

The background of the page is a light gray color with a repeating pattern of small, stylized birds in flight, scattered across the entire surface. The birds are depicted in various orientations, suggesting movement and flight.

**Improving Sexual and
Reproductive Health and Rights
in Cambodia and Myanmar:
The Roles of Community
Engagement Policy and
Implementation**



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Abstract

Community engagement has been advocated as a policy tool to empower community in health planning and provision of public health services. Yet literature about implementation and

its impact is limited. This research attempts to examine the role of community engagement in improving awareness and access to sexual and reproductive health and rights in Cambodia and Myanmar. This study is qualitative based on literature review and primary qualitative data from key informant interviews and focus group discussions. Twenty seven key informant interviews and 17 focus group discussions were conducted in two health districts in Cambodia and two townships in Myanmar. Cambodia has long implemented community engagement policy and community mechanisms had been established nationwide. In contrast, Myanmar has no policy on community engagement. Information from interviews with health authorities indicates that in both countries, the implementation varied by health district and existence of community health interventions. Community mechanisms were important in improving information exchange, mobilizing populace support of public health services and health schemes and serving as community health resources in health education and referral. In Cambodia impact of community mechanisms on sexual reproductive health and rights (SRHR) was more pronounced, less so in Myanmar. Community mechanisms have made valuable contributions to improving SRHR. Myanmar needs a policy on community engagement. Impact of community mechanisms could be enhanced with strong implementation and support.

Keywords: community engagement, sexual and reproductive health and rights, information exchange, populace support of public health services

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Introduction

The right to health is stated in article 25 of the 1948 Universal Declaration of Human Rights as part of the right to an adequate standard of living. Right to health includes the right to prevention, treatment, and control of diseases as well as the right to equal and timely access to essential medicines and basic health services, to maternal, child and reproductive health. Sexual and Reproductive Health and Rights (SRHR) encompasses the right of all individuals to make decisions concerning their sexual activity and reproduction free from discrimination, coercion, and violence (United Nations, 1995). SRHR encompasses a wide range cross-cutting issues and services, including contraceptive information and services; maternity care; prevention and appropriate treatment of infertility; safe abortion and post-abortion care; prevention, care, and treatment of sexually transmitted infections, HIV/AIDS, reproductive tract infections, and reproductive cancers; information, education, and counseling; prevention and surveillance of violence against women, care for survivors of violence; and actions to eliminate harmful traditional practices such as FGM and early and forced marriage (International Planned Parenthood Federation (IPPF), 1996). Specifically, access to SRHR ensures individuals are able to choose whether, when, and with whom to engage in sexual activity; to choose whether and when to

have children; and to access the information and means to do so (UN Foundation, 2016).

Disparities in SRHR in Asia are pronounced, with the need for SRHR services heavily concentrated in Southern and Southeastern Asia. These two regions are home to 57 percent of Asian women of reproductive age (15–49) but accounting for 88 percent of maternal deaths and 83 percent of newborn deaths in Asia as a whole (2014).

Sexual reproductive health and rights are particularly important issues among migrant workers. The sexual and reproductive health and rights of women migrant workers are often subject to regulation by both countries of origin and destination. Mandatory pregnancy testing and control of migrants' sexuality and reproduction by conditions of their employment are widespread discriminatory health practices in South-East Asia (International Labour Organization (ILO), 2016).

As part of efforts to improve public health services, engagement of communities has been advocated as a policy tool to empower and incorporate voices of community members in the planning and provision of public health services. This research attempts to examine the role of community engagement in improving awareness about and access to sexual and reproductive health and rights in Cambodia and Myanmar.

Community engagement has been understudied in Low- and Middle-Income countries and little is known about various methods of implementation, enabling factors and challenges in the implementation and the potential benefits to the community. This study aims to fill this gap in evidence and to document and analyze factors influencing design and implementation of the mechanism, with a particular focus on its effect in the field of sexual reproductive health and rights.

The research attempts to provide answers to the following questions: First, what are community engagement policies/mechanisms available and being implemented in Cambodia and Myanmar? Second, how and to what extent are the community engagement policies implemented in the areas of sexual and reproductive health in both countries? Third, how does the implementation of these policies/mechanisms impact on access to sexual and reproductive health services and rights?

Different forms of engagement have been used at different levels – personal, institutional, for different purposes—health service access, health outcome, financing, and with a variety of interventions including community scorecard, group, and representation. Community engagement approaches are used in a variety of ways to facilitate participation, ranging from the more utilitarian, involving lay delivery of established health programs, to more empowerment-oriented approaches and the variations highlights a paradigm shift from viewing the involvement of communities as an errant form of public health action, to seeing communities as an essential part of the public health system (South & Phillips, 2014). There are many forms and levels of community engagement, including health facility committee (McCoy, Hall, & Ridge, 2012), creating and linking health structures and community (Kaseje et al., 2010), improving dialogues between community and providers, facility planning and community health monitoring (Björkman & Svensson, 2010) and community health workers (Manandhar et al., 2004; Vaughan et al., 2015). Participatory approaches with dialogue and accountability mechanisms linking patients to providers can result in improved health care quality and outcomes (Ciccone, Vian, Maurer, & Bradley, 2014). Research in

public engagement is found to be critical in identifying processes of engagement and ensuring support in the implementation, for example, in Vietnam social research was used to design a community engagement framework for a new dengue control method led to more sensitive, thorough, culturally comprehensible and ethical consultation processes (McNaughton and Duong, 2014).

Engagement of community in health programs is influenced and challenged by several factors, including perspectives and perceptions of community participation, limitations of the necessary supportive systems, the structural and cultural factors of marginalization, community stratification and organization, mobilization, and the political context (Woelk, 1992). A review of background papers on Bangladesh, Pakistan, Cambodia, Ghana, and Tanzania suggests that equity in access to health services largely depends on a system that ensures a combination of facility-based service delivery and outreach services with a functioning referral network (Talukder & Rob, 2010).

Cambodia

Cambodia is a Southeast Asia country with a population of 15 million, 60 percent of which are under 30 years of age (National Institute of Statistics, 2015). With an annual growth rate of 7 percent in the last decade, Cambodia has become a lower-middle-income country in 2015 with a Gross National Income of USD 1077 per capita and poverty rate reduced to 17 percent in 2012 (World Bank, 2016). Cambodia's health system comprises three levels: the central Ministry of Health (MOH) and subsidiary departments, national centers and hospitals; the provincial; and the district where front-line service delivery takes place in referral hospitals and

primary care centers. Cambodia has 88 Operational Districts, 97 referral hospitals, 1105 primary health facilities called health centers (HCs), and eight national hospitals (Ministry of Health (MOH), 2015a). Cambodia's public health system is weak and quality of public health services is limited. About one-third of the first contact for healthcare takes place in public sector facilities (National Institute of Statistics, 2015). Despite remarkable progress in the health sector, population health outcomes remain poor. Table 1 shows population health and health services indicators of Cambodia and Myanmar. Rights to health are enshrined in the Constitution of Cambodia. Article 46 of the constitution says that "A woman shall not lose her job because of pregnancy. Women shall have the right to take maternity leave with full pay and with no loss of seniority or other social benefits. The state and society shall provide opportunities to women, especially to those living in rural areas without adequate social support, so they can get employment, medical care, and send their children to school, and have decent living conditions" (Council for the Development of Cambodia, 2017).

Cambodia has implemented a policy for community involvement since the 1990s. Two primary mechanisms are employed for engaging communities such as village volunteers called Voluntary Health Support Group (VHSG) and Health Center Management Committee (HCMC) (MOH, 2008). Through the two mechanisms communities have been involved in a wide range of health interventions, including dengue service provision (Khun & Manderson, 2008), malaria surveillance (Cox et al., 2014; Yasuoka et al., 2012), tuberculosis case finding (Lorent et al., 2015b; Lorent et al., 2015a), promotion of uptake of antenatal care, facility delivery and referral to hospitals (Skinner & Tung, 2009), HIV/AIDS prevention

and responses (Thomson et al., 2012; Chang, Kong, Phal, Pugatch, & Allen, 2010) and health service financing (Jacobs and Price, 2003). In a project using the human rights-based approach to improve quality of health services VHSG and HCMC were engaged in capacity building and community mobilization in community outreach and education related to client's and provider's rights (Deutsche Gesellschaft für International Zusammenarbeit (GIZ), 2009).

Myanmar

The Republic of the Union of Myanmar, located in South-East Asia, with a population of 51 million. The country is divided administratively, into Nay Pyi Taw Council Territory and 14 States and Regions. Ninety percent of the population is Buddhist. The country enjoys a rapid economic growth averaging around 7 percent annually in the last few years, and the poverty level went down to 25 percent in 2013.

Myanmar health care system evolves with the changing political and administrative system. It has a pluralistic mix of the public and private system both in the financing and provision. Health care is organized and provided by public and private providers. As of 2014, there were 1,056 public hospitals and 1,684 rural health centers (MOH, 2014a). Poor population health is among the biggest challenges for the country.

After the alleged democratic transition in 2011 in Myanmar, there have been increasing signs of the government's adopting community engagement in planning, development, and provision of health services. Community engagement is included as one of the strategic areas for the country to achieve universal health coverage

(MOH, 2014a) although the detail on the strategy is not available. The community was to be engaged in the identification of disadvantaged under-served and vulnerable populations and the preparation of the Township health plans (MOH, 2014b). Several other policy documents mention community engagement (though details are little): The National Strategic Plan for the Young People’s Health (2016-2020) (Ministry of Health and Sports (MOHS), 2015), Myanmar National Health Plan 2017-2021 (MOHS, 2017), community engagement as a strategy for promotion and delivery of RH services and information (MOHS, 2014).

In Myanmar, communities and providers were involved in consultation on issues of reproductive health and family planning (MOH, 2015b) and in health workforce planning and improvement (MOH, 2014a). Community health volunteers form one of the health workforces and are necessary for the emergency. Civil societies and International organizations, many of which have been recently allowed to operate in the country have initiated several community-based health projects and mobilize communities, support, and participation (Teela et al., 2009).

In a setting where active conflict, resource scarcity, and logistical constraints prevail, provision of maternal health services within health centers and hospitals is unfeasible, and alternative community-based strategies such as employing Lay Maternal Health Workers (MHWs) are implemented (See Table 1).

Table 1: Population health and health service indicators

Health and Health Services Indicators	Cambodia†	Myanmar
Population (million)†	15 (2015)	51.9 (2010)
Infant mortality rate (per 1,000 live births)	27	40*

Health and Health Services Indicators	Cambodia†	Myanmar
Under-five mortality rate (per 1,000 live births)	35	50*
Maternal mortality ratio (per 100,000 live births)	170	141*
Average life expectancy at birth		(2011)
Male	67	63
Female	70	67
Percentage of births attended by a skilled provider	89	60*
Percentage of people aged 15-24 who know about HIV prevention		
Male	42	18*
Female	50	16*
Total health expenditure per capita	USD 52†	USD 28**
Total health expenditure (% of GDP)	5.6%†	1.7**
Government health expenditures (as % of general government expenditures)	11.5†	3.3
MD/physician/Medical officer (per 1000 population)	.16††	.55**
Nurses/midwives (per 1000 population)	.79††	.53**
Total (%) adult literacy rate (2008-2012)	73.9	92.7
†††		

*Myanmar Demographic and Health Survey (Preliminary Results) 2015-2016; **Myanmar Health In Transition Study 2014
 † Annual performance monitoring report 2012; †† World Bank database (<http://data.worldbank.org/country/cambodia>; accessed January 10, 2017); ††† Webpage of UNICEF, accessed January 10, 2017: https://www.unicef.org/infobycountry/myanmar_statistics.html and https://www.unicef.org/infobycountry/cambodia_statistics.html

Method and Data

This article is a qualitative study based on two-country case studies. The study is based on literature review, documentary analysis and primary data from key informant interviews and Focus Group Discussions. Review of literature and documents focused on identifying existing policies and mechanisms of community engagement and health problems they intend to address, with a view of constructing a framework for collecting and analysis of data.

Data sources and research sites

Data came from two sources: policy and operational documents and primary qualitative data. The research employed key informant and focus group discussion to collect primary qualitative data.

Key informants were officials of the Ministry of Health, health districts and provincial health department (in case of Cambodia), townships and districts (in case of Myanmar), representatives of non-government organizations (NGOs) and local authorities. The officials were pre-selected because of their roles in the management of health services, and their knowledge or experience in community engagement.

In Cambodia, the interviews were conducted with 12 key informants, including community leaders, and nine focus group discussions were held with a total of 76 participants aged ranging between 16 and 60. Fifty-eight of participants were female. In Myanmar, the interviews were conducted with 15 officials (including two NGO representatives and one parliamentarian) and eight focus group discussions were held with a total of 86 participants.

Two health districts in Cambodia and two townships in Myanmar were selected as study sites. These are the locations where initiatives of community engagement in the field of sexual, reproductive health have been identified and implemented. In Cambodia, two health districts were selected as research sites: Kampot health district (Kampot province) and Angroka health district (Takeo province). Kampot district has a population of 144,000 and 14 primary health centers. Angroka has a population of 141,393 and 15 primary health centers. Research sites in Myanmar were two townships: Kyauktan (in Yangon region) and Pakokkutownship (in Pakokku district). Kyauktan has a population of 167,448 and Pakokku 290,139.

Data collection and tools

Different question guides were formulated for different respondents (their roles) in key informant interviews and focus group discussions. The questions were based on the information from the review of literature and documents and consistent with the research questions, for example, knowledge/awareness about existing policy/strategies used in community engagement; their perspectives on community engagement, assessment of the implementation of the policy, the extent of implementation, including enabling factors and challenges in the implementation.

Data were collected between May and November 2016. Researchers traveled to study sites, conducted interviews and held focus group discussions.

Analytical Framework

We crafted a framework which is the simplification of previous policy analysis frameworks (Walt & Gilson, 1994; Gilson & Raphaely, 2008; Molyneux, Atela, Angwenyi, & Goodman, 2012). We attempted to simplify the framework and made it more in line with our research theme and questions. The theoretical framework has three components which connect and interact with one another. These components are the creation and revision of policy, policy implementation, and policy impact. Policy creation and revision refers to the formulation of policy contents which encompass statements of purposes, actors involved, and manners in which community is represented, the kind of persons representing community, knowledge, and capacity required of them. Policy revision is seen as a necessary process by which policy contents are reviewed and revised with purposes to steer the direction of development and to provide a platform for new development in the field. Policy implementation is the actual operationalization of the policy contents; in this case, community involvement and power relations among stakeholders are manifested in how decisions are made and resources allocated. The impact is the application of community involvement in term of awareness among the population about reproductive health services and rights, the responsiveness of health system to community demands and demand and supply of health services in service provision, physical access, user-friendliness, and affordability.

Results

The results are structured following the component of the framework.

Cambodia

Community engagement policy and contents

The community has been recognized as an essential component of health service organization in Cambodia. The importance of community involvement in the management and use of health facility services was embedded in the MOH's documents "Guidelines for Developing Operational Districts" and "the Charter on Health Financing" formulated and endorsed in 1997. Two mechanisms were first introduced—Health Center Management Committee and Feedback Committee. In 2002, the Feedback Committee was renamed as Village Health Support Group by the Inter-Ministerial Committee on Primary Health Care. The community participation policy was revised in 2008. The objective of the policy is to "encourage community members to actively participate in the health system for the overall improvement of the health situation throughout the Kingdom of Cambodia." The policy is based on the principles of community participation: ownership/ representation, gender balanced, transparency, and partnership.

Village Health Support Group (VHSG) and Health Center Management Committee (HCMC) are the primary mechanisms for community engagement and participation in health. Table 2 describes significant roles and implementation issues of VHSG and HCMC. VHSG are two-person teams of community members whose leader (usually a chief or vice chief of a village) is elected by the community

and supported by the other member. Every village should have VHSG. The requirements for VHSG include literacy and activism in community development. The primary roles of VHSG are to represent the community, communicate health-related messages between health authorities and community and vice versa and depending on priorities to feedback and report on health-related matters, for example, disease outbreak, people's satisfaction with health services, etc. A health center has an HCMC that is made up of 10 to 11 members who are from among local authority (commune council), vice chief of the health center and another health provider, and VHSG members. The primary roles of HCMC are to ensure efficient operation of the health center through support and review of HC operational plan and mobilization of community support for health activities and schemes, such as setting up user fee table, organizing identification of the poor, etc.

VHSG and HCMC work with many stakeholders, including health authorities, health providers, local authority and development partners, i.e., NGOs active in the community (See Table 2).

	Health Center Management Committee (HCMC)	Village Health Support Group (VHSG)
Role	<ul style="list-style-type: none"> - Oversee and provide strategic guidance for overall management and development of HC services: - Maintain linkages between the HC and communities through VHSG Leaders and 	<ul style="list-style-type: none"> - Assist in the collection of health information and monitoring of village health situation, including outbreak, morbidity, mortality and populations of interest - Provision and follow up of

	<p>other CP structures and facilitate inter-sectoral coordination to promote Community Participation in health and health-related areas</p> <ul style="list-style-type: none"> - Promote healthy behaviours and Community Participation in HC activities with the VHSG - Strengthen an effective functioning of the HCMC and the VHSG 	<p>information and essential services</p> <ul style="list-style-type: none"> - Provision and follow up of essential diagnosis and treatment services (e.g. in relation to TB treatment, malaria, child diarrheal diseases, etc.) - Provision of essential commodities (e.g. certain family planning products, ORS, etc.)
<p>Implementation</p>	<ul style="list-style-type: none"> - All health centers have HCMC established - Frequency of meeting of HCMC varies, from monthly to quarterly - Constrained by lack of support to VHSG to travel and attend meetings - Pre-occupations with other activities result in frequent delay of meeting - Representative of health center (usually chief) often dominates the meeting 	<ul style="list-style-type: none"> - All villages under health center coverage have VHSG established, two to three persons per village depending on the size of population in the village - Often work on an ad-hoc basis and at the request of health centers - Receive training from health centers and health NGOs - Work with a wide range of development organizations, not limited to health

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- | | |
|---|---|
| <ul style="list-style-type: none"> - Dominant issues discussed at HCMC are related to waiting time, lack of equipment/medicine, staff behavior and lack of funding for maintenance and facility operation, and lack of fund for supporting subsidy for the poor. | <ul style="list-style-type: none"> - Primary works concern health education, dissemination of health information, mobilization of community for health activities - Incentivized with training and support for travel and sometimes financial support - Turn-over of VHSG is frequent - Activism is seasonal and varies |
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Awareness of the community participation policy among providers and health authorities is high. Provincial and district health officials cited both VHSG and HCMC as primary mechanisms to engage the community in health and encourage community participation. More commonly, among providers, local authorities, and villagers, the two mechanisms were referred to by these names. These groups appear to be familiar with the purposes and functions of the mechanisms.

HCMC is also a forum to relay information from the community to the health services in health matters. This task includes information about people's satisfaction with the health services and the need to mobilize community support for particular health scheme. A chief of health center said that

HCMC is essential as the members, such as monks or Achar/teachers, are trusted and respected in the community, and they can mobilize support from the community like raising fund to assist the poor" (KII # 10).

Most of the interviewed informants said the VHSG's roles were vital because they provided assistance to health providers and authorities in gathering and updating health information and more importantly mobilizing community support for public health services.

Policy Implementation

In interviews, the officials of Takeo and Kampot Provincial Health Departments explain that VHSG and HCMC mechanisms had been established province-wide, and frequency of implementation of their roles varied by health district depending on available funding and time commitment.

The health centers visited had HCMC members between 10 and 13. Of these members, at least two members were Chief of HC and one provider and at least one local authority from the commune office. The rests were VHSG and respected elders, including monks. In Takeo, an NGO called Buddhism for Health operated health equity fund for primary health care to support the poor and vulnerable families and ensure their access to primary health care.

Monks are particularly prominent in HCMC functioning in fund management, fund-raising and encouraging populace participation in the health scheme.

Interviews with providers and members of VHSG and HCMC indicate that all VHSG and HCMC had been oriented on their

roles and actively engaged in community health and primary health services. In areas where there are many health programs and initiatives, VHSG were more active. All VHSG served as health agents and received training on health topics, such as TB, dengue, etc. Due to the high turn-over of VHSG, not all of them had been trained in SRHR, such as STD, HIV and reproductive health including family planning and safe motherhood. The training of VHSG varies by geographic area and presence of NGO health program. For example, in Takeo, RHAC (Reproductive Health Association of Cambodia) were active in the last two or three years and trained VHSGs in family planning and safe abortion.

Information from key informants indicates that implementing community engagement requires adequate support, and supporting VHSG and HCMC varies by geographic area and financial support available. VHSG and HCMC may meet on a two- or three-month interval. Interviewed providers said VHSG receive travel support of USD2 for attending the meeting. If there are NGOs working community health in the area, the NGO usually provides support to VHSG meeting. “We had RHAC support VHSG in their works to disseminate information about family planning and safe abortion for the last few years.”

In the absence of support from NGOs, the conduct of HCMC is supported by revenue of the health center or in a combination of the revenue and health scheme such as health equity fund and NGO health program.

In the area of rights to health, many health providers based in public health facilities indicated that they had received training on client's and provider's rights as part of a health program by GIZ to educate population and providers about health rights.

Information from focus group discussions, however, indicated that population education about health rights is limited and does not sustain. In the two health districts visited, training on client and citizen rights to health has been absent for a long time since the termination of the health program supported by GIZ.

According to providers in Kampot where GIZ project promotion of human rights-based approach to health was implemented, the charter on client's rights and provider's rights-duties were formally endorsed by the MOH; the charter was also disseminated nationwide. The objective of the charter is to improve client-oriented health services, promote awareness among the population of rights to health and appropriate health-seeking behaviors, promote awareness among health providers of rights and responsibilities in delivering health services, and improve ethical practices of health service providers.

Several informants agreed that in the implementation of HCMC, health center chiefs and commune council members were perceived to be most influential in the committee as they were in positions of authority; among these, health providers and the chiefs were usually better educated. Their words had weight, and they knew how to speak and convince others. Some commune council members were quite vocal and dominated in HCMC meeting. They demonstrated confidence and leadership and health center providers had to be mindful when they spoke.

Policy impact

The impact of community engagement through VHSG and HCMC could be viewed based on health outcomes and health

services at facilities. On the demand side, the impact of the policy implementation was considered concerning the increased awareness about health issues and health services and the population's participation in public health activities. On the supply side, the impact was considered in terms of improved feedback to improve quality of health service provision, better functioning of health facility, improved staff behaviors, and better coordination for information sharing and exchange.

Many community people who participated in focus group discussions agreed VHSG and HCMC were more instrumental in raising awareness about health facilities and services, educating people about health issues and mobilizing people's support for health causes. Many noticed that VHSGs were active in community health education since they received training from NGOs or HC staff on various health topics. As part of the community work, VHSGs made essential contributions in building linkages between community and health facilities.

All the four facilities had long been established and were well known to people. However, informants and community people recalled the kinds of activities which were implemented to raise people's awareness of the health facility. The impact of community engagement is varied by facility and health district depending on the level of activism and health interventions implemented at the local level.

Several providers said awareness of health services was the first step toward having people accessing and trusting them. One way to achieve that was to have people come and try the services, as time went by people become aware of and familiar

with providers and services. Providers also credited VHSGs for their enormous contributions in outreach activities for immunization, health education and provision of vitamin supplement. VHSGs lived and worked in the villages and knew everyone there and could mobilize people most effectively.

Related to rights to health or SRH, participants in FGDs indicated limited knowledge and hesitated to speak about it. A few participants, however, seemed to indicate that health rights were being exercised in the community. “These days people are not afraid and can say things they want to when providers are rude or don’t see patients...”

Respondents seemed to have a limited understanding of reproductive health and rights. There was a term for reproductive health in Khmer. And not many respondents could elaborate on what the term meant. However, they could raise what was encompassed under reproductive health and mentioned words, such as family planning, marriage, reproduction, diseases which affect reproduction.

Among youths, there was little understanding about the concept of health as a human right. Only a few were able to elaborate about health rights. However, none could provide details about what it meant by “accessing good health services.”

Related to HCMC, many providers interviewed raised that HCMCs were most useful in improving the functioning of health facilities and quality of services. This function includes establishing user fee tables and initiating fundraising to support the poor and vulnerable families and communicating feedback from the community to improve services.

Commune councils agreed that the role of HCMC in community health development was indispensable in many

respects, such as they ensured words from community reached the facility and providers were aware of and improved their shortcomings. This role was often related to issues in waiting time and staff behaviors. Representing the community, HCMC negotiated with health providers on the prices, with consideration of the affordability, transportation cost or distance to the health facility.

Community people and providers agreed that VHSG and HCMC were active in promoting and raising fund for the scheme which pays for health services received by the poor and vulnerable.

Knowing or gaining acquaintance with the providers was said to be a factor in opting to use a service. The fact that providers were the local people in the community was always helpful in attracting users. A female provider said "We had more and more clients as people became familiar with the facility. Before we had only a few newborn deliveries a month, now we are busy almost every night with delivery".

The common health services used included antenatal care, vaccination for pregnant women, children, pregnancy check, delivery, and consultation. However, those who could afford private health services said to have used private clinics commonly for child health problems and delivery.

Accessing health services among youths seemed to be limited. Few youths involved in group discussions had ideas about what services to provide at the facility, and few reported to have used the service there. There were two main reasons for this fact. First, they rarely got sick, and when they got sick they would get medicine from a drug store and get self-treatment; second, for girls, rumors and speculations for why a girl needs to go to the facility really discouraged them from accessing the service.

Myanmar

Existence and content of policy on community engagement

Community engagement or participation was mentioned in several health policy documents. Community engagement was included as one of the strategies for Myanmar to achieve universal health coverage (MOH, 2014a). However, details about the strategy were unavailable.

There seemed to be a consensus among key informants and discussants that there was no policy on community engagement in the health sector in Myanmar. Many respondents, including medical officers and parliamentarian, said they were not aware that such specific policy exists. Some respondents said that the word was in the policy documents, but lacked elaboration.

Despite the lack of the policy, forms of community engagement that have been implemented have led some to believe that a policy exists. None of the respondents was able to refer to a policy document which provides details. Some respondents said however that community engagement policy has been in place for some time, although it has not been declared openly.

There was a strong convergence that the country needs a policy on community involvement. A provider at a private clinic said, "It is important to have community engagement mechanism in Myanmar because a policy is a guideline and can establish the systematic community feedback mechanism. If the community can engage more in health development, supply and demand will be harmonized and community satisfaction is attained."

The most common form of engagement cited was the public meeting to make announcements related to health initiatives. In Kyauktan, as respondents said, from time to time there were meetings to announce news related to health or a newly established public clinic.

Implementation of community engagement

Implementation of community engagement occurred but was limited in scale and scope, and often with the support of NGOs and IOs. Two references were made in the document "Health in Myanmar 2014" about community works includes community health volunteer with a focus on referral and assistance in delivery and township health planning (MOH, 2014a).

Community engagement was implemented on an ad hoc basis and varied by local agent implementing the activity and rule of the funding agency. Works by NGOs and development partners were limited in geographical and population coverage and range of health services. Among the non-profit sector, lack of fund was said to be a factor in limiting the reach of their projects to serve more people. A staff member of MSI said, "We did what we could with the available funding, we could not reach more people with limited funding."

Officials interviewed said, the non-profit sector was prominent in different engaging communities in the health sector. This included non-profit clinics, Myanmar Red Cross Society, and local civil society and international NGOs. Myanmar Red Cross Society had a major role in community health and

was present in all townships in the country. International NGOs were active in working with marginalized population groups and people affected by internal conflicts, for example, the Mobile Obstetric Medics project working on improving maternal health among different ethnic populations (Mullany et al., 2010), Population Services International and Marie Stopes International implementing projects related to STI, HIV/AIDS and RH health service provision through networks of private providers and RH clinics (Sudhinaraset, Diamond-Smith, Thet, & Aung, 2016).

Several respondents said few meetings of local people led by the authority were conducted in the past, and once in a while, there was the dissemination of health information conducted by INGOs, such as PSM [Population Services Myanmar].

According to informants, Myanmar Red Cross Society worked in the community and provided education on SRH using mass media, loudspeakers, and print materials. Their works were carried out through community volunteers, who received short training. Topics related to SRH in the dissemination included teen pregnancy, prevention of STI and HIV transmission, where to seek care for pregnancy and sickness.

Over time, participation and engagement of the community in health development have increased, mainly through health projects by local and international NGOs. International organizations, such as Marie Stopes International run clinics and provide sexual reproductive health services.

Charity clinics represented a significant player in health service provision, at least in townships where they were present. In Kyauktan none of the respondents in the village visited could

mention names of international organizations working on health development. However, respondents mentioned charity clinics located at the town center as places to seek care. The charity clinic was well known to villagers. In Kyauktan, with a strong sense of community, the clinics were able to organize and offer health services, with contributions in material and cash from the community and land from the local authority. The clinics offered services related to pregnancy care, delivery, diabetes care, hypertension, health education and many more. Run by volunteers, the proceeds from service payment could only keep clinics open.

In Pakoku township, Marie Stopes International was mentioned and said to offer reproductive health services and information both to youths and adults. A staff member of MSI said, “We had several clinics that teens could visit, but they had to pay. Some were not able to pay.”

Impact on awareness of, access to, and utilization of SRHR

Despite the lack of a formal policy on community engagement, the fact remains that various agencies had implemented forms of community engagement at varying intensity, awareness about sexual and reproductive health and rights varied by the township.

Respondents from the two townships demonstrated limited awareness about the rights to SRH. Very few respondents from both townships could describe what the rights to SRH meant. They had self-doubt about their understanding. A woman said, “Isn’t it meant if we can have the number of children we want” while a man said, “Is it right to say it is about health in the reproductive tract.”

When asked about right to SRH, an older person in Kyauktan township referred to Buddhist teaching that says “All living things have rights to life and good health is pre-condition for life, this includes human.” Also, in his opinion, rights to sexual and reproductive health were the same, as these were inherent to living things. This conviction seemed to be shared among old people interviewed.

There was a higher awareness of sexual and reproductive health as concepts and problems. Many respondents were able to describe examples related to sexual and reproductive health problems. SRH was understood as a concept which is new whereas SRH problems were seen as more practical terms. These problems included teen pregnancy, family planning, STI, HIV, and pregnancy care. Awareness about these problems was high among both youth and adult respondents. They were able to name like STIs and HIV, methods of prevention of HIV and STI transmission, problems associated with pregnancy, consequences of early sex, family planning, changes in body anatomy, and pregnancy care.

Common sources of information on SRH cited by respondents included peer talks, talks with older people, print materials such as health journals, magazines, and mass media such as television and billboards. Many in-school youth respondents said the school was a source of information.

Private clinics or self-medication were the sources of care, according to many community people who participated in group discussions.

Related to SRH, many respondents met expressed the need for greater availability of public health services and information. They said the current public health services were limited in a

range of services and availability and the information about the service was not available. The need included abortion, sexuality education, and counseling. A medical officer said, “the services do not cover all the needs of adolescents such as a terminal abortion for unwanted pregnancy and this type of services is not available.”

The lack of public health services for young people was reflected in the words of a 27-year old nurse, "... we provide health care in term of preventive, promotional, curative and rehabilitative for young people in our health center, but due to limited budget and human resources, a specific program for adolescents was not functioning well."

Many youths and community people agreed that constraints in accessing SRH seemed a principal problem, this included lack of public health facilities and services and providers, long distance to facilities and road conditions. Moreover, confidentiality was cited as a major factor in the decision to access public health services and needed to be improved. Convenience was another factor in accessing health services. Convenience here is in term of ease of access, with short waiting time and friendly staff. In the words of an 18-year-old girl, "I prefer clinics and private hospital; it is quite convenient [to access]."

Discussion

This research explores the roles of community engagement in improving sexual and reproductive health and rights in Cambodia and Myanmar. Literature indicates that engagement of community is essential in planning and creating effective and lasting community health interventions, either in public or private non-profit sector.

There are similarities and contrasts between the case of Cambodia and Myanmar in term of existence and implementation of community engagement policy in the two countries. Community engagement activities have been implemented in both countries, although the scale of implementation differed.

In term of policy on community engagement, Cambodia has a policy on community involvement and has fully implemented it whereas Myanmar does not have an official policy on the community engagement. The Cambodian policy provides detailed guidance on how the mechanisms such as VHSG and HCMC are established and their roles in health development (MOH, 2008). The engagement mechanisms were followed and the establishment of mechanisms, VHSG and HCMC was nationwide and had been utilized in all activities involving community health, including in sexual reproductive health and rights.

In Myanmar, the term community engagement is mentioned in several policy documents (MOH, 2014a) although details on implementation and forms of engagement are not elaborated. Instead, the main activities are mentioned, such as maternal community volunteers. Such absence of clear policy on community engagement may mean a lack of guidance in this area and leave some officials unsure of what to do with the community. In Myanmar, the scale of implementation of engagement activities also varied by the support. For example, the only township with the support of international partners has been actively incorporating community involvement as part of the community health/planning project (Watt et al., 2016). Support by international partners to community health and health system strengthening is limited, and the inadequate government

health budget does not allow long engagement of community as desired (Sommanustweechai et al., 2016).

In both countries, the lack of budget and human resources were important factors limiting the implementation of community engagement mechanisms. In Cambodia, although the community mechanisms have been established, their functions have not been implemented fully. Most often, they are active in their role when requested by the health authority or when there is support from NGOs. Similarly, in Myanmar, the limit in health budget allows partial scaling up of community health volunteers.

There were complex dynamics and power relations between stakeholders in the community engagement in Cambodia. This complication is caused by differences in education and links to institutions with power. Commune councils have been empowered to coordinate works across sectors and are central commands of local authority supposedly coordinating works of all sectors, including health.

The awareness about rights to health and reproductive health seems to be limited among the population in both countries. This limitation may have been due to the lack of enthusiasm to talk about this topic as it is often viewed as taboo in both of these conservative societies.

Buddhism was referred to as the source of knowledge about rights to health among elderly respondents in Myanmar. However, this was not the case among Cambodian respondents who were also Buddhist. Many respondents find the interpretation that all living things have inherent rights to health as part of the basic necessity for a living is logical and convincing. This interpretation suggests

that Buddhism teachings have had some impact on the understanding of rights to health among the population. In Cambodia, the increase in knowledge about rights to health in Cambodia has occurred thanks partly to many years of support and interventions by NGOs and IOs, with the support of the government policy, and the social media. Given the dominance of Buddhism in both countries, health programs could leverage and integrate Buddha's teachings in promoting understanding about health rights.

Understanding about SRH is poor and abstract at best, and people can relate more knowledgeable when referring to SRH services, such as family planning, treatment of STIs, care for reproductive tracts, etc. This shallow understanding suggests the lack of education in this area and the need for a more systematic education in this area both for those in school and community people.

There is a substantial similarity in access to and utilization of SRH services in both countries. In Cambodia, community mechanisms are crucial in mobilizing community support and encouraging the use of SRH services as more public health facilities have been built and more facilities rendered youth-friendly (MOH, 2015a) making access to health services more convenient. In Myanmar, change in political system has attracted external support, and many community projects have been implemented to improve the uptake of SRH services and information (Suk, 2016; Sommanustweechai et al., 2016).

Limitations

This study had some limitations. First, only two sample districts and counties among many were chosen for each country.

Clearly, the results were not representative, but only indicative of SRH situations and community engagement in the countries, as there were variations across the districts and counties. Secondly, as this was a qualitative study, showing the impact of implementation of community engagement policies on access to and utilization of SRH health services was not possible. The method was chosen partly because of the lack of baseline data on SRH situations. In the case of Cambodia, there was a consensus among health officials and community people that community engagement contributed to improved SRH through increased exposure to information and knowledge, interactions around SRH topics and referral to SRH services.

Conclusions

Various forms of community engagement have been implemented in both Cambodia and Myanmar and contributed in a significant way to the development of sexual and reproductive health and rights in the countries. In both countries, awareness about sexual and reproductive health and rights among the populations and resources for these areas vary by geography and by the support of the government and international partners. Cambodia's community engagement policy is the essential part of the community health contributing to a reduction in maternal and child mortalities and prevalence of HIV and STIs. There is a need for an emphasis on rights to health and reproductive health and SRH education and services among youths. In Myanmar, community health is to some extent hindered by the lack of community engagement policy. There is a need for improvement in information about reproductive health services and access to and utilization of these services, particularly among youths.

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