Collective Voices

EXPLORING THE BARRIERS TO HEALTHCARE ACCESS IN MYANMAR
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“Most of my children were born with the traditional birth attendant of the village. Two of my children were born without help from anybody. My husband was on a journey. Out of ten children, just five are alive and five 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.”

Kids play outside during a community meeting, where their parents discuss the barriers to health in southern Chin State

Photo: Ar Yone Oo Social Development Association
We are sincerely grateful to the Collective Voices implementing partners – Ar Yone Oo Social Development Association, Bright Future, Charity-Oriented Myanmar, Community Agency for Rural Development, Community Driven Development and Capacity Enhancement Team, and Phan Tee Eain. Their efforts to coordinate the activities of their partnering community-based organizations, and produce insightful qualitative information about community health experiences informs this report. They have shown strong commitment to ensuring that poor and vulnerable people in their communities are empowered, informed, and involved in health service planning and decision-making, embodying the spirit of the Collective Voices project.

We would also like to thank the community-based organizations - Khawnuthung Rural Development Organization, ‘K’Cho Land Development Association, Matupi Women’s Organization, La Wee Mon, Rainmanya Charity Foundation, Hnee Pa Daw, Social Care Volunteer Group, Development Parami, Ayeyarwady Social Development Organization, Love in Action, Green Land Social Development Organization, Chin Youth Organization, LanPyakye Sin, Ah Lin Yaung, Paung Ku, LanPyekye, Triangle Women Support Group, Rainbow Women’s Organization and Colors Rainbow. Their local expertise ensured that the Collective Voices project was able to capture the voices, insights and experiences of poor and vulnerable people in their communities, often going to extraordinary lengths to ensure that those in extremely remote and hard-to-reach areas had their voices heard.

Most importantly, 3MDG would like to thank the women and men who shared their time, personal experiences and perceptions about health. Without their voices, this work would not have been possible.

3MDG gratefully acknowledges its government partners – the Minister and staff of the Ministry of Health and Sports. We are pleased to be sharing this report highlighting community voices with them, in line with their current focus on community-centred, responsive health service planning. Particular thanks are due to the township health personnel in the target communities for their enthusiastic participation and commitment to the Collective Voices objectives.

Thanks are due to the entire 3MDG staff, in particular, the Performance Management Unit, and the individuals who guided and provided valuable feedback and support to the Collective Voices initiative throughout its development. Special thanks are given to Jessica Hyne for compiling this report.

Lastly, 3MDG gratefully acknowledges the donors for their kind contributions to improving the health of the poorest and most vulnerable people in Myanmar, particularly women and children – Australia, Denmark, the European Union, Sweden, Switzerland, the United Kingdom and the United States of America.

This document is based on the findings of the first stage of the Collective Voices project submitted by the six Collective Voices implementing partners. The views expressed herein can in no way be taken to reflect the official opinion of the donors contributing to 3MDG.
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<td>3MDG</td>
<td>The Three Millennium Development Goal Fund</td>
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<td>ART</td>
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<td>ARROW</td>
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<td>mover</td>
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<td>KAP</td>
<td>Knowledge, Attitudes and Practices</td>
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<td>LGTB</td>
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<td>PDSG</td>
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<td>RMNCH</td>
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<td>TBA</td>
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Collective Voices: Understanding Community Health Experiences is the product of a partnership between Myanmar’s Ministry of Health and Sports, the 3MDG Fund, local organizations and people living across Myanmar. This report - one of the products of this partnership - gives voice to individuals and communities drawn from across many areas of the country and represents a snapshot of lived experiences across the country during the second half of 2015.

The report has the potential to make a significant contribution towards ongoing efforts to improve the health and well-being of people in Myanmar. This publication presents information gathered, during a six month period in 2015, by the 3MDG Fund’s Collective Voices partners through more than 500 community-led consultations held across six states and regions in Myanmar.

The report is critical reading for those who are interested in understanding how health is experienced across the length and breadth of Myanmar. With solid analysis, it offers a glimpse of how, in communities across Myanmar, healthcare is sought, how health and well-being are understood and what needs to change within communities and within the health sector if the right to health for all is to become a reality and within reach.

The demand for better health and the right to health can only be effectively addressed through collective efforts, and only if these efforts address both the underlying social determinants of health as well as ensuring the widespread availability of healthcare which is acceptable and affordable. As this report demonstrates, so much hinges on the outcomes of individual patient-provider episodes. Beyond better health outcomes, the report emphasizes the opportunity that currently exists to improve upon levels of trust in public institutions in Myanmar.

Paul Sender
Introduction

The 3MDG Fund was established in 2012 to address the basic health needs of the most vulnerable people in Myanmar. Across Myanmar, levels of maternal and child mortality are high, and most deaths are from preventable causes. Among specific diseases, the leading causes of death and illness are tuberculosis (TB), malaria and HIV/AIDS. There are significant inequalities in health status and in access to affordable, quality healthcare, especially in rural and hard-to-reach areas and among the most vulnerable populations. Health system challenges undermine the capacity of the public sector to deliver basic healthcare.

By pooling the contributions of seven bilateral donors - Australia, Denmark, the European Union, Sweden, Switzerland, the United Kingdom and the United States of America - 3MDG aims to address the barriers that limit access to healthcare through a rights-based approach. This approach was outlined at the outset of the 3MDG Fund, identifying an overarching goal to "contribute to national progress towards the health MDGs through a rights-
Based approach. This will reflect the principles of non-discrimination, equality, participation, transparency and accountability and will give high priority to strengthening voice and accountability including through building the capacity of civil society and community structures. The 3MDG rights-based approach is underpinned by the four principles of responsibility, fairness, inclusion, and ‘do no harm’, which promote the set of positive changes needed in the health sector.

Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. A rights-based approach looks beyond community needs, placing human rights principles at its centre, providing a framework that considers a “more genuinely inclusive and democratic process of involving people in decision-making over the resources and institutions that affect their lives”. It focuses on advocacy and empowerment to build capacity and consciousness, calls for resources to be shared more equally to ensure they reach marginalized people, engages beneficiaries in an active process of social transformation, and makes connections between participation, accountability and citizenship. Furthermore, a rights-based approach supports a two-way process, of strengthening public institutions on one side and bolstering the capacity of civil society on the other.

The right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programs, or the adoption of specific legal instruments. 3MDG is supporting key stakeholders, including government, NGOs and community-based organizations with resources and practical tools to adopt improved health policies and deliver better health services in a more responsible, fair and inclusive way.

This has meant working to ensure equitable access to health services for the most vulnerable, enhancing the participation of communities in health planning, decision-making and implementation, and including the voices of marginalized people. It is supported by substantial work to generate learning, evidence and awareness as well as capacity to address inequities, in particular those that are gender-based.

In line with these goals and to promote voice, learning and evidence, this report aims to explore and better understand community health experiences in Myanmar. It considers the ways in which people feel included or excluded from healthcare, the challenges they perceive in accessing health services, and the extent to which they feel they are participating in health-related planning and decision-making. It looks at two main areas: firstly, what people say they encounter when accessing the health system in Myanmar. That is, what their perceptions and experiences are as recipients of health services. Secondly, the report considers the wider social conditions in which people live and how this can influence their views and experiences of health and healthcare in Myanmar. In other words, how do the ‘social determinants’, such as socioeconomic status, education, culture, language, gender and social norms affect people’s understanding of health and influence their choices in seeking healthcare, as experienced and articulated by community members.

1.1 COLLECTIVE VOICES: UNDERSTANDING COMMUNITY HEALTH EXPERIENCES

3MDG recognizes that civil society can promote people-centred health by creating an enabling environment for broad and active citizen participation. Additionally, local civil society actors are “demonstrably and deeply committed to relieving the suffering of Myanmar’s poor and marginalized.”

In March 2015, the 3MDG Fund launched a new and innovative initiative, directly funding local civil society organizations with an initial US$50,000 each to explore and identify the social barriers that hinder access to healthcare in Myanmar from the perspective of communities themselves.

“Collective Voices: Understanding Community Health Experiences” was established in partnership with six lead, local organizations working with a further nineteen community-based organizations in a consortium arrangement (see map on page 11). Together these organizations undertook community consultations in six states and regions to generate information and improve understanding of the social factors limiting access to healthcare. The six organizations are:

1. Ar Yone Oo Social Development Association
2. Community Agency for Rural Development
3. Bright Future
4. Community Driven Development and Capacity Enhancement Team
5. Phan Tee Eain
6. Charity-Oriented Myanmar

Over the first six months of their grants, Ar Yone Oo Social Development Association and Community Agency for Rural Development explored the social barriers to health in Chin State (in the southern and northern areas respectively), to develop a greater understanding of how cultural and linguistic diversity influences access to health information and health services, while also considering gender and health-related knowledge, behaviors and attitudes in remote villages.

Bright Future, located in Mon State, developed greater understanding of how health seeking behaviors, including customs, beliefs and local dialects, can affect access to health services. They also aimed to understand the views and perspectives of health service providers, and to facilitate improved mutual understanding between them and communities. Meanwhile, Community Driven Development and Capacity Enhancement Team, also located in Mon State, explored community awareness about sexual and reproductive health, and the extent to which people are utilizing family planning services.

Lastly, Charity-Oriented Myanmar and Phan Tee Eain both had a strong focus on girls’ and women’s access to healthcare. Charity-Oriented Myanmar’s objective was to increase women’s access to health services by learning about the role of women and girls in health-related decision-making at the family and community level in Magway and Ayeyarwady regions.

Similarly, Phan Tee Eain explored ways to improve access to health services for disadvantaged women (in particular poor women, women infected and affected by HIV, lesbians and transgender communities) in Yangon, Ayeyarwady Region and Shan State. To do this, both organizations needed to develop a greater understanding of the relationship between gender and health-related knowledge, behaviors and attitudes in their target communities to generate information and improve understanding of the social factors limiting access to healthcare.

1.2 METHODOLOGY

The first step of this two-stage project focused on community voices, with more than 500 community meetings undertaken across project areas in Myanmar, mostly at the village level. The six lead organizations generally provided oversight, coordination and technical guidance to the project, while their partnering community-based organizations were largely responsible for implementation aspects, including facilitating the participatory community meetings. This structure enabled project implementation to be conducted by people living within or near to the target areas.
villages, and for the discussions to be held in culturally sensitive ways and in local languages.

At these meetings, Collective Voices organizations explored health seeking behaviors relating to gender equity, social inclusion, ethnicity, language, poverty, education and information, and participation in health planning and decision-making. At the same time, the organizations worked on strengthening the relationships between healthcare providers and communities throughout the process, by including State and Township Health Departments in the project meetings, and bringing providers and communities together to discuss constraints in health service provision, and to jointly consider ways to improve service quality, access and utilization.

The organizations facilitated community meetings using Participatory Learning Action (PLA) tools, including the Ten Seeds Tool, Venn Diagrams, Social Mapping, Health Service Mapping and Problem Trees. Some of the organizations also held individual interviews with community participants to understand their personal health concerns and barriers they had experienced. 3MDG provided training to the organizations on PLA methods and tools, encouraging this approach due to its emphasis on:

- **Active participation of communities in the issues that shape their lives**
- **Using tools that enable all community members to participate regardless of age, gender, ethnicity or literacy levels**
- **Enabling local people to prioritize issues based on knowledge of local conditions, utilizing collective analysis and learning**
- **Providing a catalyst for communities themselves to take action on what is uncovered**
- **Developing realistic solutions**

Based on this first stage of consultations, the Collective Voices implementing partners produced a summary report, outlining their key findings, and used this to inform the design of their second stage project activities to address the most important barriers to health articulated by their target communities. These projects are currently being implemented and will continue through to December 2017. Information on the second stage of the Collective Voices projects can be found on the 3MDG website.8

Collective Voices aims to catalyze changes in health inequities in two related ways. Firstly, by empowering people who are often the most vulnerable, but might ordinarily be marginalized from the health planning and decision-making process, to voice their specific health needs and enable resources to be directed towards addressing those needs. Secondly, by bringing together health stakeholders from the provider side and user side, Collective Voices has started opening up pathways of communication and engagement, facilitating a culture of openness and creating opportunities for greater trust, accountability and inclusion.

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“I borrowed money from the village rich people with interest of 20 kyats per 100 for treating the ailment of my child. After he recovered, we couldn’t return all we borrowed and we lost our small house which was kept as collateral”.

This 3MDG initiative has been flexible and adaptive, enabling organizations (in consultation with communities) to identify and articulate barriers using their own language and conceptual framework. It has not imposed a pre-defined, prescriptive, or one-size-fits-all programmatic approach from the outset, instead encouraging learning from the ground up, followed by the generation of locally-appropriate solutions to overcome the key barriers once they have been uncovered. In practical terms, this has meant that Collective Voices implementing partners have undertaken projects that are contextually relevant and resonant with their different target communities.

Despite their different geographical areas and target populations, there are many commonalities across their findings, showing how language barriers, poor health knowledge and education, lack of family planning and health decision-making power of women, and community reliance on traditional and informal practitioners all contribute towards ill-health in Myanmar. While many of the findings are not new or surprising, it is important to recognize that these are the views of communities themselves, articulated through community-based organizations. Perhaps most importantly, through this process, the Collective Voices organizations (not previously connected to the health sector) have learned about health barriers and the role that they can play in addressing some of the challenges going forward.

1.3 LIMITATIONS

It is important to note that the findings presented throughout this report are based on community consultations led by small, local civil society organizations (not academic or research institutions), conducted in a selection...
Young girls in Magway Region said that their fathers were the heads of their households, and were usually responsible for deciding when to see a doctor.

Photo: Charity-Oriented Myanmar
of townships and villages in Myanmar. The qualitative results and discussion are therefore limited, as they only reflect the voices and perceptions of the people who participated in community meetings and interviews, as documented and interpreted by the community-based organization facilitators in those locations.

Myanmar’s socio-political context is rapidly changing and evolving, and it is worth noting that the community voices reflected in this report were collected from April to October in 2015, and offer only the personal perspectives of individuals at a specific point in time. They are not intended for extrapolation and application to the rest of the population in those states and regions, nor in Myanmar at large.

Despite these limitations, the results nevertheless stand as an important record, highlighting the diverse ‘voices’ and lived, personal experiences of particular community members in accessing healthcare in Myanmar. They provide insight into the perceptions, motivations, attitudes, behaviours and experiences of vulnerable people in different locations across the country, exposing perspectives and opinions that are not necessarily well-understood or documented in Myanmar to date.

If we consider health to be “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”, then more lived experiences, such as those articulated through Collective Voices, must be taken into account, in order for health outcomes to improve. Without understanding what people think and feel, and why they act or fail to take action to access healthcare, it will be difficult to tailor appropriate and effective health interventions to combat the key factors influencing ill-health in Myanmar.

9. (World Health Organization (WHO) 1946)
The 3MDG Fund was established in 2012 to address the basic health needs of the most vulnerable people in Myanmar. Across Myanmar, levels of maternal and child mortality are high, and most deaths are from preventable causes. Among specific diseases, the leading causes of death and illness are tuberculosis (TB), malaria and HIV/AIDS. There are significant inequalities in health status and in access to affordable, quality healthcare, especially in rural and hard-to-reach areas and among the most vulnerable populations. Health system challenges undermine the capacity of the public sector to deliver basic healthcare.

Purpose and outline

The purpose of the report is to document and explore the diverse needs and experiences in accessing healthcare in Myanmar, and to use this as a basis to tailor appropriate solutions to achieve better health outcomes for all people in Myanmar.

After completing the first stage of community consultations, Collective Voices organizations submitted separate project reports summarizing the key barriers experienced by communities in accessing health services. This report collates and summarizes the results, highlighting the broad trends and themes across all partners. It places the voices of the organizations and the community members front-and-centre; but also situates their findings in a wider body of relevant, current literature on health, gender, culture and conflict in Myanmar.

The report is intended for use as a resource by all interested stakeholders working to improve access to healthcare in Myanmar. It highlights the voices of poor and other
reliance on informal practitioners for healthcare and in delayed health seeking behaviors, also discussed in this section.

The second section explores the social determinants of health, as perceived and articulated by community members. Although the social determinants of health are highly interdependent and interrelated, this report is divided into five broad categories for discussion and analysis, reflecting the major barriers identified by the Collective Voices organizations.

The first chapter explores socioeconomic barriers, including poverty, ancillary costs of health services, and the financial spillover effect on family members, all of which contribute to delayed health seeking practices. This is often compounded by a lack of health information and knowledge that limits people's ability to feel empowered and to make informed health decisions, issues that are discussed in more detail in the second chapter of this section. In the final three chapters, the report explores how cultural practices and language, stigma and discrimination, and gender norms can all diminish social inclusion and have wide-reaching implications on people's health status and outcomes.
Perceptions of health service provision

Health service provision is shaped by interactions and relationships between patients and health providers within the health system, each with their own values, beliefs, attitudes, experiences and histories.

As Sheikh, Ranson and Gilson explain, “health systems are human systems. At their heart is a personal encounter, the interaction between the patient and the health provider – sometimes tenuous, often contested, but always with the potential for humanity and compassion.”

In Myanmar, health service provision occurs in a wide array of settings across the country, in diverse, complex and remote locations, with people coming from enormously different backgrounds. While health services should ultimately meet the needs of people and society, there are often many challenges
and constraints that limit the ability of this goal to be achieved.

During the Collective Voices consultations with community members in six states and regions, people perceived a range of barriers connected to health service provision that can hinder their access to quality healthcare. Common issues included limited or non-existent health infrastructure and human resources, particularly in remote, hard to reach and conflict-affected areas; poor communications infrastructure in some areas hindering communities from receiving health information, education, and services; and poor roads and challenging weather conditions, reducing the ability of healthcare providers to access people in remote areas for service provision. While this is a challenge faced by all in hard-to-reach areas, it is of particular concern for the elderly and disabled, who may struggle to make long journeys on foot or by motorbike.

Communities also discussed their reliance on informal healthcare providers and the reasons for this, alongside their perceptions of quality of care received at health facilities, and the attitudes of staff providing the services.

Many communities provided insight into how they perceived their relationship with healthcare providers, in particular highlighting issues around trust which they felt needed to be strengthened. They also noted the challenges in communication and coordination at many levels of the health system - between communities and healthcare providers, between formal and informal providers, and between all stakeholders in the wider health sector. These issues are discussed in further detail throughout this section of the report.

In addition to shedding light on the perceptions of community members, all of this material provides an opportunity to think about what changes could occur in the operational environment of health service provision to better meet the needs of communities, and communicate the challenges experienced by healthcare providers in Myanmar. Furthermore, it may provide a starting point to consider the types of resourcing, capabilities and capacity building support needed by health providers to enable them to effectively respond to people’s diverse health needs.

10. (Sheikh, Ranson and Gilson 2014)
3.1 INFRASTRUCTURE, REMOTENESS AND RAIN

“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 get the necessary materials and medicines for birth control.”

PARTICIPANT IN COMMUNITY MEETING, CHIN STATE

Primary healthcare services should be available as close to where people live as possible. However, low health spending in Myanmar and a historical preference for investment in tertiary healthcare services has resulted in a shortage of basic healthcare centres and personnel in hard-to-reach areas. Coverage of basic health services in states and regions with high proportions of hard-to-reach areas is low compared to other parts of Myanmar, despite the greater health needs found in the communities in hard-to-reach areas.

The issue of limited health infrastructure and human resources for health was cited across all of the six states and regions of the Collective Voices initiative. This included, for example, villages as far apart as those in remote Chin State and those in Ayeyarwady Region, demonstrating that this was perceived as a universal barrier in accessing health services. Not surprisingly, the major barriers cited were those relating to the distance of communities from health facilities; lack of adequate roads or transport to reach the facilities; and limited available health staff in remote areas.

Collective Voices partners operating in rural and remote areas stressed that long distances and poor roads between health seekers and health-providers played a significant role in both demand and supply of health services. With most of the country’s population living in rural areas, and only 6km of road per 100km², 75% of which is unpaved, for many Myanmar people, lack of quality infrastructure acts as a major barrier to health access. This is particularly challenging in border-regions and conflict-affected areas. Collective Voices partners all drew attention to the increased isolation of hard-to-reach villages during the monsoon wet season. Community Agency for Rural Development, a partner located in Chin State, noted:

“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.”

COMMUNITY AGENCY FOR RURAL DEVELOPMENT COMMUNITY MEETING, CHIN STATE

This situation is confirmed in a recent UNDP Local Governance Mapping exercise in Chin State, finding that “widespread poverty, low population density, challenging mountainous terrain and an underdeveloped infrastructure are all severe barriers for development.” Further, though some improvements in the past three years have been noted, shortfalls were still evident in the lack of supplies, equipment and sufficient supportive infrastructure, in addition to qualified and available staff in the health and education sectors.

An emphasis on building and improving tertiary healthcare infrastructure, rather than expanding and supporting primary healthcare facilities and personnel has made it more difficult for people in remote areas to access healthcare, and has led to tertiary facilities being overburdened with minor cases. Station hospitals are often underperforming and provide poor quality service due to a lack of staffing, supplies, and appropriate equipment. This produces inequities not only in health outcomes between regions, but also entrenches socioeconomic inequalities within them, as the rural poor are

“Almost all of the project villages have no basic health staff for their village but they have access to some extent to health services from nearby village midwives. One village is a hard to reach area among others. The people from that village rarely receive health services even from nearby midwives”.

Findings from Charity-Oriented Myanmar Community meeting, Ayeyarwady Region
more reliant on private providers, including traditional healers, informal health practitioners, and drug shops for their healthcare needs.20

3.2 HUMAN RESOURCES FOR HEALTH

Based on their consultations with communities, Collective Voices organizations claimed that a lack of appropriate and available health staff created difficulties in accessing healthcare when needed. In Myanmar, public health staff typically receive low wages and this can create lack of motivation, again with the impact being higher in remote and conflict-affected areas where turnover is high, vacancies go unfilled, and health centres are unable to ensure adequate services are available.21 This contributes to the public perception of a lack of responsiveness and poor quality of services from certain healthcare providers as discussed later in this report.

Collective Voices organizations, Community Agency for Rural Development and Ar Yone Oo Social Development Association, remarked that access to care from midwives and auxiliary midwives was difficult due to the relative hardship of Chin State postings and the lack of physical infrastructure in place to support them:

“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.”

FINDINGS FROM COMMUNITY MEETING, CHIN STATE22
to address the common illnesses and health needs of their communities. For example, findings from community meetings in Mon State indicated that the community has unmet needs for health services for RMNCH, communicable diseases, non-communicable diseases and locally borne diseases.23 This was reiterated in Chin State communities that argued “there is an urgent need for a midwife or auxiliary midwife trained and paid by the government in every village.”24

Low levels of public investment in health means that often the quality of healthcare available in communities is low.25 While health expenditure as a proportion of gross domestic product has increased dramatically in recent years, it was starting from a low base, so investment levels remain low overall.26 Weak or non-existent health service infrastructure affects the quality of care available to many households.27 Inadequate and unreliable supplies of essential medicine and medical equipment, as well as inadequate numbers, maldistribution and high turnover of staff further compromises the quality of care.

This was particularly relevant for community members with specialized health needs. As Phan Tee Eain documented in the quote below, a lack of specialist services, coupled with a negative service experience, represents a serious barrier to health utilization in a population that is already extremely vulnerable to health risk and poor health seeking behavior.

“…I tried to get some information about my son who is also PLHIV. He is only 4 years old. But there is no specific counseling session for children, and doctors didn’t explain to me clearly what to do and how to do it for my son.”

Likewise, in Mon State, Bright Future found that the community recognized the special health needs of elderly people, but felt that those needs were not being met. A village elder explained that “it would be good if there was a volunteer group who can visit the houses of people with disabilities and elderly people so that they are not neglected.”29

In one township, Charity-Oriented Myanmar found that due to the lack of Basic Health Staff in the surveyed villages, most villages relied on the tertiary care facility. For some villages, the General Hospital served as the healthcare provider point even for small or minor health issues. However, for emergency cases or specialist cases, Charity-Oriented Myanmar found that villagers preferred to use private service providers, indicating that they did not find the hospital reliable for these sorts of services.

This pattern was repeated in other districts, with community members in Mon State concerned that the lack of health infrastructure and human

Participants in training sessions see how the Collective Voices project fits into the broader Health for All objectives of 3MDG.

Photo: 3MDG
resources in their area was not only limiting health access by limiting health resources, but was also affecting the quality of care that available services are able to deliver.

“...in some remote facilities, not all sanctioned positions are filled. The existing staff in those facilities bear the burden of covering additional tasks and often become overburdened.”

FINDINGS FROM COMMUNITY MEETINGS IN MON STATE

Particularly in rural and conflict-affected areas, quality healthcare is affected, with sub-centres lacking the resources to provide adequate care. Prioritization of tertiary infrastructure over primary health facilities represents an inefficient allocation of public health resources. The Collective Voices experiences indicate that this approach has led to scarce services that become easily overburdened. A greater focus on primary care would allow for a wider distribution of basic health services, lifting some of the burden from larger facilities, and contribute towards the goal of reaching universal health coverage.

3.3 FORMAL/INFORMAL DIVIDE

Many Myanmar people, particularly those in remote and hard-to-reach areas, rely on informal providers, traditional birth attendants, and religious leaders for many of their healthcare needs. In Mon and Chin States, informal healthcare providers are a major source of healthcare information, advice and treatment. However, Collective Voices partners often felt that informal providers do not deliver a quality service to patients. This magnifies existing health inequalities; poor people are most likely to pay out-of-pocket for informal healthcare services, and they are more likely to receive poor quality service for using such a service.

In Chin State, this was considered mostly a result of informal sector providers lacking training or adequate hygienic medical equipment. Ar Yone Oo Social Development Association explained that “women delivered at home with traditional birth attendants (TBAs), and the TBAs often used a bamboo blade and traditional medicines, did not wash their hands properly, and did not use gloves.” In a similar fashion, Bright Future noted:

“We have cases of rabies... and the patient was brought to the monastery. The monk gave him a religious prescription and recited prayers. But finally the patient died. There are similar cases like this, with people finally dying without getting any anti-rabies treatment.”

FINDINGS FROM COMMUNITY MEETINGS IN MON STATE

Due to their limited health education and precarious legal status, informal health practitioners may not identify urgent health cases or feel reluctant to refer difficult cases to formal healthcare centres for fear of being reprimanded. This is concerning for cases of complicated births, complications arising from unsafe abortions, and other antenatal complications, given the high rate of maternal mortality in Myanmar. This trend is beginning to change, with 3MDG partner Community Agency for Rural Development facilitating a conference between township health personnel and informal health providers in Chin State to open up channels for health information-sharing and to establish relationships to promote referrals of complicated cases.

Furthermore, in some cases, traditional birth attendants (TBAs) and informal providers are preferred over formal providers, due to their close relationship with community members. In a reproductive health needs assessment of peri-urban Yangon, researchers found that TBA preference was widespread, despite relative proximity to formal care providers. They also found that TBAs were the primary providers of unsafe abortion, and that demand for abortion is high. Likewise, although post-abortion care
is available through the formal sector, many women either do not know that these services are available, or fear repercussions or judgement from the providers.\textsuperscript{41}

While many of the Collective Voices implementing partners noted the gaps in knowledge of informal healthcare providers, Community Agency for Rural Development made specific reference to the division between the informal and formal sectors as a barrier to health in Chin State, explaining that “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.”\textsuperscript{42} To some extent, community members were also aware that they were not receiving quality services from informal providers:

\begin{quote}
\textit{“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.”}
\end{quote}

\textbf{WOMAN FROM CHIN STATE}\textsuperscript{43}

In rural and hard-to-reach areas, community members’ heavy reliance on traditional and informal health practitioners can lead to delayed attendance at health centres, and people not receiving the healthcare they need at the right time. Ensuring these practitioners can identify when a patient needs to be referred on to further medical care can make a crucial difference in health outcomes, even the difference between life and death in some cases.

\subsection*{3.4 PERCEIVED QUALITY OF CARE AND ATTITUDES OF HEALTH STAFF}

Real or perceived mismatches between available healthcare services and community health needs, real or perceived poor service quality, and real or perceived systemic indifference to community feedback impact the ways that community members experience and use health services. One of the overarching objectives of the Collective Voices initiative is to develop networks through which people can voice their health needs and receive responses, are informed on health issues, and have the information and confidence necessary to access quality services. At present, Collective Voices partners considered these networks to be limited or non-existent, restricting the extent to which health services can be responsive to the community’s health needs.

Collective Voices partner Charity-Oriented Myanmar explored this theme most comprehensively of all the partners, focusing their Stage 1 work on the perceived quality of care at health facilities in Magway and Ayeyarwady. Their findings illustrated how patients felt at each facility, and whether they felt that the facility provided a good service, based on its responsiveness to their needs, affordability, timeliness of service, and staff attitudes. During mapping exercises and discussions exploring how and where participants access healthcare in Magway, Charity-Oriented Myanmar found that poor people access healthcare differently, despite holding similar perceptions of the quality of care provided by each clinic.

Charity-Oriented Myanmar learned that perceptions about provider attitudes and responsiveness were major factors influencing the ways that communities access healthcare. In Labutta, they found that villagers preferred one particular hospital over others, despite it being more costly, as it was seen as providing a more reliable service. Only two of the ten villages surveyed (those for whom physical access to the preferred hospital was the most difficult) used another for common diseases. However, in these two villages, community members would also choose the preferred hospital in emergency cases. This demonstrates that community members in Myanmar are taking into consideration service quality (including responsiveness), service availability, and service appropriateness when making health seeking choices.

\begin{flushright}
\textsuperscript{41} Sheehy, et al. 2015). \textsuperscript{42} (CAD 2015). \textsuperscript{43} Ibid.
\end{flushright}
“...poor and vulnerable people usually go to the General Hospital or a second Hospital for emergency cases... The villagers perceive the second hospital to have a moderate level of accessibility but the responsiveness is not considered satisfactory and the feedback acceptability is experienced as weak in that hospital.”

“People who can afford it go to private hospitals because of their reliability and to save time.”

“Poor villagers go to one Eye Clinic... Some people who can afford it go to a better Eye Clinic.”

FINDINGS FROM MEETINGS WITH PLHIV46

“Participants mentioned that at [one hospital], prevention of mother to child transition (PMCT) services were not properly recommended for or explained to the patient.”

“At the start, counseling was done for me, but now as an older patient, counseling is not done properly. If I want to know something, I have to ask for the doctors, but they are mostly busy and cannot pay attention to me.”

33 YEAR OLD MALE PLHIV47

Research suggests that when a healthcare user has a poor perception of a healthcare provider’s attitudes, they are less likely to use that service.48 In many cases, community members have a weak relationship, or no relationships, with formal healthcare providers, especially when they are located physically far from where they live. Part of the function of the Collective Voices project is to bring together healthcare providers and healthcare users to help form stronger relationships, improving attitudes of both parties toward one another.

UNDP’s local governance mapping reports indicate that the attitude of health staff is a major influencing factor in perceived service quality.49 Indeed, over 50% of respondents across Myanmar who felt that health service quality in their state or region had declined over the past three years cited worsening attitudes of healthcare staff as the primary reason for that perception.50 This echoed statements made by Collective Voices community members, for example, one participant in Chin State explained that “health staff are not friendly towards village women and their families who cannot afford additional drugs and equipment.”51

In several cases, community members felt frustration with healthcare workers who they said would not discuss in detail their health concerns and answer their questions. Charity-Oriented Myanmar’s research in one Ayeyarwady township found that in two villages with a choice of authorized practitioners, community members mostly relied on the practitioner who was considered to be more responsive in providing services and taking the time to discuss health concerns with patients. Phan Tee Eain’s situational assessment uncovered similar results:

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At the same time, however, low salaries in the public health system affect health service providers’ motivation to deliver a high-quality service experience, and staff retention issues in hard-to-reach areas may impact on this too.52 Additionally, healthcare workers in Myanmar are frequently overburdened or inadequately trained.53,54 This, in addition a lack of community support may also affect motivation of staff members and their perceptions of patient attitudes towards them.55 Importantly, in the Ministry of Health’s 2012-2017 Strategic Health Workforce Plan,56 the government aims to develop mechanisms through which health sector staff are able to voice issues that affect their performance and motivation.

3.5 TRUST

Focusing on “people-centredness” in service delivery can create shifts in health worker practices and processes of communication, and strengthen leadership and management within the health system.57 Putting people first in how services are designed and delivered rather than establishing them on the basis of diseases, or for the convenience of clinicians, can help to shape health services in the public interest.

One of the consequences of poor interpersonal experiences with health staff is an erosion of trust, serving as an additional roadblock against accessing timely and appropriate healthcare. Facing real or perceived discrimination or an unfriendly reception from healthcare providers is one avenue through which the relationship and level of trust between health seeker and health provider breaks down.

This is especially true in conflict-affected areas where ethnic tensions play a major role in the way that relationships between communities and the central government are constructed. In their desktop review of the needs and concerns of ethnic groups and ethnic communities, the Peace Donor Support Group (PDSG) noted that “[t]he ethnic groups feel marginalized and discriminated against from the centre, manifested in their lack of political influence on...it was found that due to the prolonged historical conflict between Ethnic Mon Militants and the Government Army, local communities still do not easily trust the government health system (including BHS), preferring to use ethnic traditional healers especially in far remote ethnic minority areas.”

FINDINGS FROM PROVIDER MEETINGS IN MON STATE60

national and local politics, absence of social and economic development, lack of access to services such as health and education, and lack of rights, including in relation to culture and language.”

Likewise, Bright Future found that relationships between the community and the public health system had acted as a barrier to health in the communities they engaged with in Mon State. This lack of trust may be residual fear from past tense relationships between the community and the government. In places where the central government does not hold (full) control, the perception that the government is trying to wrest more control over the administrative functions of a community may also be a source of mistrust.

For Bright Future, a sense of mistrust from community members resulted in patients’ preference for traditional healers and other informal healthcare solutions, deferring seeing a doctor for longer.

Similarly, community members surveyed by Ar Yone Oo Social Development Association were reluctant to trust a new healthcare provider over the informal sector provider who has formed close community ties over many years. The midwife “reported that community members do not follow her message about regular antenatal care and delivery with a skilled birth attendant. In some discussions, community members reported that the midwife was very young and they had better impressions of the village traditional birth attendant.”

Bright Future also mentioned “difficulties encountered in dealing with health personnel from the non-state actor government [during their Collective Voices project]. Permission was needed to meet medics from non-state actors (NSA) but finally we did well for our community and provider meeting sessions by intensive coordination with NSA senior personnel.”

Conflict-affected areas, particularly those that are non-government controlled, have lower than average access to healthcare. In order to deliver healthcare services in contested areas, INGOs require permission from the central government, which may compromise their position of independence within communities in conflict with the government. Therefore, local community-based organizations like the 3MDG Collective Voices partners can be better placed to communicate with the various stakeholders, but also face challenges in establishing trust in the host communities and with government authorities. Complicated relationships between authorities, INGOs, CBOs and communities can thus further marginalize members of these communities from quality healthcare.

Proper consultation and engagement with all key conflict stakeholders in conflict-affected areas prior to the project design and delivery is a key tenet of 3MDG’s conflict sensitivity strategy. This means that representatives from relevant government agencies, armed opposition groups (especially health departments where these exist), other health providers and civil society organizations are consulted about where, how, if and what kind of interventions are best to take place. On-going, routine consultations with stakeholders are effected throughout the program lifecycle. In programs facilitating co-operation on health interventions between government and non-government entities, this is an important measure in contributing to

Health staff do not communicate well about health services that are available to the community, and the community prefers to get full information from health staff.”
confidence and ensuring an up-to-date shared understanding of the progress of health support.

3.6 COMMUNICATION AND COORDINATION

A major consequence of limited basic health penetration is the impact it has on the ability of the public health system to listen to community voices and respond to community needs. Although there has been a drive to establish and strengthen village health committees (VHCs), in practice there have been difficulties in maintaining their activities or getting them off the ground. Bright Future, in Mon State, found that health services were not seen to be responsive to their communities’ needs due to a lack of involvement at the village level in health planning and a lack of access to feedback mechanisms.

There is no involvement of communities in the health planning processes, and there is weak coordination of health services among the health providers (government health staff, NGO staff, private practitioners, military health staff, and medics from non-state actors).”

FINNDS FROM COMMUNITY MEETINGS IN MON STATE

When they are established, there have also been challenges in constructing channels of dialogue between the village level and the township level health committees, leading to poor coordination and inadequate feedback response. In their summary of the first stage of the Collective Voices project, Charity-Oriented Myanmar noted: “[there] is weak coordination between the local community and government sectors at the village level, and CSOs and government sectors at the township level. Very few or no meetings or exchanges among those parties lead to barriers to sharing health knowledge and information and less engagement between them.” As one of their four major findings, this demonstrates how important this factor is in acting as a barrier to health.

In Chin State, Ar Yone Oo Social Development Association noted that the disconnection between service providers and communities were resulting in poor health promotion results:

“Further engaging the community in health services through VHC and community participation in village health promotion is essential.”

FINNDS FROM COMMUNITY MEETINGS IN CHIN STATE

Importantly, Bright Future considered the flipside of poor communication and coordination, noting that it also affected health service providers, potentially impacting on service quality and staff motivation. They explained that “service providers felt that another barrier was not getting the full commitment and support from the communities for their service delivery.”

In Chin State, where informal healthcare providers are often the only form of care that is available in communities, Community Agency for Rural Development was concerned with the lack of communication and coordination between the formal and informal sector. Although these providers usually have not received any training, they have strong community links and are trusted by their patients. Community Agency for Rural Development found that informal providers were anxious to receive health information and training to improve the quality of care they can provide to their patients.

“I never attended health and medical training at all. I just read a first aid booklet, written in Burmese. No networking with medical practitioners has been existent at all. We are all working individually. So we have no knowledge improvement on modern medical treatment and health information at all.”

INFORMAL PROVIDER FROM CHIN STATE

A 3MDG display booth at the Gender Equality Network 16 Days of Activism Forum.
Photo: 3MDG
Establishing connections between the formal and informal sectors and building the capacity of the people in the informal sector who are already providing healthcare of sorts may be an efficient way of deepening the penetration of basic health or first aid services, especially in areas where staff retention is low.

3.7 IN SUMMARY

Relationships form the heart of health service provision and use. Personal encounters between health providers and health users affect perceptions of quality of care or level of community support. Myanmar’s healthcare system faces the challenge of meeting the needs of a diverse population who are often difficult to reach with limited resources. High personnel turnover, among other issues, limits the ability for community members to form trusting relationships with formal healthcare providers, especially in remote areas.

The Collective Voices partners found that this dynamic, in many cases, altered community perceptions about healthcare workers and the formal healthcare system more generally, preferring instead to consult with informal practitioners, who are typically excluded from the formal healthcare system. This means that poor and vulnerable people risk receiving poor quality care or no care at all, or delay or avoid seeking healthcare from formal providers. Strengthening ties between communities, healthcare workers, and informal providers will be vital in delivering better health for all in Myanmar.
Social determinants of health

“The inequities in how society is organized mean that the freedom to lead a flourishing life and to enjoy good health is unequally distributed between and within societies.”

Health is a cross-cutting issue that impacts and is impacted by social, political, cultural and economic conditions experienced by individuals and communities. It is therefore useful to approach health as a social phenomenon within a broader social justice framework. The World Health Organization (WHO) defines the social determinants of health as “the conditions in which people are born, grow, live, work and age.”

Poor and unequal living conditions can create ill health for particular groups of people, and major differences in health outcomes are closely connected to degrees of social disadvantage. The social determinants of health require us to look at how fairly health is distributed across the social spectrum and to consider the reasons for unequal health status.
Social Development Association, Collective Voices partners operating in Chin State, the poorest state in Myanmar, found that economic concerns were a major barrier to health seeking in their communities.

One woman from a village in southern Chin State explained that she had many pregnancies, and one time she fell pregnant again when her baby was four months old. She was very weak after being pregnant and delivering so many times, and she lost consciousness after deliveries on some occasions. She blamed poverty because she could not afford nutritious food during pregnancy and childbirth which made her tired and produced serious health risks during pregnancy and childbirth.

Collective Voices partners found that major socioeconomic barriers stemmed from people’s inability to pay for consultations where user-fees are present, inability to pay for medication, and ancillary costs associated with healthcare services, such as lost time due to travel, cost of transport, and accommodation costs of family members accompanying ill patients to urban health facilities.

4.1.1 Poverty

Poverty acts a barrier to healthcare and can cause ill health; a range of socio-economic conditions stemming from poverty can influence a person’s health and their demand for health services. Food scarcity and poor nutrition can cause malnourishment and low birth weight, lack of education may lead to earlier marriages resulting in complicated pregnancies and births, and illiteracy.
limits health awareness, reducing the ability to understand the causes of ill health and when and where to seek healthcare.

Myanmar is a country in transition. In the past five years, the country has experienced high rates of GDP growth, averaging 7.4%, and increased economic opportunity in line with more liberalized trade policies. However, in Myanmar, 26% of the population still lives below the poverty line, and the poverty rate is twice as high in remote and hard-to-reach areas where healthcare infrastructure is weak. Ethnic groups and conflict-affected areas are more likely to have high poverty rates alongside limitations to accessing healthcare due to language barriers or conflict.

‘Out-of-pocket’ payments (meaning that people use their own money) are the dominant way of paying for health services, placing many households at risk of incurring catastrophic expenditure in meeting healthcare costs. The World Bank notes that unexpected healthcare costs are the dominant cause of shock to household income in Myanmar. That is, unexpected health expenses are the main reason that a household surviving just above the poverty line would fall into poverty. Households already existing below the poverty line are unable to cope, relying on support from their communities, families, charitable organizations and inadequate social protection measures, or they forego healthcare altogether.

Although government health providers are supposed to provide medication free of charge to poor people under a cost-sharing scheme, in practice this is not always taking place. In surveys conducted in late 2013 and early 2014 in Chin State, UNDP found that in 82% of patients were sometimes or always required to pay for their medication out-of-pocket at their regular health facility, and, of those, the vast majority were not given an explanation as to why they were required to pay.

4.1.2 Ancillary costs

In addition to the direct costs of receiving health services and medications, Collective Voices partners noted that many of the most acute financial pressures on people seeking healthcare were the associated ancillary costs of lost time, travel expenses, and missed work.

Time

For people living in remote areas, such as in Chin State, the amount of time it takes to reach a health centre or to receive health information acts a significant barrier. Collective Voices partners in Chin State (Ar Yone Oo Social Development Association and Community Agency for Rural Development) both remarked that the journey times to reach healthcare centres were prohibitive for community members. Ar Yone Oo Social Development Association noted: “Sometimes there are conflicts or misunderstandings between health workers and the villagers about health services. People are very poor and cannot pay for medicines that are sold by health workers. Health workers mostly distribute free medicines provided by the government, and they also bring some important medicines that they are supposed to sell with suitable prices. Most of the patients take medicines with credit, without paying cash up front.”

OBSERVATIONS FROM COMMUNITY MEETINGS IN CHIN STATE82

Development Association further noted that the majority of villagers’ livelihoods depend on engaging in farming work during the daytime in areas around 90 minutes from their village. This places significant and prohibitive time pressures on households needing to travel long distances for healthcare services or health education.

Likewise, hospital or health clinic waiting times can be lengthy. Rainbow Women’s Organization, a CBO partner of Phan Tee Eain, found that even where appropriate healthcare services were relatively nearby, seeking healthcare was often still time-consuming.

“...waiting time is one of the main barriers for us. I have to go to the clinic or hospital in the early morning before 7am, the doctors arrive at 8:30 or 9am... then we have to wait for the doctors and finally we finish all the procedures for one day around 12:30 or 1pm... then we go back home and can’t do any work for that day!”

42-YEAR-OLD FEMALE PLHIV

Travel and transport
Transportation in Myanmar is disproportionately expensive: low levels of vehicle penetration, limited roadways and slow travel times coupled with competing demands for the few resources raises market prices for transportation.84 This places an uneven burden on poor and vulnerable people, who are more likely to live far from regional centres, and therefore more likely to face high transportation costs to access healthcare.

“...the main barrier for me is travel. I have to go to Yangon to take anti-retroviral therapy (ART) every month. The travel cost is normally around 30,000 kyats per visit. It is also time consuming. I need to stay at my friend’s house for one or two nights, and I have to miss work during the days that I’m going to get ART.”

50-YEAR-OLD MALE PLHIV

The Ministry of Social Welfare86 acknowledged this cost as a major factor impacting healthcare access in Myanmar, recommending that vouchers for transportation costs be considered as an option to reduce this barrier.

Travel costs may also be a contributing factor to low healthcare staff retention rates in remote communities,87 healthcare personnel prefer to be located in cities as the pay differential of being located in remote or hardship positions is inadequate to cover their additional travel costs. This means that this factor places communities in remote and hard-to-reach areas at a double risk of being unable to access appropriate healthcare when they need it.

Labor
In Mon State, Bright Future noted that health information sessions conducted by health providers were conducted during work hours - “it is difficult for rubber plantation workers to attend to the outreach sessions of Basic Health Staff who normally come during the daytime work hours when the workers are busy with their jobs”.88 The notion of sacrificing wages in place of health education is not viable for poor and otherwise vulnerable agricultural workers.

There is also a gendered dimension to this barrier to health, which has a particular impact on women and children. In Mon State, Community Driven Development and Capacity Enhancement Team found that pregnant women often performed physical work for the duration of their pregnancy:

“...[the] labor burden for women continues until pregnancy, and pregnant women have to work until term in labor-intensive jobs such as extracting palm leaves used for roofing.”

FINDINGS FROM COMMUNITY MEETINGS IN MON STATE89

Further, low rates of school attendance, especially in rural areas, suggests that many Myanmar families use the wage-earning potential of their children to improve the immediate household income.90 These findings

indicate that poverty is the primary immediate concern in poor Myanmar households, meaning that health issues are addressed secondarily, if at all. Ensuring equitable access to healthcare for poor people in Myanmar will rely on healthcare providers’ ability to provide service that causes minimal interruption or disruption to income earning.

4.1.3 Financial spillover effect

“...when I became HIV positive, my wife took over my business. I was going to the hospital and caring for myself to get ART. The household income was low and one of my children had to leave school to help my wife in the shop. These are also barriers for me, especially from the perspective of economic burden”.

INTERVIEW WITH 33-YEAR-OLD MALE LIVING WITH HIV

Collective Voices partners found that families’ very limited budget for healthcare costs and inability to meet the costs of health services, medication and emergency care could have a spillover effect on other family members. Community Agency for Rural Development noted that in Chin State, because large family sizes and poverty are common, drugs are not affordable if many are to be bought, and there is typically a shortage of money for emergency care, transportation, medicine and nutrition.

In Collective Voices interviews and group discussions, community members in Mon State explained that they often borrow money from employers or take small shop loans with huge interest rates, using their belongings as collateral. This demonstrates that in this community the poor are vulnerable to “catastrophic health costs” – a situation in which healthcare costs exceed 40% of household income after subsistence needs have been met, and the costs they pay to access healthcare may push them deeper into poverty. This is a particular concern for those with long-term or chronic illnesses, who require frequent medical care or medications.

For example, Phan Tee Eain, a Collective Voices partner working with PLHIV noted that for mothers with HIV, using infant formula rather than breastfeeding was prohibitively expensive; meaning that they were at a higher risk of transferring HIV to their children. Furthermore, they found that children from a PLHIV household may drop out of school to help their parents, due to hospital costs and healthcare costs, compromising their livelihood potential and perpetuating the cycle of poverty (and subsequent poor health outcomes).

Lastly, in remote areas, when people do attempt to move beyond their villages to access health facilities, they can experience further barriers such as the cost of accommodation for family members accompanying an ill relative at an urban hospital. Community Agency for Rural Development explains:

“The majority of community participants find it difficult to find appropriate transportation and affordable lodging when they need to go to an urban hospital. Instead they typically go to informal health service providers.”

FINDINGS FROM COMMUNITY MEETING, CHIN STATE

4.1.4 Delayed health seeking practices

Collective Voices situational assessments showed that it is common among poor Myanmar people to delay seeking appropriate healthcare when they or a person they care for falls ill. The costs associated with attending medical clinics or hospitals means they are often only used as a last resort, after exhausting home treatments or treatment by untrained traditional practitioners or midwives. While the motivations to delay care are diverse (and are discussed in other chapters), the financial barrier to accessing healthcare, including the cost of doctors’ consultations and the cost of drugs, constitutes a major factor for many community members.

A total of 94% of meeting attendees in

We normally go to the grocery store to take anti-pyretic and anti-inflammatory medicine. The composition of drugs was prepared by the shopkeepers. It costs less than seeing doctors and health staff. We only go to the clinic if we are not relieved by the composite drugs from the grocery store.”

COMMUNITY MEETING PARTICIPANT IN MON STATE

Delaying healthcare may lead to more serious healthcare needs and worsen health outcomes, ultimately driving up the direct and indirect costs of healthcare to the patient and the health system.

4.2 INFORMATION TRANSPARENCY AND KNOWLEDGE

A major factor influencing health outcomes in Collective Voices communities was a lack of information about the health services that they had access to, and a lack of knowledge about appropriate healthcare for maintaining healthy lifestyles. Providing people in communities – including women, ethnic groups and people with disabilities – with information that helps them to access health services is a critical component of the Collective Voices projects, and of 3MDG’s Health for All program more broadly.

While the new government has made commitments to seeking out community voices in an effort to design a more responsive healthcare system, poor and other vulnerable groups are at risk of being unintentionally further marginalized by this process if they lack the necessary information about how to participate and the necessary knowledge to be an informed participant.

“The Collective Voices project should continue to develop awareness of health rights and entitlements of communities across a wide range of health issues, including a comprehensive health package at each level of healthcare.”

RECOMMENDATIONS FROM COMMUNITY AND PROVIDER MEETINGS IN MON STATE 104

4.2.1 Information gaps

Bright Future, a Collective Voices implementing partner working with migrant communities and ethnic groups in Mon State found that there is a disconnect between the messages being provided by the formal health sector and the messages being received by communities. In particular, communities are not aware of how and when they can access healthcare. Bright Future explained that “some communities don’t know particular health providers plans and schedules to visit particular villages for routine outreach sessions.”105

Furthermore, many participants in Mon State were misinformed, noting that they avoided accessing health services due to the fact that they feared high costs, despite many services and medications being free of charge. This perception was confirmed by healthcare providers in the community. These information gaps may feed into related perceptions about service quality and community support of public health service providers more generally, as discussed in the first section of this report.

“Phan Tee Eain, a Collective Voices implementing partner who focuses on PLHIV, found that some participants were not aware of the risks of and treatments for opportunistic infections, despite currently being on treatment plans for such infections.

“The hospital gave me some drugs, not only antiretroviral therapy (ART), but also other drugs, but I don’t know exactly what these drugs are for…”

COMMENT FROM 50-YEAR-OLD MALE PLHIV108

Poor and other vulnerable groups lack appropriate feedback mechanisms with healthcare providers, perpetuating health and development inequalities and further eroding trust between communities and formal healthcare providers.109 This has been acknowledged by the Ministry of Health and Sports in Myanmar, with a renewed focus on building an accountable and collaborative health system that is in touch with “ground realities”, and that solicits constructive feedback and the voices of the people as a key touchstone in their universal health coverage strategy.110

4.2.2 Limited health education

“Water related diseases such as diarrhea, dengue fever and skin infections were found to be common in these townships, especially in summer and the rainy season. These diseases are related to sanitation, hygiene and individual behaviors, showing the need for improved personal hygiene habits and better understanding of disease transmission.”

FINDINGS FROM COMMUNITY ENGAGEMENT IN AYEYARWADY AND MAGWAY REGIONS111

Likewise, even when patients receive appropriate care from the formal sector, they are sometimes not informed about the reason for the treatment they are receiving or have received. This lack of information is disempowering as it impacts the patient’s control over their own health outcomes and their understanding of appropriate health seeking practices for in the future.107
Research suggests that health literacy, that is, the ability to obtain, read, understand and use healthcare information, is a better predictor of health than age, race, education, income or employment status. Therefore promotion of health literacy is vital for improving the health outcomes for vulnerable people in Myanmar. The Collective Voices implementing partners found that access to health education was rare. This was particularly the case in rural areas, but was also relevant to vulnerable groups in urban settings. Phan Tee Eain, for example, found that the majority of their community meeting participants had never attended a health talk or health education session.

In Chin State, where the majority of Collective Voices communities are in hard-to-reach areas, access to health education was cited as one of the major barriers to improved health outcomes and health seeking behaviors. Ar Yone Oo Social Development Association explained that “the communities are eager to have a functioning Village Health Committee and suggested providing them with some health-related training.”

This is a particular concern when it comes to sexual and reproductive health. Although currently the nationwide school curriculum does cover basic sex education for students, this program is only available in secondary schools, to which many (41%) young people in Myanmar have no access. Young people were found to obtain much of their knowledge about sexual and reproductive health, often inaccurately, from friends or family members.

“Chin villagers commonly discuss their personal or family health issues with friends before going to a health practitioner. They only go to a hospital as a last resort.”

OBSERVATIONS FROM COMMUNITY MEETINGS IN CHIN STATE

Community members gather to discuss the challenges of accessing healthcare in Mon State. Photo: Community Driven Development and Capacity Enhancement Team

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.

Findings from Community Meetings in Chin State

This finding is supported by recent research done by the Gender Equality Network (GEN) on cultural norms, social practices and gender equality in Myanmar that indicates that men are the principal decision-makers when it comes to family planning in Myanmar households, and are often apprehensive, or even hostile, towards the use of contraception or other family planning methods.

Collective Voices partners found that in Myanmar, the social taboos surrounding open discussion and information sharing about sex and sexuality lead to propagation of misinformation and knowledge gaps when it comes to sexual and reproductive health. Phan Tee Eain found that many people, despite having good sexual and reproductive health knowledge, also still held traditional beliefs. For example, one young participant from the women and girls discussion group said, “Mum...”

4.2.3 Social norms that limit knowledge sharing

Societal norms around the sorts of health issues that are commonly discussed within the family and community limit knowledge sharing, particularly around sexual and reproductive health. Sex and sexuality remains a largely taboo topic within Myanmar society.

Community Agency for Rural Development explained that “families have no practice of discussing sexual health. A very small portion of people talk about their sexual health with their partners.” Because of this silence around sexual behaviors and practices, many people in Myanmar feel uncomfortable speaking about sexual and reproductive health issues. This was a common theme in many of the Collective Voices analyses, leading to a lack of knowledge and empowerment to act on issues like sexual health rights, reproductive health, and family planning.

Furthermore, Collective Voices partners observed a norm of patriarchal control and power within the domestic sphere when it comes to reproductive choices and health limits women’s knowledge about their rights and options in terms of contraception and the number and spacing of their children. For example, community participants in the Charity-Oriented Myanmar study said that the main decision-maker for health related issues at home is a man. This was supported by Phan Tee Eain, with most women participants identifying fathers as the key decision-makers regarding healthcare for family members. It was also reiterated in the studies done by Chin partners, Ar Yone Oo Social Development Association and Community Agency for Rural Development.

“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.”

Findings from Community Meetings in Chin State

This finding is supported by recent research done by the Gender Equality Network (GEN) on cultural norms, social practices and gender equality in Myanmar that indicates that men are the principal decision-makers when it comes to family planning in Myanmar households, and are often apprehensive, or even hostile, towards the use of contraception or other family planning methods.

Collective Voices partners found that in Myanmar, the social taboos surrounding open discussion and information sharing about sex and sexuality lead to propagation of misinformation and knowledge gaps when it comes to sexual and reproductive health. Phan Tee Eain found that many people, despite having good sexual and reproductive health knowledge, also still held traditional beliefs. For example, one young participant from the women and girls discussion group said, “Mum...”

is my consultant for changes in puberty, how to manage menstruation, what to eat and not to eat. She also suggested that I should remember the date of my period and not wash my hair during my period.125

In Bilin Township, Community Driven Development and Capacity Enhancement Team found that villagers were not used to exchanging information and speaking openly about reproductive and sexual health issues even within their own families.

“...the function of sex organs, puberty and reproductive organs [are] less discussed, due to existing traditions not to exchange understanding within families and siblings.”

FINDINGS FROM COMMUNITY MEETINGS IN BILIN TOWNSHIP126

In Chin State, Community Agency for Rural Development noted similar findings, further remarking that community members in Thantlang were far less likely to discuss sexual and reproductive health than those in Hakha, suggesting that entrenched social practices such as this become more pervasive in isolated areas.

Social taboos about sexual and reproductive health do not just produce a knowledge gap but can also impact on health seeking behaviors; Community Agency for Rural Development found that in Chin State, women were reluctant to discuss reproductive and health issues with their health practitioner. They said, “we don’t have a female quack or doctor in our region [12 villages]. Therefore, we women, at times, go to male quacks for our women’s sickness but sometimes we dare not tell them our illness.”127

GEN’s research into the role of taboos in sexual and reproductive health seeking practices support these findings. They found that both women and men felt restricted in terms of the health conditions they felt comfortable sharing with other people or seeking care for, due to concerns that their reputations may be compromised for transgressing social norms,128 The tension between traditional, conservative cultural values and modern ideas about health information sharing also came out in a discussion Phan Tee Eain led with women and girls:

“All women and girls stated that female reproductive health problems and gynecological problems are common for females to face, and therefore they should not feel ashamed... However, none of them had been tested for cervical cancer. They know that it can be screened for and it should be, but have not done that before.”

FINDINGS FROM COMMUNITY MEETINGS WITH WOMEN AND GIRLS, YANGON129

Social norms and expectations around women’s role as care-givers within the family were also found to reduce their exposure to health information and education. Ar Yone Oo Social Development Association noted that “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 proportions of women in VHCs and village health activities are considerably low, which needs improvement.”130
These findings point to the in-practice difficulty in contravening deeply-held cultural beliefs and practices, even where knowledge and attitudes support behavior change. The taboo around speaking about sex and sexuality stems from related social norms and values about the role of women in the community. These ideas and their impact on the health outcomes of women are explored further later in this report.

“When the meeting explored the reasons for poor access to health services, most issues were linked to cultural and superstitious norms, myths, and language barriers relating to health promotion.”

FINDINGS FROM PROVIDER MEETINGS IN MON STATE

4.3 CULTURE AND LANGUAGE

Myanmar’s 51 million people are representative of the country’s position at the strategic crossroads of Asia. The rich ethnic and linguistic diversity of Myanmar highlights the vibrant and heterogeneous cultural traditions and regional distinctiveness. Myanmar is one of the most ethnically diverse countries in the world, with at least 135 ethnic groups comprising 30-40% of the population, and over 100 languages in use.

Ethnic groups are concentrated in the country’s resource-rich border regions, often placing them in geographically hard-to-reach areas. This means that ethnic and linguistic minority groups are less likely to have access to high quality healthcare. All border states have been the scene of modern-day conflict, some of which are among the longest-lasting insurgencies in the world.

While traditional medicine is supported and protected by the Myanmar government, many harmful superstitions endure. This was a particular finding of the Collective Voices partner Bright Future, whose work took place in Mon State, a conflict-affected region with ethnic and linguistic minority groups.

4.3.1 Culture and tradition

Superstition and tradition are integral parts of cultural practice and cultural understanding. Looking at how these traditions interweave with health seeking practices among Myanmar refugees on the Thai border, Bodeker et al found that “traditional spiritual beliefs and practices are [deeply imbedded] within the culture, village social systems and illness perspectives of patients.”

A common theme arising from the Collective Voices community consultations was that cultural and traditional norms and practices guide community health seeking behaviors. While reliance on superstitious or traditional remedies

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In communities across Myanmar, Collective Voices partners found that traditional and superstitious beliefs played a part in how people sought healthcare.

Photo: Phan Tee Eain

played a larger role in areas where access to the formal sector is limited or non-existent. Collective Voices partners in all areas found that culture and tradition played a role in how the community sought and practiced healthcare. For example, Phan Tee Eain found that women and girls, PLHIV and lesbian and transgender groups in Yangon “are generally influenced by traditional Myanmar medicine and harmful social norms.”

Collective Voices partners learned that ancestral medical practices and superstitions played a role in how their communities accessed healthcare. In ethnic communities where informal sector healthcare provision was prevalent, such as Chin and Mon States, these traditions and superstitions sometimes informed dangerous practices by informal providers and spiritual healers (see box on this page). In Chin State, Community Agency for Rural Development found that superstitious beliefs further isolated remote community members from health services by limiting the days on which it is culturally acceptable to travel.

“In some cases, even when access to formal healthcare is available and affordable, community members supplement their treatment with traditional medicines or treatments, a trend that is supported by formal research findings. In Mon State, a mother at a community meeting noted: “I always put a few drops of urine into the eyes of my son whenever he has red eyes.”

Bright Future, in particular, collected many stories about traditional or community-based remedies to disease. Of all of the Collective Voices partners, superstitious and traditional beliefs dominated the narrative about health barriers in the communities in Mon State. Bright Future found that traditional healthcare practices were often a part of home-based healthcare in Mon State, and that these remedies were the first line of defense against poor health, well before seeing a formal healthcare practitioner. One community meeting participant explained, “for me, I tried to cure by myself taking traditional medicines at home. Here, at home, I’m the practitioner for my family. We only go to the

“Some families rely on roadside pharmacy and traditional herbal medicines as the first resort of treatment; they use boiled betel leaves and medicinal salt for curing minor ailments. In one case, a spiritual leader removed the evil spirit from a 14-year-old by violently hitting her back until she fainted.”

“The wound of the snake bite was healed with ground rice and the patient was first fed chili pieces and chili powder before being sent to the nearest health facilities.”

“The local treatment for epilepsy is a spoonful of salt.”

“The ancestral practices are still being used by communities, like sitting on a hot brick after applying turmeric during puerperium.”

“For the remedy of red eye, they often add dangerous unknown powders given by traditional healers into the eyes. The drug doesn’t have any registration. As a result, the patient was about to lose part of their vision and was sent to an eye specialist.”

“...the social determinants of health were mostly linked to traditional superstitions, spiritual practices and religious prescriptions of ailments.”

Findings from Bright Future community meetings in Mon State.
traditional healer if the fever has not subsided or ailment is not relieved.\textsuperscript{140} The practice of indigenous medicine is codified and regulated in Myanmar, and there are several traditional medical hospitals in the country’s major cities.\textsuperscript{141} However, in most cases, the traditional birth attendants, ‘quacks’, and spiritual healers that Collective Voices community members referred to in their reports are unlicensed and untrained providers.

"Some of the participants indicated that they took traditional medicine together with western medicine for the treatment of HIV."

FINDINGS FROM COMMUNITY MEETINGS WITH PLHIV\textsuperscript{142}

Community Agency for Rural Development, in particular, noted that due to their lack of legitimacy within the medical community, informal sector providers are often excluded from healthcare policy, and have little to do with their formal counterparts, despite acting as the main providers of healthcare within their communities. In the second phase of the Collective Voices project, Community Agency for Rural Development is working to build networks between the formal and the informal sector in Chin State to redress this imbalance.\textsuperscript{143}

4.3.2 Language

Myanmar’s population is linguistically diverse, with over 100 indigenous languages in use.\textsuperscript{144} Linguistic minority populations, typically but not always located in ethnic areas of the country, face additional barriers to healthcare, as they are often unable to communicate their symptoms, history, and health questions to healthcare workers.

"As health information is written in Myanmar language in posters, pamphlets or notice boards, we find it difficult to understand and follow some messages. We wish to get health staff who can communicate in Mon language fluently."

COMMUNITY MEETING PARTICIPANT FROM VILLAGE ELDER GROUP, MON STATE\textsuperscript{145}

Collective Voices partners found that in ethnic minority regions, there is often a mismatch between the languages spoken by health staff and the languages spoken by the population it serves. Healthcare workers in Myanmar are required to have at minimum a full high-school education; something that only 16.6\% and 19.6\% of adults in Mon State and Chin State respectively have (compared with 37.5\% in Yangon District).\textsuperscript{146} The rural-urban education gap creates a deficit of suitably qualified linguistically diverse healthcare workers. For the same reason, patients in linguistically diverse regions are less likely to have learned a common language with their healthcare worker.

"Many community members in Mudon Township only understand some common words of Myanmar language and when they are in urban tertiary hospitals, they cannot explain thoroughly to the doctors or nurses about the history of their illness."

FINDINGS FROM COMMUNITY MEETINGS IN MON STATE\textsuperscript{147}

Collective Voices partners in Chin State and Mon State, Ar Yone Oo Social Development Association and Bright Future respectively, remarked that due to their lack of legitimacy within the medical community, informal sector providers are often excluded from healthcare policy, and have little to do with their formal counterparts, despite acting as the main providers of healthcare within their communities. In the second phase of the Collective Voices project, Community Agency for Rural Development is working to build networks between the formal and the informal sector in Chin State to redress this imbalance.\textsuperscript{143}

literacy; Lai language (the dominant language spoken in Chin State) uses Latin script, whereas Myanmar language uses Burmese script. Therefore, “literacy and language problems in accessing health information and preventative health messages are important for the village community.”

Many ethnic groups in Myanmar have a troubled history with the central government when it comes to cultural expression and national identity, including the use of ethnic languages. Where linguistic difference is a factor determining access to healthcare information and health knowledge, it strengthens and deepens existing social inequalities between majority and minority populations in Myanmar and can erode trust between ethnic populations and the public service.

In Mon State, Bright Future found that the frustrations that arise from language barriers can lead to misunderstandings and conflict, creating a negative attitude toward the formal healthcare providers, and impact on trust between the community and the health system (the issue of trust is explored earlier in this report).

Bright Future found that language barriers between the patients and healthcare staff in Mon State are often overcome through the use of a broker or interpreter who is able to speak Burmese. This not only places an additional ancillary cost on these patients, but also places a distance between the patients themselves and the healthcare delivery interaction, widening an already unequal power relationship.

Glenn Martínez argues that language barriers block “a patient’s ability to take control of the management of disease and to exert agency in health seeking behaviors.” This creates a schism between the patient and the healthcare delivery system that Martínez links ultimately with a loss in the patient’s ability to manage their disease and practice appropriate health seeking behavior.

4.4 SOCIAL INCLUSION

The Collective Voices project is immediately concerned with seeking out the voices of the poor and otherwise vulnerable in the community to learn about their health seeking behaviors and experiences, using this as a basis for improving access to healthcare. In each case, the Collective

Due to difficulties in proper communication with health staff at tertiary hospitals, the communities typically have to hire a broker to communicate with health staff on their behalf. The worst scenario is when there is an emergency; they do not have knowledge on what to do but have to follow the decision of the brokers which is costly and disempowering.”

FINDINGS FROM COMMUNITY MEETINGS IN MON STATE

At a community celebration, Bright Future stages an educational healthcare performance. Photo: Bright Future

Voices implementing partners, the community-based organizations they partnered with, and the communities themselves worked together to determine who in the community was vulnerable to being socially excluded from healthcare or health knowledge and information.

They found that some groups in each community faced greater barriers than others to living healthy lives and seeking appropriate healthcare. This is a function of the stigma and discrimination faced by some groups, issues of degraded trust between some groups and healthcare providers, and issues of mobility or immobility impacting on access for some groups.

Reaching out to, and soliciting the voices of, diverse people who face difficulty in accessing healthcare is important for addressing issues of health inequality in Myanmar. Furthermore, it is important to understand how the conditions impacting on health access intersect, and it is common for one patient to be marginalized from the health system along several lines. These activities can also help us to understand broader social trends as part of sustainable, coordinated and people-focused development.

Bright Future, a Collective Voices implementing partner working with conflict-affected communities in Mon State, drew attention to the need to take in the sociopolitical environment to better understand health barriers, and the inescapable reality of health access and conflict. In order to address this issue:

“Activities were created for new basic health staff to learn about health seeking behavior, cultural barriers, and conflict consequences for Mon and ethnic groups.”

OUTCOMES OF STAGE 1 OF COLLECTIVE VOICES, MON STATE

4.4.1 Stigma and discrimination

Phan Tee Eain, who conducted their Collective Voices research with PLHIV, lesbians and transgender people, and women and girls, found that stigma and discrimination was a central inhibiting factor to health access for
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 healthcare.

Findings from Bright Future community meetings in Mon State
A major social barrier to health according to lesbians, transgender people and people living with HIV (PLHIV) is stigma and discrimination from families and society towards them.”

Findings From Meetings with Lesbian, Transgender and PLHIV People

The issue of stigma is reflective of broader social trends that undermine equal access to healthcare, and point to a need for a stronger focus on inclusion and equity in all development activities, not just health.

The stigma and discrimination faced by sexual and gender minorities was found by Phan Tee Eain to affect the ability of these communities to access healthcare both directly and indirectly. Discriminatory practices were experienced by some participants in the health seeking process; with doctors and nurses treating PLHIV and sexual and gender minority communities differently to other patients. One woman with HIV explained, “when I was at the hospital with complaints of abdominal pain during pregnancy, the hospital staff, especially nurses, put me aside from the other patients, provided less care, and took extra precaution using many gloves. They treated me poorly at the time of treatment... I was feeling sorry for being treated like that.”

Stigma and discrimination also impacted the health outcomes of PLHIV and sexual and gender minorities through indirect ways; community and family judgements and exclusionary behavior impacts on earning potential which, in turn, limits the affordability of healthcare. Another woman with HIV said, “I was selling pork meat at the market. When people knew that I had HIV they said ‘don’t buy the things from her, she is HIV positive and can infect you’... I was so depressed.”

The social impact of stigma and discrimination from society, families, and medical professionals has spillover effects. PLHIV and LGBT people have higher than average rates of mental illness, particularly depression. In Myanmar, the level of internalized stigma for PLHIV is quite high, with over 75-85% of PLHIV reporting to suffer from low self-esteem due to their HIV status, and 21-26% of PLHIV feeling suicidal as a result of their diagnosis.

“They felt sorry and depressed as soon as they were diagnosed with HIV. One of the participants attempted suicide once she was diagnosed with HIV.”

Observations From Meetings with PLHIV

Although mental illness is an area of health that is frequently overlooked in Myanmar, there is anecdotal evidence to suggest that the mentally ill also face stigma and discrimination that impacts their access to appropriate healthcare. This is also a relevant consideration for people living in conflict-affected areas, people who use drugs, sex workers, internally displaced people, ex-combatants, and elderly people.

4.4.2 Migration and mobility

Collective Voices implementing partners also noted the ways in which community members moved around could exclude people from health services and social life more generally. Whether by creating pockets of internally displaced people who are unreachable by health services or by creating an environment that is unsafe to walk around in at certain times, the mobility restrictions in conflict-affected areas...
and communities directly impact on health seeking behaviors and access to healthcare when needed. Furthermore, in circumstances where the government deems it unsafe or insecure to operate in a conflict-affected area, high-risk communities remain out of reach of both government and INGO support.

Stateless people and displaced persons living in the border regions of Myanmar face additional, structural constraints on their movement and access to care. In Rakhine State, the Muslim community faces imposed restrictions on their movement, negatively affecting access to healthcare. In IDP camps on the Myanmar-Thailand border, many people have no access to government healthcare services, and make the journey across the border to Thailand or China to access healthcare at the border clinics. This leaves them vulnerable to arrest and extortion, language barriers and misunderstanding treatment or diagnoses, and is often expensive.

Lack of mobility is also an issue for other vulnerable groups; the elderly and the disabled may face additional difficulties in accessing healthcare, particularly if they need to cover long distances. HelpAge International found that over 50% of older people in Myanmar faced mobility constraints, and over 20% faced serious limitations on physical movement.

Collective Voices partner Charity-Oriented Myanmar analyzed the relationships within families in Ayeyarwady, and found that grandparents typically do not have a close relationship with their children, and only have a distant relationship with their grandchildren. Although Myanmar has a strong culture of care for the elderly, the interplay of distant intergenerational familial relationships and changing demographics pushing many younger family members away from their home village or town for economic opportunity places older people in Myanmar at a high risk of facing even greater social barriers to health.

“In 100% of the beneficiary girls in this project have no chance to be involved in decision-making on health issues in the family, including their own.”

Observations from Community Meetings in Ayeyarwady Region and Magway

In all of the Collective Voices communities, gender played a critical role in health knowledge and health seeking practices. Photo: Charity-Oriented Myanmar

Conversely, some sectors of the Myanmar population are highly mobile, and that also comes with several social barriers to health. In particular, migrant workers and sex workers have a high risk of developing illness or injury, but are particularly difficult to reach with delivery of regular health services. Within communities where many residents seek employment away from home on a seasonal basis, basic health services and health education often fails to reach the migrant workers, due to mismatched timing issues. This was a factor that Bright Future identified as a major barrier to health for migrant workers:

“Local issues like reorganization of outreach plans of BHS to cover more migrant clusters were raised during the meetings.”

FINDINGS FROM COMMUNITY MEETINGS IN MON STATE

Migrant workers and sex workers can face additional vulnerabilities in seeking healthcare due to their undocumented status and occupational illegality. Lack of appropriate identification and immigration documents exclude many from health services both inside and outside of Myanmar.

4.5 GENDER

In 2014, the Gender Equality Network in Myanmar released a report detailing the “social and cultural norms in Myanmar, and their impact on men and women in relation to family and community life, work, health, and education.” Using qualitative tools, including focus groups, in-depth interviews, community questionnaires, and media analysis they gathered information from 543 men and women from seven states and four regions in Myanmar.

This study revealed that although cultural values are shifting, and gradually women have more opportunity and equality in Myanmar than ever before, social and cultural norms govern the roles and worth for men and women, and these norms impact life opportunities in different ways. This is revealed in labor participation and political representation indicators, in which women tend to be less likely to work, less likely to hold a position of political power, and more likely to bear the sole responsibility for unpaid domestic and care work.

Many analyses of women’s health in Myanmar deal almost exclusively with issues of maternal, reproductive and sexual health. While this focus does represent areas of healthcare that disproportionately affect women, it perpetuates a problematic perspective that conflates women’s personhood with their reproductive function. The community experiences gathered by Collective Voices partners unveiled that Myanmar women face social barriers to care across all spectrums of health issues.

According to Collective Voices partners, women face greater difficulties accessing healthcare and information for myriad reasons; including lower economic independence, lower rates of health education, greater restrictions on movement, and lower availability of appropriate care-providers. Additionally, many health issues that exclusively or disproportionately affect women - such as sexual violence, domestic violence, and unwanted pregnancy - face a social stigma and are routinely silenced.

The Collective Voices partners detailed issues relating to women’s empowerment, social norms and customs, and double- or triple-labor burdens as the major obstacles augmenting the barriers to health for women. Phan Tee Eain also shared voices from the transgender and gender nonconforming community, highlighting their specific barriers in accessing healthcare. In reality, these categories are not mutually exclusive, and impact on and feed into each other. However, for ease of analysis, these classifications form the framework of discussion below.
Women in northern Chin State discuss their health seeking practices and barriers to health.
Photo: Community Agency for Rural Development
4.5.1 Empowerment

The social factor most commonly cited by Collective Voices partners that limits women’s access to healthcare in Myanmar was a lack of agency over their health and health seeking behavior.

Particularly when it came to reproductive choices, Collective Voices partners found that women faced social and marital pressure that limited their choices and behaviors. This was due to a range of factors that could be largely categorized into those stemming from the normative social value placed on women in society at large, and those stemming from a lack of women’s economic independence.

The Social Value of Women

The GEN study revealed that women in Myanmar are often imagined as having value only in relation to their husband and their reproductive function. They found that in communities all over Myanmar, proverbs suggesting that a woman without a man is incomplete or flawed were typical.

One Collective Voices partner working in southern Chin State found that perspectives on the social value of women primarily manifested as a social and marital pressure to have many children. Ar Yone Oo Social Development Association focused heavily on the reproductive burden of women in their region, collecting and recording voices from women and documenting their experiences with reproductive and sexual health. In particular, they found that Chin women faced enormous social pressure to have many children, mostly without a trained birth attendant, frequently up until advanced maternal age or under other high-risk conditions.

Another woman explained, “I had fourteen pregnancies, however, only eight children are alive. I don’t want to have children again but my husband wants children.”

Casting women solely as reproductive beings not only narrows the scope of healthcare needs for women, but also generates blind spots in men’s reproductive and sexual health needs. A woman from Chin State said, “I really want children, but I could not have them. Therefore, I am looked down upon by the surrounding community and they even urge my husband to remarry again to have boys for descendants. In fact, it is not my fault. I am in good health. My husband is not in good health and is always weak; therefore I believe that’s the reason we could not have children.”

This is played out in social norms that value virginity, and in the fact that few sexual and reproductive health services exist for young people. This impacts the health seeking behavior of both young men and women, however, due to a social double-standard that upholds virginity and modesty norms more strictly for women, the impact on women is likely to be more marked.

Economic Dependence

“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 the fallopian tubes to stop pregnancy. However, I rarely do it because I am afraid others would criticize and look down on me. All the couples want as many children as they can, so I am afraid of practicing such birth control.”

MOTHER OF TEN CHILDREN, CHIN STATE

“Most of the participants identified fathers as the key decision-makers because they work outside of the home and earn the money that the family needs for the household. Only a small portion of decisions are made by mothers who spend more time with family members.”

PHAN TEE EAIN FINDINGS FROM COMMUNITY MEETINGS

Household division of labor was also cited as a major influencer of health-related decision-making in Myanmar by Collective Voices partners. By and large, men are responsible for income-earning and productive labor in Myanmar households, and women responsible for household and reproductive labor. These gender roles are deeply entrenched and internalized, as Charity-Oriented Myanmar found when they discussed gender roles in their communities in Ayeyarwady Region, one woman explained that “it is already defined what men have to do and what women have to do. Everyone knows about it and follows it of course.” Another woman said, “my husband works for our family income. So I have nothing to do if I don’t do house chores and cooking.”

While it is not uncommon for women to participate in productive labor, men are still considered the primary income-earners, and the heads of the household. As such, they determine the conditions under which healthcare is sought. GEN notes that men in Myanmar often feel anxiety about their role as provider and leader of their family and it is therefore understandable that given the financial stress that health seeking can cause on households, men may seek to control the conditions under which it is undertaken.

“"The main decision-maker for health related issues at home is a man... mainly men decide whether a family member will take medicine or go to the clinic, and will also determine certain conditions for taking medicine, going to the clinic or hospitals and will choose the hospitals or clinic for treatment."

FINDINGS FROM COMMUNITY MEETINGS, AYEYARWADY REGION

Notably, in the communities in Mon State that are characterized by households with male household heads who earn their income in rubber plantations or in Thailand, Bright Future found that women were the primary decision makers about health seeking and health practices.

“"Here, in our community, we women decide about seeking healthcare for family members. As our husbands are busy with their own business (even sometimes they travel and stay in plantation sites for long periods), we are the ones who decide the treatment of ailment for family members."

FINDINGS FROM COMMUNITY MEETINGS IN MON STATE

4.5.2 Social Norms

In many communities that Collective Voices partners engaged with, men’s control over healthcare and health seeking does not always stem from the interplay of financial implications.
and their position as provider. In Myanmar, it is typically seen as a woman’s duty to have children; to prevent pregnancy can be interpreted as an affront to that duty. This is part of a greater cultural narrative that values women’s sacrifice on behalf of her husband, family and community.

In support of this idea, Collective Voices partners found that men were often resistant to the use of contraception to prevent or space pregnancy. This played out in an activity conducted among women and girls by Collective Voices partner Phan Tee Eain, finding that in some groups, pregnant women would receive less food than the household head. In fact, poor nutrition was cited as one factor that impacted on difficult

“Traditionally women used to have many children: the average total births per woman is eight, reported from community consultations and interviews. Chin women are eager to have control over their pregnancies and use contraception however, they cannot overcome the pressure from their husbands and community (social norms) about having many babies.”

FINDINGS FROM COMMUNITY MEETINGS IN CHIN STATE

My husband demands that I have a lot of children. I often experienced dangers of easy miscarriage and we used birth control after the fourth child. But I experienced health problems and side-effects from the birth control and we dare not practice sexual reproductive health anymore. Therefore, I am afraid of pregnancy again”.

AR YONE
OO SOCIAL DEVELOPMENT ASSOCIATION INTERVIEW WITH A MOTHER OF 10, CHIN STATE

Interviews with women in southern Chin State uncovered a social and marital expectation to have many children.

Photo: Ar Yone Oo Social Development Association

or dangerous childbirths for Ar Yone Oo Social Development Association community meeting participants. In a social environment in which women are expected to sacrifice, they are likely to delay or forgo seeking healthcare, especially if it is forbidden by their husband or father, comes with an economic cost, or they are unable to perform their caregiving roles in doing so.

The norm of sacrifice carries over into a culture of silence around issues of domestic and sexual violence. In GEN’s report on the state of women in Myanmar, a Mon woman is quoted as saying, “They say, ‘once you have built a pagoda, let any crow or vulture rest on it’. It implies that once a woman is married to a man, no matter how good or bad he may be, all she has to do is endure her husband’s actions and behaviors.”187 Collective Voices partners struggled with this silence; in some groups, domestic and sexual violence was invoked, but rarely expanded upon by community meeting participants.

“There appear to be many hidden issues in communities, including violence against women. Some community members described instances in which, during the critical illness of his wife, the husband had neglected her and ran away after selling common family belongings as well as abandoning the children.”

FINDINGS FROM COMMUNITY MEETINGS IN MON STATE188

“She committed suicide because she couldn’t withstand any more cruelty of her husband who used to hit her after he was drunk every day.”

FINDINGS FROM COMMUNITY MEETINGS IN MON STATE189

The health implications around failure to report and receive redress for sexual or physical abuse cover a broad spectrum of acute and chronic physical, sexual and reproductive, and mental and behavioral illnesses and diseases.

While abuse is certainly not condoned in Myanmar culture, there does tend to be an acceptance of the inevitability around violence against women in Myanmar communities.190 This manifested through strong cultural requirements for women to behave and dress in certain ways, and through the notion that women need protection. The underlying persistent threat of possible (sexual) violence impacts women’s social access to health, through limiting their mobility, their educational opportunities, and their sexual and marriage choices.191

As women are generally held to be the ‘bearers of culture’ in Myanmar, their obligation to uphold norms and values are more strongly socially enforced.192 This means that there is a gendered double standard in which certain social taboos, such as sex outside of the context of marriage and divorce that generally results in more permissible attitudes towards men transgressing...
“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 to go far away for work. I don’t know where she stays and works, she does not contact me.”

MOTHER OF 7, CHIN STATE

The interplay between the gendered nature of education outcomes in Myanmar and social and religious taboos means that women may be unable to seek reproductive and sexual healthcare. Collective Voices partner Community Agency for Rural Development found that in Chin State women did not want to disclose their sexual and reproductive health concerns to a male health provider.

“There is a lack of female health service providers and women in the communities faced difficulties in getting the right treatment.”

FINDINGS FROM COMMUNITY MEETINGS IN CHIN STATE

Community Agency for Rural Development also found that in Chin State there was a lack of private wash spaces for women. As washing is usually done outside, and a woman exposing her body is a serious taboo, the lack of private wash spaces for women raises health and hygiene concerns for women in that State.

4.5.3 Labor Burden

As discussed in the discussion about empowerment, health-related decision-making is primarily the responsibility of men in households in Myanmar. However, Collective Voices partners noted that women are expected to be the primary caregivers inside the home, and thus are responsible for preventative and rehabilitative care.

“Women take a more central role in prevention and long-term home-based care.”

FINDINGS FROM COMMUNITY MEETINGS, AYEYARWADY REGION

“Women care for children and bear the responsibilities associated with pregnancy and delivering babies.”

FINDINGS FROM COMMUNITY MEETINGS IN CHIN STATE

“...many experience stigma and discrimination from the community, at school and from family members. They were told that they are not suited to the community environment by wanting to be a man although being born female.”

Phan Tee Eain observations from group discussions with trans-men.
Women’s lack of agency around health seeking practices compromises their ability to effectively perform their assigned role as carer, and has the potential to increase their labor-burden by prolonging or intensifying illness in the event that timely healthcare is not sought. The contradiction in these roles underlines the relative social value that is placed on productive versus reproductive labor.

Although traditionally it was uncommon for women to engage in productive labor activities, social norms and economic necessities have changed over time, opening up more opportunities for women to work outside of the home. However, this has not been accompanied by a shift in terms of household responsibilities and childcare. Furthermore, as women are expected to act as the bearers of culture and religion in Myanmar communities, they often have responsibility placed on them to engage in volunteer activities for their communities and religious institutions. This triple-burden of labor was noted by both Collective Voices in Chin State, Ar Yone Oo Social Development Association and Community Agency for Rural Development, with the latter directly linking this paradigm to unequal access to health advocacy and leadership.

“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...

Moreover, they are involved in community-based activities through the Church or other organizations/ 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.”

FINDINGS FROM COMMUNITY MEETINGS IN CHIN STATE

Three Collective Voices partners, Ar Yone Oo Social Development Association, Bright Future and Community Driven Development and Capacity Enhancement Team, noted that the labor burden of women also placed them at risk for complications during and after pregnancy, as they are expected to continue performing labor-intensive work until the baby is born, and return to work very quickly afterwards. Heavy physical work during pregnancy and the immediate postpartum period may have adverse effects on the health of both the mother the child, and places a higher caloric burden on the mother, often in situations where caloric intake would fall below the WHO recommendations, increasing risk further.

“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.”

FINDINGS FROM COMMUNITY MEETINGS IN CHIN STATE

4.5.4 Gender norms

The social response to transgressing gender norms was one area of focus for Collective Voices partner, Phan Tee Eain. Presenting, identifying, or performing the socially ascribed and acceptable roles of a gender in line the sex assigned at birth presents a significant challenge for LGBT people in Myanmar.

Phan Tee Eain’s community-based partner, Colors Rainbow, worked with lesbian and transgender communities in Yangon and Shan State to determine the major social factors influencing their health choices. They found that the lesbian and transgender communities faced social isolation, familial rejection, discrimination...
and abuse for transgressing norms about gender representation and behavior. The examples below show instances of violence against transgender people and of the discrimination shown towards them.

“...my father doesn’t like me behaving or dressing like a girl. When I go outside, I sometimes wear clothes like a girl, but never at home. Sometimes, my father beats me when he sees me wearing clothes like a girl. He said ‘get out of my home if you make MSM friends.’ Also among my friends, I was called ‘Ah-chout’ [man who has sex with men] and teased by some friends.”

TRANS-WOMAN

“...when I was a student, my parents put me at the female only school. I was so disappointed when I had to wear the female school uniform and had to dress like a girl. I wanted to be like a boy. When I behaved like a boy, even my teacher discriminated against me and looked down on me compared to other students saying that I’m a girl but I wanted to be a boy, what’s the point? Friends in my class also didn’t like me. Later on, I was not happy to go to the school and missed school...”

TRANS-MAN

Beyond stigma and discrimination, transgender people face the same social and cultural taboos that impact sexual and reproductive health across the board, particularly women. Phan Tee Eain found that the lesbians and the transgender community at large experienced discrimination within the health system (see Section 4.4.1). The fear of discrimination, coupled with the social norm that prohibits seeking sexual and reproductive healthcare from health professionals of the opposite sex places a limitation on seeking and receiving sexual and reproductive health services for transgender people.

“...it was said in the community that I may get HIV because I’m a transgender person. Living together with another man is not acceptable in our community. People look down on us. Even to get counseling and testing, it does not feel very convenient or comfortable for us sometimes, especially if the medical doctor at the clinic at is a female, I feel shy to consult with her.”

TRANS-WOMAN

The precarious social position inhabited by LGBT people may also act as a barrier to accessing appropriate healthcare when needed, while exposing them to greater health risks. The social antipathy many LGBT people in Myanmar face leaves them vulnerable to physical violence, poor job and livelihood prospects, substance abuse, and other mental health issues. All of these factors further marginalize LGBT people from healthcare access in Myanmar, one factor that is cited for Myanmar’s high HIV rate in MSM communities (10.7% in 2013). Discrimination such as that faced by many in the LGBT community in Myanmar can prevent many from receiving the information and healthcare they need. Achieving health for all will rely on ensuring that healthcare is provided in a way that is just, fair, and mutually respectful towards all people who require healthcare.

In summary, the social conditions under which people live have a tangible impact on the ability to practice a healthy lifestyle, and to seek out and receive appropriate healthcare when it is needed. The Collective Voices partners found that poor people in particular face difficulties in accessing healthcare; where the cost of care itself may be prohibitive, but also ancillary costs, such as time, travel and transport, and labor commitments acted as a financial disincentive to seek out care.

Information gaps, health education deficiencies and social norms that discourage information sharing around certain health conditions meant that Collective Voices partners found that appropriate health seeking practices were often not practiced. This was intensified in some regions by language barriers, traditions and superstitions.

Finally, certain social groups are more at risk of being excluded from social life more generally, and therefore risk marginalization from the healthcare system. Phan Tee Eain found that PLHIV and lesbian and transgender groups faced discrimination, or worried about facing discrimination, from healthcare providers. Both highly mobile people, such as migrants, and people with mobility restrictions face exclusion from community life, and risk missing out on health information sessions and other outreach.

Finally, gender plays a significant role in how people access healthcare and in health outcomes in Myanmar. Collective Voices partners found that women lacked agency when it came to making their own reproductive health choices, and they were often socially pressured to have many children. They are often economically dependent on their husbands, and therefore restricted in terms of making choices about their healthcare, or whether to stay in a potentially abusive household.

While norms are changing around women’s participation in the workforce, meaning that women are now more economically liberated than ever before, women still face expectations of performing all or most household and caregiving duties, and play a larger role in religious and community duties. Transgressing gender norms can have serious social consequences for men and women alike, including facing serious stigma and discrimination, leading to adverse health outcomes for LGBT people in Myanmar.
Conclusions and next steps

In Myanmar, there are significant inequalities in health status and in access to affordable, quality healthcare, especially in rural and hard-to-reach areas and among the poor and other vulnerable populations. Through its Collective Voices initiative, 3MDG has promoted a responsible, fair and inclusive health sector, targeting barriers that limit access to healthcare through a rights-based approach, recognizing that every person has the right to enjoy the highest attainable standard of health.

The real value of the Collective Voices findings presented in this report is in their ability to stimulate a conversation around how healthcare provision can be structured in Myanmar going forward, a country which has such incredible diversity. The Collective Voices work shows that gaining a thorough understanding of the different contexts is an important first step, particularly when articulated through the voices and perceptions of community members themselves. It also shows that local civil society organizations can play a significant role in contributing
to this understanding, shedding light on the immense diversity of social settings and health experiences in different locations across the country, and the unique and contextually-specific challenges for specific population groups.

Collective Voices stresses that health is formed within social, economic, political and environmental contexts. Investing in local organizations and bolstering their capacity is a worthwhile endeavor if we aspire to meaningful involvement of people, especially the most vulnerable, in the health planning and decision-making processes that affect their lives. Moreover, this learning-by-doing approach has the potential to build awareness, capacity and local ownership among the individuals and organizations involved, creating a stronger enabling environment for the set of positive changes needed in the health sector.

The Collective Voices findings clearly indicate that health solutions need to be tailored to different settings; that there is not one approach that can easily be applied successfully to all townships and villages alike. People have different perceptions, different priorities, different cultural and linguistic backgrounds, and different socioeconomic and gendered circumstances, all of which shape and influence their views about health service provision, their health needs and health seeking practices, and ultimately their health outcomes. It is therefore necessary to firstly understand community perspectives on the social barriers hindering access to health services, before relevant solutions can be determined.

Additionally, the Collective Voices findings suggest that fundamental changes may need to occur in the relationships between healthcare providers and the community they serve, especially the poor and marginalized, to achieve improvements in service quality, access and utilization. Further, the results provide an entry point for considering areas in which healthcare providers may need support and capacity building to enable a more trusting relationship to evolve. Again, local community-based organizations can play a valuable role here, in bridging gaps between communities, health service providers and relevant authorities.

Moving forward, the Collective Voices organizations are now testing small-scale, tailored and community-based solutions to some of the health challenges identified by communities in their project areas. While they are tackling the issues in different ways, they nonetheless share some common overall objectives, which are to:

- Empower women to make personal and family health decisions
- Improve health seeking behavior in the community
- Increase participation and engagement between healthcare providers and target communities
- Strengthen the capacity of CBO partners

The Collective Voices initiative illustrates that with the right, local actors on board, communities can be mobilized around the challenges they face, and there are increasing opportunities to receive feedback from local communities and to disseminate relevant health information to them. Positive indications are that, through flexible and locally-led approaches, community-based organizations can contribute to increased community uptake of health services by facilitating greater health awareness, knowledge of health rights, and trust between providers and people, thus integrating communities more fully and meaningfully into the health system.


Htwe, Union Minister Dr. Myint. Inaugural speech delivered by the Union Minister Dr Myint Htwe to health professionals of the Ministry of Health and officials of the Department of Sports and Physical Education at 13:00 hrs, on 1 April 2016, Ministry of Health, Naypyidaw [translation] (April 1, 2016).


