The Responsibility to Protect: Inequities in international aid flows to Myanmar and the Democratic People's Republic of Korea and their impact on maternal and child health

Authors

1. John Grundy
Public Health Consultant
Nossal Institute for Global Health
The University of Melbourne
Cambodia Office, Phnom Penh Cambodia
jgrundy@unimelb.edu.au
johnjgrundy@hotmail.com

2. Kathryn Bowen
Research Officer
Australian National University, Canberra Australia
kbowen@anu.edu.au

3. Dr. Peter Annear
Research Fellow
Nossal Institute for Global Health
University of Melbourne, Australia
pannear@unimelb.edu.au

4. B.A. Biggs
Associate Professor
Medical School
University of Melbourne, Australia
babiggs@unimelb.edu.au

Abstract

The Union of Myanmar and the Democratic People's Republic of Korea (DPRK) are the most disadvantaged aid recipients in Asia. In this paper we describe and analyze the inequities in international aid flows to these countries from a health equity and "responsibility to protect" perspective. Review of public health and health systems literature and examination of international aid flows reveals that countries with a comparable gross national income receive total aid flows 11 to 12 times larger than do Myanmar (Burma) and DPR Korea (North Korea). Although the issue of aid effectiveness in these governance contexts remains a significant challenge, there is nonetheless a joint national and international responsibility to protect women and children through the careful targeting of health humanitarian aid and development programs.

Keywords

Myanmar, North Korea, Responsibility to Protect, Maternal and Child Health

Introduction

The Republic of the Union of Myanmar (Myanmar) and the Democratic People's Republic of Korea (DPRK), have among the highest rates of child and maternal mortality rates in the Asian region. And yet, in terms of both national and international investment, over many years the two countries have recorded the lowest rates of national health investment per capita, and have historically also recorded some of the lowest rates of international health aid flows.

This paper explores the global health policy environment within which additional development assistance could be provided to Myanmar and DPRK, and identifies various sanctions and other 'isolationist' policies that have led to unacceptable inequalities in international aid flows. We have utilized published literature and the databases of the Organization for Economic Cooperation and Development (OECD, 2008) and the Global Health data bases of the World Health Organization (WHO, 2009), as well as primary source data accessed by the lead author through field visits to North Korea (n=6) and Myanmar (n=6) between 2006 and 2010 for national immunization planning and health system strengthening proposals in both countries (Grundy and Moodie, 2009, Tin et al, 2010).

Development assistance and the responsibility to protect

Conceptual rationale for Overseas Development Assistance

Disparities in health within and between nations are often attributed to the inequitable distribution of power and resources, the inappropriate design of national health care systems, the effects of globalization, and the failure to implement primary health care appropriately (WHO, 2000, WHO, 2003, Wilkinson, 1996, WHO, 2009,). A broad consensus has emerged that the development of health systems is a fundamental and necessary condition for securing the health rights of populations both within and across borders (Hunt and Backman, 2008). Conflicts,

pandemics, emerging diseases, climate change and bioterrorism are ongoing threats to national and global security and the resolution of these issues requires a high level of international cooperation. This has led to the idea of global health diplomacy, defined as being the "multi-actor negotiation processes that shape and manage the global policy environment for health" (Kickbusch et al., 2007). Global health diplomacy has seen the rise of "soft power" negotiations (environment and health) as a balance to the "hard power" negotiations of previous decades, which have focused more on war, economy and trade as instruments of international security. The rise in soft power has also been associated with increases in international aid flows in the last decade, which have been motivated in part by the realization by governments that health and disease have security implications (Bond, 2008). However, more "silent" though more pervasive public health problems such as malnutrition and maternal and child mortality have not received major consideration in foreign policy. This is particularly evident for Myanmar and the DPRK, where the boundaries between international cooperation, health security and the practice of foreign policy remain unclear.

Equity, rights and the responsibility to protect

Underlying the notions of global health diplomacy and rights of access to health care is a concern with the issue of h**e**alth equity. Equity in health has been conceptualized as a measure of difference in access or outcomes based on social or economic exposures, such as wealth and education status and location. Equity as a measure of difference can be contrasted with efficiency, which refers to the average level of health in a society (Arokiasamy, 2009). Both the average level of health and disparities within health within societies are equally important in public health impact assessment and should be measured simultaneously (Delamonica, 2005).

In terms of taking action on health inequities, a social justice or rights based approach is useful to assess the extent to which these measures of difference can be considered acceptable or not. The principle underlying a rights based approach is the entitlement of all to health care access, regardless of background characteristics of nationality, class, location, educational status or gender. That is, a vital assumption underlying any discussion of health inequity is the sense of 'fairness' or 'social justice' and the implications this has for health policy making. While both inequality and inequity refer to differences, equity discourses suggest that these differences are fundamentally unjust. That is, not all inequalities are unjust, but all "inequities are the product of unjust inequalities" (PAHO, 1999). This link between inequity and injustice is further reinforced by the observation that a sense of justice should form the central concept in the formulation of public policy and on the instruments for achieving the aims of this policy (Sen, 1999).

Regionally and globally, international instruments have been established to protect health security and health rights, including International Health Regulations, the Millennium Development Goals, The Universal Declaration of Human Rights, The Convention on the Rights of the Child and the recent World Health Assembly mandates on primary health care and the social determinants of health (WHO, Commission on Social Determinants, 2009). As well, the Special Rapporteur on the right to health at the United Nations recently developed an agenda for the "right to health." This recognizes that accessibility to a quality functioning public health care services is a fundamental right of individuals and communities and core social institutions, in the same way as is the right to access to a fair justice system or a democratic political system (Hunt, 2008) (Hunt and Backman, 2008).

A related concept is that of the "responsibility to protect." This concept has been traditionally interpreted in terms of the international community's accountability for protecting citizens of other States from harm when the State is considered to have failed in its central role of

protecting its own citizens (Institute for Global Policy, 2001). Specifically, a UN General Assembly statement of the outcome of the World Summit Outcomes in 2005 states that "each individual State has the responsibility to protect its populations from genocide, war crimes, ethnic cleansing and crimes against humanity." As a corollary to this statement, the international community "should, as appropriate, *encourage and help States* to exercise this responsibility." (UN General Assembly, 2005)

In wider health and social scientific literature however, the responsibility to protect has been interpreted more specifically as a principle warranting international interventions to protect citizens from reported human rights abuses. It should be noted that the concept of responsibility to protect is overwhelmingly preventive and has a strong emphasis on State capacity building to support protection of citizens (Evans, 2007). As described above, there has also been a resolution identifying access to health systems as a fundamental human right, which raises questions as to the exercise of this right in the context of state failure to protect through provision of basic social services to its populations.

If we consider access to a health system by women and children as a 'right' in the same sense as access to a justice or a democratic political system, the question remains as to whose responsibility it is to protect women and children should States either fail or lack the capacity to safeguard their rights. This paper will describe and analyse the roles of the international community in adopting collaborative approaches to encourage and assist States to meet the acute health needs of their populations. We emphasize measures already implemented, and those that will be required in future to reduce the currently high maternal and child mortality rates in both Myanmar and the DPRK.

Regional trends in overseas aid flows and maternal and child health

Data presented in Figure 1 demonstrate that aid flows per capita to DPRK and Myanmar are among the lowest in the region.

[Insert Figure 1]

Most notable is the discrepancy between the scale of needs in the public health situation (as assessed by maternal and infant mortality rates) and the flow of health aid. Using Under-5 Mortality as a proxy for health status, Figure 2 demonstrates that, despite having high child and maternal mortality rates compared to the least developed countries in the region, health aid flows between 2006 and 2008 have been significantly lower in Myanmar and negligible in DPRK.

[Insert Figure 2]

Table 1 examines the declines in child mortality rates in the last 18 years, according to data published by the World Health Organisation (WHO, 2011). Myanmar and DPRK are in the group of countries with the lowest mortality reductions in recent years, although it should be noted that in the last 10 years gains have been made in child health indicators in Myanmar. Both countries have achieved lower declines in child mortality than the south east Asian regional average decline of 48% in this time period.

[Insert Table 1]

The twin effects of low rates of overseas development assistance (ODA) and low rates of national health financial flows in DPRK and Myanmar have the potential for reducing health system capacity below the critical level required to maintain basic supply functions. Recent national health accounts data provided through WHO indicates that on a per capita basis, the Government of Myanmar invests only $1 per person per annum of government resources in health and the Government of DPRK even less ($0.30 per annum). Similar low resource flows in other key sectors (see Figure 1) such as food, energy and water and sanitation expose populations to

broader catastrophic health effects associated with social and environmental determinants of health.

Health and development in Myanmar

Health and health systems in Myanmar

Myanmar (population 48 million) has a high level of geographic and ethnic diversity, including more than 100 national groups, many of whom are speaking different languages and dialects. The state was governed by military rule for over 40 years before the regime transformed itself into an ostensibly civilian, parliamentary form of government in 2010. The experience under this regime has been characterised by internal armed conflicts, by very low state investments in the social sectors, and externally by economic pressure (in the form of international economic sanctions and 'isolationist' policies), particularly since 1990. To date, trade sanctions and international isolation of Myanmar have not achieved the full restoration of democracy, although the elections in 2010 and the transition to civilian rule indicates some reform steps towards constitutional and democratic rule (International Crisis Group, 2011).

Gross National Income (GNI) per capita was estimated at US$578 in 2008, close to the lowest annual income rate in Asia (UN Data, 2011). Health indicators mirror this economic performance. The under 5 mortality rate is 66 per 1000 live births and the maternal mortality rate is 240 per 100,000 pregnancies (WHO, Global Health Observatory, 2011). According to Myanmar's National Health Plan, progress in reducing maternal and child mortality is sluggish and requires higher priority in order to reach the millennium development goals (MOH, 2007a). Although some gains have been made in disease control programming including HIV (Williams et al., 2008), tuberculosis control (Maung et al., 2006) and immunization (MOH, 2007b), progress is reported to have been uneven across the country (Tin et al., 2010).

Myanmar's health system is networked by 1481 Rural Health Centers (RHC), staffed by midwives and public health inspectors. In addition there are community health workers and auxiliary midwives based in villages providing a more limited level of primary health care services to the community. Health services access is affected by a range of barriers including remoteness, insecurity (particularly in border regions), poor health workforce distribution, ethnic diversity, financial barriers to access and lack of basic primary care infrastructure (MOH, 2007a). Health care access is further restricted by poverty and illiteracy; the International Crisis Group reports that more than 30% of children under 5 suffer from malnutrition and that nearly half the school age children never enroll (International Crisis Group, 2008).

Of particular concern is the issue of access to essential obstetric care for pregnant women and the care of their new born (neo-natal care). In Myanmar, sustained periods of low investment in the health sector have resulted in the steady erosion of the health system and of the health workforce required to sustain maternal and child health care for the population. Townships (with populations between 100,000 and 300,000) lack operational budgets to provide adequate health outreach services to rural and remote populations and are lacking in basic emergency equipment including ambulance transport. The growth of midwifery numbers from more than 8,000 to more than 9,000 during 1988-2007 appears to be well below the growth in national population (MOH, 2008b). The WHO reports that the nurse/midwife-to-population ratio is 8 to 10,000, well below the regional average of 13 per 10,000 (WHO, 2011).

A widespread decline in the health care infrastructure in Myanmar is also evident, with rural health centres commonly lacking delivery rooms, electricity, and water and sanitation systems. Up to 73% of mothers deliver their infants in village homes in the care of non-professional health providers, often far removed from the availability of emergency medical care should either they or their infants require it (WHO, 2011).

For many mothers and children the outcomes are catastrophic. The most recent estimate provided by WHO indicates that up to 56,000 children under the age of five die annually in Myanmar, mostly from preventable causes (WHO, 2011). A mortality and morbidity survey conducted by UNICEF in 2003-2004 concluded that seven out of 10 childhood diseases could be attributed to just five main causes – acute respiratory infections, diarrhea, measles, malaria and malnutrition – all of which can be prevented through access to food security and basic primary medical care (UNICEF, 2003).

Overseas Development Assistance in Myanmar

Historically, Myanmar has been largely excluded from all forms of multilateral development assistance (with the exception of some support through UNICEF, WHO and UNFPA). Additionally, a US$98 million grant from the Global Fund to Fight HIV, TB and Malaria was cancelled in Myanmar due to allegations of government constraints on in-country monitoring processes (Parry, 2005). There are wide differences in the approach taken by bilateral development agencies towards Myanmar from countries such as China, the USA, Thailand and Japan. The most restrictive sanctions have been applied by the USA and to a lesser extent countries within the EU. Japan and Thailand have been more liberal in their policies (Steinberg, 2007).

However, in recent years, changes have taken place in the governance of ODA programs, which suggests that there may be prospects for improved health aid flows to Myanmar. Following the cancellation of the Global Fund grant, a "Three Diseases Fund" (for Malaria, TB and HIV/AIDS) was established with the support of Australia, the European Commission (EC), the Netherlands, Norway, Sweden and the United Kingdom (UK) (Three Diseases Fund, 2012). The fund pledged US$100 million over five years and has stringent governance arrangements,

particularly related to financial flows, but at the same time highlights innovative international strategies to provide humanitarian and development assistance despite the obstacles presented by domestic and international political relations. Additionally, the Board of the Global Alliance for Vaccines and Immunization (GAVI) awarded a grant of US$32 million to Myanmar in 2008 for implementation of a health system strengthening strategy in 180 townships across the country (GAVI Alliance, 2008).

The recent Nargis cyclone disaster in the delta region of Myanmar resulted in important developments in international cooperation. It is estimated that 2.4 million people were severely affected by the disaster and nearly 140,000 died or are missing (OCHA, 2008). Following the disaster, aid commitments increased substantially; a recent preparedness and recovery plan identified the need for US$53.8 million for reconstruction of the health sector in Nargis affected areas (International Crisis Group, 2008). More than US$800 million has been identified for multi-sector resource programs between 2009 and 2011 to rehabilitate the cyclone affected areas (International Crisis Group, 2008). Ten townships (out of a total of 360 in Myanmar) were severely affected by Nargis; this provides some idea of the scale of the investment required to reconstruct and rehabilitate wider areas of the country adversely affected by remoteness, conflict and low levels of economic and social sector investment.

One of the important governance outcomes of the recovery effort was the establishment of a Tripartite Core Group (TCG) to oversee the design and implementation of the recovery plan (TCG 2008a, TCG 2008b). Following an ASEAN-UN International Conference organized with the Government on 25 May 2008 in Yangon, the TCG was formed with membership consisting of the Myanmar Government, ASEAN, and the United Nations to coordinate relief efforts. This initiative for disaster recovery opens up the potential for regional political and economic groupings to take up a higher profile in ensuring health security of populations. The more recent

award of Global Fund Grants to Myanmar should also open up the potential for wider investment by the international community in development assistance programs in maternal and child health, building on lessons learned from GAVI Health Systems Strengthening and Nargis Recovery planning efforts.

Health and development in DPRK

Health and health systems in DPRK

With a population of 24 million (CBS, 2009), DPRK is bordered by China, Russia and the Republic of Korea (South Korea) . Following the collapse of the Soviet Union, DPRK experienced a sharp decline in economic output, and GDP halved in a five year period (Grundy and Moodie, 2009). This was also a period of natural calamity (floods and droughts). In the late 1990's, famine was reported in many parts of the country. Since 2000, there has been some recovery in economic and social conditions, with a return to economic growth, gradual opening up of economic markets, and slight improvements in health indicators relating to nutritional status and mortality (International Crisis Group, 2005).

During intermittent six-party talks between USA, China, Japan, Russia, DPRK and South Korea, international aid, energy supplies and economic sanctions were being used as negotiating points to encourage denuclearization of the country.

Economic sanctions and international relations have had an impact on health outcomes in DPRK and have put additional limits on health systems development. Along with domestic constraints, such external factors have increased the vulnerability of the population to natural disasters. The succession of droughts and floods in the 1990s, coupled with an economic downturn, resulted in a nation-wide malnutrition crisis from which the country is still recovering. For the last decade, the domestic production of food has been insufficient to meet national needs.

According to the World Food Program, in 2004 28% of the population (6.5 million) still relied on international food programs to sustain basic food supplies. Additionally, the aforementioned improvement in food security experienced by DPRK between 2001 and 2005 has been reversed in recent years, and the country's reliance on external food supplies is increasing. This decline in self reliance has been attributed to such factors as low output of the farming sector, long-term decline in soil fertility, shortages of inputs, extreme weather events, and internal constraints on market activities. As a result of these factors, about 40 percent of the population (8.7 million people) was classified by the World Food Program and Food and Agriculture Organization (FAO) in 2008 as requiring urgent assistance (World Food Programme, 2008).

Although an analysis of four nutrition surveys conducted between 1998 and 2004 indicates a substantial reduction in the prevalence of malnutrition (using indicators such as wasting and stunting), it still remains that a third of children under the age of six suffer from chronic malnutrition (MOPH, 2009).

Despite international isolation, DPRK has a well-resourced health workforce with health system facilities run by over 181,000 trained staff. The 'household doctor' system provides integrated first line preventive and curative services for every 130 households and forms the basis of the DPRK health system. There are 44,760 household doctors in DPRK, all of whom are medically trained. A survey conducted in 2004 by UNFPA indicated that 87% of births were conducted in health facilities (the vast majority in county hospitals) with 98.2% of deliveries attended by trained health staff (UNICEF, 2006).

Despite this, health conditions for women and children remain grave in DPRK (McCurry, 2010). There are significant barriers to access to health services for the population, including lack of fuel and energy supplies at facilities, meaning that hospitals need to work in sub-zero conditions in winter months. Shortages of essential drugs, anesthetics and blood supplies are

evident across the country (Grundy and Moodie, 2009). Factors limiting maternal access to essential obstetric care include lack of essential equipment and skills at the Ri level (sub-county level), where 28% of births take place, lack of diagnostic skills in early detection of risk, and logistical challenges to referral in the harsh winter months. Due to a lengthy period of economic sanctions, health staff remains isolated from the latest innovations and technical developments in international health.

In one field study conducted in 2008, a review of maternal death cases outlines clearly the extent to which mothers are limited in their capacity to access basic obstetric services. In one county, managers reported that recent maternal deaths could have been avoided if the facility had had appropriate blood supplies. The facility had no blood stocks, there was no refrigerator for storage of blood, and there was inability to screen for diseases such as HIV, hepatitis and malaria. In another case, a family arrived at the hospital with the pregnant mother. After the delivery, the woman suffered hemorrhage and required transfusion, but there were no blood stocks. The family offered to provide their blood, but there was no basic equipment such as intravenous sets, and the woman died. With basic equipment and transfusion capacity, this woman, and many more like her across the country, would have been saved (Nossal Institute, 2009).

Overseas Development Assistance in DPRK

DPRK is subject to very low international aid flows (see Figures 1and 2) and has experienced a range of cancellations of and limitations on international projects and programs in recent years. The original grant of the Global Fund to DPRK was withdrawn prior to project commencement. However, in Global Fund Round 8, a sum of $36,369,191 was awarded to DPRK for Tuberculosis and Malaria control programming (The Global Fund to Fight HIV AIDS). The only Global Health Initiative currently active in the country is the Global Alliance for

Vaccines and Immunization (GAVI). In addition, there are very few (less than eight) international NGOs functioning in the country, which contrasts with a country like Cambodia (population 14 million) where over 100 international and national NGOs are active in the sector (Medicam, 2010).

The international aid program to DPRK has been under sustained international political pressure. In January 2007, UNDP operations were suspended following allegations from the United States Government of "irregularities" in the UNDP program (UNDP, 2010). An external audit of the United Nations' activities in DPRK found that "there has been no large-scale or systematic diversion of UN funds provided by the world body's agencies" (UN News Centre, 2008). DPRK has had no access to international finance institutions such as the World Bank, International Monetary Fund, or the Asia Development Bank. Participation by the DPRK as a World Bank member would require the political support of most of the Bank's member governments and is only likely to result if outcomes of the recently cancelled "6 Party Talks" are recommenced and result in favorable outcomes (Morrow, 2006). While the IMF comprises 184 member countries, the voting rights system ensures executive decisions are strongly influenced by dominant Western policy interests. In Japan, the question has been asked whether ODA can be used as "an effective tool for the normalization of relations between Japan and North Korea as well as for helping to generate peace and stability in the Northeast Asia region" (Söderberg, 2006).

Recently, the World Food Program scaled back its humanitarian food assistance program in DPRK after months of funding shortfalls. Of the US$504 million budget for a planned emergency operation, 4.5 % failed to materialize due to declining levels of development assistance. Although 6.2 million people were targeted by the emergency operation conducted by WFP last year, because of funding shortfalls *only 2 million* could be assisted (World Food

Programme, 2008). There are, however, signs of new ODA commitments, including a long term South Korean aid package for Women and Children (WHO/MOPH, 2008) and the recent award of a GAVI health system strengthening and Global Fund health grant to DPRK.

Despite these limitations in ODA, there is evidence that international assistance is helping to improve access to health care services in DPRK. In the field of tuberculosis control, the directly observed treatment approach has been scaled up nationally, case detection rates have been consistently above 90% since 2003 and treatment success rates in excess of 85% continue to be achieved (MOPH, 2008). Following the re-emergence of malaria in the 1990s, the MOPH has dramatically reduced yearly caseloads from 296,540 cases in 2001 to just 7,436 cases in 2007 (MOPH, 2010). Immunization trends have indicated a steady improvement in EPI coverage from 68% in 2003 to 92% in 2008 (DPT3) (MOPH, 2009). Despite significant gaps in the health system, reports from WHO indicate that investments in maternal and child health have resulted in reductions in maternal deaths, diarrhea cases and post surgical deaths (McCurry, 2010).

The examples above demonstrate that despite the constraints of internal security, which sometimes can set limits on the capability of health advisers and managers to move freely within all regions of these countries, programs can still scale up to high levels of coverage in some programmatic areas. The capability to achieve these outcomes and impacts stems mostly through working through national health systems, both of which, though extremely under resourced, have highly experienced national program managers and, in most cases, a wide reach of primary health services across both countries. The development of United Nations health agencies in both of these countries in the last 10 to 15 years, most of whom work in close collaboration with Ministry officials, also enables an opening up of communication pathways for development that would not otherwise have been possible.

These examples demonstrate that public health gains can be made through international health partnerships in these two countries, despite the instability of international relations and challenges associated with the national governance context.

Lessons from Myanmar and DPRK

Similarities and Differences between Myanmar and DPR Korea

There are some notable differences in governance and the approach to health development assistance in Myanmar and DPR Korea. Clearly, as DPRK is a highly centralized State, the potential for health management and system reform in this context, including the participation of civil society, is highly constrained. In the Union of Myanmar, there is significantly more policy space for discussion and negotiation on health reforms of health planning and financing, and for the engagement of civil society in health development.

However, there are three areas that present striking similarities on the ground between the two countries: the under resourcing of the health sector by the State, the very low rates of international aid flows up until 2008, and the stagnating health conditions of women and children in the two countries. This is most evident in the very poor access in many locations in both countries to quality, life saving essential obstetric and neonatal care services that we have outlined earlier.

It is this similarity in inequity of access that raises the question of the responsibility to protect, regardless of differences in governance context.

Equity, Rights and the Responsibility to Protect in Myanmar and DPRK

The cases of Myanmar and DPRK illustrate the need for a consistent "justice and fairness" platform to underpin the call for a more collaborative humanitarian effort to protect the populations in these two countries.

It is evident that increased humanitarian assistance can reduce preventable deaths by ending the association between inequitable health outcomes, in terms of consistently high maternal and child mortality rates, and the equally inequitable allocations of domestic national resources and international health aid.

It is also evident that the low access to essential emergency obstetric and neo-natal care, and the persistently high rates of maternal and child mortality in both countries have brought into question the capability of the State as well as the commitment of the international community to assure the right to access to basic health care services. These inequities and the inability to secure the health rights of the population raises the question as to whose responsibility it is to protect the population in such circumstances and how this should be done?

The responsibility-to-protect principle has previously been applied to justify humanitarian interventions in Africa. Such interventions often focus on the "last resort" approaches of legal sanction or military intervention. Some writers have claimed that such proposed humanitarian interventions based on the responsibility to protect have failed in locations such as Darfur and in Myanmar as a result of concerns by some Security Council member regarding the sovereignty of member states (Sarkin, 2005).

The examples of Myanmar and DPRK highlight the issue of the capability of the international community to exercise the responsibility to protect in situations where the State, through low social sector investment over extended periods of time, has palpably failed to meet its responsibility to protect its own population. Here the question is whether the lives of women and children should be put in jeopardy by the failure of the international community to undertake a

humanitarian intervention in ways that are possible within the given circumstances, or whether the international community should simply refrain from action in light of the State's own lack of responsibility.

In order to work through this policy dilemma, a more important consideration for the international community is how to assist in *building the State's capacity* for meeting the humanitarian needs of its own population. As both a humanitarian and longer term development field of endeavor, assistance to the health sector provides the opportunity for a dialogue between international and domestic partners on humanitarian needs initially, and development needs over the longer term. This is already evident in the partnership between the Government of DPRK, the World Health Organization, and The Women and Children's Health Project of the Republic of Korea (South Korea), where a dialogue has taken place on mechanisms for easing the plight of women and children in the north. The potential for partnership has also been demonstrated in Myanmar through collaborative efforts for Post Nargis recovery activities and through recent commencement of Global Health Initiative programs. Intervention strategies may be more effective when couched in terms of *encouraging and helping* States to exercise the responsibility to protect (UN General Assembly, 2005). Moving from the concept of "humanitarian intervention" in another State to collaborative efforts to exercise a joint national and international responsibility to protect (through regional mechanisms or global health initiatives) presents the best prospects for alleviating the conditions of women and children in these two countries.

Implications for health and foreign policy

The health and health-systems situation in these countries indicates that the foreign policy strategy of sustaining the isolation of these two countries and restricting humanitarian and social-sector ODA has negatively affected the wider population. A "soft power" foreign policy option

that involves a qualified level of international engagement, including a minimal level of humanitarianism, particularly with respect to the health and food security sectors will be more effective.

The partnership arrangements of the Global Health Initiatives and the Republic of Korea with DPRK for Women's and Children's Health are a significant development, as are the "3 Disease Fund" and the Tripartite Group regional initiative to respond to the Nargis disaster in Myanmar. These examples indicate that, despite the turmoil and tensions of international relations and questions surrounding governance in these countries, there is still sufficient space for international and regional partnerships for human and health security that can ease the plight of women and children in these countries. This approach is in keeping with international polices and the experience with international aid in "fragile state" settings.

One review of the application of Paris Declaration aid-effectiveness principles in Afghanistan, Burundi, the Democratic Republic of Congo and Nepal concluded that effective aid delivery was dependent on a deeper contextual analysis in each country and application of flexible aid modalities, and highlighted the importance of staying engaged over long periods to give success a chance (OPM/IDL, 2008). This principal of "staying for the longer term" particularly applies to rebuilding the health care workforce, which in many of these settings, and particularly in the case of DPRK, has been isolated from international developments for very long periods of time (Doull and Campbell, 2008).

Although both DPRK and Myanmar should not be considered fragile states (as they have each maintained power for more than four decades), they have both demonstrated weak governance arrangements for ensuring delivery of basic social sector services to their populations. That is, although the State is strong in both cases, their populations are vulnerable and exposed to high rates of preventable and premature mortality. Therefore, it is arguable that aid-effectiveness

principles apply equally in these settings, particularly given the humanitarian needs of the population.

Regional political networks and global international health partnerships could provide new and more flexible opportunities to address the current distortions in international health aid. This would help to shift the onus of responsibility for health security and protection from sole dependence on nation states to a shared national and international responsibility through regional political and economic groupings and the wider international health system, incorporating multilateral and UN agencies and Global Health Initiatives. Larger steps will be required (as described in Figure 3) to build regional and international consensus on the foreign policy settings and aid instruments to be applied in order to implement the commitments of international health agreements.

[Insert Figure 3]

By applying a stronger "health lens" to the analysis of foreign policy, prospects for striking a better balance between the "power and prestige" and "peace and prosperity" objectives in current foreign policy settings can be achieved (Kickbusch, et al., 2007), (Bond, 2008).

Conclusion

In Myanmar and DPRK, the State has failed in its responsibilities to invest in appropriate health system development for effective health care of the population over the last 20 years (Natsios, 2001), (Terry, 2001), (MSF, 2008). Equally, in light of the international agreements outlined in this paper, and despite recent improvements, the international community has, by withholding equitable allocations of international social-sector aid, also failed in its responsibility to protect the interests of women and children over an extended period of time.

Health and other social systems are on the verge of collapse in Myanmar and DPRK due to these decades of national and international neglect. This is in large part due to failed national governance in these two countries. Poor national governance has been exacerbated by international foreign policy that has not, in fact, achieved the desired aim of regime change. Instead, foreign policy and associated inequities in international aid flows have exacerbated the chronic conditions of extreme health and social insecurity of highly vulnerable populations.

Current international instruments for management of health security, such as international health regulations, MDG agreements and human rights agendas, are effective in so far as they express political commitment. In practical terms, however, the allocation of international health resources remains mostly determined by narrow foreign policy concerns rather than a commitment to fairness and justice, particularly in relation to the health needs of women and children.

In order to address these inequities, and provide relief for the extremely harsh health conditions for women and children in these two countries, there is a strong case for the practice of a more humane foreign policy that recognizes the joint obligation of national and international communities to protect the health rights of populations in vulnerable societies. While the governance context in these two countries continues to provide major challenges for aid effectiveness, there is nonetheless a responsibility to protect women and children through the careful targeting of collaborative health and humanitarian aid programs.

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Figure Legend

Figure 1. Average International US $ per Capita Aid Flows *(All Sectors)* Asia Region

Figure 2. Average International US $ Per Capita *Health* Aid Flows 2006 – 2008 and Under 5 Mortality Asia Region

Figure 3. Some Suggested Strategies to Reinforce Regional Public Health Security