

Poverty and Health in Contemporary Burma

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Like their counterparts in other poor countries, people in Burma are caught in a vicious cycle of poverty in which limits to health care access and prohibitive health care costs feature as cause and effect. Public health care provisions in Burma are inadequate and of low quality, further exacerbating the health crisis and contributing to poverty. According to the World Health Organization, poverty is strongly correlated with poor health outcomes globally. The World Bank has reported that approximately 85% of the global population lives below the poverty line, but share 90% of global disease. In addition, people from less developed countries pay for more than 50% of their preventive and curative health care costs out-of-pocket (WHO 2003; World Bank 2014).

This paper discusses the mutually reinforcing interrelationship between poverty and health using cases from a clinic in an impoverished neighborhood near Mawlamyine, in Mon State. These case studies are based on the first author's experiences and observations as a primary care doctor in Mawlamyine as well as conversations with patients, caretakers, medical experts, religious and community leaders, and public health scholars.

Our findings are grouped around four central themes: 1) Poverty results in no or inadequate treatment as a result of inability to pay for care. 2) Health care quality is generally low, resulting from both a lack of trained health professionals and the proliferation of inadequate health care options. 3) Reliance on traditional and spiritual healing practices can result in negative health outcomes or delayed medical care. 4) The costs of health care lead to livelihoods strategies with negative health outcomes. First, we establish a framework that situates poverty and health as connected, and which further situates poverty as a cause and consequence of poor health outcomes. This is followed by a brief discussion of methods and context before presenting several cases of patient experiences. We conclude by contextualizing the implications of these cases for the implementation of the National Health Plan by using it as a framework to draw out the broader implications of this work for policy.

Theoretical Framework

While a thorough discussion of the meaning and definitions of poverty is beyond the scope of this article, briefly, we conceptualize poverty as the deprivation of access to basic necessities including food, shelter, clean water, and health services. Drawing on Amartya Sen (1999), poverty can be understood as a lack of freedom to create and maintain life in a way that is valued. Further, we agree with Nicholas Stern (2004), who argues that the empowerment of individuals and collectivities to lead healthy lives is both a path out of poverty as well as a worthy goal in and of itself.

Medical anthropologist and physician Paul Farmer (2005) argues that poor health is a central cause and driver of poverty. He frames lack of health care options for the poor as a fundamental human rights issue and a common characteristic of unequal societies. Further, Farmer suggests that severe

inequality is maintained through the failure to provide quality health care or public health provisions to the poor and constitutes an essential element of structural violence.

The relationship between poverty and ill health has been widely studied, establishing several key factors. Scholars have found that the need for health care and its related costs are causes of poverty (Jacobs, Ir, Bigdeli, Annear, and Van Damme 2012). Poverty is itself a barrier to accessing health services, but poor access to health care is also a factor in the creation and maintenance of poverty (Peters, Garg, Bloom, Walker, Brieger, and Rahman 2008). Further, when health care is needed but is either delayed or not sought at all because of financial restraints, people's health deteriorates further, resulting in both higher health care costs and lost income from inability to work (Narayan 2000; Smith 1999). In these ways, access to health care and poverty are part of a vicious circle in which poverty leads to poor health and poor health maintains poverty (Wagstaff 2002).

Low quality care and limited availability of quality care coupled with availability of alternative health care providers also contributes to negative health outcomes of poverty (Chaudhury and Hammer 2004; Hanson 2003). There may be greater availability of informal health care options for the poor, such as the use of pharmacies as primary care providers (Mendis 2007; Akin and Hutchison 1999; Van Der Geest 1987). Limited availability or availability of only culturally inappropriate health care may lead to a preference for traditional providers including spiritual healers (Asharaf 1982; Young 1983), or for private practitioners of varying quality who are readily and affordably available within impoverished communities (Rohde & Viswanathan 1995). Whether pharmacy care, self-treatment, or traditional healing methods, these

strategies emerge in the absence of other options and are associated with negative health outcomes in many cases.

Healthcare in Burma

People in poor countries have less access to health services than those in wealthier countries, and that the poor in a given country have less access than others (Peters et al. 2008). This is the case in Burma, where the government officially acknowledged widespread poverty in 2011 and where 27 percent of the population lives on less than one dollar a day (UNDP 2011), meeting the World Bank definition of absolute poverty (Coudouel, Hentschel, Wodon 2002; Houghton & Khandker 2009). The majority of the population lives in rural areas of the country and relies on agriculture for their livelihood.

The British colonial government, in order to improve the quality of healthcare among the local populations, founded Myanmar's healthcare system. Since 1962, the quality of health care has declined gradually due to mismanagement and lack of investment in the sector. In recent years, the government of Burma has drafted a health development plan, most recently revised in 2010, which includes addressing poverty as a factor in health outcomes, and providing universal health care coverage. It remains to be seen what the outcome of this effort will be in the long term (Ministry of Health 2014).

Political changes since 2010 have allowed international organizations and donors to provide humanitarian and health assistance. Consequently, more data on the health situation in Burma has become available. However, there has been little scholarly work on health care behavior among poor people in Burma. Out of total government spending, health-related expenditures constituted 1.03 percent in 2010-2011, 1.05 percent in 2011-2012, and 3.14 percent in 2012-2013 (UNICEF 2013). These changes are in an effort to meet object-

ives related to health set out in the National Health Development Plan (WHO 2014).

Private expenditure on health care is 93.7 percent of the total expenditure on health care in Burma, indicating that a high proportion of health care costs are borne by individuals and families (World Bank 2014). This percentage is high compared to countries in the region closely ranked according to the United Nations Development Program's Human Development Index shown in Figure 1. In addition, the high rate of private expenditure drives inequality in health, where those who can afford to pay for healthcare receive expensive care in private hospitals in Yangon or in neighboring countries. Those who cannot afford such treatment are subject to limited and low quality public healthcare (Xu 2006).

Figure 1: Country Comparison Human Development Index/Out of Pocket Expenditure

Country	Human Development Index Ranking*	Out of Pocket Healthcare Expenditure**
India	130	89.2%
Lao PDR	141	78.8%
Nepal	145	79.9%
Myanmar	148	93.7%

*UNDP 2015

**World Bank 2014

Methodology

This paper emerged from the first author's observations and experiences as a general practitioner working in clinics serving poor and underprivileged populations in Mawlamyine. The stories included here have been anonymized and details have been changed to protect the privacy of individuals. The intention is not to offer systematically collected data, but rather to provide a broad analysis of the intersection of poverty and health in Burma using a grassroots practitioner perspective.

The clinic that serves as the site of observation for this paper is located in a suburban community of Mawlamyine that was established after the Than Lwin Bridge Project in 2005 resulted in the displacement of a significant population. Bamar, Mon, and Indian are the three largest ethnic groups, with small populations of Kayin, Rakhine, Shan, and Chinese. Buddhism is the majority religion, and there is also a sizable Muslim population. Although the community is made up of mixed ethnic and religious backgrounds, they have coexisted peacefully. The ward administrator and the administrative committee members proportionately represent ethnic and religious diversities and effectively manage cross-cultural conflicts based on religion and ethnicity.

This relatively newly established ward still lacks basic infrastructure for residents. The drainage system is inadequately installed in this quarter and there are frequent floods during the rainy season. The roads are in poor condition, and require collective efforts from the community to be maintained. There is no government health facility, but there are private health care providers, consisting of three doctors (including the first author), all of whom travel from other parts of Mawlamyine to run clinics. The ward also has one nurse, one midwife, one health assistant who owns a pharmacy and an additional pharmacy serving the health needs of the community. In this context, pharmacies are categorized as major health care providers because they recommend and sell medicines to the community.

All of these practitioners are compensated directly by patients and are not associated with government-supported health programming. Most patients are daily wageworkers or are unemployed, and in order to keep the clinic accessible, rates for basic care range between 1,500 and 2,000 kyat. The clinic offers only primary care, with occasional assistance from a laboratory for diagnostics, and surgery in urgent circum-

stances. Resources are limited, which affects the kinds of care provided.

Poverty and Inadequate Treatment

In Burma, most patients pay for the costs of health care out of pocket (World Bank 2014). As a result, poverty serves as a barrier to access quality health care. Poor people often avoid visiting the clinic when they are sick to avoid paying the associated fees. The majority of patients who come to the clinic have admitted that they do not seek treatment at the clinic when they are first sick. Instead, they attempt self-care by staying at home and trying short-term recovery strategies instead of consulting with professional and officially recognized health care providers. Many poor people struggle to make ends meet on a daily basis and do not have extra money to pay for unexpected illnesses. While this research was not designed to determine prevalence of such cases, anecdotal evidence and professional experience indicate that it is common for poor people in Burma to avoid health care, and the associated costs, leading to worsening conditions and more expensive or untreatable conditions as the illness progresses.

Even when people do receive medical attention, the cost of care may be too high for them to afford recommended treatments, resulting in noncompliance, premature discontinuation of treatment, or denied treatment altogether. One patient, a 34-year-old man, noticed a wound around his mouth two years ago and consulted with a medical doctor who recommended further tests to identify the cause of disease. It was estimated that the diagnostic process and treatment would cost at least 90,000 kyat. During a clinic visit, he said to the first author, "I would rather die than pay such an amount for medical treatment. I cannot pay that much money." He could hardly speak with his large mouth wound, which was possibly cancerous. He

passed away from starvation because he was unable to consume food and water through his mouth.

Inadequate treatment is also common in cases where patients cannot afford the costs of treatment. The first author treated a 65-year-old man with a diabetic foot. He needed proper blood sugar control treatment at the hospital until his leg ulcer healed. He explained to the author that he was not able to obtain the treatment because, “I do not have enough money to pay for my stay at a hospital nor do I have children around to look after me.” This man came to the clinic almost every day to receive outpatient treatment for his leg ulcer and medication to treat his high blood sugar. Ultimately, however, this care was inadequate and after several months his health suddenly deteriorated due to the spread of toxic bacteria into his blood. He was taken to the hospital, but passed away immediately after being admitted. This man was unable to receive the intensive treatment he needed due to cost barriers and, as a result, died from a treatable condition.

Untreated morbidity poses a major challenge in Burma. When people delay treatment and seek alternative and cheaper health care, they end up facing higher medical costs from diseases that have progressed. Lack of basic health education, which is also partly a result of poverty, often has serious health consequences. One of the first author’s female patients, a 35-year-old, was separated from her husband. She had 2 children, and had to depend on her mother. Before she was separated, her husband used to give her alcohol to drink whenever she was sick and had difficulty breathing. She became addicted to alcohol, which gave her liver disease. She went to the hospital one or two times for treatment but failed to get regular treatment because she did not have money. She seemed to know nothing about the causes of her disease apart from the fact that her disease was not curable. She died after taking a compound of petroleum sludge and infant feces, which she heard would

cure her disease. These examples demonstrate how poverty can prevent individuals from gaining access to proper treatment. This results in untreated morbidity, premature death, and disability.

Lack of Quality Care

The short-term recovery treatment-seeking behavior of the poor has led to “patient-driven treatment” putting pressure on some registered doctors to treat patients according to patients’ preferences. These include the prescription of medicines that may have a short-term curative effect, but have a long-term devastating impact. Some medical doctors and health workers frequently inject patients with colorful but cheap multivitamin fluids to attract patients and increase their profit. These vitamin injections are not harmful, but have no obvious benefit for patient health. Some patients experience good feelings after injections, which can be mildly addicting. Patients willing to spend money for this, and those who provide such treatments can make a significant profit. Other physicians choose to inject drugs that induce feelings of euphoria, like calcium gluconate. There was a medical doctor who used this treatment and was eventually sued by a patient because the patient experienced a blackout after receiving an injection.

People who are poor and cannot access professional and registered health care providers sometimes seek assistance from other healthcare providers who are relatively cheaper or offer alternative remedial solutions. These alternative health care providers include those who do not have proper training, and those who use traditional healing techniques. Some providers have experience working at a hospital or clinic as nurse’s aids or janitors. A former janitor from a private clinic in Mawlamyine began treating patients after his retirement. He used injectable medicines including calcium gluconate, which gives a short-term high, making his patients frequently seek

this treatment with dire health consequences. The first author also treated three patients who suffered from long-term kidney problems resulting from long-term receipt of calcium gluconate injections administered by alternative health care providers.

The lack of physicians in rural areas makes residents depend on these alternative health care workers. Health assistants are common in Burma, and are trained for 3 years on primary preventive health care and the treatment of minor illnesses. Despite limited training, they end up playing the role of primary physician in impoverished rural areas. Lack of quality control mechanisms, patient protections, or continuous medical education of health workers undermines the quality of health care provision for the poor. Many incidences of premature death have occurred due to misdiagnosis by unqualified physicians and health care providers. One health assistant who runs his private clinic in Mawlamyine once treated a patient by local injection at the nape of the neck. Due to the lack of aseptic conditions, the patient suffered an infective inflammation of the bone joints and was paralyzed.

Even if the poor can pay for the cost of treatments prescribed by healthcare providers, there is no guarantee that their health will improve because of the poor quality of health services. One patient, a 50-year-old male construction contractor, experienced an inability to move his limbs and went to one of the well-known clinics in Mawlamyine. He was diagnosed as having had a stroke. He complied with prescribed treatment although it was expensive, but his condition did not improve. He arrived in the end at the author's clinic, impoverished from the high cost of treatment and still unwell. The author administered vitamin B₁ tablets for three days, after which he improved. The misdiagnosis of the patient by substandard healthcare providers resulted in prolonged illness,

depleted resources, and lost income with devastating financial consequences for the patient and his family.

People often try short term and cheap recovery methods to get well from minor illness by buying over-the-counter medicines from the drug store, market, or pharmacies and seeking traditional healing alternatives. In Burma, officially, persons who sell medicines are required to take a month-long pharmacology training course. However, the certificates, even for the short course training, can be purchased by anyone able to pay. As a result, drug vendors often have very little knowledge of the medicines they dispense. At most drug stores anybody can buy drugs by mentioning one or two symptoms to the vendor or pharmacist. These are common short-term recovery strategies that are very cheap and accessible.

Traditional Healing Practices

In Burma, especially in rural areas and in communities with lower levels of education, there are widespread traditional beliefs and practices that tend to punish the sick. In some cases, if a patient has been ill for a long time, family members may assume that the person has already died, and that their body has been possessed by evil spirits. Some behaviors in particular, such as insomnia and excessive eating by patients, are considered signs of evil possession of the dead body. Family members may then seek the assistance of traditional spiritual healers, which may cost between 300,000 to 1,500,000 kyats, to deal with evil spirit. The healer may offer prayers, touch, and other practices. A common practice is to administer poison to patients in order to drive the evil spirit out of the patient's body. Family members may also administer poisons on their own in order to expel the evil. Consequently, the patient passes away. The first author estimates that 3 to 5 people die per year from this practice in the quarter in which his clinic is located.

A 65-year-old man, a retired civil servant, had been paralyzed and was unable to move one side of his body and to control his bladder. The family members rented a house to keep him alone and provided only a food supply. The old man had to take care of himself with a little financial support from sons working in Thailand. He became depressed with an impact on his appetite, and suffered insomnia. He became hostile and used foul language, which family members interpreted as a sign of possession by an evil spirit and sought help. A traditional healer performed a ceremony to drive out the evil presumed to be causing the illness, which resulted in his death.

The poor also seek advice and treatment from astrologers, a widely used and respected resource in Burma, and other spiritual healers for their health issues. If a person becomes sick, a family may go to astrologers to ask for advice, including the name of the doctor whom they should consult. There are currently more than 100 astrologers in Mawlamyine, and several in the ward. This can be expensive practice that has the benefit of psychological encouragement for patients, but which does not contribute to the medical treatment of illnesses.

Spiritual healers can charge high fees for their services. A young Muslim teacher, a university graduate, who suffered loss of movement in his limbs, said he felt better after he received treatment by neurologist in Yangon. However, when he returned to Mon State, he met with a spiritual healer who guaranteed a complete cure. The spiritual healer scraped his whole body with his holy knife, charging 800,000 kyats per treatment and assured the young teacher that he no longer needed to see his physician. After receiving 15 treatments and losing almost all of his money and property, his condition deteriorated. When he went back to his physician, he was told that the disease was in an irreversible condition due to delayed treatment, and the patient is chronically disabled.

In 2013, a mother brought her 11-year-old daughter with cerebral palsy from upper Burma to the clinic. They initially went to spiritual healers and tried traditional medicines before they visited the hospital. Afterwards, her brain growth had stunted, which in turn stunted her physical growth and she became handicapped. Consequently, her elder sister dropped out of school in order to look after her. Her mother took her to several hospitals and sold their property to pay for treatment. After they lost their property and savings, they moved to Lower Burma where they tried to start a new life. “Since she was 1 year old, we have spent all we own and now we are left with nothing. Our child is not getting better either. We have already given up on looking for more treatments because we have no money left. We are just trying to work to meet daily expenses.” In this case, delayed and incorrect treatment resulted from the costs associated with healthcare.

Livelihoods Strategies and Health

Illness can result from unhealthy and unsustainable income generating activities practiced by the poor with few opportunities for work. A 46-year-old female patient found out that she could earn money from selling her blood when she took her child with dengue hemorrhagic fever and received a blood transfusion at the government hospital. She had to pay 40,000 kyat for service fees for hospital workers who sought necessary blood for her child. Recognizing the opportunity for income, she began selling her blood, joining other poor people in Mawlamyine who sell their blood several times a month. It is common for these people to develop anemia and some of them suffer heart failure from severe untreated anemia from too-frequent blood draws. She earned 7,000 kyat per draw or more depending on the demand for her blood type. She eventually passed away with anemic heart failure.

The author treated a 29-year-old female who was a sex worker. She told the author that she was once engaged in sex with 15 university students who asked for unprotected sex. Although she was HIV positive she agreed to their request because she was afraid of losing her customers and the potential income, which she needed to raise her three children. Sometimes she forgot to take her medication or failed to make regular clinic visits because she was too busy working or could not afford them. She exposed a number of her clients to HIV and damaged her own health.

In addition to livelihoods strategies that carry health risks, there are many medical emergencies where people are forced to take out high-interest loans to pay for care. For the poor, daily income typically just meets their daily food expenses, so they lack access to cash on short notice. Loans carry high interest rates, and often take years to repay. Borrowers may have to sell their house and other property in order to pay off a loan. In this way, ill health as an exacerbating factor for poverty is clear for those without resources available to assist them in obtaining care in an emergency.

Policy Implications

As noted above, Myanmar has drafted a comprehensive national health plan. The plan includes targets around the provision of universal healthcare, building public-private partnerships for healthcare provision, strengthening oversight of training and certification of health practitioners, and the regulation and promotion of traditional medicine (Ministry of Health 2014). Though the original plan was drafted in 2000 and the Ministry of Health has been working with the World Health Organization and other international health organizations for several years, the themes illustrated in this paper demonstrate that much remains to be done. Using the four themes discussed here, we have several recommendations for implementation of

the National Health Plan to address the central issues we have identified.

Investing in the deployment of universal healthcare is absolutely necessary to ensure that healthcare is available without creating undue hardship in the lives of citizens leading to entrenched poverty and maladaptive livelihoods strategies. This will require significant investment in rural healthcare systems in particular. The National Plan's goals surrounding health education are promising, but an overall weak educational system in Burma may make this goal especially challenging to meet. Thus, concerted efforts to develop the nation's educational system, especially for the poorest, stand to benefit the country not only on a human capital basis, but also in terms of securing better health outcomes for the population. Prevention, of course, in the long run stands to decrease health-related costs for individuals and the state overall, and as such, general education as a vehicle for health education could be especially effective in supporting efforts to meet the goals set out in the National Health Plan.

A particular focus on monitoring health services in rural areas is especially warranted, as the poor rural population of the country has least access to affordable, and reliable healthcare. Overall, greater attention to standardized training and regulated certification for healthcare practitioners from physicians to midwives and pharmacists would greatly increase access to quality healthcare for a huge proportion of the population. By focusing on improving the safety and standards of a broad selection of healthcare providers can ensure that care will be available on an affordable basis. The current plan's provisions for promoting and regulating traditional medicine also has great potential to decrease risks to those who seek such forms of healthcare, while helping to fill gaps in healthcare availability.

Conclusion

As these cases illustrate, poor people in Burma have limited access to quality healthcare. Reduced health access leads to untreated morbidity, which gives rise to the state where more intensive treatment is required or treatment is no longer effective. Some cases of unsought or delayed healthcare even result in death. There are substantial impacts on psychological, social, and economic well-being associated with ill health, which feed back into the problem of healthcare access. In this way, people become trapped in a vicious cycle of poverty and poor health.

As Burma continues to reform and additional attention and resources are devoted to addressing pervasive poverty and the associated issues of health, education, and financial well-being, it will be essential to recognize the link between poverty and health. The current state of health in the lives of the poor of Burma has the potential to inform future policy and programmatic directions for the country, both internally, and with regards to foreign aid.

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