



Preliminary Findings from March 2015 Reproductive Health Assessment in the Eastern Border Region of Burma

Partners' Report

Introduction

The 2015 ceasefire in Burma (also known as Myanmar) is expected to change the political and donor environment in the country. Community Partners International (CPI), the Women's Refugee Commission (WRC), faculty of the Harvard Humanitarian Initiative (HHI) and community health organizations undertook an assessment in March 2015 on how to improve community-based sexual and reproductive health (SRH) services given the changing political situation in the region. The study sought to:

- identify key problems related to access to SRH services among rural border communities;
- assess perceived quality and consistency of existing SRH services;
- examine the successes of the Mobile Obstetric Maternal Health Workers (MOM) Project and identify areas for improvement.

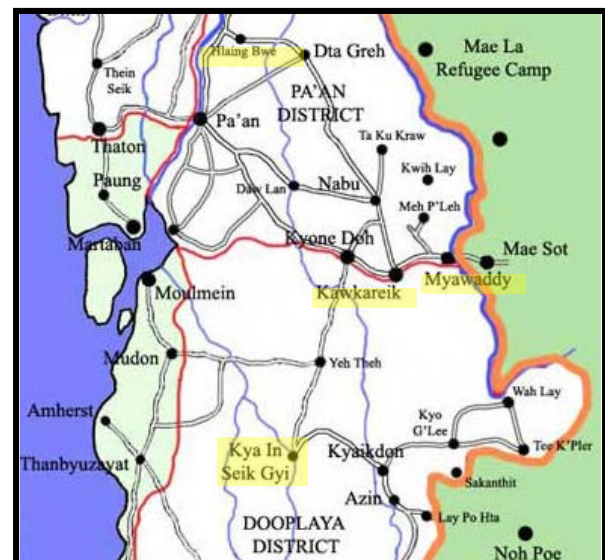
The MOM Project is a community health worker initiative that provides mobile services for antenatal care, clean delivery, postnatal care, basic emergency obstetric care, family planning and post-abortion care to roughly 124,000 people in four ethnic states in Eastern Burma.

Study locations

The study was conducted in March 2015 in Mae Sot and Chiang Mai, Thailand, and in four townships in Karen State, Burma. Three villages were selected in each township: one with an ethnic health clinic; one that was far from a clinic; and one that was close to a government military base.

Research process

The research team used focus group discussions and key informant interviews to learn the perspectives of village women, health workers and representatives of community-based organizations (CBOs) in Karen State, Mae Sot and Chiang Mai. Trained health workers from ethnic health organizations (EHOs)¹ conducted 12 focus group discussions in the 12 villages; participants were women of reproductive age (18-49 years) with children under five who were likely to have accessed SRH services. They also interviewed 12 health workers, one in each village. Staff from the WRC and HHI interviewed 20 representatives of CBOs.



¹ These EHOs are Back Pack Health Worker Team (BPHWT), Burma Medical Association (BMA), Karen Department of Health and Welfare (KDHW) and Mae Tao Clinic (MTC).

Throughout the process, the research team consulted partner organizations to include their priorities and perspectives, and to develop recommendations. Preliminary findings were shared at CPI's "Obstetrics on the Move" forum in Yangon in September 2015.

Learning

Issues around access to SRH services

- **Cost:** Women reported high costs for transport (motorbikes, motorboats, cars, taxis), medicines, contraceptives, consultation fees and food. In particular, they reported that it was extremely expensive to access a hospital. Some women also mentioned they needed to pay at checkpoints crossing from Myawaddy to Thailand, which increased their cost burdens. Where the health facility was close and services and/or medicines were free and well supplied, women said they faced few difficulties in accessing services.
- **Decision-making:** Women reported they primarily made their own decisions to seek health care. Husbands and family members played a lesser role in decision-making. Stakeholders (staff from CBOs) reported that shyness and cultural taboos prevented women who were facing complications from an unsafe abortion from seeking medical care in a timely manner.
- **Pregnancy services:** Women and stakeholders stated that the first point of contact for health care is occasionally delivery, when they see a midwife (or other health workers²). Women reported that most deliveries continue to take place at home.
- **Family planning:** Stakeholders and health workers provided mixed feedback around customs and cultural factors that influence a woman's ability to use family planning. Women who were not using family planning raised concerns about side effects. Women and stakeholders said that adolescents and unmarried women have a difficult time accessing family planning due to shame, shyness or fear. Stakeholders reported that community leaders could help parents understand the importance of providing SRH information for adolescents.
- **Supply chain:** Women noted shortages of contraceptives (pills, injections). Health workers agreed that lack of medicines, supplies and equipment prevented women from coming to the clinic.
- **Security:** Overall, stakeholders and women reported that security has improved inside Burma, which shows a major shift from the early days of the MOM Project. Several stakeholders noted they have less money for their programs, resulting in fewer trainings and follow-up activities, staffing, per diems and supplies to clinics. Stakeholders mentioned that sexual violence occurs in areas where the military is present, as well as in zones with high economic activity, including around the jade mines of Kachin State.

Perceived variability and quality of existing SRH services

- On the whole, women reported being happy with the health workers, including nurses and midwives, that they see. However, some mentioned that health workers sometimes use an impolite tone when they talk with clients. Women and stakeholders often said that government hospitals offer lower quality care than CBO clinics. Women generally reported having to purchase medicines and contraceptives at a private pharmacy if the health worker or clinic lacked supplies.

Successes of the MOM Project and areas for improvement

- **Successes:** Stakeholders said that the MOM Project was successful because of several factors, including: buy-in from leaders; remote, outreach services and field trainings; effective training of trainers model with tiered levels of workers; ability to understand the capacity of health workers; empowerment of trainers; and motivation for health workers to give back to their

² In the EHO areas, there is no cadre of midwives, but other cadres fill the gap.

communities.

- **Areas for consideration:** Stakeholders mentioned the importance of:
 - mapping services to prevent duplication of services by organizations and increase coverage;
 - assessing the field-level trainings beyond pre-/post-tests, including through direct observation;
 - better defining roles for health workers;
 - ensuring recognition/accreditation of the health workers by the Myanmar Government; and
 - ensuring the provision of birth certificates to children living in contested areas or areas controlled by nonstate armed groups. The Eastern Burma Retrospective Mortality Survey found that only 7.95 percent of children surveyed in 2013 have an official birth record.³
- **Emerging Issues:** Stakeholders reported that CBOs felt undermined in contested areas where the government is working with international NGOs to build hospitals and implement services. They also mentioned domestic violence, sexual violence/rape and trafficking as concerns. Some stakeholders and health workers were concerned about early marriage due to economic or family considerations. Lack of family planning awareness was perceived to contribute to early pregnancy.

Participant recommendations

- **Women** asked for medicines and supplies, especially contraceptives, and for their pregnancies to be managed completely. They also requested more medics/nurses and more clinics/hospitals where they do not exist, and shorter distances to free health care.
- **Health workers** requested a medic/midwife/nurse in every village. They also asked for medicines, equipment, family planning supplies and electricity for a cold chain. Other requests included the ability to manage post-partum hemorrhage, as well as food and clothes for women and children.
- **Stakeholders** noted the need to address convergence of health systems and advocate for trained health workers to be recognized by the Myanmar Government. They also noted the need for adolescent SRH and services to prevent and respond to sexual violence, especially in Kachin and Shan States. Finally, they suggested having health projects with a livelihoods component for sustainability.

Recommendations

Government of Myanmar

- Recognize the important role that EHOs/CBOs play in the provision of quality services, and officially recognize EHO workers.
- Address hidden charges to accessing essential public health services.
- Increase the government budget for health care for the entire country to improve service availability.
- Improve the quality of primary health care services at hospitals and health facilities.

Donor governments

- Continue to support innovative community-based service delivery models.
- Recognize the important role that EHOs/CBOs play in the provision of quality services and encourage the Myanmar Government to recognize EHO workers.

³ Health Information System Working Group, Eastern Burma Retrospective Mortality Survey, 2015.

- Maintain technical expertise to EHO areas, and engage with EHOs to better understand the situation at the community level.
- Enable flexible, multi-year funding to ensure service coverage, especially in remote regions.

Implementing organizations (CBOs, EHOs and/or INGOs)

- Provide comprehensive services that address SRH, nutrition, immunizations, adolescent health, gender-based violence (GBV) and other services.
 - Ensure that supply chain management and stock analysis systems are functioning so that medicines are available in clinics every time they are needed.
 - Identify and engage with partners for expanded program on immunization (EPI) programs in all catchment areas.
- Incorporate indicators on GBV into routine monitoring and evaluation (M&E) systems and report on this regularly.
- Assess staffing needs and devise a plan to train staff and place them in the field.
- Assess workforce retention; identify reasons why health workers leave their jobs and develop and implement interventions to resolve this challenge.
- Ensure that village health education programs include adolescent health.

Next steps

CPI, WRC and HHI are sharing the findings at local, regional and global forums to draw attention to the continued need to support community-based SRH services, as well as leverage more support for partners to implement the recommendations. We also aim to publish the findings, with contributions from partners.

Limitations

Due to time and logistical constraints, only one group discussion and one health worker interview could be conducted in each village. This limited the amount of information that could be collected. Further, the type of health worker or who they worked for was not always clear when women mentioned them in the discussions, which made it difficult to interpret some of the information.

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