

CHAPTER II

LITERATURE REVIEW

The purpose of this research study was to explore the factors that influence rural women's access to reproductive health services as well as to plan appropriate interventions that can improve access to reproductive health care in Kun Hing Township in the southern Shan State, Burma/Myanmar. The researcher reviewed documents in a step by step order as follows:

2.1 Reproductive health: a human right

Reproductive health is fundamental to the social and economic development of communities and nations and is at the core of human development (WHO, 2003). The Programme of Action adopted by consensus at the 1994 International Conference on Population and Development (ICPD) brought in a paradigm shift from actions aimed at achieving specific demographic targets, to those focused on attainment of reproductive health, through a holistic and coherent framework, guided by the principles of human rights, equality, and gender equity. At ICPD and at the 5-year follow-up session (ICPD+5) convened by the United Nations, governments committed themselves to providing access to reproductive health care to all individuals of appropriate age no later than 2015. The adoption of the Programme of Action marked the beginning of a new era in which governments and international agencies would advocate for reproductive health and rights and for improved quality of care (UNFPA, 1994).

2.1.2 Definition of reproductive health

The 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women held in Beijing expanded the right to family planning to include the right to better sexual and reproductive health. Building on the World Health Organization's definition of health, the Cairo Programme defines reproductive health as: "state of

complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases" (Glasier, 2006, Türmen, 2009) .

2.2 Definition of Universal access

Universal access means that basic health services and information are available, accessible and acceptable to meet the different needs of all individuals. This requires that people can safely reach health service delivery sites without travelling long distances or spending a great deal in transit from their homes to the health facilities. Universal access also means that individuals with disabilities can easily access buildings. Services and treatment must be affordable, and based upon the principles of equity; so that poor people do not bear a higher burden of health costs in comparison to wealthier segments of society. The provision of health care should also be sensitive to social and cultural considerations, including gender, language, and religion.

Universal access requires that health services are of adequate quality (i.e. with respect to availability of skilled medical personnel, approved drugs and equipment that have not reached their expiration dates, and proper infrastructure including safe water and sanitation). It also implies that health service providers do not discriminate on the basis of sexuality, gender,

ethnicity, and/or age. In many countries perceived poor quality of services, inappropriate treatment, and discrimination by health professionals deter many people from using available health services.

Universal access to SRHR (Realizing Rights and Health & Development Information Team) encompasses access to information and services on prevention, diagnosis, counseling, treatment and care. In rural areas, of the Shan State, communities rarely have access to the above mentioned types of information and services (Realising Rights Consortium, 2006).

2.2.1 Definition of Access

“Access” consists of at least five components with respect to the provision of health services. These include availability, affordability, acceptability, appropriateness, and quality. All five components are applicable to the key elements of reproductive health care. The latter includes family planning; maternal and newborn care; prevention and management of unsafe abortion; prevention and management of reproductive tract and sexually transmitted infections (RTI/STIs), including HIV/AIDS; and the promotion of healthy sexuality. The multi-dimensional nature of reproductive health care can make it difficult to ensure consistent and harmonized reporting of progress towards “Universal Access”. Access to reproductive health care is a multi-dimensional concept with multiple determinants. “All countries should strive to make accessible, through the primary health care system, reproductive health care to all individuals of appropriate ages as soon as possible and no later than 2015” (WHO/UNFPA, 2003). Regarding the 5 components of access, that frequently apply to most remote areas, certain RH services will be available while other services will be not available [e.g. in many villages one can buy oral contraceptives from local “drug shops” and/or from AMWs who live and work in their community]. Contraceptive pills, used in the Shan State, are often imported from China and India, while some are produced in Myanmar. As such instructions, on how to properly use these contraceptives, are often in Chinese and/or English. This makes it very difficult for rural women to follow the instructions and/or to take certain measures if they encounter specific adverse side effects from the contraceptives. Contraceptive pills that are imported from China are usually cheap and affordable, but villagers cannot read the Chinese instructions. Another problem is that local “drug shop” personnel do not know how to adequately store or maintain contraceptive pills, and

as such the quality and efficacy of these products can deteriorate even before they are purchased by the interested client.

2.2.2 Accessibility to Health Care Services

Equity in health as “reducing unfair and avoidable disparities in health outcomes between groups, and ensuring access to equitable health care on the basis of need” (WHO, 1996).

Access to health care services is the process intimated from the need for health care to contacting and using health services (WHO, 1978).

“Accessibility is the number or proportion of the given population that can be expected to use a specified facility, service, etc., given a certain barrier to access, which may be physical (distance, travel, time), economic (travel cost, service fee, time cost) or special and cultural (language) barriers.”

- (1) **Geographical accessibility:** this is the transportation, travel time, the physical distance from living place of people to the primary care facility. This distance is measured not only by how far but also by how difficult, how long to reach it, because the characteristics of the distance are reflected by the process of going to the health facility.
- (2) **Functional accessibility:** it is the process and method of managing of care for those who need it. The ways that care is delivered to patients affect the accessibility to care.
- (3) **Financial accessibility:** it is the payment for the use of services. The amount of payment is the means of measurement only when one relates it to the ability to pay by people. Financial access also relates to time and money spent to reach health services. Time means cost since patients have to sacrifice their earning time to arrive at the intended health services.
- (4) **Cultural accessibility:** it relates to the appropriateness of methods used with the cultural patterns of the community (Tun Linn Thein, 2008).

2.3 Reproductive health in Myanmar

Approximately 37% of currently married women are using a method of contraception, including traditional methods. Method failure appears to be a common problem in Myanmar, as 37% of women seeking treatment for complications of abortion reported contraceptive use at the

time the pregnancy occurred (UNFPA Myanmar, 2002). The proportion of married women who use modern contraceptive methods has increased to 38.4 percent in 2007 (UNFPA Myanmar, 2009).

2.3.1 Reproductive health in rural areas

Poverty can often be used to describe the situations of many women living in rural areas in many developing countries. The relationship between poverty and poor health is a well-documented phenomenon, and yet, one that shouldn't be assumed. Wealth creates more access to finance and other resources and makes a difference in nutritional intake, water and food quality as well as an explanation for better environmental conditions. Non-medical determinants of health are equally important in understanding the health status of women in the reproductive ages and public health practitioners must include these in their planning and programs that are geared towards health promotion in this age-gender and area specific cohort. (Paul Andrew Bourne, Joan Rhule, 2009).

In Myanmar each township has approximately five rural health centers. As well as providing services, rural health centre staff oversee the services provided from four or five sub-rural health centres. In addition, voluntary health workers, auxiliary midwives, and community health workers provide services at the village level. In addition to public health services, private general practitioners are active in most urban areas. There are many private drug shops in urban areas and even in rural areas, small shops often sell a limited range of drugs. Traditional medicine practitioners and informal health care providers also serve the population (WHO, 2005).

One of the problems in conducting research in many areas of Myanmar, especially with respect to rural or remote communities, is the lack of reliable data and/or access to journal articles or special reports dealing with health conditions in these geographic areas. Much of the health data presented in government [e.g. MoH] or international agency [e.g. UNDP, UNICEF, and UNFPA] documents are highly incomplete or unrepresentative of the overall health situation within Myanmar. Most health facilities, for example, are located in large towns or cities; especially in the "ethnic states" such as the Shan State. As such a very small number of patients/clients actually make use of these facilities due to the poor quality of care, the "pay-for-

service nature" of treatment even for very poor patients, and the far distances villagers have to generally travel from their homes to reach these urban-based health facilities.

In many areas of the country, including much of the Shan State, the central government does not operate mobile or outreach health services for rural communities, even with respect to preventive and promotive health services such as immunizations and family planning. In brief there is really little, if any, accurate or reliable data concerning rural health conditions, and their affect on RH status, in the Shan State. This study will be one of the first efforts to obtain a better understanding of RH health issues and problems, as well as the services available, in the Shan State.

2.3.2 The Physical Setting of the Reproductive Health Survey "Study Area":

Kun Hing Township, located in Loilem district, has an estimated population of 56,415 of whom approximately 65 % are female. Local health workers, who served as interviewers for this RH survey, claimed that there may be more than 600 rural villages scattered throughout Kun Hing Township. Their "geographic area", located in the south-central portion of the township, contained 8 "sub-districts" or "tambols" that included approximately 90 rural communities.

The road communications network between villages and the township center, and/or between different villages, is quite poor as the area generally does not have any paved roads. Most roads, in fact, are narrow paths or "village tracts". Traveling becomes very difficult during the rainy season when thoroughfares become flooded or covered in a thick layer of mud. Most villagers use ox-carts or bicycles to travel from place to place. Very few families own motorcycles or other means of motorized transportation. The most common means of transportation is traveling by foot. In the rainy season villagers can travel only on foot or by ox-cart. In certain sections of the "survey target area" local residents can also travel by small boats. These small vessels are powered by oars and not by outboard motors or engines.

Most communities in the "survey target area" do not have easy access to the outside world. Although some villages have access to public pay telephones, most do not. In one village in the "survey target area" the only "pay telephone line" is owned by one of the local residents. Even in those communities where one has access to a public telephone, the reception is usually

poor. In more recent times, however, some villagers have purchased mobile telephones, but this group probably represents a very small percentage of the people living in the "survey target area".

Like many communities in the Shan State, the villages included in the "survey target area" are rural. Some of them are quite remote from the township center. Villagers generally do not have access to clean/safe potable water. Villagers living near the Pang River or other local streams usually use these water sources for their daily needs as well as for agricultural purposes. Most households have not constructed sanitary latrines and use the near woods, fields, and forests for this purpose. Where a latrine has been constructed it is generally a "pit-latrine".

Nearly all adult villagers are farmers or engaged in other agricultural activities throughout much of the year, depending upon the season. The principal crops, in the "survey target area", are irrigated and upland rice [both the glutinous and non-glutinous variety], garlic, groundnuts, sesame, soybean, maize, and various vegetables grown in kitchen gardens. Villagers generally do not plant fruit trees as commercial crops, but many households nevertheless have different kinds of fruit trees in their garden [e.g. mango, jackfruit, banana, pomelo, tamarind, guava, etc.] that family members consume throughout the year. One of the major reasons that local residents do not systematically plant more agricultural products is that villagers do not have access to large markets and so it is difficult for them to sell their crops. Villagers can usually only exchange and/or sell their goods within their own village or in nearby communities, as well as the small township/sub-township centers.

2.4 The Health Care Delivery System in Myanmar

The Ministry of Health (MoH), at the central level, is composed of 7 departments. This includes health, health planning, medical sciences, traditional medicine, and 3 departments of medical research. The largest department is the Department of Health (DoH) which employs 93% of the MoH's personnel and represents 74% of the MoH's expenditures. The DoH is responsible for preventive, promotive, curative, and rehabilitative care, as well as supervising state, division, and township level health departments and hospitals and clinics. The "organogram" drawn-up by the Ministry of Health, in Nyapyidaw, is quite different from that which is found "on the ground" in many townships in the Shan State. According to the MoH each state/division, as well as district and township, has its own "health department". Township

health departments are responsible for providing curative, preventive, and promotive care. Township hospital staff provide curative health care as well as training for health workers, while health assistants (HAs) and health nurses, at the township health departments, are responsible for preventive and promotive health care. Each township is supposed to have “station hospitals” located at strategic areas within the township, as well as 4-5 rural health centers (RHCs). The RHCs are staffed by a health assistant, a public health supervisor (PHS), a lady health visitor (LHV), and a midwife that are trained in public health and primary health care (PHC). Below the RHC level are 4-5 sub-RHCs each with a midwife and public health supervisor. The sub RHCs are supposed to provide health care to a cluster of 5-10 villages which have a network of Village Health Workers (VHWs) that are trained to assist sub RHC staff.

The VHWs generally consist of Auxiliary Midwives (AMWs) and CHWs who are trained for 6 months but who are nevertheless considered to be volunteers, that do not receive any financial remuneration. The AMWs are allowed to assist with home deliveries, but are not authorized to administer any injectable medication. Although health services are “free”, as part of MoH policy, since drugs are often not available in adequate quantities in public health institutions, patients are compelled to purchase their own medical supplies/drugs from the market. Thus according to a WHO report, private expenditure on health care in 2003, as a percentage of all health expenditures in Burma, came to 80.6%. This means that for every 100 Baht spent on health care, the government spent 19 Baht while individual patients and/or their families spend 81 Baht. Healthcare spending in Myanmar is primarily being paid for by out of pocket (OOP) costs by the general public. According to IPSOS Business Consultation report regarding health care in Myanmar in 2013, OOP payments accounted for 92.7% of the total healthcare expenditures.

2.5 PRECEDE model

This model developed by Green and Kreuter in 1974 which based on a theoretical foundation that addresses comprehensive assessment and program planning. The PRECEDE-PROCEED model provides a comprehensive structure for assessing health and quality-of-life needs and for designing, implementing, and evaluating health promotion and other public health programs to meet those needs. PRECEDE (Predisposing, Reinforcing, and Enabling Constructs in

Educational Diagnosis and Evaluation) outlines a diagnostic planning process to assist in the development of targeted and focused public health programs. PROCEED (Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development) guides the implementation and evaluation of the programs designed using PRECEDE.

PRECEDE consists of five steps or phases (see Figure). Phase one involves determining the quality of life or social problems and needs of a given population. Phase two consists of identifying the health determinants of these problems and needs. Phase three involves analyzing the behavioral and environmental determinants of the health problems. In phase four, the factors that predispose, reinforce, and enable the behaviors and lifestyles are identified. Phase five involves ascertaining which health promotion, health education and/or policy-related interventions would best be suited to encouraging the desired changes in the behaviors or environments and in the factors that support those behaviors and environments.

PROCEED is composed of four additional phases. In phase six, the interventions identified in phase five are implemented. Phase seven entails process evaluation of those interventions. Phase eight involves evaluating the impact of the interventions on the factors supporting behavior, and on behavior itself. The ninth and last phase comprises outcome evaluation—that is, determining the ultimate effects of the interventions on the health and quality of life of the population.

In actual practice, PRECEDE and PROCEED function in a continuous cycle. Information gathered in PRECEDE guides the development of program goals and objectives in the implementation phase of PROCEED. This same information also provides the criteria against which the success of the program is measured in the evaluation phase of PROCEED. In turn, the data gathered in the implementation and evaluation phases of PROCEED clarify the relationships examined in PRECEDE between the health or quality-of-life outcomes, the behaviors and environments that influence them, and the factors that lead to the desired behavioral and

environmental changes. These data also suggest how programs may be modified to more closely reach their goals and targets.

Among the contributions of the PRECEDE-PROCEED model is that it has encouraged and facilitated more systematic and comprehensive planning of public health programs. Sometimes practitioners and researchers attempt to address a specific health or quality-of-life issue in a particular group of people without knowing whether those people consider the issue to be important. Other times, they choose interventions they are comfortable using rather than searching for the most appropriate intervention for a particular population. Yet, what has worked for one group of people may not necessarily work for another, given how greatly people differ in their priorities, values, and behaviors. PRECEDE-PROCEED therefore begins by engaging the population of interest themselves in a process of identifying their most important health or quality-of-life issues. Then the model guides researchers and practitioners to determine what causes those issues—that is, what must precede them. This way, interventions can be designed based not on speculation but, rather, on a clear understanding of what factors influence the health and quality-of-life issues in that population. As well, the progression from phase to phase within PRECEDE allows the practitioner to establish priorities in each phase that help narrow the focus in each subsequent phase so as to arrive at a tightly defined subset of factors as targets for intervention. This is essential, since no single program could afford to address all the predisposing, enabling and reinforcing factors for all of the behaviors, lifestyles, and environments that influence all of the health and quality-of-life issues of interest (GREEN and LAWRENCE).

Therefore, when considered together, PRECEDE-PROCEED has nine phases. The first five phases are diagnostic, addressing both educational and environmental issues. These include: phase (1) social diagnosis, phase (2) epidemiological diagnosis, phase (3) behavioral and environmental diagnosis, phase (4) educational and ecological diagnosis, and phase (5) administrative and policy diagnosis. The last four comprise implementation and evaluation of

health promotion intervention. These include: (6) implementation, (7) process evaluation, (8) impact evaluation and (9) outcome evaluation.

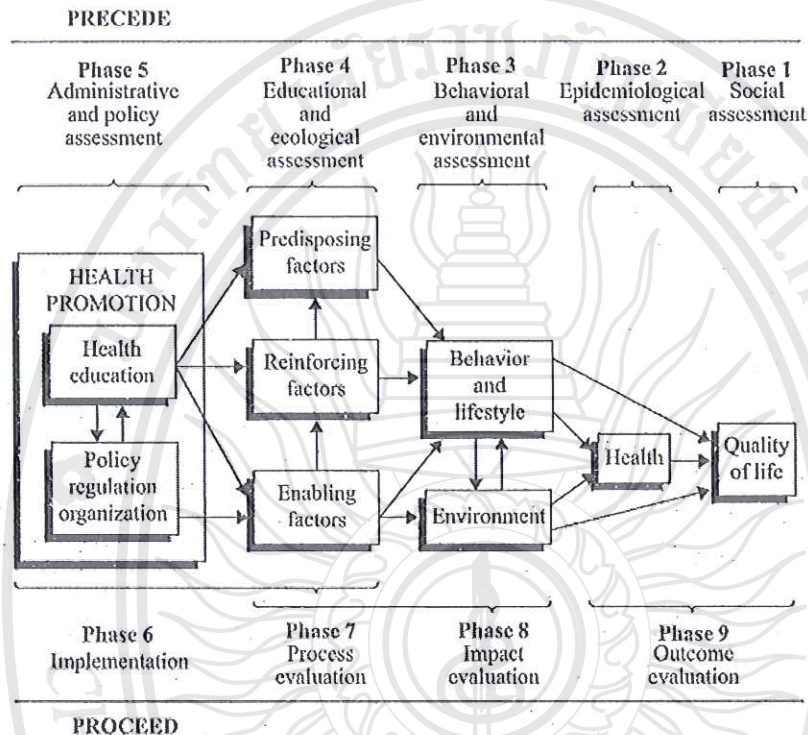


Figure: The PRECEDE-PROCEED planning model (Green & Kreuter, 1991, 1999)

Phase 1: Identifying the ultimate desired result. The first phase in the program planning phase deals with identifying and evaluating the social problems that have an impact on the quality of life of a population of interest. Social assessment is the “application, through broad participation, of multiple sources of information, both objective and subjective, designed to expand the mutual understanding of people regarding their aspirations for the common good”. During this stage, the program planners try to gain an understanding of the social problems that affects the quality of life of the community and its members, their strengths, weaknesses, and resources; and their readiness to change. This is done through various activities such as developing a planning committee, holding community forums, and conducting focus groups,

surveys, and/or interviews. These activities will engage the audience in the planning process and the planners will be able to see the issues just as the community sees those problems.

Phase 2: Epidemiological diagnosis – Epidemiological assessment deals with determining and focusing on specific health issue(s) of the community, and the behavioral and environmental factors related to prioritized health needs of the community. Based on these priorities, achievable program goals and objectives for the program being developed are then established. Epidemiological assessment may include secondary data analysis or original data collection. Examples of epidemiological data include vital statistics, state and national health surveys, medical and administrative records etc. Genetic factors, although not directly changeable through a health promotion program, are becoming increasingly important in understanding health problems and counseling people with genetic risks. They may be useful in identifying high-risk groups for intervention.

Behavioral diagnosis – This is the analysis of behavioral links to the goals or problems that are identified in the social or epidemiological diagnosis. The behavioral ascertainment of a health issue is understood firstly through those behaviors that exemplify the severity of the disease (e.g. tobacco use among teenagers). Secondly, through the behavior of the individuals who directly affect the individual at risk (e.g. parents of the teenagers who keep cigarettes at home), and thirdly, through the actions of the decision-makers that affects the environment of the individuals at risk (e.g. law enforcement actions that restrict the teen's access to cigarettes). Once behavioral diagnosis is completed for each health problem identified, the planner is able to develop more specific and effective interventions.

Environmental diagnosis – This is a parallel analysis of social and physical environmental factors other than specific actions that could be linked to behaviors. In this assessment, environmental factors beyond the control of the individual are modified to influence the health outcome. For example, poor nutritional status among school children may be due to the

availability of unhealthy foods in school. This may require not only educational interventions, but also additional strategies like influencing the behaviors of the school's food service managers.

Phase 3: Identifying and setting priorities among health or community issues and their behavioral and environmental determinants that stand in the way of achieving that result, or conditions that have to be attained to achieve that result; and identifying the behaviors, lifestyles, and/or environmental factors that affect those issues or conditions.

Phase 4: Identifying the predisposing, enabling, and reinforcing factors that can affect the behaviors, attitudes, and environmental factors given priority in Phase 3. Once the behavioral and environmental factors are identified and interventions are selected, the planners start to work on selecting factors that if modified, will be most likely to result in behavior change and sustain this change process. These factors are classified as predisposing factors, enabling factors, and reinforcing factors. Predisposing factors are any characteristics of a person or population that motivates behavior prior to or during the occurrence of that behavior. They include an individual's knowledge, beliefs, values, and attitudes. Enabling factors are those characteristics of the environment that facilitate action and any skill or resource required to attain specific behavior. They include programs, services, availability and accessibility of resources, or new skills required to enable behavior change. Reinforcing factors are rewards or punishments following or anticipated as a consequence of a behavior. They serve to strengthen the motivation for behavior. Some of the reinforcing factors include social support, peer support, etc.

Phase 5: This phase focuses on the administrative and organizational concerns, which must be addressed prior to program implementation. This includes assessment of resources, development and allocation of budget, looking at organizational barriers, and coordination of the program with all other departments, including external organizations and the community.

Administrative Diagnosis - to assess policies, resources, circumstances, prevailing organizational situations that could hinder or facilitate the development of the health program.

Policy Diagnosis - to assess the compatibility of the program goals and objectives with those of the organization and its administration; does it fit into the mission statements, rules and regulations that are needed for the implementation and sustainability of the program.

AusAID used PRECEDE-PROCEED model to evaluate Women and Children's Health Project in Papua New Guinea. The Women and Children's Health Project was a large Australian funded aid Project that sought to improve the health of women and children in Papua New Guinea between 1998 and 2004. Community development and health promotion interventions aimed to increase community support for attended birth and children's health. Green and Kreuter's [Green, L. W. and Kreuter, M. W. (2005) *Health Program Planning: An Educational and Ecological Approach*, 4th edition. McGraw-Hill, New York] PRECEDE-PROCEED model of health program planning was applied retrospectively to critique the design, implementation and evaluation of the Project. An outcome evaluation (2006) provided data for this analysis and investigated long-term impact using a multi-methods approach. Application of the PRECEDE-PROCEED model was useful, but the model fails to sufficiently well identify 'inhibiting factors' as part of the educational and ecological assessment during the planning phase. Pre-defined objectives and contractually obligated outputs in a donor funded business model negatively influenced Project activity and outcomes. Despite this and the challenging context for implementation, Project interventions improved interaction between the community and health systems, and improved use of maternal child health services (Helen Elizabeth Scott Ashwell and Lesley Barclay).

2.6 Conceptual Framework

PRECEDE Model was applied as a conceptual framework. The basic research methodology conducted a series of three different questionnaires in 17 villages in the Kun Hein Township area of the Southern Shan State, Myanmar.

Conceptual framework

Independent Variables

