and 19 per cent owned a TV. Information access was thus a key issue. Female-headed households had increased from 17.9 per cent in 1991 to 19.3 per cent in 2001, with more female-headed households in urban areas than in rural areas. Whilst the overall mean size of the household remained the same in 2001 as in 1991, at 5.2 persons, the average female headed household was 4.4 persons; the average male headed household was 5.4 persons. The TFR rate for women aged 15-49 had declined to 2.4 births per woman (1.8 for urban women; 2.6 for rural women)

⁶⁰ [Myanmar Ministry of Health \(2007\) *Health in Myanmar*. \(Yangon: Ministry of Health\), p.p. 37, 73.](#)

⁶¹ [Myanmar Ministry of Health \(2007\) *Health in Myanmar*. \(Yangon: Ministry of Health\), p. 43.](#)

from a high of 2.7 in the 1997 FRHS. Fertility performance was concentrated in the age group 20-35 years. The contribution of those younger than 20 years and older than 40 years was said to be small. Teenage births in the 15-19 years bracket contributed 5-6 per cent of the overall TFR.

The TFR was impacted on by an increase in the proportion of never-married for both male and female: 44 per cent of women aged 15-49 and 47 per cent of men aged 25-49 had never married. However, the total marital fertility rate was 4.9 births per married woman, a reflection of the high proportion of unmarried women who contribute no births or very few.

The mean number of children ever born to ever-married women (EMW) was 3.0, while per currently married women (CMW) was 3.1. For both EMW and CMW the mean number increased with age. By the time a woman reached the end of her childbearing years, she was likely to have given birth to around five children. Across all ages, 8.1 per cent of EMW and 8.3 per cent of CMW had no children. Some 94.4 per cent of pregnancies resulted in live births. Of the remaining six per cent, abortion (illegal in Myanmar) accounted for 4.4 per cent and stillbirths 1.2 per cent.⁶² The median birth interval was around 40 months. This rises with increasing educational attainment, from 37 months among women with little education to 45 months among women with a university education. Birth spacing programmes are a major activity of the domestic NGOs, especially the MMCWA. In a village outside Sagaing, Upper Myanmar, in 2000, I was advised by the women that they were waiting for their new supply of contraceptives, usually provided by the MMCWA, and donated by China. They were abstaining from marital relations until these supplies arrived which

⁶² [Illegal abortions account for around 50 per cent of registered maternal deaths based on data maintained in official hospital records \(James 2003\).](#)

occurred sometime in the following week. Most family planning services are provided by the private sector on a seven days per week basis as these are often more accessible than public facilities which have more limited hours of accessibility.⁶³ In a study of access issues in the delivery of reproductive health services in two townships, Bago and Kalaw, Thein Thein Htay and Michell Gardiner found that public sector birth spacing services were available only in one third of Myanmar's townships. RHCs were open only on three mornings per week and sub-RHCs between one and three mornings per week. At other times, the public health staff made home visits connected with a range of reproductive health services. In the public sector, contraceptive services are officially available only to married couples, although no proof of marriage is required.⁶⁴

According to the Department of Immigration and Population/UNFPA FRHS survey, 94 per cent of those interviewed in the nine domains had knowledge of various contraception techniques. This result was attributed to greater exposure to the birth spacing programmes of domestic NGOs, the needs of CMWs to regulate their fertility, and the desire of CMWs to improve their reproductive health. The prevalence rate for use of contraceptives, all methods, among CMWs aged 15-49 years, was 37 per cent. Some 33 per cent of CMWs were using modern methods; 4 per cent used traditional methods. This represented an overall increase from 28 per cent in the 1997 FRHS survey and may be compared favourably with Laos (29 per cent), The Philippines (28 per cent), and Cambodia (19 per cent.)⁶⁵ The most popular

⁶³ [Thein Thein Htay and M. Gardiner, \(2005\) 'Service factors affecting access and choice of contraceptive services in Myanmar,' S. Lerner and E. Vilquin \(eds\) *Reproductive Health and Unmet needs and Poverty*, \(Paris: Committee for International Cooperation in National Research in Demography\), pp. 367-398.](#)

⁶⁴ [Ibid, pp. 370,374, 377.](#)

⁶⁵ [World Health Organization, \(2005\) *World Health Statistics 2005*, \(Geneva: WHO\), pp. 29, 31, 27.](#)

contraceptive method was injection (15 per cent), followed by daily pill (9 per cent), IUD (less than 2 per cent); and condom use (0.3 per cent). Use of modern contraceptive methods was higher in urban areas than rural areas; and highest in Yangon Division, whilst lowest in the largely Muslim Rakhine state in the west.⁶⁶ More than 23 per cent of women with no children were using a modern contraceptive method as a way of spacing the first child. Some 56 per cent of EMW and CMW approved contraceptive use, and 52 per cent of husbands. Among CMW not currently using contraception of any kind, some 40 per cent gave fertility-related reasons; some 16 per cent gave method-related reasons; and 14 per cent expressed opposition to use. Among current non-users, some 26 per cent said they intended to use contraception in future; 70 per cent said they did not intend to use it; and 4 per cent were unsure.

In Myanmar, a very high proportion of births still take place at home. At the time of the FRHS, births delivered at home among the households surveyed, accounted for 83 per cent; only 14 per cent were delivered in government hospitals and clinics; 2 per cent were delivered in private hospitals and clinics. However, the survey showed an improvement in the percentages of births attended by qualified health professionals from 46 per cent in 1997 to 57 per cent in 2001. The proportion delivered by traditional birth attendants declined to 39 per cent. (It is uncertain who attended the remaining 4 per cent of births.)

In terms of health care interventions, some 53 per cent of currently pregnant mothers had at least one tetanus toxoid injection. Some 76 per cent received antenatal care (ANC) from qualified health professionals (65 per cent from nurses and

⁶⁶ [Use of permanent sterilization methods in Myanmar is restricted; a woman must be at least 30 years of age and have at least three living children before she can apply to a State or Division level sterilization board for permission to undergo the procedure. Vasectomies are legally available only to men whose wives have received permission for a sterilization procedure, but whose health inhibits them from undergoing the surgery. See Thein Thein Htay and Michelle Gardiner \(2005\), p. 377.](#)

midwives; 11 per cent from medical doctors). Some 16 per cent received no ante-natal care, and 7 per cent received ante-natal care from traditional birth attendants. The proportion receiving ANC from health professionals was higher among the better-educated mothers, and higher in urban than in rural areas which may be both a function of cost and ease of access. The mean number of ANC visits during the last completed pregnancy was 4.1. Urban located mothers made 6.5 ANC visits, and rural mothers 3.4 ANC visits.⁶⁷

According to the FRHS, around 75 per cent of children under five years old received BCG, Polio, DPT and Measles immunizations. (This correlates well with WHO (2005) which estimated that 76 per cent received BCG, 73 per cent received Polio, 73 per cent also received DPT, and 75 per cent received Measles immunizations). Children receiving no immunizations at all decreased from 14 per cent in 1997 to 9 per cent in 2001. Some 4.9 per cent of children under 5 had had diarrhoea during the two weeks to 24 hours prior to the survey. Around 2.1 per cent had it for around 3 days. Some 37 per cent were given oral rehydration therapy using ORS packets, and around 18 per cent received no treatment. Around 33 per cent were taken to a health facility. Breastfeeding is said to be ‘universal’ in Myanmar, which may account for the comparatively low percentages of children in the survey who had suffered from diarrhoea during the stipulated period.⁶⁸ Male infant mortality levels were higher than female, and increased with rising birth order. As in previous results, there were regional differentials, with Yangon Division producing a better overall

⁶⁷ [To improve maternal and child health, iodated salt programmes, vitamin A and B programmes for expectant mothers have been introduced in an effort to stem the incidence of maternal anemia \(James 2005\).](#)

⁶⁸ [NGOs working in the cyclone affected areas have requested that people not donate infant formula, but allow mothers to breastfeed, as they are concerned that waterborne diseases will result from mothers using dirty water to make the formula and that they do not have the equipment to sterilize the feeding bottles.](#)

health picture and Rakhine producing the least favourable results. There was a strong inverse association with the mother's educational level for all results.

With regard to HIV/AIDS, knowledge of this disease among EMW and CMW was quite widespread, yielding a result of 93 per cent. The sources of this knowledge were said to be friends and relatives, health workers, radio and television, video/MMCWA and other NGOs who had instituted health education programmes. Knowledge was highest among those with access to all three media: radio, television and newspapers ie the urban population. Some 74 per cent of EMW stated that HIV could be transmitted from an infected mother to her newborn child. For never married women (NMW) the result was 71 per cent. Knowledge of sexually transmitted diseases (STDs) among both EMW aged 15-49 and NMW aged 15-49 were 84 per cent and 81 per cent respectively. Their knowledge derived from the same sources as for HIV/AIDS.

In assessing Myanmar's progress towards achievement of the Millennium Development Goals, WHO in 2005 considered that targets for improved water and sanitation had been achieved and that the infant mortality rate (IMR) had been halved in the 1990-2003 period. In 1998, the World Bank had estimated the IMR at 119 per 1000 live births (LB). By 2006, the World Bank had reduced the IMR to 48 per 1000 LB.⁶⁹ WHO in 2005 again reduced the IMR to 40 per 1000 LB. However maternal mortality rates (MMR) remain stubbornly high at 360 per 100,000 LB (WHO 2000 data).⁷⁰ Many of these are accounted for by the complications of abortions, others by maternal anemia and pregnancies not attended by qualified health professionals. Ultimately, improvement in the quality of reproductive health care services, and

⁶⁹ [World Bank, \(2006\) *Labour Migration in the Greater Mekong Sub-region*. \(Bangkok: Synthesis Report Phase I, World Bank\).](#)

⁷⁰ [World Health Organization, \(2005\) *World Health Statistics 2005*. \(Geneva: WHO\), p. 12.](#)

further reduction in both the IMR and MMR may benefit from greater in-depth investigation of the requirements of Myanmar women both in terms of the availability and cost of the services provided by the state and the private sector.⁷¹

CONCLUSION

In this brief article, it is not possible to give a detailed discussion of every aspect of Myanmar's health policy and practice. I have sought to highlight the interactions between the INGOs, NGOs, and the Myanmar Ministry of Health in achieving improved health outcomes for the population. I have also sought to arrive at as robust a set of health statistics as possible in order to gauge the resources available to the health sector, the health outcomes achieved by the combination of both public and private resources, and to provide an overview of the kinds of assistance still needed from the international community in order to arrive at more effective health care interventions for this vulnerable population. Whilst a considerable number of INGOs are assisting with this development, and I have not been able to mention here more than just a few, it is noteworthy that the Ministry of Health in its latest report has gone out of its way to acknowledge those with whom it is closely cooperating to achieve better outcomes. Amongst these, WHO, UNDP, UNICEF, Population Services International, UNFPA, Save the Children UK, World Vision and Marie Stopes International have been working closely with the domestic civil society sector as well as with the government sector, mostly in providing what is called 'technical

⁷¹ [Thein Thein Htay and Michelle Gardner, \(2005\) 'Service factors affecting access and choice of contraceptive services in Myanmar,' in S. Lerner and E. Vilquin \(eds\) *Reproductive Health and Unmet needs and Poverty*, \(Paris: Committee for International Cooperation in National Research in Demography\), pp. 367-398, usefully summarize the research undertaken by the Ministry of Health in two townships, Pyay in Bago Division and Kalaw in Shan State, into the unmet needs of women for reproductive health care services, and the interventions which resulted including development of new information materials, updating of training curricula and training of health care staff and private sector providers.](#)

assistance'.⁷² Nevertheless, this type of cooperation may ultimately hold the key to improved quality of health care in Myanmar. The international community appears to have, at last, heeded the call of the needy for their sustained assistance in fostering greater well-being for these vulnerable populations.

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⁷² [Myanmar Ministry of Health, \(2007\) Health in Myanmar 2007, \(Yangon: Ministry of Health\).](#)

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