Community Health Project

Report

July 2011 - June 2012

Geographic Area and Population: Hmong Culture

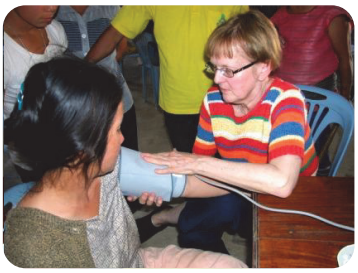
In Hmong culture, men have a higher status and more power than women. Boys are considered more important because they carry on the family name and are responsible for caring for elderly parents; boys are also responsible for the funeral rites and paying respect to the spirits of family ancestors. Thus, traditional Hmong believe that the more boys in the family, the better their financial and social situation. In Hmong society, the family and relatives are considered very important. Many family members and relatives pool their incomes to improve the family's financial and social status (Mongkon Chanbamroong refer; Satienchata, 2001). Then Hmong women marry, they are expected to have children, particularly male children, to help contribute to the financial status of the family, as well as the women's own marital status. If women are unable to have children, they face many challenges and changes within Hmong society. A woman unable to have children may have to face divorce when the husband brings a second wife into the home in hopes that the new wife will be able to have children.

Hmong villagers construct their own homes on the tops of mountains. The elderly woman is wearing the hand-woven traditional dress for her particular clan.

Type of Problems

Socio-economic and technological development have benefited people in cities, with better access to government health services being a positive result. However, this development has caused many problems such as pollution, unhealthy behavior, uneven income distribution, and other social problems. These conditions have led to social exclusion, as well as political unrest, causing both physical and mental problems for many urban residents.

Most of the people in rural areas are farmers and minority hill tribe groups with lower incomes and lower standards of education when compared with urban residents. The majority of rural villagers work in agriculture and use harmful pesticides without knowing how to use them safely; their health often suffers because of improper pesticide use. how to care for their own health. In addition, since each hill tribe group has its own language and many older villagers do not speak Thai, it is very difficult for hill tribe members to communicate their symptoms if they are able to visit a health care facility. Many hill tribe villagers are also uncomfortable sharing personal information about certain types of symptoms and illnesses because of cultural perceptions of certain topics. It is difficult to travel to the local government health centers and hospitals; it often takes an entire day to reach a rural hospital or health centers where there is often only one doctor to care for many patients.



A health survey of hill tribe villagers living in Mae Sa Mai Village, Chiang Mai Province was conducted by the Thai Ministry of Health. This survey found the following:

Women 35-39 years:

- 31.2% are uneducated.
- 93.8% work in agriculture.
- 78.1% marry between ages 15-19 years old.
- 92.2% do not know about breast cancer.

- 68.8% have not examined their own breasts.
- 82.8% have not been examined for breast cancer by a doctor or health practitioner.
- 75 % of women have never been examined for other cancers.
- 53.1% have never had an annual health check-up.
- 78.1% have never been checked for diabetes.
- 82.8% have never had their blood pressure checked.
- 54.7% menstruate regularly.
- 75% do not know reasons for irregular menstruation.

A study on women of child bearing age shows that these women do not lead healthy life styles. They have never been examined for breast or other cancers due to ignorance and shame. According to Hmong traditions for women, sex is something to be hidden and not talked about.

Men 25-29 years:

- 21.1% are uneducated.
- 34.5% work in agriculture.
- 72.6% have insufficient income and debts.
- 62.8% have middle sized families with an average of 4.3% male.
- When sick, most of them go to community health centers.
- 48.1% of information about health is obtained from news; 60.2 % from the radio
- 51 % have homes in good condition.
- 74.3% have toilets.
- 85% have garbage disposal.
- 97.3% drink tap water from the mountains.
- 63.2% drink un-hygiene water.
- 55.8% do not know how to prevent sexual transmitted diseases or AIDS.
- 52.2% do not smoke.
- 84.1% drink alcohol.

- 63.7% do not use addictive substances.
- 100% are not currently sick.
- 79.6% have never had annual check-up.
- 72.6 % have never been checked for diabetes.
- 83.2% have never had their blood pressure checked.
- 60.2% are not suffering from syphilis/AIDS.
- 100% have one or more risk factors which lead to STDs and AIDS, the most common being a lack of knowledge about transmission.

Most men drink alcohol and have never been checked for diabetes or hypertension. They have never had an annual physical exam and do not realize how important it is to get regular checkups.

The Thai rural population does not understand the importance of regular physical check-ups and are often unaware when they have chronic illnesses. Those who do know are unable to control the symptoms or properly care for themselves. Some have unhealthy eating habits which lead to many health conditions including diabetes, high blood pressure, hypertension, and cancer. The most common cause of death is non-communicable diseases, followed by sexual transmitted diseases and AIDS which are transmitted through unhealthy behavior. Severe injuries from road accidents often cause permanent disability which leaves the family responsible to the daily needs of the disabled member.

The Concordia Welfare and Education Foundation-Thailand (CWEFT), working in partnership with Lutherans in Medical Missions (LIMM), was able to lead a Community Health Training project in two Hmong communities in northern Thailand. These types of trainings are important to local communities because of widespread problems with inadequate access to health and wellness resources, along with limited education and health facilities among rural hill tribe populations. Thus, it is important to provide information to rural residents in the following areas as they relate to overall health and wellness: encouragement, prevention, rehabilitation, and community health services. Attaining and maintaining good health is the primary goal and the reason for implementing an effective health and wellness program among more isolated rural populations. This type of program is best put into place by sharing knowledge about good health care and self care practices with villagers, while also training them to identify and control known risks factors. By educating residents and creating an awareness of health risk factors, it is

much easier to prevent those conditions that can be prevented and identify more serious conditions for follow-up with a health care professional. To do this, residents learn to value their health and well-being, as well as recognize potential health problems and lifestyle risk factors. Residents can then help family members and neighbors to identify risk factors and/or current symptoms to address current and potential health problems.

Through the Community Health Training Project, community residents are encourages and more aware of their health and well-being, while also working closely with one another to improve or enhance relationships and ties within the community. The trainings are also an excellent opportunity for residents to network with other agencies to connect their rural community with a larger health care system for those who need further care or medical treatment beyond their own community.

Goals

The goal is to train minority hill tribe villagers living in remote areas of Northern Thailand in the area of basic health care and prevention. Villagers will learn how to identify symptoms for common diseases and conditions. Villagers will also learn how to prevent and manage chronic diseases so that villagers are able to maintain their quality of life with their families. Upon completion of the training, participants will be able to share their knowledge and understanding of health care and prevention within their communities.

Participants at the trainings in Baan Khun Khuay Kay Village, Chiang Rai Province (left) and Baan Mae Sa Mai Village, Chiang Mai Province (right).

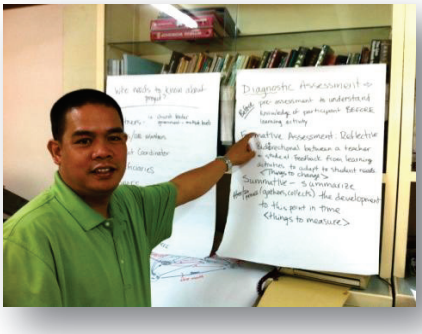
Objectives

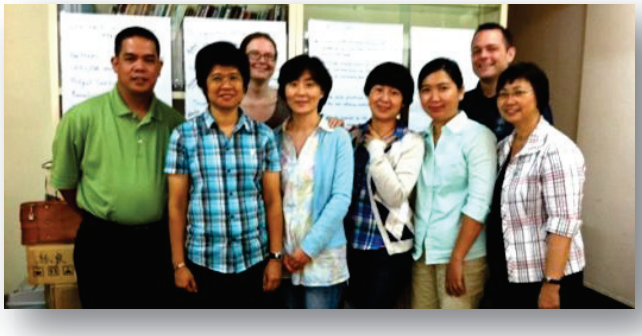
1) Volunteers are trained in community health care where they learn basic health knowledge which is then shared with their family and other community members to prevent diseases and improve overall health and wellness.
2) Work with a network of local church and community leaders will lead trainings with villagers and volunteers four time per year; trainings will include information about basic health care, monitoring, and prevention.
3) After a volunteer completes one year of four training sessions, they will have mastered the skills presented and will be able to identify ways to reach out to the community to better the overall health and well-being of fellow residents. This can be done in a variety of ways including creating an area for exercise, leading exercises, sending a health volunteer mobile unit to train villagers in other communities, and/or set up a community clinic by coordinating with the Thai Ministry of Health and the village administration organization to allocate funds. Volunteers who complete the four training sessions could also invite other organizations to provide knowledge, share equipment and allow villagers to contribute money to purchase medical supplies and equipment for use in the community.
4) Behavior and habits change in positive ways due to this basic health knowledge training.
5) The community and others working in the community cooperate and pool resources to meet the needs of the community.
6) The community is able to run the program on its own without outside financial support for the health trainings.
7) The community is empowered and realizes how it can be more self-sufficient.
8) Increased health knowledge in communities without significant access to health resources.
9) The community is transformed from scarcity thinking to empowerment and from individual/family focus to community focus.
10) Health skills practiced in the community use the most effective methods known.
11) The concept of community grows within the project site.
12) This project is a tool for the church in sharing the Gospel and demonstrating God's love to neighbors and in the community. The church currently plays a central role as it helps to coordinate

and conduct the trainings. Church members who attended the trainings then follow-up and coordinate with the other members in the church. This helps is so that they can build relationships and share the burden in demonstrating the love of God and share the Gospel with their neighbors.

Achievements :

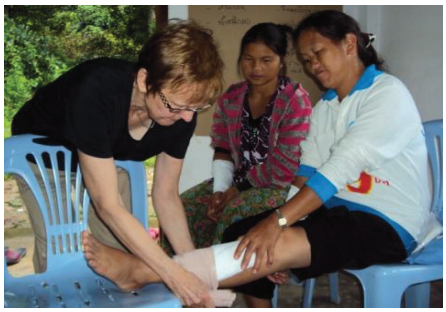
1) Use information from surveys and research of different agencies to identify the area, needs and health related problems of each village to optimize the topics discussed during trainings.
2) CWEFT took a team to meet the village headman and visited the homes of the villagers to ask for cooperation in working with the local church to help identify health concerns. Villages visited include—Lohkho Village, Kamphangphet Province; Pakamai Village, Pobpra District, Tak Province; MaeSa Mai Village, Mae Rim District, Chiang Mai Province; and, Khun Kheuy Krai Village, Terng District, Chiang Rai Province. All villages visited are 1-2 hours from the nearest government and travel on local roads is difficult for the majority of the year.
3) CWEFT representative joined the CHE Meeting on May 3-4, 2011 in Hong Kong. The training was lead by the LCMS Asia Facilitator for Human Care. Much of the time was spent working with other human care workers from across Asia to help set goals for LCMS-CHE programs in the region. Participants created general goals for LCMS-CHE programs in Asia.





4) The trainings were held on July 7-11, 2011 at the Baan Khun Khuay Kai village in Chiang Rai Province and the Baan Mae Sa Mai Village in Chiang Mai Province. The LIMM team also brought medical equipment to demonstrate and allow villagers to practice using the equipment. At the

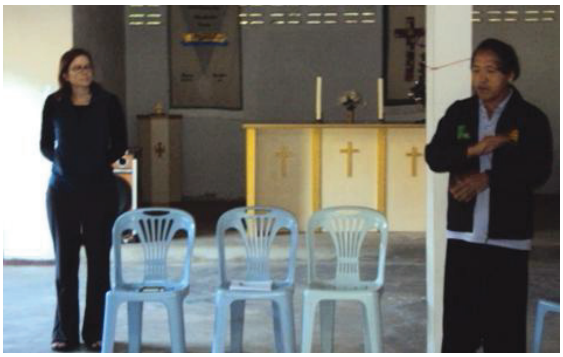
trainings, villagers had the opportunity to express their opinions and help set guidelines for future trainings and health care projects with community leaders, religious leaders and local village health care staff. There was a particular emphasis on empowering local residents to care for the young, elderly, and disabled. Villagers also received basic medical supplies and equipment to begin setting up a community clinic in the village.



5) In October 2011, a CWEFT team followed up in the villages. Residents in both villages were running their community clinic and holding monthly health care and wellness meetings with residents. The CWEFT team saw how training participants had shared what they learned about disease prevention and basic health and wellness with their neighbors. In addition to providing much needed medical care and wellness information, training participants were also very effective at identifying symptoms, determining individual health histories, monitoring diabetes, and keeping appropriate records for each person. Local community health volunteers also shared the workload among one another so as to maximize the benefits to the community while sharing the time spent. Volunteers also spent time encouraging residents and sharing basic health information with village leaders and elders—this was an important component in the success of the local clinic, as

volunteers were able to receive the initial training in Thai and then share all that they learned with all of the residents in their own Hmong dialect. On average, 30-40 people attend the monthly health and wellness meeting where they check their overall health, ask questions about any symptoms they have, check their blood pressure, and monitor their diabetes.

6) On January 19-21, 2012, Mrs. Michelle Cagnin, Human Care Facilitator from LCMS International joined a CHE training. Mrs. Cagnin was able to assess and evaluate the project by meeting with village leaders and volunteers; she also attended the training and led some topics. Participants eagerly shared their thoughts, ideas, and questions. There was also a new couple who attended the training; they had just returned to the village after working in the city and are very interested in becoming more actively involved in the program.



7) After visiting in January and better understanding the needs of the people with regard to both health training and community development, CWEFT met with Mrs. Michelle Cagnin, Human Care Facilitator from LCMS International, to discuss the possibility of doing both the health training and community projects in the future. Mrs. Cagnin indicated that so long as the ultimate purpose of CWEFT's human care outreach projects are to further the outreach and evangelism of the local

church. Since the local church has always played an integral role in coordinating the trainings and using them as an important tool in the church's outreach and sharing God's love with community residents, CWEFT has worked with local churches to identify further opportunities for outreach. CWEFT has been working with a local Vocational College to help in arranging training courses. There is also interest in a variety of self-sufficiency projects to further benefit the local communities. One of these proposed projects is to re-use the rice chaff rather than burning it and adding to the widespread air pollution in northern Thailand; the chaff can be resold for a variety of household uses. Another project is ferment mangoes that were not sold during the regular mango season; this allows mangoes that would normally be discarded to be preserved and later sold.

8) On March 10-11-12, 2012 CWEFT held a community health training with CHE trainees at a training center in Uttaradit Province.

9) On May 29-31, 2012, another training will be in both villages in Chiang Mai and Chiang Rai provinces.

10) In June, training participants will arrange a basic health care clinic at a local school to share with many local residents about health and hygiene.

11) After the most recent trainings, 40-50 people have been attending the monthly community health care meetings.

Evaluation Results

Since LIMM has been working with CWEFT on a series of health trainings to equip local residents in northern Thailand to provide basic health monitoring and care in their communities, local community leaders report that health officials have noticed positive changes in the health and wellness of residents in communities where the trainings have been held. A hospital in Chiang Rai province reports that residents from Baan Khun Kluay Kai village in Chiang Rai are more careful about making healthy food choices, monitoring their blood pressure, and managing diabetes. There are also weekly health activities and exercise opportunities which are lead by a local women's group leader. This project has also been a great tool for the local church to share the Gospel and demonstrate God's love to the community. Church members who participated in the training followed-up and coordinated with other community members to share what they learned at the training, as well as why they care so much. In addition to helping strengthen and build relationships, church members and the local pastor are now naturally sharing the Gospel and praying for participants and all community residents. The trainings were a wonderful opportunity for local church leaders and participants to share the Good News with community members who do not attend the church.

Obstacles

1. Local roads to get to the community are only easily passable during the summer months. So while residents are available year-round (depending on the particular planting or harvest cycle), it is difficult to reach them during most of the year due to difficult road conditions.

2. Residents' availability is very limited due to the rigorous farming seasons they must maintain. Very low household income levels make it difficult to focus on health trainings, as nearly all residents must spend nearly all of their time working their land. This leaves little time to participate in extra trainings and such, particularly during planting and harvest seasons. Thus, it will be important to be flexible in scheduling with the more remote villages that are almost solely dependent on agriculture for their livelihoods and well-being.
3. Residents in the community who do not farm often must spend much of their time traveling throughout the region to work as day laborers, which also makes it difficult to identify and work with long-term community residents for health trainings.

Actual Budget

	USD	THB
Income		
LIMM support	4,261.58	131,043.58
Expenses		
Accommodation	340	10,200
Transportation	1,170	35,100
Training Material	165.80	4,974
Food for Trainee	667.00	20,000
Stipend for Local Training	200.00	6,000
Charcoal Training-Outside Community	260.13	7,804
Total Expenses-until April	**2,802.93**	**84,078**
Balance on Hand for May and June Training	**1,458.65**	**43,759.50**