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Participation of Beneficiaries in Community Health Care Program: The Case of Tanghpre Parish, Kachin State, Myanmar

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Abstract: This study determined the perception on the participation level of village people as beneficiaries of a community health care project, which served as a development strategy in four villages of Tangphre Parish in Kachin State, Myanmar. A total of 62 beneficiaries including one project staff served as respondents of the study. Data were collected through a combination of individual survey and key informant interviews. Results of the survey were analyzed using descriptive statistics.

Results showed that the perceived level of participation was moderate in all phases. Project activities such as health prevention trainings; support for basic needs; and provision of medicines, supplementation and treatment; and referral services were the motivating factors that increased the participation of the grassroots. The beneficiaries' contributions in terms of their resources like food, labor, shelter, knowledge, and time were

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indicators of their commitment to the project. Highly favorable attitude, improved skills, and knowledge of the community health care workers, health and development committees, and project staff were important factors that encouraged the beneficiaries to achieve the project's objectives.

Political conflicts and lack of transportation were found to be the major barriers to program implementation. Hence, there is a need to address the conflicts and improve the peace and order situation in the villages. There should also be a close collaboration of the Community Health Care and Development Program with the national government and the Kachin Independence Association to address a wide range of issues in attaining basic needs and in improving all aspects of the people's lives.

Keywords: *participation, program management, program effectiveness*

INTRODUCTION

Myanmar (formerly Burma) is one of the countries in Southeast Asia with an estimated population of about 58 million (World Food Programme, 2012). Myanmar is among the region‘s most ethnically diverse countries comprising 135 officially recognized ethnic races, two-thirds of which live in the rural areas. These include the largely Buddhist, Burmese-speaking Burman majority. Non-Burman ethnic groups live predominantly in highland areas and are culturally and linguistically distinct from each other and from ethnic Burmans, who traditionally reside in lowland, central Burma. These non-Burman ethnic groups include Kachin, Kayah, Kayin, Chin, Mon, Bamar, Rahkine, and Shan (Human Rights Watch, 2012).

Among the states and divisions, Kachin State is the northernmost state in Myanmar, bordered by China and India. The state is populated mostly by the Kachin people, a predominately Christian group with a Tibeto-Burman language and a culture and identity distinct from Burma's Buddhist majority and ethnic Burman population (Physicians for Human Rights, 2011). Of the 46,660 estimated population of Kachin State (Lin, 2014), majority of the people dwell in vast hilly regions mainly engaged in the cultivation of a large amount of arable land for their staple food and social welfare. Despite the country's significant human potential and natural resources, Myanmar is still categorized as one of the world's least-developed countries. It ranked 149th out of 187 countries and territories assessed in the 2011 United Nations Development Program (UNDP) Human Development Report.

The World Health Organization (2008) stated that about 70 percent of the population in 284 out of 325 townships of Myanmar live in malaria-endemic areas. Infant deaths were caused by acute respiratory infections, diarrhea, brain infections, low birth weight, premature births, and malaria.

In Kachin State, most mothers have between five and eight children. Half of their children die before they reach the age of five because of diseases that can be easily prevented or cured, such as malaria, diarrhea, or pneumonia. Electric power, clean drinking water, and health services are luxury resources in the villages. Nine out of 10 people go hungry for four months every year (Health Poverty Action, 2013).

There are international and local NGOs whose programs are aimed at addressing these problems. However, with government's stringent rules, organizations have limited opportunities to provide interventions. One of these organizations is the Community Health Care and Development Program (CHC&DP), which was founded by Sr. Susanna of the Columban Order of the Roman Catholic Church.

CHC&DP worked with the communities in five target parishes, consisting of 24 target villages and six non-target villages in Tangphre Parish in the Myitkina District of the Kachin State. The Program, which ran from 2009 to 2011, considered all community members (men, women, children, and adults) as participants.

Under the Program, common diseases and other health-related issues were identified and activities for a three-year project were set up in the target areas. Community mobilization strategies conducted were capacity building, organizing the village volunteers, and mobilizing the village development committees. These strategies were aimed at helping the local people identify their basic needs and lead their communities in addressing these needs.

Mosquito nets, blankets, rice, and cash were identified as basic needs. These were provided to them with the assistance of the community health care worker according to the Program criteria. The village volunteers were also provided with health and development trainings and given medicines and equipment to treat common diseases. Nutrition supplementation activities for backyard gardening and seeds were provided as an important component of the Program.

Consequently, the Program had a lot of positive outcomes, namely: improved handwashing practices, correct usage of mosquito nets, improved personal hygiene, and observing balanced diet. Furthermore, the rural people were able to build fly-safe latrine and undertake backyard gardening with local resources.

However, while there were many positive health outcomes from the Program, people's participation in some Program areas was rather low.

Objectives of the Study

The general objective of the study was to determine the beneficiaries' perception on their participation in the CHC&DP as a community development strategy in Myitkyina, Kachin State, Myanmar.

The specific objectives were to: 1) describe the level of participation of the target beneficiaries in Program management; 2) determine the level of effectiveness of the CHC&DP vis-à-vis its immediate objectives; and 3) analyze the facilitating and constraining factors of Program effectiveness.

METHODOLOGY

The study was conducted in Tangphre Parish, Kachin State in 2012 upon completion of the Program which was implemented from 2009 to 2011. The study sites were four villages, namely: Tang Bau Yang, Bum Nyen Yang, Pung Tswi Yang, and Ngreng Kawng.

The study used a survey research design with interviews among the participants. The respondents were selected from the household beneficiaries: 21 in Tang Bau Yang, 31 in Bum Nyen Yang, 62 in Pung Tswi Yang, and 46 in Ngreng Kawng. The sample size of 62 was computed using Slovin's formula and selected through draw lot method. The samples were drawn as follows: 8 from Tang Bau Yang Village, 16 from Bum Nyen Yang, 28 from Pung Tswi Yang, and 10 from Ngreng Kawng using proportional allocation. Secondary data such as Program documents were reviewed.

Quantitative and qualitative data such as the respondents' socio-demographic characteristics, participation in the program management phases, program effectiveness, and facilitating and

constraining factors were collected through face-to-face interview using a structured questionnaire. Close and open-ended questions were used in the questionnaire to elicit the required information from the household respondents. To ensure reliability of the instrument, it was pre-tested on two persons who came from nearby target villages. The data were collected by the principal researcher with the assistance of four enumerators.

A set of guide questions was prepared for the staff-respondent to gather additional information and to provide context for the information from the survey. Qualitative analysis was used in this study. Descriptive statistics such as frequency counts, percentages, mean, weighted mean, over all weighted score (average of the mean score of each statement), and adjectival rating scale were used to analyze the findings.

The perceived level of participation was measured using a rating scale of 1-5, where 5 = very high, 4 = high, 3 = moderate, 2 = low, and 1 = very low. The mean scores were interpreted as high (3.68-5.00), moderate (2.34-3.67), and low (1.00-2.33).

RESULTS AND DISCUSSION

Socio-demographic Characteristics of the Respondents

Most of the respondents were male and with ages ranging from 24 to 74 years old, married, and head of families. Majority (93%) had very low level of education, most reaching only primary grade level. Out of the 62 beneficiaries, 21 percent had not gone to school at all. Only 55 percent had gone to primary school (Grades 1 to 4); 18 percent to secondary school (Grades 5 to 8); 5 percent to high school (Grades 9 to10); and only one to college. The average of schooling is three years (Table 1).

Table 1. Socio-demographic characteristics of the beneficiaries

PARAMETER	TOTAL (n=62)	
	Frequency	Percentage
Age (years)		
24 – 33	17	27
34 - 43	20	32
44 - 53	16	26
54 - 63	6	10
64 - 73	2	3
>74	1	2
Mean = 42.77		
Sex		
Male	34	55
Female	28	45
Educational attainment		
Have not gone to school	13	21
Primary (Grades1-4)	34	55
Elementary (Grades 5-8)	11	18
High school (Grades 9-10)	3	5
College	1	2
Mean = 3 years		
Range = 0-13 years		
Occupation		
Farmer	60	96
Teacher	1	2
Catechist	1	2

Majority of the respondents (96%) were farmers. Only two did not engage in farming - a school teacher and a catechist (Table 1). Studies have shown that age is related to participation (Liu, 2003), and education is a key component to improving income, economic competitiveness, and health (De Stefano & Moore, 2010). Greater participation by women also leads to improvements in health, nutrition, and poverty for the women, men, and families (Bill and Melinda Gates Foundation, 2008).

Beneficiaries' Attitude Towards the Project's Health-Related Trainings and Support

Of the 62 beneficiaries, 28 (40%) agreed and 14 (27%) strongly agreed that "the trainings given were clear, relevant, and included health prevention education and other related trainings" (WM=3.8). They believed that the trainings were important. One target area was given at least two trainings of four to five days in a year. The trainings employed several methods such as role playing, storytelling, singing, group work, presentation, practical, and lectures based on the beneficiaries' existing knowledge (Table 2).

For the statement "the volunteers and committees were well trained and their skills improved during the implementation," 18 percent strongly agreed and 48 percent agreed (WM=3.8). After attending the basic community health care workers trainings, the community health workers (CHWs) could give health education, administer treatment, and organize the beneficiaries to participate in the project implementation. In addition, the target villages were provided with books, pamphlets, and VCDs as learning materials, which they brought back in their villages.

Some 28 beneficiaries (45%) strongly agreed that the "basic support provided by the Program such as money, food, and medicines were effective" (WM=4.2). The 24 beneficiaries (39%) who agreed with the statement mentioned that the villages were often intensely affected by rice shortage, floods, and diseases.

Table 2. Beneficiaries' attitude towards the projects' health-related trainings and support

No.	STATEMENTS	RESPONSE (n=62) SA F	SA %	A F	A %	N F	N %	DA F	DA %	SDA F	SDA %	Range	Weighted Mean	Adjectival Rating
1	The trainings given were clear, relevant, and included health prevention education and other related trainings.	14	27	28	40	19	31			1	2	1-5	3.8	Highly favorable
2	The volunteers and committees were well trained, and their skills improved during the implementation.	11	18	29	48	22	35					3-5	3.8	Highly favorable
3	I find the program's basic need support to be effective.	28	45	24	39	8	13	1	2	1	2	1-5	4.2	Highly favorable
4	The medicines and facilities provided by the program are relevant and affordable for us.	20	32	32	52	10	16					3-5	4.2	Highly favorable
5	Because of the project, illness as well as death rate decreased.	21	34	24	39	12	19	3	5	2	3	1-5	3.9	Highly favorable
	Overall Weighted Score												4.0	Highly favorable

Legend: Categories: SA = Strongly Agree, A = Agree, N = Neutral, DA = Disagree, SDA = Strongly Disagree
Rating Scale: Highly Favorable = 3.68-5.00, Favorable = 2.34-3.67, Slightly favorable = 1.00-2.33

However, there was no organization that supported such basic needs. Eight beneficiaries (13%) were neutral, one beneficiary (2%) disagreed, and one (2%) strongly disagreed with the statement.

Further, 20 (32%) strongly agreed and 32 (52%) agreed that "the medicines and facilities provided by the Program were relevant and affordable for us" (WM=4.2). The beneficiaries shared that there had many serious illnesses and high death rates in their community in the past. At present, however, people are healthy because of the medicines and facilities provided in the communities. The medicines are of good quality and the prices are more affordable compared to those bought from shops or other people.

Lastly, 21 beneficiaries (34%) strongly agreed and 24 (39%) agreed that "illness as well as death rate decreased compared to the past because of the Program" (WM=3.9). They explained that the villages then were not conducive places to stay as it boded possible sickness. At present, the beneficiaries feel secure. However, 12 beneficiaries (19%) were neutral, while three beneficiaries (5%) disagreed, and two (3%) strongly disagreed with the statement.

The study showed that majority of the beneficiaries agreed with the statements. They became more aware of the value of good health, especially the women who used to be malnourished and suffered insomnia due to loss of appetite. They felt proud because they were able to avail of safe and reliable treatments and medicines. In the past, they did not know much about sickness prevention and had no access to medicines.

Participation of Beneficiaries in the Project

Mac Ginty and Williams (2009) stated that public or local participation through the years have become prominent theme in

relation to development and peace building. The high success of programs and projects depended on the high level of participation from the beneficiaries. Participation means full involvement of the local leaders and the household members or villagers from pre-planning up to the monitoring and evaluation phases. Thus, the target beneficiaries' perception on their level of involvement in the project was assessed to see whether this was a critical success factor of the project. Appendix Table 1 provides information on the beneficiaries' participation in the different phases of the project.

Pre-planning phase. Of the 62 beneficiaries, 19 beneficiaries (31%) had moderate level of participation in "initial discussions with local authority and the community." As regards to Statement 2, a total of 24 beneficiaries (37%) had very low and four (6%) had low levels of participation in identifying, analyzing issues, and presenting the conditions of the village. For Statement 3, a total of 21 beneficiaries (34%) had very low, while seven (11%) had low levels of participation in the formation of village health and development committees and in the selection of volunteers. Based on the overall results, the beneficiaries had moderate level of participation in the pre-planning phase (OWS=2.7).

In the pre-planning phase, the priest and the catechists initiated the discussion about the current situation and issues in the target areas. After the discussion, the program leaders made the decision of entering the target areas or not. Their decision was communicated to the priest and catechists only and not to the national government authorities and the Kachin Independence Association (KIA).

Results revealed various reasons for non-participation among the beneficiaries in the pre-planning phase. Some were engaged in farm work; some had many children to take care of; some often travelled out of the village for jobs like hunting, gold mining, and farming; and there were no educated persons in the house.

The staff-respondent also gave answers that were consistent with the beneficiaries' answers regarding the pre-planning phase. She was involved in the preparation stage as facilitator; she led the planning activities; and she prepared the agenda for the entry of the Program in the target areas. However, she mentioned that the priest, catechists, and villagers were not included in this phase and that only a few beneficiaries were engaged in planning. The staff mentioned that they conducted home visits to find out the real condition in the villages. They conducted awareness campaigns, identification, and discussion of issues specifically on the health improvement strategy against malaria, diarrhea, and the need for modern fly-safe latrine and safe and clean water.

Overall, there was moderate participation in the specific activities, except in Statement 1, "deficiency in advocacy," which can be considered as the weakness of the Program management. The staff were not able to communicate first with some leaders.

Planning phase. As for Statement 1, a total of 21 beneficiaries (34%) had very low and five (8%) had low level of participation in organizing people to attend the workshop. For Statement 2, some 20 beneficiaries (32%) had very low and eight (13%) had low participation in attending the workshop in setting activities and in sharing of responsibility. As for Statement 3, 18 beneficiaries (29%) had high and eight (13 %) had very high participation in contributing materials and resources and in sharing of food and accommodation.

Overall, the beneficiaries had a moderate level of participation in the planning phase (OWS=2.7). This appeared to be a consequence of the lack of participation in the pre-planning phase. Some leaders and beneficiaries were not familiar with the Program because of their inability to participate in the pre-planning phase. Hence, they hesitated to participate in the planning phase.

During the survey, 41 beneficiaries (66%) said that they participated in the planning. Those who did not participate reasoned out that they were constrained by household, school, and farm works; they had frequent travels; and there was no educated person in the house.

The staff–respondent mentioned that she led the planning activities as facilitator, coordinator, communicator, and reporter of all the issues identified. She asserted that these had been put in the plan. Further, she participated whenever there was a preparation for the activities in the villages and had to follow up these things.

Based on the results, majority of the beneficiaries participated in the planning phase in many forms, but they moderately participated in specific activities. According to Swanepoel and De Beer (2006), planning is one important aspect to take into account to be successful in community development. Planning must involve everyone and should not just be the prerogative of few members.

Implementation phase. Some 24 beneficiaries (39%) had moderate level of participation in organizing communities for different activities. Further, 21 beneficiaries (34%) had a moderate level of participation in trainings and meetings. Lastly, 22 beneficiaries (35%) had moderate participation in contributing resources and suggestions for the activities. Likewise, 21 beneficiaries (34%) had moderate level of participation in formulating income-generating activities.

Overall, the beneficiaries had moderate level of participation in the implementation phase (OWS=2.9). However, participation level increased slightly compared to the previous phases since the Program changed its communication and organizing strategies. This time, the Program communicated with the religious leaders to organize or rally the people to participate. Later, they also involved the village development committees that were elected by the beneficiaries. The members of the committees

organized the beneficiaries to participate in the implementation of the Program. Hence, the participation of the beneficiaries reached a moderate level at the implementation stage.

In terms of the beneficiaries' participation in the implementation stage, 37 beneficiaries (60%) said that they participated, while 25 beneficiaries (40%) said they did not.

The staff-respondent explained that the project staff and the beneficiaries had different roles in the implementation phase. The roles of the staff include providing health education, contributing to meeting basic needs, and sharing responsibilities with the committees and the CHWs in monitoring and evaluation. For the community members, it was important to attend the health trainings. The community's participation level was found to be very low during the trainings. It was mostly the women and children who participated.

The staff-respondent also asserted that there were beneficiaries who did not participate in the meetings because they did not understand well the project and its activities. She observed that some communities did not have much interest in the Program.

Overall, majority of the beneficiaries had moderate participation in the implementation phase. Those who participated benefited more than the others in terms of health education and other development-related trainings. The basic needs and referral services were delivered to the most difficult households according to the criteria. Further, medical attention such as treatment, home visits, and other technical assistance were offered to the people in the villages. As Swanepoel and De Beer (2006) pointed out, implementation is not for the project management team alone but also for the affected people.

Monitoring and evaluation phase. In this phase, 24 beneficiaries (39%) had very low and six (10%) had low level of

participation in regular monitoring and discussions. On the other hand, 22 beneficiaries (35%) had very low and four (6%) had low level of participation in analyzing the condition of the people and in collecting data. Meanwhile, 25 beneficiaries (40%) had moderate participation in contributing resources and materials for the workshops. Some 21 beneficiaries (34%) had very low and 9 (15%) had low level of participation in the data collection and evaluation stage. Another 21 beneficiaries (34%) had very low and four (6%) had low level of participation in presenting the conditions of the target villages and in writing the report.

Overall, the beneficiaries had moderate level of participation in the monitoring and evaluation stage (OWS=2.6). Monitoring was mostly done on committees and CHWs' performance. Their skills were in giving treatment and health education, record keeping, and communicating problems to the beneficiaries. However, evaluation was conducted only once at the end of the first year of project implementation in three villages except in Pung Tswi Yang village.

Summary of beneficiaries' participation in the project. The beneficiaries had moderate level of participation in all the phases. However, pre-planning activities (Statements 2 and 3) were done without much participation of the local people and leaders. This resulted to a moderate participation of the beneficiaries in the planning phase. Realizing the condition, the project staff together with the committees and CHWs exerted much effort in organizing the beneficiaries to participate in the implementation activities. These included trainings, workshops, and income-generating activities.

As regards to monitoring and evaluation, there was moderate participation by the beneficiaries. Evaluation was conducted only once during the first year of project implementation in the three villages, namely: Tang Bau Yang, Bum Nyen Yang, and Ngreng Kawng. According to the project staff, implementers, and beneficiaries, results of the evaluation helped them to identify mistakes and learn from them.

The staff–respondent mentioned that a formative evaluation was done during the first year of implementation with only the beneficiaries and herself as participants. However, they were not able to conduct a summative evaluation at the end of the Program.

Measuring Program Effectiveness

Participation is one of the key factors for program effectiveness (Reid, 2000). In this study, program effectiveness was measured by asking the beneficiaries their perception on whether the program objectives had been achieved through the following statements: 1) having been provided with health and capability trainings, the volunteers and development committees in the target areas will support the communities in implementing the project; 2) having attained knowledge about the prevention of common diseases, the communities in the target areas will be able to prevent the common diseases affecting them; 3) the communities in the target areas will be provided medical attention and the poor people will be supported on their basic needs; 4) having learned the basic techniques of backyard gardening and locally available aids, the communities in the target areas will implement backyard gardening for adequate nutrition; 5) the poor people, having been provided with educational aids and techniques for income generation, will implement income-generating activities for the school children; and 6) being provided with capability trainings, the facilitating skills of the CHC&DP staff will be improved, and would enable them to provide the best services to the community.

Appendix Table 2 shows the statements and the indicators for each objective as well as the corresponding weighted means and adjectival ratings. The respondents used a scale of 1-5 to reflect their opinions on the achievement of the six objectives. The weighted mean is qualitatively described as low (1.00-2.33), moderate (2.34-3.67), and high (3.68-5.00).

The Program was rated high (OWS=3.9) for the achievement of Objective 1 indicating that the beneficiaries' needs have been met. Majority of the beneficiaries received community health and development-related trainings and support from the Program. The staff–respondent affirmed that the Program had given health and other related trainings through participatory method, which included actual practices. The Program conducted trainings with external resource persons, but only for the community health care workers and not for the villages. She attested that the volunteers and the committees were able to support the communities in implementing the project after the trainings.

The Program was rated high (OWS=4.2) for the achievement of Objective 2 because the respondents were able to gain prevention and development-related knowledge. Further, they were able to apply the health practices they learned and prevent diseases, hence improving their health conditions. The project staff affirmed that the project provided health education on the prevention and treatment of common diseases. The attendees, she said, were able to prevent and manage well diseases such as malaria, diarrhea, and pneumonia.

Achievement for Objective 3 was also rated high (OWS= 4.0). The beneficiaries improved their health conditions and met their basic needs. Majority of the beneficiaries received different forms of medical attention that improved their health. The staff confirmed that the Program provided the basic needs of the most needy beneficiaries as well as care and treatment for all and the seriously ill patients were referred to clinics when needed.

Objective 4 had low achievement rating (OWS=2.2). Although they received seeds, majority of the beneficiaries were not able to implement the backyard gardening project very well. While they mentioned having received less training, the staff said that they did provide training on basic agriculture and backyard gardening methods to the beneficiaries. They also gave seeds such as those of beans, ladyfingers, water crest, roselle, and soap acacia

leaves to those interested. The seeds were not locally available but could be planted in the villages. The communities were able to do backyard gardening, but as explained by the staff, this may have been perceived as ineffective because there was not much improvement on the nutrition of the communities.

The effectiveness of the CHC&DP Objective 5 was rated low (OWS= 2.1) because the beneficiaries claimed that they did not receive educational aid. Neither did they receive information on income-generating activities. The staff believed that her role was supposed to be facilitative; the beneficiaries were expected to be participative in generating ideas and in discussing about the potential opportunities and options.

Lastly, the Program was rated as high in the achievement of Objective 6 (OWS=4.0). The beneficiaries observed that the project staff were well trained and have improved their facilitation skills during project implementation. The project staff affirmed that she was able to improve her skills because she received trainings on basic community health care, facilitating and communication skills, leadership, and proposal writing as well as a medical short course. Further, as health facilitator, she was able to echo all of these to the villages and to other organization staff members.

Facilitating and Constraining Factors to Program Success

Facilitating factors. Out of the 62 respondents, 58 (94%) observed some contributory factors to project success (Appendix Table 3). Many of the beneficiaries (17) cited unity of spirit and participation, followed by provision of funds (6), and medical treatment (5). These include financial and material support such as medicines, food supplementation (like milk powder), and seeds.

The staff-respondent mentioned similar contributory factors to success such as recommending good health practices

(e.g. use of mosquito nets) and conducting home visits. As results of these interventions by the project staff, tuberculosis patients recovered from serious conditions and the incidence of malaria decreased. Overall, the health of the local people improved.

Constraining factors. Only 21 out of 62 beneficiaries (34%) mentioned having observed constraining factors (Appendix Table 4). Some of these were personal reasons such as political conflicts (6), transportation difficulties (3), and lack of interest (2).

Some were attributable to how the project was implemented (e.g., people did not implement it well, there was not much discussions and meetings). Others had difficulty working together. They were not able to understand because of low education, family, and work concerns. One mentioned that many leaders were forced to enter into the Kachin Independence Army, hence the lack of leaders to lead the project.

Factors Towards Achieving Program Outcomes

The following factors were drawn as factors toward achieving project objectives:

1. The participation of women was an effective strategy in delivering information to family members in the household because they were the ones who mostly took care of the children. Greater enfranchisement and participation by women lead to improvement in health, nutrition, and poverty of people in the community (Bill and Melinda Gates Foundation, 2008).
2. The basic trainings of community health workers and the development-related trainings of beneficiaries provided essential health education and skills for implementing the project activities. Further, the beneficiaries were able to prevent and treat common diseases.

3. Supply of basic needs, supplementation support, medical attention, and referral services brought positive changes. Many malnourished beneficiaries and under-breastfed children were treated with supplement food-like milk powder and multivitamins. Further, the poorest households were provided with their basic needs. Those who were sick with common diseases were diagnosed and treated by the community health workers. The seriously ill, on the other hand, were referred to the hospital and clinics in Myitkyina.

4. The beneficiaries' moderate level of participation contributed towards achieving the Program objectives. Participating in meetings, workshops, trainings, and discussions enhanced their knowledge and skills. Hence, they were able to contribute cash, labor, food, and other necessary resources to make the project effective and efficient. As Reid (2000) emphasized, participation is one of the key factors for program effectiveness.

5. Highly favorable attitude and adequate knowledge and skills of the Program staff and community health workers enhanced their efficiency and effectiveness. The community workers overcame challenges such as cultural barriers, shyness, fear, and political conflicts. Their different forms of sharing knowledge such as brainstorming, group discussions, storytelling, singing, role playing, and demonstrations in the fields were observed to be effective since the adults and children were able to absorb and apply these lessons.

CONCLUSIONS

Based on the results of the study, the following conclusions were drawn:

1. The project has adequately assisted the community health workers and the village health and development committees in managing health care projects under the CHC&DP. The objectives of CHC&DP were based on the needs of the communities.

   In general, the Program has successfully achieved four of its six objectives as reflected by the high ratings of the beneficiaries.

2. Health prevention education and development-related trainings were necessary to enhance essential knowledge to prevent diseases and improve lives.

3. The favorable attitude and adequate knowledge and skills of the project staff and their well-defined roles and responsibilities toward the program helped the beneficiaries increase their capacities, develop mutual respect, and sustain participation, which enhanced program effectiveness.

4. Basic needs and medical supplies, referral services, and food supplementation were important support factors that addressed the beneficiaries' basic concerns.

5. The beneficiaries' participation in program management contributed significantly to program effectiveness.

6. The demographic characteristics of the participants were contributory to the successful implementation of the health projects.

7. The weaknesses of the project were identified to be limited trainings on backyard gardening, political conflicts, transportation, and the lack of basic infrastructure.

RECOMMENDATIONS

The strong collaboration and commitment of both national government and Kachin Independence Association will strengthen project effectiveness.

To effectively prevent hunger, poverty, and diseases in the villages, the national government should be responsible for providing education, health services, proper communication and transportation facilities, and agricultural subsidies. On the other hand, KIA should provide the basic needs, protection, and security to the local communities. Further, KIA should be responsible for the education, health services, and infrastructure of their controlled areas. Since agriculture is the major livelihood of the communities, the KIA government should likewise enhance the agriculture sector.

NGOs and faith-based organizations including the CHC&DP must be allowed to supplement the peoples' needs by providing them technical assistance and educational trainings. They should be empowered to emerge as community-based organizations.

REFERENCES

Bill and Melinda Gates Foundation. (2008). *Gender Impact Strategy for Agricultural Development*. Retrieved from Bill and Melinda Gates Foundation Community Portal: www.gatesfoundation.org/learning/Documents/gender-impact-strategy on 14 May 2013.

Calderon, F. & Gonzales, C. (1993). *Methods of Research and Thesis Writing*. Mandaluyong City, Philippines: National Bookstore.

De Stefano, J. & Moore, A. S. (2010). *The Roles of Non-State Providers in Ten Complementary Education Programmes*. Development in Practice, 20 (4&5): 511-526.

Health Poverty Action. (2013). Beating Malaria in Kachin. Retrieved from Health Poverty Action: http://www.healthpovertyaction.org/where-we-work/asia/myanmar/beating-malaria/ on 14 May 2013.

Human Rights Watch. (2012). *Untold Miseries: Wartime Abuses and Forced Displacement in Kachin State*. Retrieved from Human Rights Watch: www.hrw.org/sites/default/files/reports/burma on 19 September 2012.

Lin, S. (2014). *Burma Releases Preliminary Results from First Census in Decades*. Retrieved from IRRAWADY: www.irrawaddy.org on 2 January 2014.

Liu, G. (2003). *Community People`s Perception of Participation and Performance of the Natural Forest Protection Project (NFPP) in Sichuan, Province, Mainland China*, Unpublished Thesis. University of the Philippines Los Baños, College, Laguna, Philippines.

Mac Ginty, R. & Williams, A. (2009). *Conflict and Development*. Abingdon: Routledge.

Physicians for Human Rights. (2011). *Under Siege in Kachin State, Burma*. Retrieved from Physicians for Human Rights: https://s3.amazonaws.com/PHR…/Burma-KachinRpt-full-11-30-2011 on 19 September 2012.

Reid, N. (2000). C*ommunity Participation*. US: USDA Rural Development, Office of Community Development.

Swanepoel, H. & De Beer, F. (2006). *Community Development. Breaking the Cycle of Poverty*. Landsowne, South Africa: Juta and Co. Ltd. 317 pp.

World Food Programme. (2012). *WFP in Myanmar Looking Forward 2013-2017*. Retrieved from World Food Programme: www.wfp.org/.../Looking%20 Fordward_ WFP%20in%20Myanmar% on 19 September 2012.

World Health Organization. (2008). *WHO Country Cooperation Strategy in Myanmar 2008-2011*. India: Country Office for Myanmar.

Appendix Table 1. Beneficiaries' perception on their level of participation in the project

No.	PHASES/ACTIVITIES	RESPONSE (n=62) VL F	VL %	L F	L %	M F	M %	H F	H %	VH F	VH %	Range	Weighted Mean	Adjectival Rating
	Pre-planning Phase													
1	Participate in initial discussions with local authority and the community	15	24	6	10	19	31	17	27	5	8	5-3	2.8	Moderate
2	Participate in identifying, analyzing issues, and presenting the conditions of the village	24	37	4	6	21	34	5	8	9	15	2-1	2.5	Moderate
3	Participate in the formation of village health and development committee and the selection of volunteers	21	34	7	11	8	13	19	31	7	11	2-1	2.7	Moderate
	Overall Weighted Score												**2.7**	**Moderate**
	Planning Phase													
1	Participate in organizing people to attend the workshop	21	34	5	8	15	24	15	24	6	10	2-1	2.7	Moderate
2	Attend the workshop in setting the activities and sharing of responsibility	20	32	8	13	14	23	17	27	3	5	5-1	2.6	Moderate

Appendix Table 1. Beneficiaries' perception...(*Continued*)

No.	PHASES/ACTIVITIES	RESPONSE (n=62)										Range	Weighted Mean	Adjectival Rating
		VL		L		M		H		VH				
		F	%	F	%	F	%	F	%	F	%			
3	Participate in contributing materials and resources, food, and accommodation	14	23	7	11	15	24	18	29	8	13	2-5	3.0	Moderate
	Overall Weighted Score												**2.7**	**Moderate**
	Implementation Phase													
1	Participate in organizing communities for different activities	14	22	5	8	24	39	18	29	1	2	5-3	2.7	Moderate
2	Participate in trainings and meetings	12	19	6	10	21	34	18	29	5	8	5-3	2.9	Moderate
3	Contribute resources and suggestions for the activities	13	21	2	3	22	35	18	29	7	11	2-3	3.0	Moderate
4	Participate in formulating income-generating activities	19	31	3	5	21	34	14	22	5	8	2-3	2.7	Moderate
	Overall Weighted Score												**2.9**	**Moderate**

Appendix Table 1. Beneficiaries' perception...(*Continued*)

No.	PHASES/ACTIVITIES	RESPONSE (n=62)										Range	Weighted Mean	Adjectival Rating
		VL		L		M		H		VH				
		F	%	F	%	F	%	F	%	F	%			
	Monitoring and Evaluation Phase													
1	Participate in regular monitoring and discussions	24	39	6	10	18	29	9	14	5	8	5-1	2.4	Moderate
2	Participate in analyzing the condition of the people	22	35	4	6	17	27	14	23	5	8	2-1	2.6	Moderate
3	Contribute resources and materials for workshops	14	23	2	3	25	40	13	21	8	13	2-3	3.0	Moderate
4	Participate in data collection and evaluation of 1 or 3-year project term	21	34	9	15	17	27	12	19	3	5	5-1	2.5	Moderate
5	Participate in presenting the condition of the people and in writing the report	21	34	4	6	19	31	10	16	8	13	2-1	2.7	Moderate
	Overall Weighted Score												**2.6**	**Moderate**

Legend: VH = Very High, H = High, M = Moderate, L = Low, VL = Very Low
Categories and Rating Scale: H = High (3.68 - 5.00), M = Moderate (2.34 - 3.67), L = Low (1.00 - 2.33)

Appendix Table 2. Indicators used in measuring beneficiaries'perception on the attainment of program objectives

No.	OBJECTIVES/INDICATOR STATEMENT	RESPONSE (n=62)		
		Range	Weighted Mean	Adjectival Rating
	Objective 1			
1	The volunteers and development committees in the village have been provided with health trainings.	1-33	4.0	High
2	The volunteers and development committees in the village have been provided with capability trainings on development-related knowledge and skills.	3-33	3.9	High
3	The volunteers and development committees in the village support the people in implementing the project.	1-30	3.7	High
	Overall weighted score		**3.9**	**High**
	Objective 2			
1	The community members have gained knowledge about the prevention of common diseases.	2-33	4.0	High
2	The community members in the village are able to prevent the common diseases affecting them.	1-30	3.8	High
3	They think that their health conditions are better now than before the implementation of CHC&DP.	5-36	4.8	High
	Overall weighted Score		**4.2**	**High**

Appendix Table 2. Indicators used...(*Continued*)

No.	OBJECTIVES/INDICATOR STATEMENT	RESPONSE (n=62)		
		Range	Weighted Mean	Adjectival Rating
	Objective 3			
1	Under the CHC&DP, we are provided with medical attention.	1-33	4.2	High
2	The people in the village are supported with their basic needs such as food, clothing, and shelter.	5-21	3.4	High
3	I am satisfied with the medical attention and the basic services provided to us.	2-34	4.2	High
	Overall weighted score		**4.0**	**High**
	Objective 4			
1	We are provided the techniques of backyard gardening and locally available aids.	3-32	1.8	Low
2	As a result of the techniques taught to us, we are able to implement backyard gardening.	2-34	1.9	Low
3	Our nutrition has improved since we are able to harvest food products from our backyard garden.	6-19	2.8	Moderate
	Overall weighted Score		**2.2**	**Low**

Appendix Table 2. Indicators used...(*Continued*)

No.	OBJECTIVES/INDICATOR STATEMENT	RESPONSE (n=62) Range	Weighted Mean	Adjectival Rating
	Objective 5			
1	Under the CHC&DP, we are provided with educational aids and techniques on income generation.	3-42	1.7	Low
2	As a result of the educational aids and techniques provided to us, we are able to implement income-generating activities to support our children's education.	3-31	2.0	Low
3	Our income- generating activities are still ongoing and we are able to generate income from them.	5-19	2.7	Moderate
	Overall weighted score		2.1	**Low**
	Objective 6			
1	The CHC&DP staff were provided with capability training.	1-28	3.9	High
2	As a result of the capability training, the facilitation skills of the CHC&DP staff were improved.	12-29	3.9	High
3	I am satisfied with the performance of the CHC&DP staff assigned in our village.	1-36	4.1	High
	Overall weighted Score		**4.0**	**High**

Categories: Rating Scale
H = High : 3.68-5.00
M = Moderate : 2.34-3.67
L = Low : 1.00-2.33

Appendix Table 3. Peceived facilitating factors to project success

SUCCESS FACTORS	RESPONSE	
	F	%
Financial support		
Money	6	
Money and participation	2	
Money and supplementation	2	
Money and medicines	1	
Subtotal	**11**	**19**
Institutional support		
Medical treatment	5	
Good support of community health workers	3	
Staff facilitation	2	
Giving health education	2	
Educational processes	2	
Meetings and discussions	1	
Actual implementation according to the plan	1	
Participation and words of encouragement	1	
Coordination of community health workers, committees, and staff	1	
Education and seeds	1	
Health education and treatment	1	
Education, treatment, backyard gardening tasks	1	
Good committee support	1	
Subtotal	**22**	**38**

Appendix Table 3. Perceived facilitating...(*Continued*)

SUCCESS FACTORS	RESPONSE	
	F	%
Material support		
Medicines, supplementation, and cash	2	
Availability of medicines	2	
Medicines and supplementation supply	1	
Support to attainment of good health	1	
Subtotal	**6**	**10**
Inspirational support		
Spirit of unity and participation	17	
Good health and spirit of unity	1	
Unity of people and good committee leadership	1	
Subtotal	**19**	**32**
Total	**58**	**100**

Appendix Table 4. Perceived constraining factors to project success

SUCCESS FACTORS	RESPONSE (n=62)	
	F	%
Observed constraining factors		
Yes	21	34
No	41	66
Total	**62**	**100**
Constraining factors		
Political conflicts	6	28
Difficult transportation system	3	14
Work and family difficulties that disabled them from attending health trainings and engaging in activities	2	9
Some disinterested people	2	9
Medicine shortages	1	5
Lack of leaders to lead the project (some have to undergo armed force groups)	1	5
Some people taking medicines who do not pay on time	1	5
Lack of education that leads to difficulty in learning	1	5
People not implementing the project well	1	5
Lack of understanding and one CHW leaving the project	1	5
Difficulty of people working together	1	5
Not much discussions and meetings	1	5
Total	**21**	**100**