Lessons Learned (in implementing the ARSH programme/project): Myanmar

Lessons Learned Overall:

Lessons learned in the UNICEF-supported SHAPE programme found that life skills education works best in conjunction with other strategies such as policy development, access to appropriate health services, community development, and supportive, positive media coverage. This is true for all ARSH programmes, which need to be embedded in a comprehensive approach which targets all levels of society.

Success Factors for Implementing Advocacy and IEC Strategies

The UNFPA-supported reproductive health project successfully employed two vehicles to deliver information and education for behaviour change at community level: the existing health infrastructure and the networks of NGOs. Through the existing health system, the project trained basic health staff, community support groups, village health workers, adolescents and youth volunteers in the community. The trained health staff and community volunteers then engaged in outreach activities through community health talks, peer education and interpersonal communication sessions. As a result, target communities were more supportive and committed to the reproductive health programme.

The community-operated reproductive health and behaviour change communication project which was implemented by JOICFP in cooperation with local authorities and community networks used a strong advocacy focus to encourage community action and participation. The broad range of local authorities and community committees involved in the project made it widely accepted. The project successfully used youth as Frontline Health Promoters whose task is to share reproductive health related information with other community members, both adults and youth.

The strategies developed for the project were based on the volunteerism of youth, which it considered also an important target in itself. The reasons for selecting youth as Frontline Health Promoters were their vulnerability to RH-related problems including HIV/AIDS, their affordability of time resources, their readiness to absorb new concepts and ideas, their assertiveness and willingness to serve their own communities.

The project found however that continuing advocacy is crucial to overcome barriers between the young Frontline Health Promoters and the community. The project cited the exceptional spirit of volunteerism of many Myanmar people as a particular success factor.

A lesson learned from the FHAM supported projects was that the provision of primary health care services among other harm reduction services (i.e. needle and syringe exchange) to injecting drug users could serve as an entry point for community acceptance of such services. The FHAM recommends that this should be considered when expanding harm reduction services to other locations.
Myths and Constraints in Implementing Advocacy and IEC Strategies

Projects implemented in the field of ARSH and HIV prevention encountered constraints related to the acceptance of messages by the community, as well as cultural and environmental factors. For example, conducting condom demonstrations with young women in Myanmar was found to be culturally inappropriate. Furthermore, according to Myanmar culture, reproductive and sexual health issues are not discussed within the family. However, it is common to share information with the same age groups for such sensitive issues. Unmarried volunteers have been responded harshly in some outreach sessions when speaking about ARSH topics in front of an audience. Depending on the ARSH topic, group education sessions need to be conducted in single sex groups to overcome communication barriers. The approach “Youth-to-Adult Education” which was used by the community operated RH/BCC project was found to be more challenging than the “Youth-to>Youth Education”, especially in the inter-actions of culturally sensitive topics. In many cases community members were unable to attend outreach health education sessions due to their struggle for their daily living; an alternative timing or individual education might be a solution.

Local beliefs i.e. intra-uterine device insertion into the uterus causes cancer, were subject to discussion and confusion among community members. Repeated orientation talks and counseling, with community members, youth volunteers and support group members were held, backed-up by health staff, to overcome opposition.

Limited availability of baseline data in the area of HIV prevention and ARSH to inform programme planning and implementation is a great constraint.

Stigma and discrimination toward people living with HIV/AIDS remain very prevalent in Myanmar, as many other countries. This has particularly been experienced in rural settings, and it obstructs access to services for those most at risk.

Some high-risk groups engage in activities that are illegal in Myanmar (i.e. sex work and injection drug use). Reaching these groups with programme interventions can be problematic, as target populations are afraid of law-enforcement officers and of arrest or deportation.

The requirement for authorization to travel reduces the flexibility of organizations to implement activities, imposes rigid planning, and results in slower implementation. The need for explicit permission for detailed activity implementation can cause delays. Organizations report that it was not possible to obtain permission to operate in some geographical areas, with security stated as the reason. Unfortunately, some of these areas are often where services are needed most.