Case Study: Community Engagement and Accountability

Integrating community engagement and accountability into disaster risk reduction activities of the Maternal, Newborn and Child Healthcare programme in rural Myanmar.

February 2016

Introduction

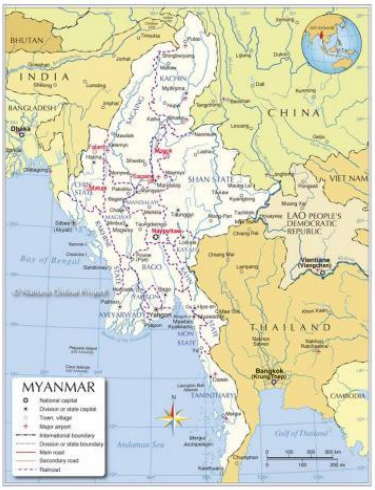
This case study seeks to document and examine a good practice example of how accountability to beneficiaries (AtB) is being achieved as part of the disaster risk reduction (DRR) element of the Red Cross Consortium[1] funded 'Maternal, Newborn and Child Healthcare" (MNCH) programme being implemented by the Myanmar Red Cross Society (MRCS) in Myanmar. This case study focuses on the DRR part of the programme as an example of how AtB and community engagement are mainstreamed in the wider MNCH programme.

This case study examines the strategy devised around three pillars of AtB: communicating with communities, enable participation of community members – including more vulnerable groups – and gathering feedback. It also touches on the strategies used for behaviour change communication.

MNCH programme village in Sagaing Region

Background

Myanmar is the largest country in mainland south-east Asia. About 70 per cent of the population resides in rural areas. Myanmar has one of the highest maternal and infant mortality rates in south-east Asia with child mortality rates above 70 per 1,000. Myanmar is also one the most disaster prone countries in the Asia Pacific region and is vulnerable to a wide range of natural disasters. Every year over one million people are exposed to floods and cyclones. While the country's coastal regions are particularly exposed to cyclones, tropical storms and tsunamis, rainfall-induced flooding is a seasonal phenomenon.



To help address this situation the Consortium has been supporting MRCS financially and technically since 2013, to implement a five-year community based health development programme. The programme targets 30,000 people (with primary emphasis on women of reproductive age and under-five children) living in 78 remote rural communities in Chin, Sagaing and Mandalay regions. The programme aims to give beneficiaries access to improved maternal, newborn and child health, water, hygiene and sanitation solutions and increase their resilience to disasters.

In Sagaing, an area vulnerable to annual flooding, it was recognised that it would not be possible to boost communities' resilience to health related issues if reducing their risk to disasters was not addressed, as disasters like flooding are one of the main causes of many health and WASH issues in the community. Therefore a DRR component was added to the programme in five communities in Sagaing, complementing the health improvement aim of the programme. The DRR component started in Sept 2014 and was handed over to communities in July. This was particularly timely given the destructive floods that hit Myanmar in July 2015, the worst that the country has seen in living memory.

One example of a DRR targeted community is the village of Tartine, nestled between the Irrawaddy and Mu Rivers, in Sagaing Township. Tartie suffers from damaging seasonal floods from both rivers between two and three times per year, forcing locals to evacuate, damaging their rice paddies, killing livestock and uprooting their lives. In the past, community members used to stay at home during the floods and had no kind of disaster preparedness plan for

[1] British Red Cross, Danish Red Cross, Austrian Red Cross, Norwegian Red Cross and Swedish Red Cross.

their village. This lack of preparedness has been addressed through the programme, and when the floods hit in August 2015, the community response was markedly different.

Overview of the DRR component of the MNCH Programme

DRR activities were implemented in five regulalry flood affected areas in Sagaing in 2015, focussing on increasing community awareness, mobilization and participation as well as some mitigation activities. Activities included firstly and assessment and then the formation of village disaster management committees (VDMCs) and the training of thirty leaders from VDMCs as well as three Red Cross Volunteers in the MRCS Community based Disaster Risk Reduction Framework (CBDRR). From this training communities were prompted to develop emergency preparedness and evacuation plans and carry out drills in their community for likely scenarios. IEC materials were also distributed to households on evacuation plans and DRR key messages. Based on community involvement and planning, tailored emergency kits (loudspeakers, tarpolins, fire extinguisher and life jackets) were provided to each community depending on the different needs and risk scenarios in each community and plans were developed to use these for income generation. Similarly the mitigation methods selected were customised to the needs of each village acknowledging that for some villages the major impact is of loss of assets while for others it is displacement. Mitigation activities included the constuction of two emergency shelters, a external wall/dyke and the procurement of boats. These were handed over to communities and now fall under the responsibility of the VDMCs.

Donation of emergency boat

Activities and approach to ensuring accountability to beneficiaries

Information provision

Transparent information provision is a critical part of the MNCH programme. From the very beginning of the DRR activities, sensitisation of communities to what MRCS was planning was an important component, with Community Mobilisers (CMs) dedicated specifically to this in the five target villages. Their role was to make sure communities understood the process and activities, ensure good communication flow between villages and the communities, take meeting minutes and gather community feedback.

Information provision to communities broadly fell into two categories:

1. Communicating who we are and what we are doing (transparency)
2. Information on DRR issues[2]

For transparent communication on MRCS activities and mission statement, MRCS produced a banner about the programme that is displayed in each village, as well as a programme Q&A document and key messages to ensure all volunteers and staff are on message. The Q&A and programme key messages were written in consultation with staff and volunteers and based on the questions that they are regularly asked by the community. CM volunteers, who are the link between the villages and the branches, received training on the Q&A and on the importance of speaking with “one voice” to avoid confusion and mis-information. This document also serves as a tool to respond to difficult questions or complaints from the community.

The programme also uses various channels to explain about MRCS and the programme (e.g. scope, duration, beneficiary selection criteria etc.) including notice boards, programme information posters, screening videos about MRCS and the MNCH programme; and through regular community meetings and community engagement by staff and volunteers.

[2] Where possible integrated with health and WASH messages

Providing communities with information on DRR issues for behaviour change and to increase awareness of hazards and risks is also a key component of the programme. This is done through defining the key messages, dissemination of IEC materials, including DRR pamphlets given to all households, recruiting more community volunteers to do social mobilisation and deliver education sessions and the use of communications hardware. TVs, DvD players, speakers and smartphones were provided to all of the target villages in Sagaing[3] as part of a wider initiative to increase their connectivity, reach, impact and levels of community health knowledge and participation. The hardware was provided to the village committees following training on its use and how to improve community engagement and participation in educational sessions, including for more vulnerable and less accessible groups of people. The portable nature of the equipment allows volunteers to take it to the people who are not able to gather in community meeting places, for example to the homes of the elderly or disabled.

The VDMCs play a large role in information provision to the wider community. They hold regular flood awareness sessions which include how to minimise the impact of damage from floods and strong winds, such as keeping emergency stock, preparation of grab bags, and strengthening homes with readily available materials. Actions are also taken to combine common messages between health, WASH and DRR related to hygiene, sanitation and access to health services. Over 3,400 people have been reached with DRR information to date.

VDMC explains village evacuation map to the community

Participation of communities

There was strong participation from the very beginning of the DRR component, from the assessment right through to the handover of equipment like boats and emergency kits. The five communities were selected in a participatory way based on prioritisation of most vulnerable villages following the CBDRR framework guidance and then a validation exercise by interviews with the communities to see what elements of DRR the community thought that MRCS should concentrate on. This included considering how best to integrate and compliment the health and WASH components.

The backbone of the DRR component of the MNCH programme was the formation of VDMCs. Sensitisation took place with the communities and the decdicated CMs. The VDMCs used a voting election system to ensure the participation and representation of people from all parts of the community, including vulnerable groups. The committees meet at least once a month and also regularly hold wider community meetings to inform the village about committee activities and what has been discussed in committee meetings. Participation was strengthened via formalising how committees engage regularly with the wider community. VDMCs develop monthly plans including for evacuation drills and other preparedness activities that the CMs follow up on to see if they are implementing them. They also drew evacuation maps together and printed them on vinyl and displayed them in an accessible place so that everyone was aware of evacuation routes.

All elements of the programme were carried out in a participatory way. For example, for the emergency kits, VDMCs had to come up with proposals of what they wanted in the kits and where this exceeded what was possible they had to negotiate with the wider community to prioritise what their greatest needs were. VDMCs also participated in the tender process of the selection of the boats. The communities also contributed with labour to the building of mitigation measures such as the dyke. Although this did

[3] and also Mogok

not totally stop the flooding in August 2015, it did mean that cars could still access the village which meant access to health care facilities.

Part of the training VDMCs received involved prioritising who was priority for evacuations and practicing this in drills. For example, some villages were able to use areas dedicated for the storage of assets to shelter more vulnerable people including elderly, who were evacuated first, during the floods. They were also able to evacuate livestock in the new boats, preventing the longer term loss of livelihoods.

In Tartine village, where villagers previously only focussed on fixing damage after disasters rather than preventing them, MRCS staff trained the VDMC on meeting protocol and techniques for coming up with solutions for their vulnerabilities and risks. The group first met to discuss the village disaster context, profile and hazards during emergencies to get a sense of the overall picture. Follow-up meetings covered potential mitigation activities and items needed for emergency response kits in the village. Kit content and other emergency equipment and measures were selected with majority approval of the group members. The prioritized items were decided based on the village's specific needs. Committee members hold their chair in high esteem, are organized and mobilized the rest of the community to get behind the plans for disaster mitigation. The committee drafted up a simple proposal of items they would need and shared this with the Sagaing MRCS branch for consideration and approval. Village leader Mr. U Tat Toe, confirms that the committee are applying their new found knowledge from the trainings and are using the materials to effectively reduce the risk of disasters by sharing this knowledge with the wider community. "The community's awareness has been enhanced and now we are better prepared because of these practical exercises and equipment. As a result, our risks will be reduced."

Feedback and complaints

The MNCH programme as a whole has a feedback and complaints mechanism in place, allowing community members and other stakeholders to provide feedback to MRCS via two channels:

I. **Face to face from community volunteers and village committees to the CMs**: CMs trained the community volunteers and village committees in what feedback is the importance of actively soliciting feedback and their role in the system. CMs systematically gather feedback from the village committees every time they are in each village and document this in their monthly report to the central programme office for their respective areas. The village committees actively seek feedback in monthly community meetings and pass this on to the CM.
II. **Suggestion boxes**: These are already in place in every village. To encourage their use CMs advocate to village committees to remind the community to use them. CMs check the boxes every month.

The community is made aware of their right to complain and provide feedback, what this is, how to use and expectations of MRCS through a variety of channels: directly from volunteers when they are conducting their other activities, via the Village Health or WASH/DRR Committees via announcements at community meetings and from posters and flyers distributed to the community. Feedback received in the mid-term view was also acted on. For example, communities were not fully aware of when they would receive the boats because of delays in procurement procedures and therefore to address this MRCS was able to clearly communicate the new timeline for arrival of the boats.

Strengthening AtB across MRCS

The example in this case study is part of a broader strategy to strengthen AtB in MRCS, both at a programmatic and organisational level. Practical illustrations of what works in the MNCH programme have served as a tool to advocate for mainstreaming across all programmes. In addition, Consortium member British Red Cross (BRC) is also supporting increasing staff capacity in AtB by funding the post of a MRCS community engagement and accountability officer and training for programme staff across all departments. BRC is also supporting the integration of AtB into other relevant training and organisational processes to emphasise its cross cutting nature, for example by including AtB in the organisational strategy, by working closely with the PMER department and through the development of community engagement and accountability standards (programmatic and organisational), tools and guidance.

Facilitating factors and key challenges

Facilitating Factors	Key challenges
• Commitment and involvement of National Society donors and management staff. • Dedicated CMs in the communities allowing for good information flow between communities and branches and excellent relationship and trust between Red Cross volunteers and community members • Strong social community networks and trust in community leaders • Programme already well-established and successful in communities before the DRR element of the programme was introduced • Changing of organisational policies to incorporate AtB: Integration of community engagement and accountability into the MRCS organisational strategy 2016 - 2020	• Not integrating all elements of AtB from the start of programme • Gap in key staffing – for example the post of M&E officer – who gathers all programme feedback from branches / programme offices - was vacant for a long time, meaning that although community feedback was gathered, there is limited analysis of it. • Feedback mechanism was being formalised at the time of this component of the programme and therefore the feedback loop was not fully in place. • Getting volunteers to systematically document feedback. • Cultural barriers to raising feedback/ complaints resulting in limited use of suggestion boxes • No fully established organisational complaints policy • Perception of staff and volunteers that they are already being accountable to beneficiaries • Limited of understanding that AtB is everyone's responsibility – although this is changing over time

Looking forward

Within the MNCH programme, as many of these DRR activities were stand alone, the next step will be to link them with branch development activities and existing structures such as local authorities to strengthen Sagaing's overall capacity to respond to floods and to integrate DRR more into health and WASH activities. Some examples of how this is already being done include in knowledge dissemnitation or how to treat water to make it safe to drink, through IEC materials and posters on household water treatment, even when access to safe water is a challenge (as during flood event). In addition, new water points have been constructed in selected communities and in order to facilitate access in times of flood and the water distribution points are situated at a higher ground in the community and the distribution points are raised. Communities will also receive training through the WASH committees on how to protect the water points before and during a disaster as well as how to act after a disaster, for example how to clean a well post-flooding.

VDMC leader and MRCS volunteers, Sagaing

As MRCS continues to improve how it integrates AtB both through organisational commitments such as the new strategic plan 2016 – 2020, and in programmes and emergency operations, the MNCH programme continues to be an example of best practice in how to better engage communities and increase accountability, particularly to strengthen cultural understanding of feedback and making use of feedback channels. Although the DRR component of the programme has come to an end, the health and component continues, as does strengthening the capacity of both communities and branches to continue activities beyond the end of the programme in 2017. Additional work has been done to integrate the monitoring of AtB activities into the programme's M&E system as part of ensuring programme quality and sustainability. AtB is a critical part of this – the more community engagement, the more participation, the more ownership and the more sustainable the services and activities after they are handed over to the MRCS branches and to the communities.