The Three Millennium Development Goal Fund
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COLLECTIVE VOICES:

UNDERSTANDING COMMUNITY HEALTH EXPERIENCES

Stage-1 Completion Report - December 2015

Acknowledgements and Disclaimers

We would like to thank the donors contributing to the Three Millennium Development Goal Fund (3MDG) for their kind contributions to improving the health of the poorest and most vulnerable people in Myanmar, particularly women and children.

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Sincerely yours,

Joseph Win Hlaing Oo @ Kung Za Hmung
Executive Director
January 12, 2016

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1. BACKGROUND

The Three Millennium Development Goal Fund (3MDG) supports the provision of health services in Myanmar and contributes towards the country's efforts to achieve the three health related Millennium Development Goals. In March 2014, the 3MDG Fund announced the launch of a US$1.5 million initiative in partnership with six organizations to improve the understanding of the social factors limiting access to health care, and to support a meaningful participation of community members for better services and consumer satisfaction.

This initiative, called "Collective Voices: Understanding Community Health Experiences", comes in support of the vision of the Government of Myanmar to reach Universal Health Coverage by 2030 and the Constitutional objective of ensuring that every citizen shall have the right to health care.

The "Collective Voices" initiative is to be implemented in two stages, and furthers the 3MDG Fund's contribution to a responsible, fair and inclusive health sector, with a focus on community engagement, to achieve better health for all in Myanmar. It also strengthens the capacity of local organizations to support the health sector now and in the future.

Community Agency for Rural Development (CAD) is one of the six organisations selected to receive this funding to explore community needs for access to health services which will be continued with further project implementation in Stage 2 of the Collective Voices initiative. The two main thematic areas for the project are; (1) Gender and Health, and (2) Cultural Dimensions of Health Seeking Behaviour.

About CAD

CAD has been working in Chin State since 2004. CAD is officially registered as a Myanmar NGO and has worked for humanitarian and development projects. CAD's strategy is empowering community and strengthening the organizational capacity of community-led organisations in project villages. In this 3MDG project, CAD is applying the same principles for collective works together with three local Community Based Organisations (CBOs) in three townships to promote accountability, equity and inclusion in Maternal, Newborn and Child Health (MNCH) services for the Chin ethnic community.

CAD has been working in Chin State since 2004 and therefore has a comparative advantage in mobilizing CBOs and community for humanitarian works. CAD is currently implementing projects in Hakha, Thantlang and Matupi in Chin State, Ye Oo in Sagaing Region, and Natogyi in Mandalay Region for food security and livelihood development, environmental conservation, conflict management and mitigation, and capacity building for CBOs. CAD's strategy is to build up community capacity and CBOs in project villages. Our organisation's strengths are in community engagement for accountability, equity and inclusion where our connection with community means that resources can be easily mobilized. CAD used its existing project office and functions in Hakha for starting up the Collective Voices community engagement project, and provided further support in coordination, logistics and financial accountability and transparency through the CAD headquarters based in Yangon.

The Project

In general, Chin State is a remote hilly area and access to health services for Chin ethnic people is difficult. Furthermore, due to the numerous linguistic dialects and difficult communication of remote ethnic rural populations in Chin State, it is very interesting to explore community health experiences of ethnic minorities and explore further innovative work to promote access to health services for this ethnic community. The objectives of the project are: promoting local and community based organizations to obtain collective voices throughout the project; gender and health - targeted MNCH services in ethnic community villages; breaking down cultural barriers and equity in access to health information and health services by the Chin ethnic population.

Geographically, Chin State has been divided into north and south. By religion, northern townships are Christian and southern townships are Christian, Buddhist and animist. Furthermore, Chin ethnic communities in rural areas are living in isolated villages and mountains (recently the Government released the results of the 2014 Census, showing that more than 80% of the Chin population are living in the rural/ village areas). Those groups experience difficulties in communication with the main community in towns and cities. Small groups speak different dialects and are not easily connected with small towns and cities. This has imposed big challenges in access to health services. Health services, hospitals and health centres are staffed with trained health person who speak Burmese and their respective tribal dialect.

Maternal and health services are essential for Chin State. In Myanmar, Chin State is relatively poor and has a higher fertility rate. Lack of knowledge and limited reproductive health and MNCH services need immediate remedies for maternal and child mortality and future development. CAD project townships (Hakha, Thantlang) in northern Chin State need immediate maternal and child health promotion. Recently, 3MDG started providing MNCH services in Chin townships. However, access to services is still relatively low because of cultural dimensions, limited access to health services for women and participation of women in health programme and village health activities. Limited access to health services for women in Chin State are related to lower reproductive health knowledge.

The operational model for this project will be simply about increasing community engagement in accountability, equity and inclusion needs of the community related to health care access. CAD will collaborate with local CBOs to facilitate full participation in community meetings and workshops to maximize potential in exploring barriers and limitations related to health care access. CAD has organized training for gender and culture related barriers in accessing health care for the CBOs with appropriate public health consultants. Furthermore, CAD provided training for organizational capacity, gender and humanitarian works to the CBOs which supported quality and timely delivery of targeted activities in project villages.

Our Partners

CAD is the lead organization for this project. Our partner CBOs are as follows:

	Organization	No. of Villages	Townships
1	Love In Action	17	Thantlang Township
2	Green Land Social Development Organization	16	Thantlang and Hakha Township
3	Chin Youth Organization	17	Hakha Township

Goal

Community engagement for accountability, equity, inclusion and transparency in health service provision through the participation and empowerment of community and CBOs in Chin ethnic remote villages.

Purpose

This project was planned as an exploration of community needs for access to health services which will be continued with further project implementation in Stage 2 of the Collective Voices initiative. The two main thematic areas for the project are (1) Gender and Health, and (2) Cultural Dimensions of Health Seeking Behaviour.

Strategies and Thematic Areas

Proposals for Collective Voices funding were required to fit within at least one of five thematic areas identified below. Proposals had to demonstrate how the project would contribute to greater understanding of the key issues within these broad themes.

- Theme 1: Gender and health
- Theme 2: Cultural dimensions of health seeking behaviour
- Theme 3: Conflict and Health
- Theme 4: Age, disability and health challenges
- Theme 5: Health information

This project focused on thematic areas 1 and 2. CAD decided to explore the following issues under thematic areas 1 and 2:

1. Understanding community health experiences through community participation
2. Addressing gender and health through focusing on reproductive health and health for women
3. Exploring barriers and limitations among the culturally distinct Chin ethnic population in remote villages
4. Promoting accountability, equity and transparency in accessing health services for the remote ethnic population in Chin State

2. OUTPUTS AND OUTCOMES

Outputs

1. CAD provided three types of training on social/community mobilization and development to our partner Community Based Organisations (CBOs) with technical assistance four times (2 times in Yangon and 2 times in Hakha). A total of 21 people from CAD and CBOs attended these trainings.

2. With local health and non-health service providers in our project area, we conducted a two-day workshop at the CAD sub-office in Hakha to explore the current situation and mind-set of local people on gender and health, and the cultural dimensions of health seeking behaviour in Chin State. A total of 18 people attended the workshop and we formulated a standard form to shape questions asked at future community meetings and discussions to obtain information for the Collective Voices project.

3. Our community meetings reached a total of 50 villages in Hakha and Thantlang townships. A total of 2,230 (1,078 from Hakha and 1,030 male and 1,200 female participants in our group discussions. The majority were married (83%) and recorded their profession as farmers.

Outcomes

1. Our local CBO partners were equipped well on social mobilization, gender issues and cultural barriers among the Chin people.
2. Our partners have gained more trust and confidence in their constituencies.
3. They improved their understanding from a lack of knowledge to practical knowledge on health access, cultural and social norms in remote areas.
4. CAD has gained a better understanding and clear information on public health issues in our project areas.
5. CAD consolidated health information on the thematic areas, which will now be used in the Stage 2 proposal to address key issues found during Stage 1 in the coming 2 years with 3MDG and other donors.
6. We listened to hundreds of local people express their different voices and views on public health care in remote areas.

3. OUR ACTIVITIES

Advocacy

Based on the previous experiences of CAD in working on health issues since 2004, we decided to start with an advocacy event in Hakha and Thantlang townships. CAD met with and explained this new 3MDG project to the Chin State Minister of Health on 14 May 2015, to facilitate increased awareness and access to health services. The Minister explained that there was no objection to this project continuing. CAD regarded this township-level coordination with the Ministry of Health as important to the success of the project, and appreciated the active participation of township and village stakeholders.

Photo 1: Advocacy Workshop in Hakha CAD Office

Strengthening the Working Committee for Community Health

On 28-29 April 2015, CAD members held a workshop together with the Township Medical Officer, Save the Children, and all 8 staff from three CBOs and 50 villages Development Committees. The representatives agreed to establish a Working Committee for Community Health, and committed to sharing information, working together, and if necessary, accepting CAD project volunteers linking with existing Basic Health Staff and identifying means to mainstream personal hygiene, reproductive health, family planning and birth spacing measures as complementary to existing services of the township, station hospitals and rural health sub-centres. Five monthly meetings were held, often including capacity building sessions.

Photo 2: A woman expressing her voice on health issues

The State Public Health Assistant Doctor (Hakha Hospital) attended the CAD workshop and shared information with the CBOs about real cases in the township and health related issues, and mapped the far off villages in terms of need and presence of midwives. She clarified that some villagers could not reach the sub-centre due to a range of health knowledge and social barriers.

CAD and its three CBO partners travelled around to all 50 villages in Hakha and Thantlang townships to assist midwives (MWs) and auxiliary midwives (AMWs) to listen to family planning needs, including explaining options and encouraging health choices and women-led decisions in families from the project villages. Priority in the selection of project volunteers was given to zone and area facilitators who worked on Save the Children (Merlin) projects in the past.

Photo 3: Staff discussing reproductive health

Community Meetings Led by CBO Partners

CAD partner CBOs led community meetings for community-based participatory planning to understand the family planning practices of communities, while extracting social barriers relating to reproductive health issues out of other prioritized health problems. CAD and CBOs supported all the equipment and refreshments for the meetings. In every village the participants were aged between 30 to 35 years. Before or after the meeting, all the staff went to meet the villagers person by person.

Photo 5: Discussion during community meeting with men's group

Methods and Tools Used

As mentioned above, CAD firstly conducted an advocacy meeting with the Chin State Minister of Health and held coordination meetings with the Township Medical Officer, Save the Children and members of 50 village Development Committees.

Then CAD developed the tools to listen to the voices of communities on CAD targeted thematic areas. CAD received training and technical support from 3MDG on participatory learning approaches, methods and tools. CAD and partner CBOs adapted the tools to be applicable and most appropriate to the local community in Chin State.

CAD and partner CBOs worked to create linkages between recruited volunteers, midwives, and AMWs working in the area to assist during their visits to the villages and likewise with Village Health Committees.

CAD used the following methods in the community meetings to get voices of the communities as follows:

1. Graffiti Sheets
2. Small group discussion
3. Case Histories
4. Brainstorm
5. Role plays

6. Task Groups
7. Worksheets
8. Whip

Tools used in participatory community meetings were:

- Social Mapping
- Resource Mapping
- Seasonal Calendar
- Venn Diagram
- Trend Line
- Causal Diagram
- Ten Seeds Method
- Wealth Ranking
- Problem Tree
- Key Informant Interviews
- Body Mapping
- Village Profile
- Pair Wise Ranking (Antenatal)

4. RESULTS

Overall Findings

Community meetings were held in 50 villages across Hakha and Thantlang. A total of 2,230 villagers from Hakha and Thantlang townships attended the community meetings. There were 1,030 male and 1,200 female participants in our group discussions. The majority were married (83%) and recorded their profession as farmers. Although our community meetings findings showed significant differences between Hakha and Thantlang in regards to attitudes and service provision, and there were also marked differences of opinion between men and women on particular issues, there were common issues in all groups; particularly, gender inequality, lack of health knowledge, and health seeking behaviour.

1. Gender

According to the discussions, women have less leisure time than men. They have to spend 2-3 hours a day on housework before and after their paid work, spending most of their time (more than 6 hours a day) generating an income, leaving little time available for leisure activities. Interestingly, family size appeared to have little bearing on the amount of leisure time a woman might have. Moreover, they are involved in community based activities through the Church or other organisations/institutions. This could suggest that there is a strong perpetuating ideal about the domestic role of women in households and society that women are expected to conform to.

An interesting finding was the perception by community meeting participants that all members of the household have equal access to healthcare, and nobody receives preferential treatment or opportunity. The majority of villagers expressed that the mother takes responsibility for child health in the family. Men and women were in agreement on this.

Apart from this, women have less voice than men in all other decision making on health care and family planning. Culturally, men are the dominant decision-maker for the whole family, indicating the importance of men's participation in better access to health services for women. Only about half of the women participants, 52% in Hakha and 63% in the more rural Thantlang, said they had voices in family planning. A small portion (24%) of women reported that they sometimes used contraception and 55% said they never did. Women with small or medium sized families were considerably more likely to use contraception 'always' or 'sometimes' (37-38%) compared to women with larger families, none of whom claimed to use contraception always and only 17% sometimes. Usage of contraception was more encouraged than discouraged by factors including cost, physical access, government and NGO information, and family planning, whilst religion and 'cultural customs' were seen to be a significant discouragers.

One big issue arising in terms of access to health care services is that there is lack of female health service providers and women faced difficulties to get the right treatment.

> *"We don't have female quack or doctors in our region (12 villages) Therefore we, women, at times, go to male quacks for our women sickness but sometimes we dare not tell them our illness."*
>
> *Female village participant*

Health Knowledge

Health knowledge on reproductive health is directly related to the cultural practices of families in Chin State and education level of the family members. There is limited health information sharing and subsequent low levels of health knowledge. The community meetings found that families have no practice of discussing sexual health. A very small portion talks about their sexual health with their partners (12% of Hakha and 1% of Thantlang participants).

A small portion of community members, who are generally more educated parents, talked to their family about sexual health. This indicates a clear (if somewhat gradual) changing of attitudes around this issue. Many of the community participants were aware of birth spacing, but they do not have wider knowledge about other reproductive health issues.

"I have never learned about reproductive health in my village. Therefore I don't know how to space my pregnancy. I have 4 children."

Female village participant

2. Health Seeking Behaviour

i. Personal Hygiene

According to the discussions in the meetings, 96% of households have their own toilet, and 90% do not have access to a private wash space (79% from Hakha and 99% from Thantlang). A total of 57% of community meeting attendees said they washed twice a week, 29% said once a week, and 11% said three or more times. The 16-30 age group tended to be most conscientious about washing themselves regularly. Soap usage was high, although 10% lower in Hakha than in Thantlang.

Hand washing before handling food was common, 45% always washed their hands before food and 52% said they did sometimes. Water quality was average in Hakha and it is reported to be of bad quality in the rainy season in Thantlang Township.

For menstruation, women usually used fabric and tampons, and some (23%) do not use anything. The reason given for this was that they did not have easy access to a female health practitioner.

ii. Reliance on Informal or Unlicensed Health Service Providers

Community reliance on quacks and traditional practitioners is quite high. In a health emergency, 72% of people in Thantlang villages and 54% in Hakha said they first turn to the quack for support. Those with larger families clearly relied more heavily on village quacks than those with smaller families, who were more likely to use government services at the first opportunity.

The villagers expressed that the larger the family size, the less likely they were to be happy with the services available. Older people tended to be less happy than younger.

The majority of Hakha townships were happy with the health services available to them but only a very small ratio of villagers of Thantlang township were happy. Farmers tended to be less happy than non-farmers.

Two important reasons are the cost for formal health care services and transportation difficulties. A total of 94% of meeting attendees in Thantlang and 59% in Hakha said they sometimes delay healthcare seeking because of the cost involved. Additionally, limited transportation options played a role in health seeking practices, with the majority of Thantlang participants saying they sometimes delayed care due to journey times to reach appropriate services. There was also a gender difference on this issue: women reported journey time/distance to be shorter than the men. This perception might be due to the fact that men are more likely to be the drivers and women the passengers, and driving is more arduous.

> *"We know quacks are not recognized and not trained by government but we have no alternative way to get doctors. Whenever we are sick, we are injected with a high price. At times they have no medicines as well. However the quacks are available whenever we need them, even at midnight they come to our sick home. They provide us with medical services and we can pay for it later when we have money."*
>
> *Female village participant*

Although the quacks are inevitably highly used by the villagers, most of them are not trained properly on health and the ethics of quality health service provision. Moreover, there is no network between formal health service providers and the quacks, and they never receive guidelines or instructions on formal health mechanisms and techniques. So it is very important to build the capacity of quacks to provide proper, basic care and to recognise emergency cases.

> *"I never attended health and medical training at all. I just read a first aid booklet, written in Burmese. No networking with medical practitioners is existent at all in my whole life. We all are working individually. So we have no knowledge improvement on modern medical treatment and health information at all. We wish CAD could start this networking strategy in our region so that we learn by sharing our experiences and knowledges."*
>
> *A quack from Sate village*

iii. Cultural and Language Issues

Chin villagers commonly discuss their personal or family health issues with friends before going to a health practitioner. They only go to the hospital as a last resort. Around 78% of participants said they discuss their personal or family health issues with friends (the community) and 94% would do this before going to a health practitioner. This is also linked with a lack of knowledge about health within the community.

Language barriers also present a barrier in accessing health services. Previously, township level health service providers were from other parts of the country and they did not speak local languages. Villagers were afraid of going and talking to them.

> *"I have been sick since 3 years ago. I went for a medical check and showed my illness to physicians who are Burmese but I cannot express my suffering to them in Burmese which I cannot speak. Therefore I used an interpreter. As a Chin person, I cannot speak Burmese language. Therefore I am not satisfied with using an interpreter to see a physician for my medical treatment. Until today, I am not fully recovered from my illness."*
>
> *Female village participant*

Summary of Key Barriers

- Health services are difficult for remote communities to access due to the distance of services from their villages.
- The majority of community participants found it difficult to find appropriate transportation and lodging when they need to go to an urban hospital. Instead they typically go to informal health service providers.
- Community reliance on quacks and traditional practitioners is quite high. In a health emergency, many community participants said they first turn to a quack for support.
- Informal health providers have no access to health and medical training. There is no practice of sharing information and guidelines or instructions on formal health mechanisms and techniques between formal and informal health service providers.
- Remote communities have very limited access to health education and to health related materials in their local dialect. They were not used to talking about information around reproductive and sexual health openly.
- Women have less voice than men in decision-making on health care and family planning.
- Poor levels of Knowledge, Attitudes and Practices (KAP) on reproductive health and family planning are compounded by male dominance in deciding the number of children, type of contraception, mode and place of delivery. Religion and cultural customs were cited as discouraging women from using contraception.
- There is a lack of female health service providers and women in the communities faced difficulties in getting the right treatment.
- The majority of houses do not have access to a private wash space for women.
- Women tend to have less leisure time than men. Further, the labour burden of women continues until pregnancy, and pregnant women have to work until term.
- Big family size and poverty are common in Chin. Drugs are not affordable if many are to be bought. There is a shortage of money for emergency care, transportation, medicine and nutrition.

5. RECOMMENDATIONS

Based on the key barriers highlighted above, we recommend the following priority actions or 'solutions' for our Stage 2 project under Collective Voices:

1. This project should increase health awareness and knowledge of communities at the village level on primary healthcare, personal hygiene, gender equality, family planning and reproductive health (RH) for behaviour change and improved healthy management.

2. It is important to aim to improve the knowledge and skills of informal or unlicensed health providers in remote areas where the majority of communities are dependent on them for their health, to ensure safer treatment for their patients.

3. The project should strengthen networking and coordination between informal and formal health service providers on diseases, treatment methodology, latest pharmacy, prevention and referral system for better service provision to remote communities.

6. GOOD PRACTICES AND LESSONS LEARNED

- The signing of the contract and disbursement of the Stage 1 3MDG funds to CAD incurred some delays which affected timing, acknowledgment and participation of project stakeholders.
- The CBOs value their participation with the project and requested long-term measures to acknowledge that CAD will continue to fund them.
- By receiving the commitment and collaboration of the TMO and township general administration, it was regarded that the ground-level advocacy was successful.
- The project revealed the need for long-term interventions on public health management, including from the government in Chin State.
- CAD is better information and has greater understanding of health seeking challenges and behaviours of local people in our project areas.
- CAD has an information base to determine and advocate for future public health interventions.
- CAD developed higher self-confidence in applying for funding to future project under UNOPS in Myanmar.
- CAD has become even more committed to supporting/upgrading the capacity and development of local CBOs.

7. ANNEXES

Table of community meetings

Village	Township	Date	No. of Attendees
Rinpi	Hakha	22-23/5/2015	40
Tiphul	Hakha	23-24/5/2015	32
Hairawn	Hakha	24-25/5/2015	31
Firti	Hakha	28-29/5/2015	33
Dauchim	Hakha	29-30/5/2015	28
Hmaikhah	Hakha	30-31/5/2015	33
Halta	Hakha	3-4/6/2015	36
Ruantlang	Hakha	4-5/6/2015	29
Ruadeu	Hakha	5/6/2015	22
Vantlang	Hakha	5-6/6/2015	36
Hrawngvun	Hakha	6-7/6/2015	19
Chuncung	Hakha	12-13/6/2015	50
Cawbuk	Hakha	14/6/2015	50
Ruavan	Hakha	20-21/6/2015	50
Lei-um (B)	Hakha	21-22/6/2015	50
Tilak	Hakha	23-24/6/2015	50
Bungzung	Hakha	24-25/6/2015	50
Lungkhin	Hakha	19/6/2015	45
Leipi	Hakha	20/6/2015	56
Lungrang	Hakha	21/6/2015	47
Phaizawng	Hakha	22/6/2015	61
Surkhua	Hakha	23/6/2015	44
Sakta A	Hakha	30/6/2015	49
Dinlopa	Hakha	1/7/2015	51
Phaipha B	Hakha	2/7/2015	60
Hausen	Hakha	3/7/2015	26
Kutchah	Thantlang	24/5/2015	35

Khuafo	Thantlang	26/5/2015	69
Arcirh	Thantlang	27/5/2015	54
Hmunthar	Thantlang	28/5/2015	67
Tlanglo	Thantlang	2/6/2015	70
Vanzang	Thantlang	3/6/2015	62
Sentung	Thantlang	4/6/2015	48
Phaikhua	Thantlang	5/6/2015	57
Hriphi A	Thantlang	27/5/2015	32
Vuangtu	Thantlang	28-29/5/2015	48
Zeiphai B	Thantlang	30/5/2015	46
Vambai	Thantlang	2/6/2015	26
Salen	Thantlang	3/6/2015	57
Tikir A	Thantlang	4/6/2015	23
Tikir B	Thantlang	5/6/2015	45
Hriangkhan	Thantlang	6-7/6/2015	55
Hmunlipi	Thantlang	8/6/2015	39
Bungkhua	Thantlang	12/6/2015	67
Fungkah	Thantlang	13-15/6/2015	49
Tahtlang	Thantlang	17-19/6/2015	32
Ngaphaite	Thantlang	25-26/6/2015	42
Innhmunpi	Thantlang	27-28/6/2015	57
Lungcuaipi	Thantlang	29-30/6/2015	28
Leitak	Thantlang	1-2/7/2015	44
Total Participants			2230

Myanmar Information Management Unit

CAD Projects Village Per Sector

Chin State