



Collective Voices: Understanding Community Health Experiences

**Community Health Experiences:
Promoting Community Access to Health Services with Accountability,
Equity and Inclusion in three Townships of Southern Chin State**

Project Report by
Ar Yone Oo Social Development Association (AYO)

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Introduction

The Three Millennium Development Goal Fund (3MDG) supports the provision health services in Myanmar and contributes towards the country efforts to achieve the three health-related Millennium Development Goals. The 3MDG Maternal Newborn and Child Health (MNCH) programme is promoting maternal and newborn and child health in Myanmar, including supporting access to health services in remote villages of Chin State.

During 2014, in areas where 3MDG is active, 8,000 women, or 15% of pregnant women, were supported through emergency referrals to hospitals after developing a complication during pregnancy or childbirth.¹ In 2014, coverage of the 3MDG Fund in Chin State reached all eight townships; Matupi, Mindat, Madupi, Tedim, Falam, Hakha, Tonzang, Thantlang, Paletwa and Kanpetlet. Though the coverage is universal throughout the region, community utilization of MNCH services are considerably low: emergency referrals for mothers in Chin were still at 5% of expected births compared to a target of 20% and under-fives referred for emergency care was 2% compared to a target of 5%.²

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.

Funded by 3MDG under the Collective Voices initiative, Ar Yone Oo (AYO) and its partnering local community based organisations (CBOs) implemented a project in three townships (Matupi, Mindat and Kanpetlet) of southern Chin State called “Community Health Experiences toward Promoting Community Access to Health Services with Accountability, Equity and Inclusion”. There are many barriers in remote communities to accessing health services, namely cultural barriers, gender, conflict, age and disability, and poor access to health information. Furthermore, there were some delays in 3MDG assisted MNCH services provision in Chin State due to difficult access during the rainy months and the high turnover of township health department staff.³

AYO has been working in Chin State for more than four years. AYO is officially registered as a Myanmar NGO and has worked on humanitarian and development projects. AYO’s strategy is to empower communities and strengthen the capacity of CBOs in project villages. In this project, AYO applied the

¹ 3MDG Annual Report – 2014

² 3MDG Annual Report – 2014

³ 3MDG Annual Report – 2014

same principles for collective works together with three local CBOs in three townships to explore community health experiences related to accessing MNCH services by the Chin ethnic community. Stage 1 commenced in March 2015 and was completed in October 2015, and this report is based on the findings from the first stage.

Rationale Including Objective and Scope

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 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. 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 70% of the Chin population is living in 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 even 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 personnel who speak Burmese and major Chin dialects.

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 are two issues needing immediate remedies for maternal and child mortality and future development. AYO project townships (Matupi, Mindat and Kanpetlet) in southern 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 is related to lower reproductive health knowledge.

This project plans to explore community needs for better access to health services. Two main thematic areas for the project are; (1) Gender and Health, and (2) Cultural Dimensions of Health Seeking Behaviour.

Goal

Community engagement for accountability, equity and transparency in promoting community access to health services in Chin State townships through participation and empowerment of community and CBOs in ethnic remote villages.

Specific Objectives and Thematic Area

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

Activities

1. Training workshop for CBOs and project staff on accountability, equity and transparency in access to health services
2. Training workshop for CBOs and project staff on gender and culture related barriers in access to health
3. Community outreach meeting to understand community health experiences about gender and health, barriers and limitations for the culturally distinct Chin ethnic population
4. Community consultations to explore needs and barriers related to health and gender and culture:
 - Access to sexual and reproductive health
 - Health needs for women headed households
 - Representation of women in health service provision, village health committees, village health volunteers, a needs assessment for community health activities, and beneficiary selection, etc.
5. Conducting a Community Awareness Workshop on Accountability, Equity and Transparency for accessing health care in the three project townships, to share/report community health experiences about accountability, equity and inclusion among the Chin ethnic remote community to 3MDG and the public.

Area Coverage (geographical and population)

This project is targeted to the ethnic Chin population in the (36) villages of three townships: Matupi, Mindat and Kanpetlet in southern Chin State. AYO fully cooperated with stakeholders and partner organizations in selection of villages and implementation of project activities. AYO used its existing capacity development model to form and develop the capacity of village CBOs, along with the village health committees (VHC) to explore and promote community access to health services.

Chin State is demographically mountainous and inhabited by numerous ethnic groups who are culturally and linguistically diverse. There is value in identifying those diverse backgrounds and experiences, as they can influence health seeking behavior among the ethnic population in Chin State. This will enable more appropriate and sustainable interventions to be developed.

Project areas were located in southern Chin State. Mindat Township is an administrative centre for the district in southern Chin State and is located in the centre of the state. Matupi Township is located in the western-most part of the state, bordering with India. Kanpetlet Township is located in the southern-most part of Chin State, bordering with Magwe Region in the east. This means that the AYO project villages were located in remote hard to reach areas, where communication and travel to the villages is mostly done with motorbikes and on-foot. Project villages and coverage household and population are summarized below:

Kanpetlet Township		Mindat Township		Matupi Township	
1	Pinlaung	1	Pu Kon	1	Par Mine
2	Kanthayoung	2	Hee Long	2	Lui Vang
3	Phonedwekyin	3	Kwe Longtha	3	Lae Kan
4	Pantaung	4	Ma Htaw	4	Sar Te
5	Hmuhchingding	5	Cha Khin	5	Lo Taw
6	Awtkant	6	Sit Wanu	6	Te Nam
7	Mawchang	7	Yaung Laung	7	Sone Sin
8	Khawtu	8	Pyone	8	Lei Sin
9	Hlalaungpan	9	Phwe Saung	9	Walan The
10	London	10	Kin Hle	10	Kwe Sar
11	Khitaw	11	Ma Chone	11	Am Swee (A)
12	Sawlaung	12	Pan Par	12	Ka Sae

Activities and Process with Quantitative Information

As AYO is an existing organization working in southern Chin State, starting up the project and coordination work with government administration and other stakeholders was easily done in a short time.

a) Training workshop for CBOs and project staff on accountability, equity and transparency in access to health services

Three staff from each partner CBO and three AYO staff attended the training workshop in Yangon in March, 2015. Six staff also attended follow up training in Yangon which was organized by AYO in the last week of March, 2015.

b) Training workshop for CBOs and project staff on gender and culture related barriers in access to health

Three staff from partner CBOs and three AYO staff attended the training workshop in Yangon in the last week of March, 2015. Those staff also attended follow-up training in Yangon which was organized by AYO in the last week of March, 2015.

c) Community outreach meeting to understand community health experiences about gender and health, barriers and limitations for the culturally distinct Chin ethnic population

72 sessions of community outreach meetings were organized in 36 project villages in Kanpetlet, Matupi and Mindat townships of southern Chin State. During the sessions, AYO and partner organizations collected data and information about community experiences in access to health in relation to gender and cultural dimensions within society.

d) Community Consultations for exploring needs and barriers related to health, gender and culture
(108) consultation sessions were organized in 36 villages from three townships. During the sessions, AYO and partner organizations collected data about community experiences in access to health, relating to gender and cultural dimensions within society.

e) Conducting a Community Awareness Workshop on Accountability, Equity and Transparency for accessing health care in three project townships

Three consultation workshops were held in the three project townships. AYO and partner CBOs facilitated these workshops. Discussion was elicited from the community on gender and cultural barriers related to health care access, while further information promoting access to health care services was given by the project team. A total of 135 participants attended (77 men and 58 women).

From these activities, AYO and the local CBOs collected information related to gender and cultural issues in accessing health services, and further plan to design a project promoting community health care access for next two years under the Collective Voices grant.

Tools and Methods

With technical support and training from 3MDG, AYO in collaboration with its partner CBOs developed tools and methods appropriate to the Chin ethnic minority, in particular considering the applicability of the tools and ensuring they would be understood by the community. For example, AYO and partners selected visual methods from the PLA tools such as pie charts, ten seeds methods, Venn diagrams etcetera as appropriate qualitative tools. These were used for the exploration of community needs under the two selected thematic areas: gender and health, and the cultural dimensions of health seeking behaviour. Further adaptation of the selected methods and tools was carefully done for language, cultural and religious sensitivity.

Field staff and local CBOs were trained at the beginning of the project and AYO conducted regular visits to the field and its partners CBOs for supportive monitoring. This programme coordinated with village health committees, health project implementing partners (such as the Township Health Department, Township General Administration Department (GAD), Myanmar Red Cross Society (MRCS), International Rescue Committee (IRC) and Marie Stopes International (MSI)), and health centres for identifying existing health services relevant to the two thematic areas.

This project promoted participation of village grassroots organizations in targeted activities. AYO also experienced active participation of these organizations through a cascade approach to community empowerment; training and capacity development, participation in assessment, programme, and scaling up of project activities. Furthermore, AYO coordinated with the Chin government, members of parliament, other stakeholders and the village administration in the AYO project.

The project worked by using the local CBOs as field partners and AYO as the lead organization. At the township level, monitoring and supportive supervision was carried out by the AYO township project team. Within the consortium, local CBOs managed the village and outreach services and AYO worked as the administrator or coordinator. The operational model for this project, put simply, is 'community engagement'. AYO facilitated and supported the local CBOs to develop skills and capacity to lead community meetings, consultations and workshops to maximize their potential in exploring barriers and limitations related to health care access.

At the beginning of the project, AYO was supported by a 3MDG programme technical expert with capacity building training to collect data and information. This training used participatory tools and Participatory Learning Action (PLA) methods and they were instrumental in exploring community barriers related with access to health services.

AYO organized training for gender and culture related barriers in accessing health services for the CBOs. Furthermore, AYO provided training for organizational capacity, gender and humanitarian works to the CBOs which supported quality and timely delivery of targeted activities in project villages. AYO also shared the experiences with community, CBOs, other implementing partners and government offices, and the 3MDG programme through reports and regular meetings.

The following methods are a summary of AYO data collection tools for cultural and gender barriers in accessing health for the rural community:

1. Community outreach meeting to understand community health experiences about gender and health, barriers and limitations for the culturally distinct Chin ethnic population
2. Community consultations for exploring the needs and barriers related to health, gender and culture
3. In-depth interviews with women who have limited health services access
 - a. Interview with a woman whose husband remarries
 - b. Individual Interview with a woman who had more than ten pregnancies
 - c. Interview with a childless woman
4. Participatory methods and PLA tools:
 - a. The Ten Seeds tool
 - b. Venn Diagram
 - c. Personal Interview

Key Findings

In general, the Chin population, especially women, face language barriers and difficulties in utilizing hospital services. They also suffer poor health knowledge because they do not have easily accessible health and education services.

There are health centres, however some have not been built (in the past, the government did not build Sub-RHCs) and basic health staff (BHS) visited villages and worked for some days only, and then went back to the townships. They did not remain stationed in the villages. This created limitations for the community in accessing maternal and newborn health services, especially MNCH services requiring emergency care. In addition, basic health services such as immunization, antenatal care, care during delivery, postnatal care, and care of newborns are very low which can lead to morbidity and mortality. Poor personal and food hygiene practices as well as sanitation are common among the village community.

The following summarizes the voices collected from the villagers:

1. **Men are dominant** in family planning and decision making: Chin women want to use contraception however men are more eager to have many children and women usually cannot resist. Our **team** voiced a need for empowerment and reproductive health services for women in the villages.
2. **Access to health services is limited:** Women deliver their babies in homes with traditional birth attendants (TBA). Women are very eager to have a delivery centre and midwife in the village for their delivery.

3. Traditionally women used to have many children: Average total birth per woman is eight, reported from community consultations and interviews. **Chin women are eager to have control over their pregnancies and use of contraception** however they cannot overcome the pressure from their husbands and community (social norms) about having many babies.
4. **Weak functioning of VHCs:** Policy encourages every village to form a village health committee. VHCs are a key catalyst of health services however the participation and proportion of women in VHCs and village health activities are considerably low. Community consultations demonstrated an eagerness of women to participate in VHCs and maternal health support.
5. Community voiced a need for the provision of RHCs and Sub RHCs to be fully functioning in the stationed villages. Currently, **health centres are under-resourced, including staff and equipment.**

Suggestions from communities and staff:

- a. The community asked for **“discussion sessions”** on gender and health knowledge to increase their awareness.
- b. The communities are eager to have a **“functioning Village Health Committee”** and suggested to provide them with some health-related training.
- c. Health system strengthening should be more focused to have **more networking and access to information** for health-related issues.
- d. Most of the **vulnerable people** (i.e. widows, people living with disabilities) have limited access to health services, and they should receive more focus for access to quality health services.

Please see annex for photos and a record of activities and achievements.

Gender

In relation to gender, Chin women are less influential in family decision-making including for their own health (sexual and reproductive health). Usually, men are considered to be the family head but women also have to work in taungya (shifting cultivation) for family livelihoods. This results in the mother not being able to rest for a long time after the birth of a newborn.

At the same time, women also care for the children and bear the responsibilities associated with pregnancy and delivering babies. In community interviews, AYO and partner CBOs found out that the average total birth per woman in project areas ranges between six and eight. Moreover, illiteracy and lack of health knowledge about mothering and childcare are common among women. Women are usually busy with household tasks and cannot attend community meetings or health training. Beyond that, the participation and proportion of women in VHCs and village health activities are considerably low, which needs improvement.



“Community Voices”

1. There is an urgent need for a **midwife or auxiliary midwife** trained and paid by the government in every village.
2. There are lots of mothers who don't know the important vaccinations required during their pregnancy period. They don't know how to take care of themselves during pregnancy. Therefore, they need **regular health education** and provision of the necessary medicines and materials.
3. Every village needs a **health committee in which the women are mainly influential** and responsible for mothers by giving trainings to women and helping one another.

Culture

From most interviews and discussions, we found out that some people did not go to the hospital on the first day of month, last day of month, and Monday of the week because they have cultural superstitions; they believe that bad things will happen if they travel on those days.

For maternal, newborn and child health, the field report revealed that women delivered at home with TBAs, and the TBAs often used bamboo blades and traditional medicines and, did not wash her hands properly, and did not use gloves.

Total births per woman are around eight on average, and the team interviewed many mothers who had ten or more deliveries. Furthermore, common barriers in access to hospital and health services identified by the project are:

- 1) **Language and attitudes of health staff** - health staff are not friendly towards village women (in general, the hospital provides free health care services including basic drugs, however additional drugs and equipment need to be bought from outside. Health staff are usually not friendly towards village women and their families who cannot afford additional drugs and equipment). Usually women's families and relatives accompany them when they go to hospital from the villages.
- 2) **Communication and information from health staff** – health staff do not communicate well about health services to the community, and community prefers to get full information from health staff. Furthermore, we found out that support to village mothers and their children are urgently needed: we propose a village fund to support mother's access to hospital, along with further nutrition support to pregnant mothers and children.

In general, the village community would prefer the RHC/SRHC to provide full scale health care services (currently they provide services through the BHS but they do not provide doctor or specialist level care). Moreover, more education is needed for mothers and parents seeking health services for their children in the RHC/SRHC. In some interviews, people reported that 1) they need syrup and liquid forms of child drugs rather than tablets (difficult to take), and recommended these be provided in the RHC and SRHC, 2) mothers did not know about immunization during pregnancy. From the interviews and discussions, the team reported more than five neonatal deaths in the last years and many miscarriages in the thirty-six villages (recorded during their visits).

Further engaging the community in health services through the VHC and community participation in village health promotion are essential. Additional comments highlighted by community are that auxiliary midwives training is good, however support like salaries, continuing training and necessary equipment is essential for quality of care.

Sometimes, there are conflicts or misunderstandings between health workers and the villagers about health services. People are very poor and cannot pay for medicines which are sold by health workers. Health workers mostly distribute free medicines provided by the government, and they also bring some important medicines which they are supposed to sell with suitable prices. Most of the patients take medicines with credit, without paying cash up front.

Under the national health plan, there were meant to be village health committee in every village, however many villages do not have a VHC. In Mindat, there are 194 villages and Myanmar Red Cross

Society (MRCS) is supporting the formation and capacity of VHCs in 30 villages, in partnership with the Danish Red Cross (a 3MDG Fund implementing partner).

Village mothers usually go to a TBA for pregnancy and delivery. In some villages, there is a midwife. In some interviews, the midwife reported that community members do not follow her message about regular antenatal care and delivery with a skilled birth attendant (MW). In some discussions, community reported that the midwife was very young and they had better impressions of the village TBA. Consequently, when mothers did not seek care for maternal health (AN, delivery and PN), the midwife could not give any necessary treatment or offer preventative measures. The skill and competency of the midwife plays an important role in communicating with the public. More competent midwives who are equipped with clinical skills and better communication skills could be one solution for the rural community.

The following are important points about MNCH services obtained from the villagers:

1) Who assists the delivery of babies for women in the village?

Based on the community interviews, AYO reported the following order of who assists the village women's delivery:

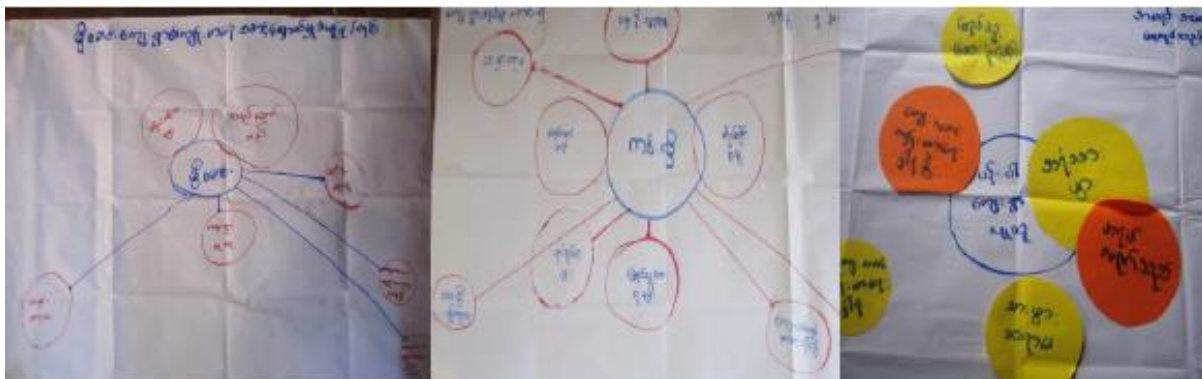
- ✓ Traditional Birth Attendant
- ✓ Auxiliary midwife
- ✓ Midwife
- ✓ Hospital
- ✓ Husband himself
- ✓ Rural Health Centre
- ✓ The mother herself

In most project villages, the TBA assisted the delivery for the majority of mothers (followed by AMWs) especially for uncomplicated deliveries however some complications were referred to hospitals and midwives. AYO would like to continue promotion of delivery by skilled birth attendants (MW and hospitals) in the next stage of this Collective Voices project because the World Health Organization recommends skilled birth attendants for every child birth. Deliveries in health centers were very rare, similar to deliveries by the husband or mother herself.

2) Which are the most influential MNCH services in villages?

The following Venn diagram from community consultations revealed that the TBA and AMW are more influential in MNCH services—care, referral and advice—than the MW. Underlying factors in the TBA's and AMW's influence were closeness to the community, no language and cultural barriers, could provide emergency services when needed, were a village resident, and encouraged mothers during their pregnancy and delivery.

Venn diagram for influencing stakeholders in Village MNCH services



The Venn diagram exercise revealed some important points as explained below:

- ✓ Village midwives (not scientifically trained or traditional birth attendants) are more reliable than a midwife and health workers sent by the government in every village. They are always ready and available for childbirth. Sometimes they are not only reliable for childbirth, but also for medication using traditional medicinal herbals.
- ✓ According to the diagram results, rural health centres are considered to be the farthest point of reach for health care service in every village. The main causes of this condition should be seriously considered to help village people access better services.



“Messages from the Community”

1. There is a need for **hospitals or better clinic construction**, and for villages which are at least 80 - 90 miles away from Mindat, doctors and health workers should be in charge of them 24 hours.
2. **Rural Health Centres** should be provided with necessary medicines, materials and full time health workers paid by the government or NGOs.
3. **Better communication** should be seriously considered for better health services for underprivileged people. Most of the villages have motorcycle roads dug by the villagers themselves; however those roads are unusable during the rainy season due to slippery roads and landslides.
4. Most of the villages are far away from midwives and health workers who are mostly living in the town. Most of them don't want to stay at the villages because there are no proper houses for them and clinics for taking care of the mothers and patients. Therefore, **proper housing for health workers and clinics** should be considered in every village.
5. Sometimes, there are **conflicts or misunderstanding between health workers and the villagers** because the people are very poor and cannot pay for medicines which are sold by health workers. Although health workers mostly distribute free medicines provided by the government, they also bring some important medicines which are supposed to be sold with suitable prices. Most of the **patients take medicines with credit** without paying money.

Community Experiences of Maternal and Child Health

During the community consultations, our team carried out in-depth interviews with mothers and explored their experiences and perceptions of maternal and child health in Chin villages. Interviews revealed that Chin women are not able to easily access MNCH services such as care during pregnancy, care during labour, care of newborn babies, contraception, and so on. Interview findings are summarized below.

A. Mother from Chin Village

One mother interviewed was a fifty-year old hill farmer from a local village. She reported that she had ten deliveries, however only five children are alive now and others died from diarrhoea, malaria, dysentery and malnutrition during childhood. She delivered all babies at the hill-farm and at home. Most of the deliveries were assisted by a TBA however she did two self-deliveries (without a birth assistant). She mentioned the following conditions as difficult/serious for her during delivery:

- standing position: bearing down baby upside-down
- delivery without husband and children
- delivery after forty years of age
- delivery of twin babies

During further discussion about the reason for many births, she explained about her poor sexual reproductive health knowledge, poor control over her own health (she wanted to try contraception but her husband wanted many children), and peer pressure (all couples want many children).

In conclusion, we recognized the importance of gender roles and women's empowerment within the family as well as access to RMNCH services for promoting maternal and child health of Chin women.

B. Mother from Chin Village

One mother interviewed was a forty-one year old villager. She delivered ten babies but three died during childhood. All deliveries were done at home with a TBA which does not fulfil World Health Organization recommendations for skilled birth attendants during delivery and the importance of institutional delivery for complications.

Furthermore, she shared her willingness to use contraception although her husband asked for many children. She also said that she often experienced dangers of easy miscarriage. Before delivery of her fifth baby, she took Deprovera (injection depo). However she felt unwell and stopped the injections.

Her story also revealed the importance of women's empowerment and access to MNCH services including reproductive health knowledge for Chin mothers.

C. Interview with a woman whose husband remarried

One woman interviewed was a forty-year old mother from another Chin village. She delivered seven times, all at home with a TBA. She had six girls that survived and one baby that died at the age of two-months. She reported some difficult conditions experienced during delivery:

- very painful and bleeding two weeks before delivery (APH) in one delivery
- very weak and loss of consciousness during delivery (explanation: at least two years is needed between deliveries and women need energy and good nutrition for each pregnancy)

She said she did not want to have more children after the above complications, however her family and husband wanted a male baby and she had only delivered seven girls.

She got a chance to attend reproductive health education sessions from the health centre, however her husband did not agree to take contraception and he wanted a boy. Later, her husband divorced her and married another woman for the purpose of getting a baby boy.

This is an example of gender roles and women's empowerment within society in remote Chin villages. She also explained that the village community blamed her and she felt very sad. She worked in shifting cultivation to feed her babies. For AYO's next stage of this Collective Voices project, we

plan to promote gender and women's empowerment together with promoting access to MNCH services.

D. Mother from Chin Village

One woman interviewed was a forty-five year old mother, also from the village. She had eight surviving children although she delivered fourteen babies. She delivered all babies at home; no birth assistant/self-delivery for four, her husband assisted in two deliveries, and the remaining were assisted by a TBA.

She said she didn't want to have children again but her husband wanted more and more children, so they didn't use birth control. She said: 'we know how to do sexual and reproductive health; however, we are far away from the hospital, clinic and rural health centre and I could not take the necessary materials and medicines for birth control'.

She said she had many pregnancies, and one time she fell pregnant again when her baby was four months old. Moreover, she shared that she was very weak after having a pregnancy and delivery so many times, and she lost consciousness after deliveries on some occasions. She blamed poverty because she could not afford nutritious foods during pregnancy and childbirth which made her tired and produced serious health risks during pregnancy and childbirth.

This story pointed out that immediate action is needed to support women and improve gender equity in the village. Moreover, promoting access to reproductive and MNCH services is essential for Chin women. In conclusion, AYO is determined to empower women to have control over their own reproductive and maternal health condition.

Risks, Challenges and Lessons Learned

1. Transportation and access to the village community is generally manageable. However some villages (satellite villages) need extra travelling time and are more difficult to access in the rainy season when landslides are common and the roads are blockaded frequently, preventing even motorbike access. As AYO partners are local CBOs and have local experience, they stayed overnight and worked with community on this project.
2. Heavy rain and disasters: in the 2015 rainy season, Myanmar was affected with heavy monsoon flooding and landslides in most parts of the country. There were some affected villages within the AYO project area however AYO was able to assist them with support from 3MDG. AYO closely cooperated with 3MDG for all activities during the disaster period.

In August 2015, there was unexpected and severe rains in many parts of Myanmar, including the project area, and massive landslides followed. With the financial support from 3MDG, AYO and its local CBOs distributed emergency food packages to the survivors in Mindat and Kanpetlet

Townships. The emergency food packages distribution covered 3000 persons (535 households) including those most in need from 29 villages of Mindat and Kanpetlet Township. The food package included rice, readymade noodles and packages of table salt. Moreover 3MDG supported the distribution of 48,000 water purification sachets, and AYO and its local CBOs distributed this to 4,779 survivors (868 households) in 32 villages of Mindat and Kanpetlet townships.

3. One of the important factors limiting access to health care for the village community is their livelihoods or farming work. Mostly, villagers (both men and women) go taungya (farming) in the daytime which is about one to one-and-a-half hours travelling time from the village. This is very important in health service provision.

The village community may not be able to access health services located far from the village as well as health services provided in the village because they have time limitations to go to health centres or to attend sessions in their village. AYO's experience during this project showed the importance of using village volunteers who communicate with and mobilize the village community for planned meetings, consultations, and campaigns in advance, and the project team stayed in the village for a few days for planned activities.

4. Community participation and the Village Health Committee (VHC) are important in universal access to health. Myanmar's National Health Plan encourages every village form a VHC however the participation and proportion of women in VHCs and village health activities are considerably low.

Furthermore, in many villages, the VHC was formed before, but was found to be non-existent or poorly functioning during this project. AYO will revitalize the VHCs and empower communities in project villages in Stage 2 of the Collective Voices project.

5. Literacy and language problems in accessing health information and preventive health messages are important for the village community. These findings will be considered for Stage 2 implementation - AYO will translate health information and education messages into local languages or design special messages to reach target populations.
6. Gender equity and addressing male dominance in the family and community is important for improving women's access to reproductive health services. According to the information collected by AYO for this project, women would like to access reproductive health services and contraception, however men prefer to have more babies. In Stage 2, AYO will implement women's empowerment initiative and will encourage participation of women in the VHC so that women can access services and have control over their reproductive health.

Recommendations

Based on Stage 1 findings and experiences, AYO plans to continue promoting and overcoming gender and cultural barriers limiting village community access to available health services in Stage 2 with its partner CBOs. Moreover, AYO will empower women through revitalizing VHCs so that currently identified gender barriers which limit women's access to reproductive health services could be overcome.

The project model recommended for promoting health service utilization will be supported with three pillars: 1) increasing knowledge and awareness, 2) creating an enabling environment for community, and 3) coordination for health system strengthening.

1. Revitalize VHCs to support access to MNCH services
 - a. Empowering women for participation in VHCs
 - b. Support VHC formation and strengthen functioning according to the 3MDG policy
 - c. Strengthen and monitor appropriate use of referral funds according to the 3MDG policy
2. Enhance Community Capacity to Access to Maternal and Reproductive Health Knowledge
 - a. Formation and training of women groups (adolescents, mothers, fathers, etc.) and training for maternal and reproductive health talks
 - b. Organize maternal reproductive health talks in communities
 - c. Support groups to assist referral patients in language, communication and other barriers
3. Facilitate utilization of MNCH services
 - a. Coordination with basic health staff (BHS) to enhance MNCH services in the villages (antenatal, delivery, postnatal, child immunization, etc.)
 - b. Organize health education sections: breast feeding promotion, immunization, diarrhea, hygiene, nutrition promotion, etc.

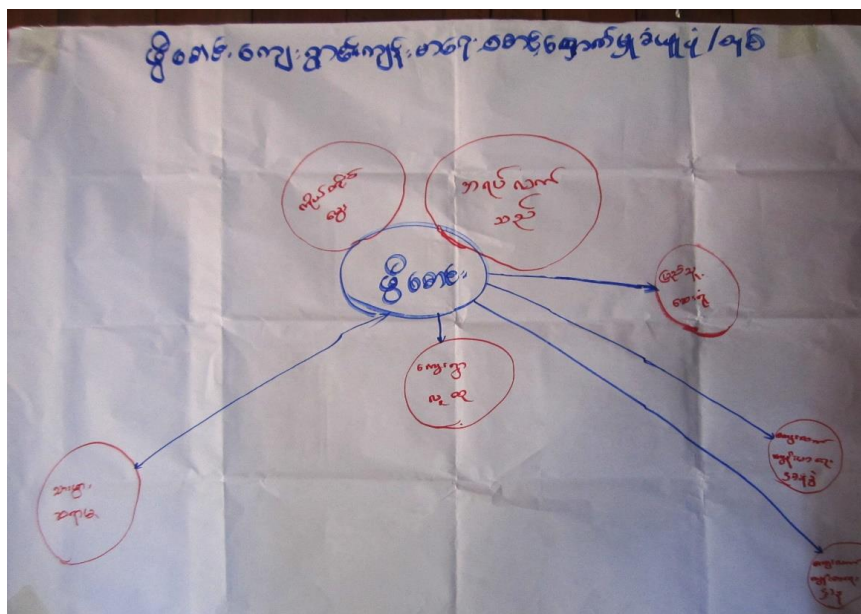
i. Village- Mindat Township



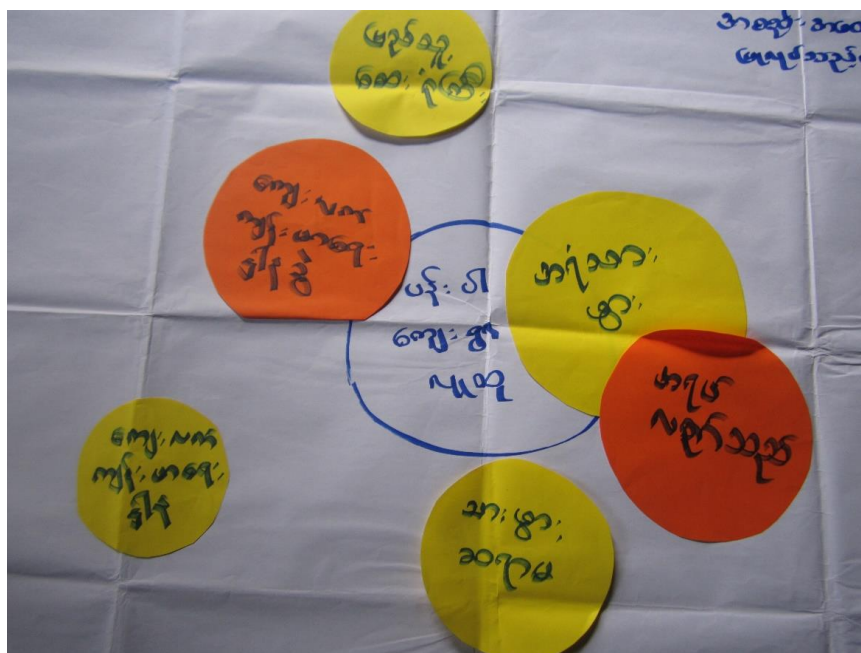
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iii. Village- Mindat Township



iv. Village- Matupi Township



Personal Interviews

i. Woman participant from the village

Age: 50
Village in Mindat Township
Occupation: Hill-Farmer
Children: 10

I delivered ten babies but only five survived. I wanted birth control but my husband didn't.

1. Where did you give birth to your 10 children?

Most of them were born at hill-farm and some are born at home

2. Who assisted you to give birth to your children?

Most of them were born with a midwife (not a scientifically trained midwife) of the village. Two of my children were born without help from anybody. My husband was on a journey. Out of ten children, just 5 children are alive and 5 died due to diarrhea, dysentery and malaria. Although we tried to treat them as much as we could, we could not save them. There were no health workers and midwife.

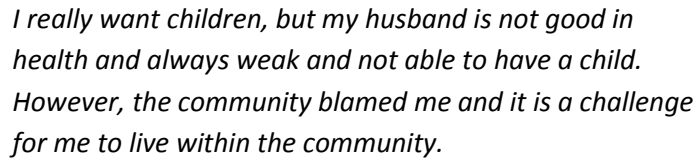
3. What kind of difficulties did you face during delivery?

- 1. Giving birth upside down position of children (up-side down position)*
- 2. Giving birth to twins*
- 3. Giving birth alone when husband and children were away*
- 4. Giving birth to the last children after 40 years of age*

4. Why do you have a lot of children?

My husband wanted children. We didn't use contraception. When we wanted to have birth control, we approached a masseur in the other village. She knows how to close fallopian tubes for inability of pregnancy. However, I rarely do it because I am afraid of others who would criticize and look down upon me. All the couples want children as much as they can, so I am afraid of doing such birth control.

ii. Interview with a childless woman



I really want children, but my husband is not good in health and always weak and not able to have a child. However, the community blamed me and it is a challenge for me to live within the community.

1. How do you feel about the inability to have children?

It is a challenge for me to live within the community. I really want children, but I could not have them. Therefore, I am looked down upon by the surrounding community and even they urge my husband to remarry again to have boys for descendants. In fact, it is not my fault. I am good in health and have a sound uterus. My husband is not good in health and always weak; therefore I believe that's the reason we could not have children.

2. What are your difficulties to be in such a situation?

- a. I need a person who would take care of me when I am sick.*
- b. I am now over 50 years of age and I cannot work like before. Therefore I find many difficulties in my family.*
- c. I am now at the end of menses and feel loss of sensitivity.*
- d. Therefore, I adopted a small child.*

iii. Individual Interview with female participant

Age: 41
Occupation: Hill farmer
Children: 10
Village in Matupi Township

My husband demands that I have a lot of children. I often experience dangers of easy miscarriage. I delivered ten babies but three died in childhood.

1. Where did you give birth to your 10 children?

All children were born at home.

2. Who assisted you to give birth to your children?

All my children were born with the help of a midwife (not scientifically trained midwife)

3. Why did you have a lot of children?

My husband demands that I have a lot of children. I often experienced dangers of easy miscarriage and we use birth control by taking syringe after the fourth child. This syringe was given by my husband. But, I experienced health problems, side-effects from this syringe and we dare not practice sexual reproductive health anymore. Therefore, I am afraid of pregnancy again.

4. Are all children alive?

No. Three children died and 7 are alive.

iv. Interview with a woman whose husband remarried

Age: 40
Village in Kanpetlet Township
Children: 7 (6 – girls)

I delivered seven girls. Although I had bad histories of delivery (pain and haemorrhage, loss of consciousness), I am afraid to take any birth control. Community prefers more boys as lawful heirs of the family.

1. Where did you give birth to all your children?

All were born at home

2. Who helped you while you give birth to your children?

All were born with the help of a (not scientifically trained) midwife

3. What difficulties did you face during delivery?

I felt a very painful uterus and hemorrhaged within 2 weeks before delivery.

a. *I gave childbirth as uterus opened and my little child died after 2 months.*

b. *While giving birth, I lost all my consciousness because I am so weak. I don't take energetic medicines or meals.*

4. Do you want to have some more children?

In fact, I don't want to have children anymore. But there are no boys among my 6 children. All are girls. Therefore, I have to bear another child until I get a boy. There are trainings for sexual and reproductive health. I accept it and would like to practice it. But my husband does not agree to do it. Not only has my husband forbid me, but also all his relatives forbid me to do birth control. It is a demand of cultural concepts which prefers more to boys as lawful heirs of the family.

5. Why did your husband remarry?

Because I am unable to have a boy

6. How do you feel to be in such situation?

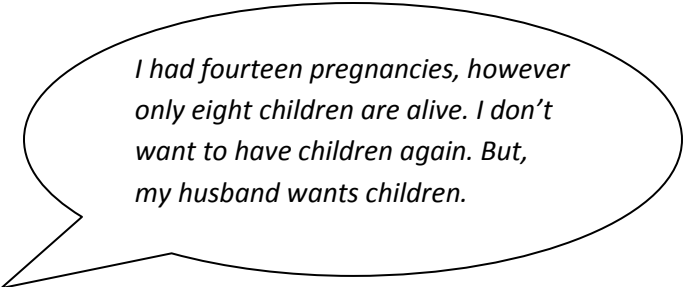
I feel sad because I am criticized and looked down on by the surrounding community. Although I tried to forbid him to remarry, he remarried. Even his relatives criticized me severely saying, "It is not right to forbid him". After their marriage, he moved to another village and does not take care of our children. Our children are growing without a father. When their father remarried, my elder daughter felt depression and stopped her education. She left far place for working. I don't know where she stays and works. She does not contact me.

7. How do you take care of your children?

I am working hard for shifting cultivation as well as breeding pigs. Most of the time, I feel depressed for I am not good in health. I am poor and have no money for medication. So, I am taking care of myself.

F. Individual Interview with female participant

Age: 45
Village in Mindat Township
Children: 14 children (only 8 alive)
6 children were miscarriages



I had fourteen pregnancies, however only eight children are alive. I don't want to have children again. But, my husband wants children.

1. Where did you give birth to all your children?

All were born at home

2. Who helped you while you gave birth?

I tried to give birth to 4 children by myself; two were assisted by my husband and another 2 were assisted by a (not scientifically trained) midwife

3. What difficulties did you face in your family life?

- a. I was pregnant again just 4 months after having my previous child*
- b. Increasing birth rate*
- c. While giving childbirth, I lost all my consciousness. I am very weak.*
- d. We are poor and I could not take food with full vitamins.*

4. Why did you have a lot of children?

I don't want to have children again. But, my husband wants children as much as he could. Then, we don't use birth control. We know how to do sexual reproductive health; however, we are far away from hospital, clinic and rural health center and I could not take necessary materials and medicines for birth control.