

COLLECTIVE VOICES PROJECT: QUALITATIVE CASE STUDY REPORT

Civil Society Organisations' contribution towards community engagement to access and demand health services and encourage communities to practice appropriate health-seeking behaviour in Mon and Chin States

December 2017



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ACRONYMS

3MDG	The Three Millennium Development Goal Fund
AYO	Ar Yone Oo Social Development Association
AMW	Auxiliary Midwife
BF	Bright Future
BHS	Basic Health Staff
CAD	Community Agency for Rural Development
CBO	Community-Based Organisation
CDDCET	Community Driven Development and Capacity Enhancement Team
COLDA	Cho Land Development Association
CSO	Civil Society Organisation
CV	Collective Voices
DRC	Danish Red Cross
FGD	Focus Group Discussion
GAD	General Administration Department
HA	Health Assistant
HH	Household
IDI	Individual Depth Interview
IP	Implementing Partner
KII	Key Informant Interview
LHV	Lady Health Visitor
LIFT	Livelihoods and Food Security Trust Fund
MNCH	Maternal, Newborn, and Child Health
MOE	Ministry of Education
MOHS	Ministry of Health and Sports
MRCS	Myanmar Red Cross Society
MSI	Marie Stopes International
MW	Midwife
OD	Organisational Development
RHC	Rural Health Center
SRHC	Sub-Rural Health Center
TBA	Traditional Birth Attendant

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This document is based on the field assessment findings of the second stage implementation of the Collective Voices project. The views expressed herein can in no way be taken to reflect the official opinion of the donors contributing to 3MDG.

Group interview with
the Village Health
Committee in Bant
Bway Kone village, Bilin
Township, Mon State.



EXECUTIVE SUMMARY

The demand for better health and the right to health can only be effectively addressed through collective efforts, and only if these efforts address both the underlying social determinants of health and ensuring the widespread availability of health care which is acceptable and affordable. Collective Voices: Understanding Community Health Experiences is an innovative rights based approach and community led project (\$1.5 million) that was initiated by 3MDG in March 2015. The project aims to empower community voices and promote demand driven health care services for Myanmar's most vulnerable populations in hard to reach regions. The "Collective Voices" initiative furthers 3MDG's contribution to a responsible, fair and inclusive health sector, with a focus on community engagement, to achieve better health for all in Myanmar. It also strengthens capacity of local organisations (civil society organisations and community based organisations) to support the health sector now and in the future.

The following report is a study of 14 villages under the Collective Voices project in the states of Mon and Chin. The objectives of the study were:

- (1) To explore Village Health Committee (VHC) members, Basic Health Staff (BHS), and community members' perceptions on community engagement in seeking and demanding health care and
- (2) To describe health-seeking behaviours relating to Maternal, Newborn, and Child Health and hygiene practices among target beneficiaries.

Upon completion of the study this field assessment has found that:

- Village health committees, with the imperative and supportive role of lead Civil Society Organisations (CSOs) and implementing Community Based Organisations (CBOs), facilitated and reinforced behaviour change in the community by following up on health messages and engaging the community in seeking and demanding health care.
- Community feedback practice has gradually been integrated into the project community.
- CBO health education and promotion sessions coupled with other development efforts contributed to the uptake of good health practices by community members.
- The presence of a village health fund and the role of the VHCs/ Volunteer Working Groups during emergency referrals played an essential part in encouraging the village community to seek health care in a timely manner.

The study recognizes that civil society can promote people-centered health by creating an enabling environment for broad and active citizen participation. The VHCs/Volunteer Working Groups play a key role in facilitating engagement between the village community and the Basic Health Staff (BHS). In order for the community to continue to be engaged in their own health the study recommends:

- There should be continued support of VHC/Volunteer Working Groups and CBOs through relevant funding and capacity building support.
- A context appropriate community feedback mechanism should continue to be explored to encourage a constructive feedback culture so that the community voices can be heard and their concerns can be addressed.
- Collective Voices health education and promotion activities should be in communities where there is a presence of other development partners and services as this has encouraged the target communities to practice healthy behaviours and facilitated Collective Voice's overall accomplishments
- Community based referral funds should be a part of the VHC portfolio.
- Initial seed funding and relevant training should continue to be provided to VHCs/Volunteer Working Groups to establish a sustainable community based referral fund.

01

INTRODUCTION

Together with the Government of Myanmar and other partners, the 3 Millennium Development Goal Fund (3MDG) strengthens the national health system at all levels, extending access for poor and vulnerable populations to quality health services. The 3MDG Fund has a significant, timely and nationwide impact improving maternal, newborn, and child health, combating HIV and AIDS, tuberculosis and malaria, and health system strengthening to deliver sustainable, efficient and responsive health care across Myanmar. 3MDG recognizes that civil society can promote people-centered health by creating an enabling environment for broad and active citizen participation. In March 2015, the 3MDG Fund launched an innovative initiative, the Collective Voices Project, directly funding local civil society organisations to identify the social barriers that hinder access to health care in Myanmar from the perspective of communities themselves and to implement a community-led project to address the social factors identified.¹

The Collective Voices (CV) project was established in partnership with six lead, local civil society organisations (CSOs) working with a further nineteen community-based organisations (CBOs) in a consortium arrangement. The lead CSOs provided oversight, coordination, and technical guidance to the project, while their partnering CBOs were responsible for implementation aspects. This structure enables project implementation to be conducted by people living within or near to the target villages and for the discussions and meetings to be held in culturally sensitive ways and in local languages.

The 3MDG CV Project was developed to raise communities' voices about their health needs, access to health services, and their right to fair and responsive health services. To achieve this aim, the CV project sought to understand social factors influencing health-seeking behaviours adversely affecting health outcomes and to support community responses to these barriers.

Central to a rights-based approach, the CV project engaged grass-roots civil society actors to investigate social determinants affecting health. Key outcomes of the CV project included:

- Empowered women who make personal and family health decisions
- Increased health-seeking behaviours of community members
- Increased participation and engagement between health care providers and target communities and increased knowledge and awareness of their health needs
- Increased capacity of civil society organisations and community-based organisations

A basic assumption underpinning the CV project “stresses that health is formed within social, economic, political and environmental contexts, and as well as being a key systems player in all contexts, civil society has a particular role in being able to influence the social determinants of health.” Thus, interventions did not rely solely on a technical approach to health, but rather aimed to address broader cultural factors which CSOs and CBOs could influence to affect health decisions. The overall aim being empowered communities’ accessing and receiving of fair health services.

02

BACKGROUND OF THE STUDY

The Collective Voices project (CV) aims to empower community voices and promote demand driven health care services. Push and pull factors operating simultaneously encourage individuals to demand and to access timely health care. Factors pushing communities to access timely health care services were largely stimulated through health education and promotion activities.

Some (8.5%) of the CV financial inputs, during the 2016 and 2017 stage 2 project period, focused on training and supporting local civil society organisations (CSOs) to conduct health activities in communities. This was to encourage individuals' uptake of correct preventive health care knowledge, correct health-seeking behaviours, and appropriate cultural/gender attitudes affecting positive health behaviours.

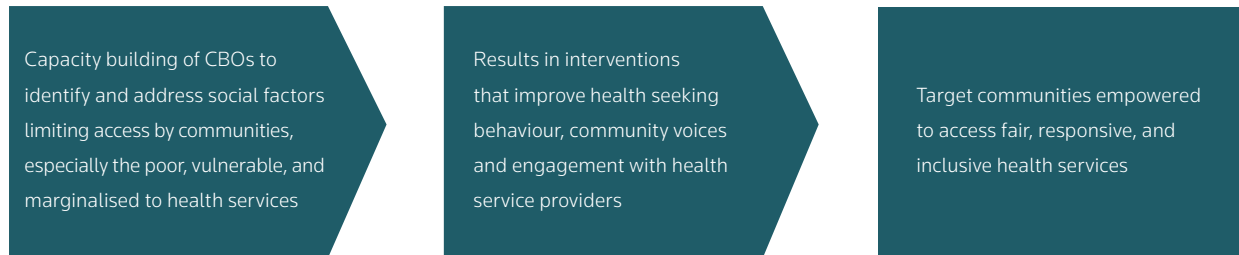
A major pull factor to encourage people to access care was fostering interaction between health care providers and target communities. The aim was not only to build the communities' trust of health care providers, but to make providers aware of communities' concerns when seeking care. The study aimed to understand the relationship between these factors and how they affected demand and uptake of health services.

Objectives of the study

The two study objectives are:

1. To explore VHC members, basic health staff, and community members' perceptions on community engagement in seeking and demanding health care
2. To describe health seeking behaviours relating to Maternal, Newborn, and Child Health (MNCH) and hygiene practices among target beneficiaries

Figure 1 Collective Voices Theory of Change



Conceptual Framework

The underlying theory of change in this exploration assumed that through the capacity building of CBOs (community-based organisations) to identify social factors that affect health-seeking decisions, the empowered CBOs would be better able to develop interventions to improve villagers' health-seeking decisions and related health-seeking behaviours. A facilitating factor for this is the formation and strengthening of VHCs. They are crucial for community engagement with basic health staff.

Thus "community engagement with health services" and "improved health-seeking behaviour" are two key outcome variables that need to be measured in qualitative terms in this exploration. See Figure 1 for the conceptual framework of the exploration, Collective Voices Theory of Change.

03

METHODOLOGY

Study Design

A cross-sectional descriptive design applying qualitative methods was used in this study.

Study Period

The study took place from August, 2017 to November, 2017.

Study Area

The study took place in Mon (Bilin and Mudon Townships) and Chin State (Mindat and Hakha Townships). Four Collective Voices organisations implemented interventions in 90 villages (Community Driven Development and Capacity Enhancement Team (CDDCET), Bright Future (BF), Ar Yone Oo Social Development Association (AYO) and Community Agency for Rural Development (CAD)). The four CV lead organisations selected four villages per each township under their project areas with the following criteria:

- One village where there is RHC (Rural Health Centre);
- One village where there is Sub-RHC (Sub Rural Health Centre); and
- Two villages where there is neither RHC nor Sub-RHC

However, the study team could not reach two villages in Chin State. Due to bad weather conditions and landslides in Mindat, and the non-availability of the village community in Hakha (both had a Sub-RHC) the study resulted in 14 villages instead of the targeted 16. (See Table 1)

Table 1- Geographic Coverage and Study Villages in Mon State and Chin State

Partners	Geographic Coverage			# Study Villages Identified	# Study Villages Completed
	State/Region	Townships	# Project Villages		
AYO	Chin	Mindat	20	4	3
CAD	Chin	Hakha	26	4	3
CDDCET	Mon	Bilin	20	4	4
BF	Mon	Mudon	24	4	4
Total number of villages			90	16	14

Study Population

Sample size determination is not applicable in this qualitative study. The study population included:

1. Village Health Committee (VHC) members
2. Basic Health Staff (Health Assistant, Lady Health Visitor, Midwife)
3. Mothers having at least one child under 5, from lower social group^a
4. Mothers having at least one child under 5, from lower social group, who had recently (within last one year) been referred to a hospital in town (either due to the mother's or her child's health condition) (in the study villages where such a case was available)

Table 2 - Completed Interviews per Township

Township	# of Group Interviews with VHC	# of KII with BHS	# of FGD with mothers having a child <5	# of IDI with referred mother having a child <5	# of villages in which Transect Walk was conducted
Mindat	3	1	3	1	3
Hakha	3	1	3	0	3
Mudon	4	2	4	2	4
Bilin	4	2	4	4	4

KII–Key Informant Interview FGD – Focus Group Discussion IDI – Individual Depth Interview

Data collection methods

As per the breakdown in Table 2, the following methods were used for qualitative data collection:

- Group interviews with village health committee (VHC) members of the study villages. This was done in each of the 14 study villages in Mon and Chin States. All members of each VHC were invited to join the group interview and most of the members participated.
- Focus Group Discussion (FGD) with mothers having at least one child under five from the lower social group. There were 6 – 12 participants in each FGD session and a total of 14 FGD sessions for the whole study.
- Individual Depth Interview (IDI) with a mother having at least one child under five from the lower social group who had recently (within last one year) been referred to the hospital in town (either due to

^aClassification of social groups is provided in the social group differences section further in the study

the mother's or her child's health condition) was done in the study villages where such a case was available. The study team conducted a total of seven interviews.

- Key Informant Interview (KII) with Basic Health Staff (BHS), including Health Assistant (HA), Lady Health Visitor (LHV), Midwife (MW), in villages where there was a Rural Health Centre (RHC) and Sub-Rural Health Centre (SRHC). Interviews with Basic Health Staff (BHS), including Health Assistant, Lady Health Visitor or Midwife, were performed in villages with a RHC. MW was interviewed in villages with a SRHC.
- Among the CV project villages in Mindat and Hakha townships, villages that had a RHC were not included so those villages were substituted with villages that had a SRHC. Depending on the availability of the BHS in each village, a KII was conducted with 2 - 3 BHS including HA, LHV and midwives in villages with RHC and with a MW in villages with SRHC. In one village that had a SRHC in Mindat township, Chin State, a Public Health Supervisor 2 (PHS2) was interviewed as the MW was away attending Nursing School and not available during the time of the interview.
- The observation method "Transect Walk" was used to verify and expand on information that was obtained in group interviews and FGDs.^{b2}. The purpose was to get the study team/interviewees out of the typical interview setting, to triangulate the information collected and to explore the new perspective on the territory, water sources (ponds, wells), supply and sanitary disposal system (toilets, drainage).

See Annex 1 for the interview guide for group interview, Annex 2 for the FGD guide, Annex 3 for IDI guide, Annex 4 for KII and Annex 5 for observation checklist.

Sampling Method

No sampling procedure needs to be applied for group interview sessions. Prior requests were made to village health committees (VHC) for a meeting with them so that all the members of the VHC could participate in the group interviews.

VHCs were requested to identify 7-11 mothers, having at least one child under five, coming from the lower social group, from different households and from different sections of the village, for focus group discussions (FGD). Considering the time limitation and availability of mothers on short notice, the request to the VHCs were made in advance to identify and gather mothers with aforementioned criteria for FGD on the proposed study dates for each village. Special request was also made to give priority invitation to those mothers having children with ages younger than two years. This was to capture mothers who delivered babies after the CV interventions took place at their villages.

VHC members were also requested to identify a mother meeting criteria set for individual depth interview (IDI) in their villages. In villages where such mothers were not available, the IDI was left out.

As for the transect walk and observation, the study team selected the guides from the community who were more knowledgeable about the studied villages

^b According to the World Bank Group a transect walk is a tool for describing and showing the location and distribution of resources, features, landscape, main land uses along a given transect.

to guide the team around the villages. For this study, at least three water sources and three toilets from each village were randomly selected and observed.

Data collection training

One day training (on data collection techniques) was held to ensure standardized data collection on informal Group Interview, FGD, IDI and key informant interview (KII).

Data management

All group interview sessions, FGDs, IDIs, and KIIs were recorded using voice recorders. There was one facilitator and one note taker for each group interview and FGD session in most of the villages. In three out of 14 villages, due to time constraints, the interview and FGD sessions were conducted simultaneously with one facilitator per each session. For IDI, the facilitator alone performed the interview with the mother.

For the villages in Chin State, a translator was also involved during the interview, FGD, and IDI sessions. The facilitator and note taker wrote up the transcripts in the same evening, and continued to do so after the data collection trips until it was completed.

Qualitative data analysis was performed manually, according to the themes and sub-themes that emerged using the matrix. Triangulations were also made between different group interviews and FGD sessions in the same township, and also between different group interview and FGD sessions between different townships.

Study limitations

- The language barrier was the main challenge for focus group discussion (FGD) and individual depth interview (IDI) sessions. In a few of the villages in Mon State, people were more familiar with Kayin and Mon languages so some of the study participants had difficulty understanding and answering the questions. The language barrier was more prominent in Chin State where all the interviews, FGD, and IDI sessions had to be performed in Chin language and the conversations were translated with the support of a translator (a staff from partnering CBO, but from another project) in Mindat and a 3MDG visiting staff member in Hakha). The study team had to rely on the information obtained through the translator.
- Transportation was problematic especially in Chin State. Transport to villages required approximately 2 – 3 hours motorbike ride to reach the study villages in Chin State. One of the villages in Mindat Township could not be reached due to the bad road conditions as there were landslides along the way to the village. Since it took a lot of time for transportation, the time to conduct interviews in the villages was limited as the team had to finish data collection in each village per day.
- Basic Health Staff (BHS) were occupied with their duties trainings and reporting so the team could not conduct interviews with BHS in two villages.

04

FIELD ASSESSMENT RESULTS

The findings have been grouped and presented as follows:

4. 1. SOCIAL GROUP DIFFERENCES

The question around social groups was included to determine if village members distinguished between social status and to ensure different status groups were included in the study. The study seeks to have a better understanding of social group differences, as perceived by the community members. In each of the study villages to make sure that mothers who participated in the study represented the lowest social group with the greatest need for health services. There were three main social groups in most of the study villages. They were self-identified as rich, middle, and poor groups. In a few of the study villages in Mon state, there were four groups: the previous three groups plus a fourth group - those without anyone to depend on (chiefly elderly people and widows). This fourth group was categorized as the poorest.

In Mon state, the social groups were classified based on their occupation, where rich people mostly run their own business (such as farming, brick production, rice vermicelli production, rubber plantation, etc.) and the poor people were mostly casual workers/daily laborers.

In Chin State, it was classified based on the possession of land, vehicle, livestock, and housing condition. It was also found out from the village community that the social group differences were regarded only as a classification of status level and there was no differentiation in how the rich or poor were treated among the community.

In almost all the study villages, the poor group was the largest, followed by the middle group.

4. 2. COMMUNITY ENGAGEMENT

CV support to VHCs/Volunteer working groups

Collective Voices supported village health committees and volunteer working groups in increasing community engagement. This was done by strengthening their capacity to manage administrative tasks and their ability to mobilize and encourage communities to focus on personal health. The result is that village health committees are more activated and support basic health staff and community-based organisations in conducting health-related activities.

The revitalization or creation of village health committee (VHC)/Volunteers working groups was to engage the community to participate in health-related activities and take a leadership role in demand driven health care.

In all the study villages, the role of the VHC was:

- to notify and gather the village for immunization,
- to mobilize and participate in health education and promotion sessions,
- to provide support for emergency referrals especially for pregnant mothers and children under 5, and
- to assist the Basic Health Staff in carrying out health related activities (such as health talks, dengue prevention measures, recording the list of pregnant women, collecting the list of fly-proof latrines, etc.).

VHC members received training on book-keeping, financial management, conflict resolution and communication, and other health related trainings. These were skills thought to create community's trust and acknowledgement of the VHC role. There was no pre-established method or time frame to set up VHCs. This activity was entirely dependent on the civil society organisations (CSOs) timeline.

CV applied different models to support the VHC in Mon and Chin. In Chin State, all nine townships have ongoing Maternal, Newborn, and Child Health (MNCH) activities supported by 3MDG-funded Implementing Partners (IPs). One part of these MNCH services is to support the Township Health Department for service delivery. This includes provision of MNCH referral support at the township

and also station hospital level if the emergency patients fall within the referral criteria.

“We learned how to properly document and record financial expenses.

We didn't know how to record that before and after receiving the training, our skills were improved.”

– VHC member from Bilin Township

In relation to VHCs, IPs provide support on organisational development trainings such as committee formation, quarterly meetings, and leadership and management trainings.

Due to limited available time, financing and human resources, IPs were not able to strengthen all VHCs covering the whole township. This is the reason why some VHCs do not function well or were not established by IPs across all townships. In Mon, there were no 3MDG supported Maternal, Newborn, and Child Health implementing partners (IPs) and the community engagement model was set-up by the CV local partners.

In Hakha, VHCs were already supported by the 3MDG IP, Save the Children. However, the CV lead organisation (CAD) does not focus on the village health committee (VHC) model. Instead, CAD formed voluntary women health promoter groups to encourage female empowerment by incorporating women in leadership roles and in health education and promotion as peer educators. The women received specific health trainings. Some were already members of the VHC. The Woman Health Promoter was a key position because she was part of the community and when MNCH support was required, she was there to facilitate the operational link between the IP supported VHC, BHS, and the villagers.

In Mindat Township, VHCs already existed in the township but did not function well because of limited capacity. Thus, VHCs were revitalized and supported with trainings by the CV lead organisation (AYO) and partnering community-based organisation (COLDA) to increase active participation of women and community mobilization. The VHCs were given health and gender-related trainings for the proper functioning of its activities. Auxiliary Midwives (AMWs) and traditional birth attendants (TBAs) from the villages were also included as VHC members. After the revitalization of the VHC, the VHCs developed and implemented a VHC plan that included environmental sanitation. The plan was monitored by CV partners.

In Bilin Township in Mon State, the lead organisation (CDDCET) recommended to the partnering CBOs that a VHC would be a good support to the village community. Partnering CBOs then explained to the village communities the roles and function of a VHC. The village community decided to form their own VHC, and the members were selected by the villagers. The VHC members felt the trainings helped the VHC function better. Their skills improved, especially in financial matters.

In Mudon Township in Mon State, the CV partners and activities were well known, but VHCs had not yet taken on the prominent role for village health support. Among the four study villages, two of the VHCs were newly set-up and two were revitalized. This was done with the support of Bright Future (BF) and partnering CBOs in the latter part of the two-year project.

At the time of the study, villagers were not very familiar with VHC activities. They did know of BF and CBO partners because they had implemented health education and promotion activities. Two of the villages, chosen randomly, had very newly formed VHCs. Actually, these VHCs were setup according to the BF project implementation plan/schedule but the schedule coincided with the CV study when these VHCs were in a start-up phase. Due to this, they had very limited experience for the study.

In one of the study villages, the VHC mentioned that they received three days first-aid training organised by BF. The other three VHCs in the study village said that they had not yet received any training for the functioning of the VHC because they did not recollect the title of the training. However, according to the training records of BF, it was noted that the VHCs had received the training as BF conducted the training on “first-aid”, “gender” and “health related training regarding the first 1,000 days of life nutrition initiative” for the VHCs.



Group interview with VHC in Kyar Kwin village, Bilin Township, Mon State.

Women representation in the VHCs/Volunteer working groups

A stronger focus on gender related messages and empowerment of women has led to greater representation of women in village health committees and volunteer working groups. The project communities have become more aware of gender equality and women are seen as trusted resources on reproductive health matters.

In most villages, at least half of the VHC members recruited were women. However, in two of the study areas in Mudon township, there were fewer women VHC members than men.

Based on the interviews conducted, the women were selected mainly because they were thought to be more suitable to carry out the activities related to reproductive health and women felt more comfortable to discuss these issues with them. Women were the ones who were mostly available in the village to carry out the activities. The importance of empowering the role of women in the village was also noted.

In one village, one of the VHC members mentioned that after the new government was elected, the government promoted gender equality and the villagers heard about that so they also paid attention to gender equality. Women were not included before but now the villagers tried to encourage women's participation. The VHCs said they heard about gender related messages from CV partner organisations, the radio, and the media.

"Women are influential in this village" said a VHC member from a village in Hakha township. "We also would like to empower the role of the women in the village".

Joint Information Sharing with Basic Health Staff

A combined result of information sharing efforts and the provision of incentives by the CV partner organizations, more villagers participated in the health education sessions provided by basic health staff.

Village health committees (VHCs) supported the Basic Health Staff (BHS), community-based organisations (CBOs) and other organisations to conduct health-related activities in all the study villages. To conduct health information sessions, first the BHS informed the village administrator, and then the VHC was then brought in to gather the village community to participate.

VHCs went door-to-door to directly inform each household to ensure participation, focusing especially on lower social groups. According to more than 50% of the VHCs and two key informant interviews with BHS, there was a shared opinion that the relationship between BHS and VHCs improved.

Comments from VHC, mothers, and the BHS revealed a shared observation that more people participated in the health education sessions since the CV project started. This could be a combined result of the VHC visiting each household to encourage people to come and the provision of some incentives (such as soap for hand washing and toothbrush, toothpaste and towels for personal hygiene).

The BHS noted that more people attended the session when it was jointly organised with CV partner organisations than when it was organised only by the BHS. The VHC mentioned that the information sharing practice had been improved and the village community was more interested in participating in the sessions.

"My work has become easier after the set-up of the VHC. Before, I had to do everything on my own including notifying and gathering village community for health education and other health-related activities. Now, VHC supports me in conducting health activities in the village and my work is running more smoothly."

—A midwife from Yaung Daung village

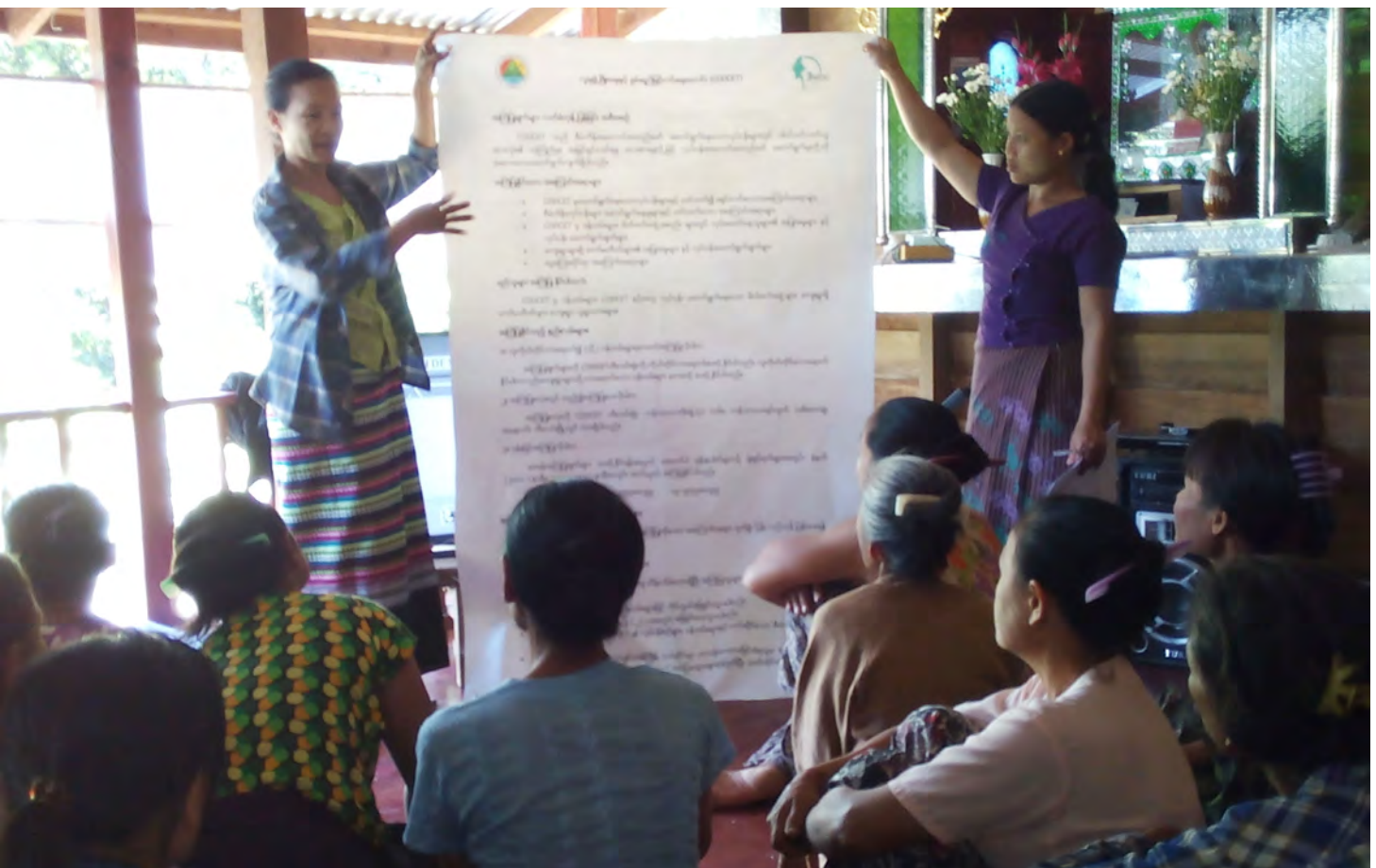
Community Feedback Mechanism

Community feedback mechanisms are a core part of the Collective Voices project. The practicing and strengthening of the feedback mechanism gives the project communities a voice and helps to better understand their health needs and concerns. 3MDG gives guidance to CV partners to engage the community about the importance of providing input on their existing health concerns. This is necessary to bring about change.

CV partners were trained by 3MDG-funded technical institution PACT on various aspects of organisational development. Soliciting feedback is one element of this. CV partners used written and verbal communication channels to ensure participation from all people was possible.

Written forms, such as suggestion boxes, suggestion forms, and suggestion letters, were not common. In response, CV partners developed different mechanisms for feedback in each area depending on the needs of the local community. For example, CV partners were encouraged to gather feedback from face-to-face workshops, community meetings, village health committee (VHC) monthly meetings, health education sessions, and provider and user meetings. The study found that in all villages, VHCs as well as lead organisations and/or partner community-based organisation (CBOs) collected verbal feedback from the community meetings. In some of the study villages, the village community gave their suggestion/feedback directly to the VHC members or partner CBO staff.

A picture showing VHC members explaining Community Feedback Mechanism to the villagers in Bilin Township, Mon State



In Mon State, the feedback mechanism was used by both the VHC and community members. VHC members, together with the lead organisations and CBOs, explained the feedback process using vinyl posters in the Myanmar language. (Although there were both Mon and Kayin ethnic groups, the CV partners decided to use a common Myanmar language for the printed posters but the information was explained in both of the local languages).

During the community meetings, verbal feedback was regularly collected from the community by the VHCs, partner CBOs and lead organisations. Based on the focus group discussions with mothers, the feedback mechanism was well known among the community. However, prior to this period, the community did not usually practice providing feedback/suggestions so they were still not accustomed to it, or they were happy with the services being provided so did not necessarily feel the need to provide feedback.

The most frequent feedback received was to have their own midwife and health centre in the villages. The study team also found suggestion boxes set-up in the study villages during a transect walk.

In Chin State, findings from interviews and focus group discussions (FGDs) revealed that community feedback mechanisms were not well understood at both the VHC/volunteer group level and community level. Awareness of the mechanism was low. While CV organisations could easily collect verbal feedback from the community through meetings, the community did not realize this as one of the communication channels of the feedback mechanism process.

During the FGDs with mothers, they said that the community-based organisations (CBOs) and village health committees (VHCs) were supporting the health-related activities of their villages and the village community already felt grateful about it. Mothers also mentioned that the villagers felt that these organisations were experienced and knew best so mothers did not want to give any suggestions. A few of the suggestions given to the VHC were mainly surrounding the request for medicines to be readily available in their villages.

During a KII with BHS in Takhauntaing Village in Mudon Township in Mon, they stated that there was no formal community feedback mechanism available at the rural health centre (RHC) or sub-rural health centre (SRHC). People came directly to Basic Health Staff (BHS) if they wanted to provide feedback/suggestion. During one interview with RHC staff, he said that he would like to set-up a mail box/suggestion box in the RHC but he could not do it without proper instruction or approval from the Department of Health, Ministry of Health and Sports.

“What they (CDDCET and VHC) were doing was complete for us. They support us in emergency situations and also loaned us money. We had nothing more to add.”

– Mothers from one CV village. They also felt hesitant ('arr-nar tae') to provide feedback to those who were already supporting their villages.

Village Health Fund

Different forms of the village health fund mechanism can be observed to support health emergencies including maternal and child referral services. Village health committees help manage and revolve the fund and increase the project community's timely service uptake from the nearest health facilities. Partners also provide assistance with transportation for emergency referrals.

CV partners had the autonomy to determine if they wanted to set up a fund mechanism and the regulations for the fund. CV partners and the village health committees (VHC) determined how the funds could be used - for all health emergencies, only maternal and child emergency referrals, and/or livelihood loans. However, in villages in Chin State, where there was a 3MDG-supported fund led by Maternal, Newborn, and Child Health implementing partners, these funds were only for emergency maternal and child referral services. These funds were part of 100% township referral coverage. In Mon, the establishment of an emergency referral fund was dependent on the CV partner project.

In the CV study villages of Bilin township (four villages), Mon state, the VHC established a revolving village health fund with CV support. The CV project provided seed funding which was added to community contributions. This was an attempt to create community ownership of a fund.

CDDCET supported villages raised 700,700 kyats per village with the combination of the CV support referral fund together with the contributions from the village community. In one village, each household had to contribute 3,000 kyats as member fees. For the other three villages, it was 5,000 kyats per household. For those who could not afford to contribute 5,000 kyats at once, the VHC allowed payment in installments.

In one of the villages, the VHC collected 5,000 kyats as member fees and monthly fees of 200 kyats for revolving the fund. The fund provided two types of loans; referral loan and others (for other needs such as livelihood). The maximum amount loaned for referral was 100,000 kkyat and the interest rate is 1% whereas for the other loan, the amount was 50,000 kyats with the interest rate of 2%.

In two of four study villages, the VHC made a list of pregnant mothers in the village and reserved a portion of the fund depending on the number of pregnant mothers (potential referral cases) so as not to exhaust the fund from other loans. It revolves with the returned amount and the interest so that it can maintain long-term sustainability

Some VHCs that were managing village health funds in Bilin Township mentioned that they would like to continue revolving the health fund after the project ends to support mothers and children during emergency referral.

A village health fund was not established by the VHCs in Mudon township study villages, Mon State. Rather, in these villages, the VHC members and the partner community-based organisations (CBOs) provided support and transportation assistance for the pregnant mothers and children under five years for emergency referrals. In all four study villages, referral transport was provided.

In two study villages in Mudon Township, an ambulance was available for any health emergency. These were financed from villager contributions as part of overall village development. Ambulances were rudimentary and were primarily used as a form of transportation. In the other two villages, the CBO had access to their own vehicle and used this for referral services. In all villages, the midwife would accompany the mother to receive services. The CBO covered the fuel costs of transport payment through their own funds (non CV funds).

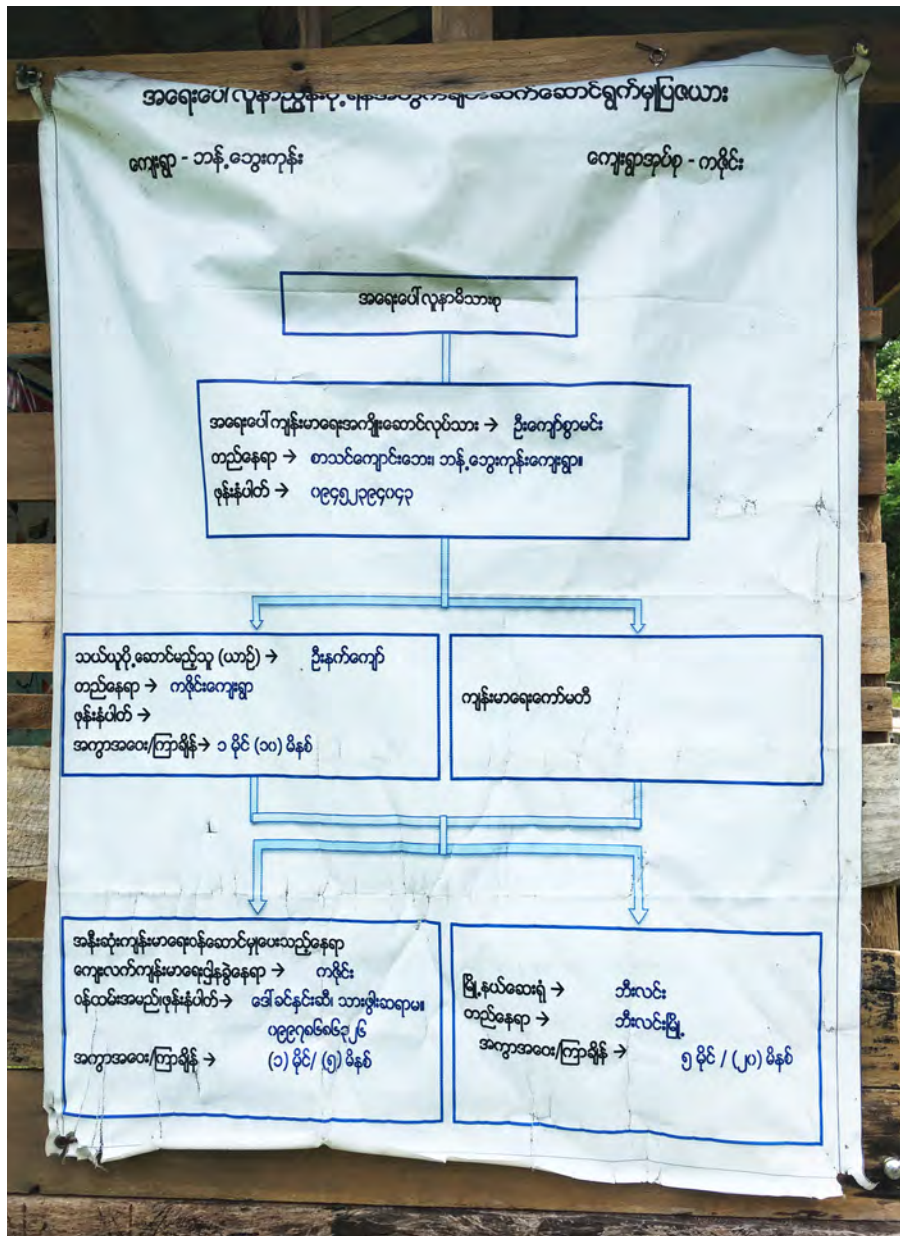
In the study villages of Mindat Township, Chin State, Myanmar Red Cross Society/Danish Red Cross (MRCS/DRC) provided Maternal, Newborn, and Child Health (MNCH) emergency referral support to the entire township. However, in villages where the VHC were revitalized by a CV partner, (AYO and partner CBO, COLDA) the partners provided funds for emergency support as part of their referral fund. The CV-supported referral fund provided initial funds for transportation that allowed women to access services in a timely manner. When the women reached the township services, mothers fitting certain criteria could claim money for emergency referral services and transport funds from MRCS/DRC in order to repay the village referral fund.

Emergency Referral

“Uncle, who is a VHC member, told me to go to the hospital and reminded me that midwife already told me to go to the hospital for delivery because this is my first child. We borrowed money from the committee. The committee gave me 100,000 kyat as referral loan so we could bring money to the hospital. I was in pain and couldn’t notify the committee but they came to my house and provided the loan for me.

A VHC member, auxiliary midwife, traditional birth attendant and my family accompanied me to the hospital. I was satisfied to deliver at the hospital because the delivery was smooth and my baby was healthy.”

– Mother who had experienced an emergency referral during delivery from Kyar Kwin village.



A poster displayed in the middle of the village describing the emergency referral support pathway and the contact persons, in Mon State. CDDCET

According to interviews with mothers and VHC members, there was an active uptake of MNCH referral services. Mothers are more confident to go to the hospital because of growing awareness and finances. In Mon, a VHC member or CBO staff member accompanies mothers to the hospital, which provides reassurance.

In most cases, mothers did not refuse to go to the hospital when being referred as most of the villages had emergency referral support services. In a few cases when mothers refused to accept a referral it was because there was no one to accompany and stay with her at the hospital (e.g. husband was away). In the poor group in Mon, mothers worried that they might not be able to afford the costs where there was no fund.

4. 3. HEALTH-SEEKING BEHAVIOURS OF MOTHERS (RELATED TO MATERNAL, NEWBORN, AND CHILD HEALTH)

The following sections on health-seeking behaviour reveal findings that are linked to gender relations. However, the study did not specifically investigate gender relations. The overall findings show that in Chin, husbands have more input into family planning, pregnancy and birth decisions than they do in Mon State. In both areas, couples discuss these issues together, but reported comments reveal that Chin men have more influence on MNCH decisions and at times the final decision on these issues.

Increased antenatal care among mothers, including migrant mothers, was observed. There was also a reported decrease in reliance on traditional birth attendants as trained health providers became more accessible. Men continue to influence on reproductive health matters, and are still seen as the key decision makers. However, women are now more actively involved in the process, aware of their options, and make final decisions by themselves or together with their husbands.



Mothers participated during an FGD conducted in Mon State.

Antenatal Care

In all the study villages, most of the mothers sought antenatal care from the midwife (MW). On some occasions when the MW was not available, mothers received antenatal care from the auxiliary midwife (AMW). In a few of the villages where the traditional birth attendants (TBAs) were still active, mothers also went to them to receive care.

Mothers were encouraged by multiple sources to obtain antenatal care from the MW. These included the assigned basic health staff, MW, CV partner organisations, village health committee members, AMWs, and village administrators. Mothers accepted antenatal care because they wanted to check the baby's condition and position, to receive immunization and vitamin tablets. They felt the MW was more available compared to the past and had increased trust in her skills. There were a few mothers who still practiced going to the traditional birth attendant during their pregnancy mainly to check the baby's position.

In Mon state, a majority of mothers received more than four antenatal care visits. During a Focus Group Discussion (FGD) with migrant mothers in Mudon Township, it was found out that migrant mothers went to MW for antenatal care and received more than four antenatal care visits. A mother who participated in FGD in Mon state mentioned that, "We went to the midwife for antenatal care because we received health education from them (pointing the project staff from CDDCET) about the importance of antenatal care." Another mother added, "The midwife also came to the village regularly to provide health services."

In Chin State, mothers mostly received 3-4 antenatal care visits. A mother from one of the study villages in Chin state said, "I knew about antenatal care from the assigned midwife, project staff from COLDA and from other organisations."

"I went to the midwife to get antenatal care because the midwife was assigned by the government to provide health services for us", said a mother from Mindat village. She added, "The midwife herself explained it to us and told us to get antenatal care".

During key informant interview with a Basic Health Staff (BHS) in Mindat Township, it was found that pregnant women were receiving nutritional support from Maternal and Child Cash Transfer (MCCT) Programme supported by LIFT. To receive this support, pregnant mothers needed to present their Mother and Child Health (MCH) Record Book, which was filled by the BHS during antenatal check-ups. This encourages mothers to seek antenatal care services from BHS. The MCCT Programme is operating in all four of the study villages in Mindat Township, but it had not started in the study villages of Hakha Township.

Decision making for antenatal care

In most of the study villages, mothers talked about their pregnancy with their husbands and their family but all mothers made the decision themselves to go for antenatal care. However, in a few study villages in Mindat Township, Chin State, mothers discussed with their husbands about antenatal care and made the decision together to choose the one they thought was the most skillful.

"We mainly discussed with our husband about whom we should go to for antenatal care and made the decision together to choose the one we thought was skillful. The health staff (midwife) were skillful so mothers mostly got antenatal care from the midwife", said the mothers who participated in the FGD from Mindat township.

Delivery

In Mon State, a majority of the mothers delivered with the Midwife (MW). Auxiliary Midwives (AMWs) and Traditional Birth Attendants (TBA) (where active) sometimes assisted the deliveries attended by the MW. Mothers with their first pregnancy were referred to the hospital by the MW for the delivery. When the MW was not available, the deliveries were attended by AMW and sometimes by both AMW and TBA. Very few mothers delivered with TBAs.

"Mothers delivered with the midwife because midwife is now easily accessible in our villages and when mothers needed emergency referral, the midwife (who is also a village health committee member) accompanied the mothers to the hospital", said a mother during a focus group discussion.

In Chin State, mothers delivered with the MW if she was available. Otherwise, the deliveries were attended by the AMW and in some cases, the TBA. In a few villages, some mothers delivered at home by themselves and their mothers, aunts or their husbands assisted the delivery. In one of the study villages, the MW was away to attend the nursing school, so the mothers mostly delivered with the AMW. A few of the mothers from FGD said that they felt hesitant (“arr-nar tae”) to call a MW when they were in labor at late hours so they called the AMW and the TBA who were readily available in their village. A few mothers also said they were close with TBAs and felt safe to deliver with them.

Decision Making for Delivery

In all study villages, first pregnancies were referred to the hospital for the delivery by midwife. In Mon State, the study found that women discussed delivery options with their husbands, families as well as with the MW, but in the end, made her own decision. In most of the study villages in Chin State, mothers discussed delivery options with their husbands, and sometimes the AMW (who is also a village health committee member) was consulted. The final delivery decision was made by the mother and the husband together.

A Chin mother mentioned, “My husband told me that since it was my first pregnancy, I may be at risk and told me to deliver at the hospital” during a Focus Group Discussion (FGD). However, in one village in Mindat Township, the husbands mostly made the decision about the delivery. Mothers in this village said usually they delivered at home by themselves. In case of any difficulties, the husband would get the person he trusted most to assist with the delivery.

Birth Spacing

Good knowledge about contraceptives and family planning can be found amongst mothers. Collective Voices partner community based organizations are essential for information sharing and community mobilization to increase service up take.

A majority of the mothers who participated in the focus group discussions in both Mon and Chin States were aware of birth spacing methods and some used modern contraceptive methods for family planning. In Mon, most mothers use oral contraceptive pills, 3-months depo injection, and a few mothers used an intrauterine device (IUD).

In Chin State, where Marie Stopes International has a sexual and reproductive health programme targeted to urban areas, COLDA provides relevant information to the project villages so that mothers from these villages could access intrauterine devices and implants. Village women received contraceptive and family planning knowledge from MW, CV partners, CBOs and other organisations in the township. The repetitive messages together with available services encouraged contraceptive uptake if the women wished.

In all study areas, mothers who did not use birth spacing methods said that they were not using those methods because they were afraid of the side effects. Some said they still wanted more children. In Chin State, mothers also mentioned that they did not use birth spacing methods as their husbands did not agree with using contraceptives. Although most women mentioned discussing the issue of birth spacing with their husbands, they ultimately went with their husband’s final decision



:A student is washing hands before lunch at Primary School at Yaung Daung Village, Mudon Township, Mon State

on whether or not to use contraceptives, which was more often than not against the use of contraceptives. One mother in Mindat Township used three months depo injection as a birth spacing method without telling her husband. Her husband did not agree to it and she said she was tired of consecutive pregnancies without adequate time between births. However, in Mon State, mothers decided by themselves whether or not to use birth spacing methods.

Child Health Care Practice

As part of overall health education and promotion messages in all villages, mothers received under five years child health care education from CV partners, AYO, CAD, BF and CDDCET, as well as from the village midwife (MW) and auxiliary midwife (AMW). Mothers who participated in focus group discussions (FGDs) said that they noticed their child was ill when the child had fever, warm palms and soles, a warm mouth when breast feeding, and was not active and or eating well.

Child health care from formal health service providers is now more accessible. Traditional medicine is not common, but it is still utilized in some cases.

Mon

In Mon it was common for mothers to go to the nearest health centre or called the MW when their children were sick. If the child did not get better, they sent them to hospital.

Traditional medicine was not very common in Mon as they have become accustomed to seeking health services and do not have as many infrastructural barriers to accessing medical care as in Chin state. For example, a mother from Mon State said during a FGD, “Nowadays, we went to the health centre directly when our child is sick. We didn’t have motorbikes before in our villages and if you wanted to reach the health centre, you needed to use horse-carts. Transportation becomes so much easier”. A mother from another FGD session also mentioned that, “I just go to the midwife whenever I think my child has a fever. We can reach the midwife easily now as she’s available close to our village. And we can also call her through our mobile phones.”

Chin

In Chin State, mothers mostly went to the hospital directly because they thought that the medicines were not available in health centres. In all of the study villages, some mothers mentioned that they gave analgesic medicines such as biogesic, paracetamol syrup, and metro syrup to the child when the child was sick as immediate measures before seeking health care.

A few mothers gave traditional medicine such as the juice from mashed honey and Khway-Thay-Pan leaves or mixed turmeric powder and soot together with lime juice. They learned these natural remedies from their elders as initial treatment. Such practices were reported more frequently by mothers in Chin than Mon State.

In one village in Chin, there is an informal health practitioner and mothers brought babies to him when their babies got sick. In Chin access to health providers is also limited. A mother from Chin State said, "We went to the community health worker from the nearby village when our children were sick. The health staff were not available in their posts and we were not sure whether the medicines will be available at the health center or not. If the child was not relieved, then we went to the Mindat hospital".

There were also emergency referrals of children in some of the study villages in Mon and a few in Chin during the past one year because of the high fever, dengue fever, and diarrhea. It was common to go first to the village MW and she decided to send them to hospital if needed. Mothers and families mostly did not refuse to go to the hospital when the MW/BHS suggested that the child needed to be referred. VHC helped and arranged transportation and financial cost to go to hospital.

Immunization

Mothers' now have better knowledge and are more aware of proper immunization for their children. Most of the children in the villages now receive immunization as a result of their mother's participation in community mobilizing activities arranged by Collective Voices partner community based organisations, health staff, and village health committees.

Villagers received immunization knowledge from Basic Health Staff (BHS) as well as from partner community based organisations in all study villages. Village health committees (VHCs) reported that some people needed encouragement since some villagers did not have enough health knowledge and some parents still believed that immunization can cause fever in children. To organize immunization events, BHS informed the village administrator and/or auxiliary midwife one day in advance, and the village administrator held a meeting with VHC/Volunteer Group who went door-to-door to announce immunization.

Almost all children in the study villages received immunization. According to mothers who immunized their children: immunization prevented diseases; immunized children were healthier and rarely got sick; and immunized children had good resistance even when they were sick compared to those who were not immunized.

VHCs and mothers both felt immunization practice had increased in the last 2 - 3 years. "We learned that immunization can prevent diseases. Previously, we had a lot of measles cases among children in our village but now, we don't hear about measles cases anymore".

Numbers went up because mothers' knowledge on immunization increased and they were aware of the value and benefits of immunization. In addition, in conducting door to door visits and notifying mothers, VHCs made sure that mothers participated in immunization events to get their children immunized.



Before the creation of the VHCs, one village in Mon State reported that one announcer was paid by the village administration to inform the immunization dates. Other sources of information were noted to be Facebook, especially for the younger generation, and positive health information provided in Thailand where many people go to work and come back.

For the migrant community in Mon State, the midwives contacted their respective bosses and asked for the list of children to be immunized and told their bosses the immunization date. The bosses informed the mothers from the migrant community to get immunization. An immunization card was given to the mothers and if they moved to another place, they could request immunization services from the nearby health center using the card.

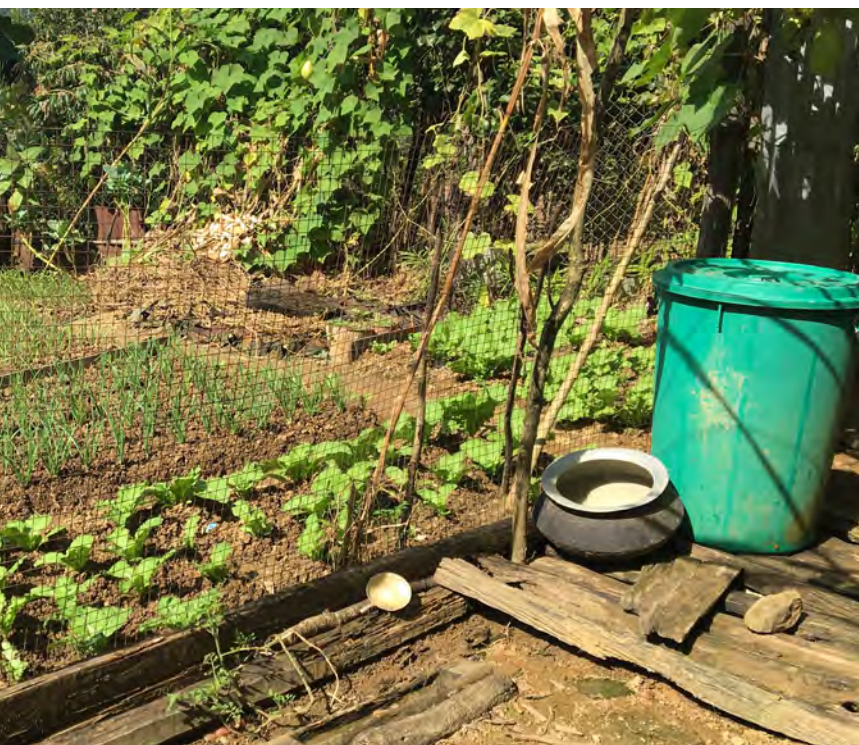
4. 4. HEALTH SEEKING BEHAVIOUR OF MOTHERS AND CHILDREN (RELATED TO PERSONAL HYGIENE)

Personal Hygiene

Mothers and children were aware of personal hygiene practices. They practiced hand washing at home, they wanted to be healthy, and keep their hands clean to prevent diseases. It was common for people to wash hands before and after eating, before preparing food, and after using the toilet. In most cases, mothers stated that they practiced hand washing according to the proper hand washing technique they learned from health education and promotion sessions conducted by CV partners and their partnering community-based organisations (CBOs). A few of the mothers mentioned that sometimes they were busy with their house chores and could not follow all the proper steps of hand washing.

▲ A toilet in Ruavan Village, Hakha Township, Chin State

▼ A proper fence was put up around the vegetable plantation in Thi Phul village, Chin State.



Compared with the last 2 years, personal hygiene practice (proper hand washing) has improved for both adults and children because villagers received a lot of health information from health staff as well as from the village health committee (VHC)/volunteers. One VHC member said

“Previously in a village festival, we washed our hands after eating but now we keep washing hands before and after eating and there is soap at the front of the pandal” The community received health education and promotion from CV partners and their partnering CBOs about personal hygiene and environmental sanitation and they tried to practice accordingly. VHCs/volunteer group further encouraged the community to take up the positive hygiene practices by regularly conducting visits around the village to check the status of fly-proof latrines, the use of latrines, and the cleanliness of the compound. In some villages, VHCs also provided regular health information not only about personal hygiene but also about household and compound sanitation in villages.

Children received personal hygiene education from their mothers, midwife, CV lead organisation, partnering CBOs as well as from teachers from school as there is a school health programme in all study townships. According to the interviews, children wash their hands more than adults in all villages

Water & Latrines

CV partners, basic health staff, and village health committees arrange community based activities in the villages to raise awareness and engagement around good sanitation practices. As a result, the communities are now more aware of environmental sanitation practices.

It was found that the community received health information regarding the clean drinking water and the use of fly-proof latrines from Basic Health Staff (BHS) as well as from the CV partners and village health committee (VHC) members. In addition, CV partners in Chin State also provided environmental sanitation education to the villages. It was noted during the transect walk that some of the wells, the water containers, the gravity flow systems, and latrines in the study villages were built/supported by other organisations implementing development projects.

In Mon State, the main water source was from wells. In Chin State, the villages got water from the spring water connected to the villages with a gravity flow system. All villages are using the same water source they have been using from the last 2 years. A majority of the community from the studied villages boiled the water for drinking and a few of them drank filtered water. Most of the people learned that drinking boiled water can prevent the germs and diseases, abdominal pain, diarrhea, and kidney stones if there is a high presence of lime in the water. In some villages, BHS and VHC worked together to distribute the water treatment tablets.

A majority of the households in the studied villages have fly-proof latrines and the community uses latrines. In a few villages, there were a few people who could not build latrines due to their financial difficulties, and they still practiced open defecation. In some villages, due to the soil condition, the village could not afford the regular maintenance costs of a latrine. One village’s quarter in Mon did not have latrines because they could not afford them and because of

poor health knowledge. However, most villagers know the benefit of using the latrine, one said, “because of using latrine, the diarrhea cases have decreased in our village”.

In two of the villages in Chin state, BHS together with VHC randomly checked the latrines and a fine of 500 kyats had been charged if the latrine is not kept clean and if the people did not use the latrine. This fine goes back into the VHC fund for providing programs and services to the community.

For waste disposal, villagers were mostly burying and burning the garbage but did not burn the waste in the rainy season and instead kept it in the compound. In some villages, VHC/ volunteer working groups gave health education and promotion about environmental sanitation. During the transect walk in Chin state, it was noted that the compound around the households and the villages’ lanes were kept clean.

Health Education and Promotion Sessions

Health education and promotion sessions, facilitated by Collective Voices partners, showed good turnout as they were made more interactive. By attending video screenings, family events with various contests, other activities, and gaining incentives, community members became more engaged in health education and promotion.

Health education and promotion was a common activity delivered by Basic Health Staff (BHS), CV partners, and other development actors. In the study villages, it was found that the village health committee (VHC) organised the health education and promotion sessions in the villages. VHC/volunteer working group informed and encouraged each household (door-to-door) in advance to attend the health education and promotion sessions. Mothers learned new things they did not know before and learned to practice properly, for example, to sleep with bed net, boil the water for drinking, and cover the food to prevent it from the flies. One mother replied that “Health education sessions were beneficial because I learned new health information that was useful for us.”

The health education and promotion events conducted by CV partners were better attended than those organised by the BHS. There were more interactive because they used videos and family contest events as well as the provision of incentives. More people were interested and happy to participate in the event.

In the migrant areas in Mon state, all workers are from construction sites and are not at home all day, so health staff (both Bright Future and midwives) left information one day in advance at their place for health education and promotion sessions and they conducted the sessions in the late evenings in their migrants’ clusters.

During the interview with the VHC members, it was suggested to provide incentives for the villagers during health education and promotion sessions to encourage greater attendance.

05

KEY FINDINGS AND DISCUSSION

1. Village health committees, with the imperative and supportive role of lead Civil Society Organisations (CSOs) and implementing Community Based Organisations (CBOs), facilitated and reinforced behaviour change in the community by following up on health messages and engaging the community in seeking and demanding health care.

VHCs have long been a source of community support in many countries.³ There is evidence that they are effective at “improving quality and coverage of health and health outcomes.”⁴ Witnessing similar potential in Myanmar, implementing partners for the CV project helped to form or revitalize VHCs/ Volunteer Working Groups.

One of the objectives of the CV project was to increase community engagement in seeking and demanding health care. VHCs played a key role in facilitating engagement between the village community and the basic health staff. VHCs were the entry points for CBOs and Basic Health Staff (BHS) to roll out their activities in the villages. VHCs mobilized and gathered the community to participate in health related activities. They were especially successful at engaging the community as VHC members, who live in the community, could go door-to-door to make sure everyone was notified of activities. As a result VHC organised health education and promotion sessions were better attended than BHS organised health education and promotion sessions. BHS were better able to complete their work.

VHCs further engaged the community to help the adoption of positive health behaviours. VHC conducted regular visits around the village to check the status of fly-proof latrines, the use of latrines, and the cleanliness of the compound. In Chin state, a fine was also set in some of the villages for the households who did not follow the positive practices. As a result of such oversight, community members participated more regularly in healthy behaviours.

“My work has become easier after the set-up of the VHC. Previously, I had to do everything on my own including notifying and gathering village community for health education and other health related activities. Now, VHC supported me in conducting health activities in the village and my work is running more smoothly”.

–A midwife from Yaung Daung village

As elected members from the community and having received training from CV partners, VHCs have become trusted entities that are able to effectively encourage behaviour change. This was particularly seen in women VHC members’ facilitation of positive behaviour change among women and mothers, especially for antenatal care, delivery, and immunization related health-seeking practices. Women and mothers in the villages felt more comfortable discussing general reproductive health related matters with women VHC members.

In Chin state, because of the geographical challenges, the midwife could not be available at all times. The presence of an auxiliary midwife, women VHC member and/or women health promoter further supported the delivery of health messages and the provision of necessary health care.

2. Community feedback practice has gradually been integrated into the project community.

The Collective Voices Project designed a community feedback mechanism to engage with the voices of the community on health matters. According to interviews with Basic Health Staff (BHS) there were previously no means for communities to provide feedback on health services at the Rural Health Centre (RHC) or Sub-Rural Health Centre (SRHC).

As part of the CV project, each CV partner set-up a feedback system. The success of the feedback mechanism depended on the emphasis which the partners invested into it. For example, in Mon State, CDDCET prepared and printed out a vinyl to be used during community meetings to explain and encourage the feedback. In other villages, feedback was requested at the end of the community meetings or sometimes after the health education and promotion sessions. Community feedback was provided verbally in group settings in a face-to-face manner and an in-person, direct manner. Written feedback, through suggestion boxes or suggestion letters was rarely practiced.

° A cultural barrier that inhibits a person’s ability to openly express his or her own opinion or concerns as it assumed to have the potential to make other parties uncomfortable or displeased

It was frequently mentioned that the community did not have anything more to add on the work of the BHS, community-based organisations, and village health committees or other organisations as those organisations were already supporting the villages considerably. It was also brought up during the study that people felt hesitant (‘arr-nar tae’)° to provide any feedback that could be perceived as a complaint.

3. Community-based organization (CBO) health education and promotion sessions coupled with other development efforts contributed to the uptake of good health practices by community members.

Health education and promotion around Maternal, Newborn, and Child Health (MNCH) and hygiene increases awareness of, and assists the demand for, health products or services. Education and awareness is the first essential step to demand driven health care. Both study findings and partner reports indicated that the use of interactive methods together with incentives increased the number of people coming to the health education and promotion sessions and expanded the number of people aware of key health behaviours.

The study interviews indicated a general awareness of correct health-seeking behaviours during pregnancy, delivery, emergencies, and for child health that aligned with the information provided by the health education and promotion sessions. While a change in uptake of services cannot be directly measured by the study, information gathered from key informant interviews and information from some of the CV partners' reports (which recorded the number of times a referral system was used), show that people were correctly seeking assistance. Whether this has changed from before the CV intervention or if people were seeking timely support cannot be determined by the data.

CV partners built upon and added to the health education messages delivered by the Basic Health Staff (BHS) and other actors forming repetitive and complementary messages. This was primarily found between the BHS and CBOs.

Previously, BHS provided health information sharing sessions in the villages which created initial awareness of topics such as vaccinations, antenatal care, handwashing, and emergency referrals. With the introduction of the CV project, health information was repeated by the CBOs/lead organisations, but in a more interactive manner (e.g. games, health quiz, festive booth or family show in local languages) and in some instances these included incentives for those who attended the HE sessions (e.g. refreshments or promotional items like soap, toothbrush, toothpaste, towel, etc.). These incentives, which were funded by 3MDG directly, increased the interest of the community to participate in the health education and promotion sessions. It was also easier for them to recall the health messages they had previously heard as it was conducted in an interactive way. It was evident from the study findings that the village community was aware of the appropriate health behaviours and beginning to practice accordingly, especially in the areas of improving personal hygiene and seeking maternal and child health services.

Personal hygiene was emphasized mainly by handwashing and latrine use. There were repetitive and complimentary messages on hand washing and latrine use messages from various sources – school, CV partners, and BHS. The consistent messaging created a norm to practice handwashing at critical times (after toilet and before meals). When probed, some mothers acknowledged that when in a hurry, they did not follow the correct procedure (washing thumbs, in between fingers) and just wash quickly. This indicates mothers are aware even if they do not follow all steps. These findings show that consistent and repetitive messaging, particularly by varied sources, can positively affect behaviour change, though more efforts are needed to ensure adherence when time is short.

Latrine use varied in villages and among social groups. The transect walks revealed that in villages where latrine use was common, there was a general trend towards fly-proof latrines and hand washing points at latrines. However, there were a few households in the project villages of Bilin Township that did not widely use latrines because of poverty and poor soil conditions. In these households, because there was a cost to build and maintain a latrine under such conditions, the poor groups could not afford latrines even if they knew how to use them.

It was also noted that there were other actors providing services that further reinforced positive health behaviours. Facilities, such as latrines, water containers and the gravity flow system, built by other development actors, increased the probability that people would act upon the behaviour change messages provided by the CBOs. For example, hand washing practices and the use of latrines.

A joint Ministry of Health and Sports and Ministry of Education school health programme promoted hand washing and nail clipping. In some schools water and toilet facilities were built. Other initiatives, both 3MDG and non-3MDG funded, further reinforced uptake of MNCH behaviours. For example, Marie Stopes International's family planning services provided contraceptive methods. Livelihoods and Food Security Trust Fund (LIFT) supported a maternal and child cash transfer nutrition programme in Chin state by providing cash for nutritional support that encouraged mothers to access antenatal care.

In Mon, the availability of mobile phone coverage allowed women to call midwives for delivery and village health committee members for emergency referral. In some instances, mothers stated they received health information from Facebook. Given the facilities and reinforcement provided by these other development entities, uptake of good health practices was possible. As a result, CV efforts, along with other development efforts, became a part of a synergistic effect of inducing behaviour change.

One final observation was in gender relations. The role that gender relations (men's role and socio-cultural norms) play in MNCH behaviour and outcomes is globally acknowledged.⁵ The study did not investigate the extent to which gender sensitization sessions conducted by CV partners played a role in MNCH behaviours. CV partner project reports show that gender sessions were a larger focus in Chin than in Mon. The study findings around health-seeking behaviours for antenatal care, delivery, and birth spacing revealed that while in both Chin and Mon couples discussed options together, Chin women relied on men's input for the final decision more than in Mon.

4. The presence of a village health fund and the role of the VHCs/ Volunteer Working Groups during emergency referrals played an essential part in encouraging the village community to seek health care in a timely manner.

A funding mechanism to support emergency referrals, whether it was 3MDG-funded or established by the VHC, was an integral part of facilitating and encouraging the community, especially pregnant women and their caregivers, to follow appropriate healthy behaviours. Since the loan repayment terms, 1% on 100,000 kyat, were acceptable to the community, people did not face barriers in accessing the fund and were more likely to repay according to the terms.

Previously, in one of the study villages in Mudon township, the mothers in the focus group discussion shared, “A few children had been referred during the past year because they had dengue-like symptoms. In one family who did not have money, the child was not relieved and the child died. The child was referred to Mawlamyine hospital but the mother could not afford to stay at the hospital for long so she had to come back to the village.” This illustrates that a lack of funding prevented community members from adequately accessing health services which led to an unnecessary death.

Through the CV Project, village health funds were immediately available in 20 project villages in Bilin township and emergency transportation services were also available in 24 villages in Mudon township which encouraged villagers to access services, particularly emergency obstetric care. According to the International Rescue Committee Knowledge, Attitudes, Practices (2016) MNCH Chin State evaluation findings, “the failure to recognize the gravity of the situation and the lack of money for transport and care were important reasons for first delay in seeking care”.⁶ The immediate availability of the referral funds increased the likelihood that the community would reach the hospital in a timely manner. Families did not have to waste time by searching for resources to cover the costs of transportation and medical fees to go to the hospital in emergency situations.

VHC members further supported the referral process as patient advocates. For example, where the auxiliary midwife and midwife were members of the VHC they provided necessary health care and advice, provided transportation, and/or accompanied mothers and families to the hospital. This patient support gave mothers and their families the confidence to visit the hospital to receive health services in a timely manner.

The CV study found that overall VHCs and village health funds (VHFs) were capable of being sustainable over the long-term. In the villages that had VHF, the VHC mentioned that the committee would like to continue revolving the health fund mechanism after the project ends to provide support, especially to mothers and children from their village during emergency referral.

“The midwife told me to go to the hospital. I discussed it with my family and village health committee. VHC members encouraged me to go to the hospital. The VHC loaned me 100,000 kyat and also arranged the car for me. As I did not have enough money, I was afraid to go to hospital and I just planned to deliver the baby at home. But the VHC encouraged me and my husband also wanted me to deliver at the hospital. Thanks to the VHC members and also the hospital staff, I had a smooth delivery”.

– A mother from Kha Lauk Inn village, who had an emergency referral for delivery

Focus Group
Discussion with
mothers at Hton
Man Village, Mudon
Township, Mon State



06

CONCLUSION

This study recognizes that civil society can promote people-centered health by creating an enabling environment for broad and active citizen participation. Local civil society actors are “demonstrably and deeply committed to relieving the suffering of Myanmar’s poor and marginalized.”⁷ The CV project invested in the capacity development of lead civil society organisations (CSOs) and local community-based organisations (CBOs) and in the formation and revitalization of the village health committees (VHCs)/Volunteer working groups. This enabled the VHCs, with the support of lead CSOs and local CBOs, to mobilize the community and encourage community participation in health-related activities for better health outcomes.

The introduction of VHCs and health education and promotion sessions encouraged villagers to be aware of and practice positive preventive health care. They also help people to know how and where to seek services. The creation of VHCs has helped to educate people about their right to health and encouraged them to share their concerns and suggestions. This is the beginnings of social accountability which in turn will enhance responsiveness of the health system.

The CV project and its partners are an instrumental part of the collective approach to catalyze a positive behaviour change effect for improved health outcomes. However, the CV project alone cannot change the behaviour of the community. For example, access to infrastructure can also contribute to community engagement in health behaviour. The building of latrines, water storage containers, and the gravity flow system has helped with better handwashing practices. In addition, the expansion of the mobile network in the last two years was also noted as being a factor that helps people reach the midwife for delivery services and get emergency referral assistance in time.

Focus Group Discussion
with mothers in Bilin
Township, Mon state.

The CV project has helped deliver behaviour change messages and VHCs are reinforcing the community's adoption of those messages. In the meantime, the infrastructure and communication developments have made it possible for people to act upon those messages and utilize health services as necessary. Collectively these have led to increased health-seeking and health participating behaviours among Myanmar's poor and vulnerable populations in the study communities.



07

RECOMMENDATIONS

1. There should be continued support of village health committees (VHCs)/Volunteer Working Groups and community-based organisations (CBOs) through relevant funding and capacity building support.

VHCs/Volunteer Working Groups can play a governance role in village level health service demand, but this requires the investment of time and resources to build up a sustainable entity. The key benefit of a VHC is that it is comprised of members who are representatives of the VHC community and are thereby part of the issues that affect that community.

Over time both well established and recently formed VHCs have shown progress with funding and capacity building support. Well-established VHCs have matured and members better understand their role to support positive health outcomes in their community. VHC members improve their skills and continue to feel validated by training received from civil society organisations (CSOs) and CBOs. This has been particularly evident with the support for emergency referral and in the VHCs' organisation of health education and promotion sessions.

For newer VHCs, training and capacity building are necessary as these VHCs are still developing the capacity to stand independently. These committees rely on the CSOs and/or CBOs to provide health education and promotion messages as their skills are limited. At this time, VHCs can currently only provide follow-up assistance on message delivery. However, they excel in mobilizing the community to access services, through collaboration and coordination with health service providers.

These VHCs will require additional support to fully develop their skills and become a long-term sustainable resource. Further, helping foster and build functioning VHCs has other advantages for additional development links.

External organisations (INGO or LNGO) seeking to support the community will be required to work through an entity that is already present and well-functioning within the community. This may be a positive pull factor for other organisations to enter as there will be less start-up efforts necessary.

2. A context-appropriate community feedback mechanism should continue to be explored to encourage a constructive feedback culture so that the community voices can be heard and their concerns can be addressed.

It is important for CV partners to encourage the community to get used to sharing their concerns and suggestions alongside the provision of a feedback mechanism. The views of civil society organisations/community-based organisations and local health needs received in the community feedback mechanisms should be incorporated into the township health planning, budgeting, and health programme decision-making processes. The feedback mechanisms should be linked with the township structure and system which will increase the responsiveness of the health system.

3. Collective Voices (CV) health education and promotion activities should be in communities where there is a presence of other development partners and services as this has encouraged the target communities to practice healthy behaviours and facilitated CV's overall accomplishments

Health education and promotion as a standalone intervention does not result in behaviour change. Further, information alone is not enough to change behaviours; health information and education sessions should be accompanied by services that encourage people to practice the behaviours. The study revealed that the presence of the hardware (infrastructure such as the availability of water for handwashing, an auxiliary midwife/midwife for assisted delivery, referral funds for emergency care) together with software (information, knowledge, and skills) allowed people to act upon the health messaging.

There was no evidence to show community uptake of infrastructure and health messaging was affected based on who the implementing partners (INGO, LNGO, GoM) were. This was evident in the multi-partner approach in handwashing. Infrastructure was contributed by an international non-government organisation and the Ministry of Health and Sports and Ministry of Education. Messages were reinforced in schools and as part of CV health education and promotion sessions. This all had a synergistic effect in inducing behaviour change for positive health outcomes.

For example, in a Chin village during a transect walk, there was evidence of latrine use in one community that had piped water. The community's compounds were generally clean with animals fenced off. Acting upon handwashing messages was easy because the facilities were available. While behaviour change does not automatically coincide with the availability of facilities, having the facilities available makes behaviour change possible.⁸

There was also a positive relationship between health education and promotion activities in the villages and general awareness of correct Maternal, Newborn,

and Child Health (MNCH) and hygiene behaviours. However, the uptake of correct health practices was positively influenced by availability of support services (funds – referral funds or LIFT cash transfers, transport support for emergency referrals, water points, and latrines).

This finding was supported by the inverse relationship for latrine use. For example, people who were aware of the positive health outcomes for latrine use, but could not afford to build a latrine, would still use open defecation regardless of knowing the health benefits. These examples indicate that the health information is the first step to creating demand, but acting upon the information requires means to do so.

4. Community based referral funds should be a part of the village health committee (VHC) portfolio.

The immediate availability of funds has allowed community members to access services without delay and increases the likelihood that people will access services because the loan repayment terms are acceptable to the villagers. Referral funds have also provided the VHC a level of credibility with the villagers.

The immediate availability of funds was the primary motivator that allowed the project beneficiaries to seek health care in a timely manner. However, the VHCs also played a secondary supportive role. VHCs provided other means of support such as ensuring patient transport to the hospital, patient advocacy at the hospital, and assistance to organize the referral. Further, villagers could rely on the VHC, through the VHF, for a concrete intervention that allowed them to take immediate action rather than delay decision making.

5. Initial seed funding and relevant training should continue to be provided to VHCs/Volunteer Working Groups to establish a sustainable community based referral fund.

The study reveals that referral funds increased the uptake of emergency referral services. It also built a sense of community health autonomy so villagers could take care of their own health needs. In an indication that villagers value these funds, some VHCs have established community contributions to a fund for health emergencies. However, communities do not always have the means to establish their own health fund.

Initial funds from an external source will enhance the efficiency of a village health fund. This finding is in line with research conducted on VHCs and health funds in India. It showed that seed funding may be necessary for the funds to initiate but with strong support like CV partnering civil society organisations and community-based organisations can provide, the fund can revolve and become larger and stronger over time.⁹

It has also been observed however, that it is unmanageable for 3MDG to continue to provide all the financial incentives that encourage people to practice correct health behaviour. The study findings suggest revolving village health funds that have acceptable repayment terms and transparent usage rules, linked to targeted health education and promotion, are also a way to provide means for and encourage communities to practice healthy behaviour. The 3MDG partner already has established community based revolving health funds with

the villagers' contribution in Bilin Township for ownership and sustainability. Until now, these village health funds have mainly been utilized for emergency referral support. There is potential for these funds to be expanded to provide incentives for health education/promotion and for increased engagement with health behaviours. Village health funds should align with both preventive and emergency health messages delivered by Basic Health Staff and CV partners. One consideration is to encourage the project villages to use funds for continued health education and promotion sessions and to potentially offer incentives through the fund. Incentives for health education and promotion sessions were a positive draw for the community and an important way to deliver health messages effectively to the community. Therefore, VHCs should consider expanding village health funds to cover these costs from time to time.

Together with providing seed funding, proper training and support is necessary for fund maintenance, transparency, and accountability. Villagers need to be assured they can access the funds if they need them in the case of a health emergency. This means that information on distribution as well as repayment must be understood and acceptable to villagers. With basic book keeping and fund management support, this continued training will help revolve funds, develop VHC credibility in the community, and give VHCs the confidence to maintain the funds and use them wisely.

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ANNEXES

ANNEX 1

INTERVIEW GUIDE FOR GROUP INTERVIEW WITH VHC MEMBERS

Greet

Note down participant characteristics

- Name
- Age
- Gender
- Role in VHC
- Job (for family earning)

Introduction (explain in brief on the purpose of the interview)

Theme 1 Social Group Differences

Can you please tell us how many social group differences are there at your village

- Probe: How can social group differences be categorized, basing on the nature of their family jobs, at this village?
- Probe: Which social group constitutes the largest? The second largest?

Theme 2 Community Engagement

Theme 2-1 Background

Can you please tell us when and how the VHC at your village was formed

- Probe: Who informed your village to set up the VHC and what information they gave you in regards to:
 - The composition of the VHC;
 - The criteria for selecting VHC members; and
 - The roles and functions of the VHC.
- Probe: Why did they tell you to include women in the VHC? Was it easy at your village to search for women representatives? How were these woman representatives selected?
- Probe: Did anyone from your village have a chance to give suggestions on selection criteria for VHC members? If YES what suggestions were given and were these taken into consideration? WHY?
- Probe: Were there changes in members since first time of formation? WHY did these changes take place?

Has any member or members of the VHC trained in anyway to support VHC formation and functioning? Do you think these trainings are beneficial for functioning of your VHC? WHY, if YES or NO?

Theme 2-2 Joint Information Sharing with BHS staffs

Since establishment of this VHC at your village, how many times have joint information sharing with BHS staff taken place?

- Probe: Please tell us how these sessions were organised.

- Probe: Please describe what information was shared?
- Probe: How did you make sure that those people from lower social group were involved?
- Probe: When did the last sharing session take place? Where did it take place? Who was there from health department? What specific information was shared during that session?
- Did villagers take part with full enthusiasm? WHY, if YES or NO.
- Probe: How was the relationship and information sharing practices with BHS 3 years ago before VHC set up and early stages of VHC formation? Do you think the information sharing has been improved? WHY, if YES or NO.

Theme 2-3 Community Feedback Mechanism

Please tell us how you listen to the voices of the community in your village. E.g. Community meeting, VHC meetings, two ways discussions, outreach sessions, etc...

- How did your VHC make sure that community can give their suggestion/feedback to VHC which is widely known among all the villagers?
- Do you consider that this is also known very well by those from lower social group? WHY?

Do you consider that the practice of villagers suggest/feedback is functioning well at your village? WHY, if YES or NO?

Were there any community feedback practices in your village 3 years ago? If YES,

- How was suggestion/feedback collected and provided to relevant service providers 3 years ago?
- Do you think the practice has been improved? WHY, if YES or NO.

Please describe to us 3 recent community suggestions/feedback that have been received

- How were they relayed to concerned persons?
- Were they actioned? WHY, if YES or NO?

Theme 2-4 Village Health Fund Mechanism

Did VHC establish Village Health Fund Mechanism?

- Probe: When did you establish the Village Health Fund?
- Probe: How did you manage the Village Health Fund?
- Probe: How much did you save for the VHF up to now?

What kind of cases do you use the VHF for? Why?

- Did the VHF cover for lower social group? WHY, if YES or NO.

Theme 3 Health Seeking Behaviours of Mothers (related to MNCH)

Please tell us where majority of mothers, especially those from lower social group, from your village go for:

- Antenatal care? (Ask WHY? /Why not?)
- Delivery? (Ask WHY?)

During past one year, were there any emergency referrals of a pregnant mother to a hospital?

- Probe: For what reasons? Who suggested the referral? How did you/ they know it was an emergency?
- Probe: What kind of assistance (financial, transport, etc.) did VHC provide to these referrals?
- Probe: Have women been referred but did not follow the advice? Why?
- Probe: What was the patient outcome of the referral?

During past one year, were there any emergency referrals of a child under 5 to a hospital?

- Probe: For what reasons? Who suggested the referral? How did you/ they know it was an emergency?
- Probe: What kind of assistance (financial, transport, etc.) did VHC provide to these referrals?
- Has child been referred but did not follow the advice? Why?
- Probe: What was the patient outcome of the referral?

What is your opinion in regards to children in your village having immunization?

- Probe: Did all children of your village get their immunizations? WHY? / Why not?
- Probe: Who gives information sessions and organises the immunization events? Is it the same as it was before (two years ago)?

Theme 4 Health Seeking behaviour of mother and children (related to personal hygiene)

Please tell us where majority of mothers, especially those from lower social group, from your village go for:

- Water sources (drink/use)? (Ask WHY?)
- Sanitary disposal (toilet/drainage)? (Ask WHY?)
- Probe: How many households from lower social group use fly proved toilets? Has the use of fly-proof toilets been improved compared to 2 years ago?

What is your opinion in regards to children receiving personal hygiene practice in your village?

- Probe: Did all children of your village get education on personal hygiene? HOW, if YES or WHY, if NO?

What is your opinion on the personal hygiene of mothers and children?

- Probe: Do you think or do not think they have improved in their personal hygiene? WHY do you say so?
- What are the reasons for such improvements/non-improvements?

Theme 5 Opinions on their further improving Health Seeking Behaviours of Mothers, Community Engagement and Personal Hygiene of Mothers and Children

What suggestions would you like to give for further improving:

- Joint Information Sharing activities in future?
- Community Feedback Mechanism in future?
- Health seeking behaviours of MNCH services by mothers, especially those from lower social group, of your village?

ANNEX 2

FGD GUIDE FOR MOTHERS WITH AT LEAST ONE CHILD UNDER 5

Participant characteristics

- Age
- Education level
- Age of last child
- No of living children
- Ethnic group
- Religion

This section looks at practices of last pregnancy and delivery as well as influences on practices, decision-making, and health seeking behaviours of maternal health)

Theme 1 Health Seeking Behaviour

Theme 1-1 Maternal health care practices

Please tell us where majority of mothers from your village go for:

- Antenatal Care? (Ask WHY?/Why not?). Do women go for 4 AN checks?
- Delivery? (Ask WHY?)

When you were pregnant with your last baby,:

- Did you get Antenatal Care for your last child? How many times? From Whom? Why?
- Who in the household made the decision to go or not go for AN Care?
- Who made the decision how to deliver the last baby? (probe for woman PLUS other such as husband, aunty, mother in law, mother) (# count) (Was this different from your other children?) If it was different, why?
- Who delivered with TBA? Who had a skilled attendant delivery (not TBA - MW, hospital, AMW)?
- Show hands, how many had at least 2 or more AN checks? (count #)
- Show hands, how many had 4 or more AN checks? (count #)
- (# difference), (# of <2)

During past one year, were there any emergency referrals of a pregnant mother to a hospital? (This can be anecdotal description to understand social norms around referrals and the value of VHC for referral uptake).

- Probe: For what reasons? Who suggested the referral? How did you/they know it was an emergency?
- Probe: What kind of assistance (financial, transport, etc.) did VHC provide to these referrals?
- What was the patient outcome of the referral? What is your opinion of this outcome?
- Have women been referred but did not follow the advice? Why?

After you delivered your last baby, did you choose to use birth spacing methods for family planning? WHY, if YES or NO.

Theme 1-2 Child health care practices

How would you know that your child is not well?

What do you do first when you feel that your child is not well?

- Gave traditional medicines? Other remedial measures at home?
- What would you do next if not improved?

During past one year, were there any emergency referrals of a child under 5 to a hospital at your village? Were your child among them?

- Probe: For what reasons were they/your child referred? Who suggested the referral? How did you/they know it was an emergency?
- Probe: What kind of assistance (financial, transport, etc.) did VHC provide to these referrals?
- Probe: What was the patient outcome of the referral? What is your opinion on this outcome?

What is your opinion in regards to children in your village having immunization?

- Probe: Have you heard about vaccination? From Where/Who?
- Probe: Did all children of your village get their immunizations? WHY?
- Did your children receive vaccination? WHY, if YES or NO.

Theme 2 Preventive Health Practices and Behaviours

This section looks at good health practices in the household

Handwashing

Is hand washing practiced in your home? Ask WHY?

- Did you receive training on methods and critical times of handwashing? (Y/N) From who/where?
- Did anyone learn something new from this? Or did you already know it?
- Do you or your children practice handwashing more frequently than before? (2 years ago)
- When do your children wash their hands?

Clean Drinking Water

- What kind of information do you receive about drinking water? From who/where?
- What is the primary source of drinking water? Does anyone boil or filter the water? Why? Why not?
- Has anyone had a family member with diahorrea in the last 2 months? If YES, What did you do then? (If anyone mention about ORS, ask how they prepare ORS)
- Do you take water from a different source than you did 2 years ago? Why?

Theme 3 Participation in Community Engagement

Have you ever participated in joint information sharing sessions (explain what these are) at your village?

- Probe: Please tell us how the last information sharing session took place at your village
- Probe: When, where, who (health staffs) came to the village?
- Probe: How were villagers informed that such an information sharing session would take place at our village?
- Probe: According to your experiences, what kind of information did they share? Do you think these are beneficial for you? WHY if NO or YES?
- Probe: Are you all aware of the Community Feedback Mechanism that exists at your village?
- Probe: Do you think this mechanism is benefitting people at our village, especially to those from lower social group? WHY, if YES or NO

Theme 4 Opinions

What suggestions would you like to give for improving:

- Access to MNCH services by mothers at your village?
- Joint information sharing at your village?
- Community Feedback Mechanism?

ANNEX 3

IDI GUIDE FOR INTERVIEW WITH A MOTHER WHO HAD EXPERIENCED EITHER SHE HERSELF OR CHILD BEING REFERRED TO A HOSPITAL DURING PAST ONE YEAR

Participant Characteristics

- Age
- Education level
- Age of last child
- No of living children
- Ethnic group
- Religion

Introduction

In case of a mother who had been referred

This interview will take place in the form of a story asking the interviewee to make a narration on her experiences and feelings (with specific dates, time, places, etc., as much as possible) from the time of suffering from danger signs and symptoms, being referred to a hospital, taking treatment at the hospital and till being discharged. Probing to be done using some of the probes used in FGD, as considered relevant. Ask also for who made the decisions as considered relevant.

Examples of probes:

- What were the signs and symptoms that she was suffering before referral
- Who made the decision: she or her husband or her parents or others (ask WHY?)
- What kind of assistance (financial, transport, etc.) did VHC provide to these referrals?
- From where else did she and her family search for assistance— financial, transport, etc?
- Experiences and feelings on arriving to the hospital and delivering there
- What was the patient outcome of the referral? What is her opinion on this outcome? Satisfaction? WHY?

In case of a mother whose child had been referred

This interview will take place in the form of a story asking the interviewee to make a narration on her experiences and feelings (with specific dates, time, places, etc., as much as possible) from the time of her child suffering from an illness, being referred to a hospital, taking treatment at the hospital and till being discharged. Probing to be done using some of the probes used in FGD, as considered relevant. Ask also for who made the decisions as considered relevant.

Examples of probes:

- How she came to realize that her child was having an illness – signs and symptoms
- Who made the decision: she or her husband or her parents or others (ask WHY?)
- What kind of assistance (financial, transport, etc.) did VHC provide to these referrals?
- From where else did she and her family search for assistance— financial, transport, etc?
- Experiences and feelings on arriving to the hospital and delivering there
- What was the patient outcome of the referral? What is her opinion on this outcome? Satisfaction? WHY?

ANNEX 4

KEY INFORMANT INTERVIEW (KII) GUIDE FOR BHS

Greet

Participant Characteristics

- Name
- Age
- Gender
- Position

Introduction (explain in brief on the purpose of the interview)

Theme 1 Community Engagement

Theme 1-1 Background

Can you please tell us when RHC/Sub-RHC at the village was established,

- Probe: what information they gave you in regards to:
 - The location of the RHC/Sub-RHC and its coverage villages;
 - The roles and functions of the RHC/Sub-RHC.
 - The health services delivering to village community
- Probe: How do you include women and children to receive service from RHC/Sub-RHC? Was it easy at the village to search for women and children?
- Probe: How do you include youths (under 35 years of age) in service provision?
- Probe: Did anyone from the village have a chance to give suggestions on the health services? If YES that suggestions were given and were these taken into consideration? WHY?
- Probe: Were there BHS changes since first time of establishment?

Theme 1-2 Joint Information Sharing with VHC

Since establishment of this RHC/SRHC at your village, how many times did joint information sharing with VHC take place?

- Probe: Please tell us how these sessions were organised.
- Probe: Please describe what information was shared?
- Probe: How did you make sure that those people from lower social group were involved?
- Probe: When did the last sharing session take place? Where did it take place? Who was there from health department? What specific information was shared during that session? Did villagers take part with full enthusiasm? WHY, if YES or NO.
- Probe: How was the relationship and information sharing practices with VHC? Do you think the information sharing has been improved? WHY, if YES or NO.

Theme 1-3 Community Feedback Mechanism

Please tell us how you listen to the voices of the community in your village.

E.g. Community meeting, joint information sharing session, two way discussions, outreach session, etc...

- How did your RHC/SRHC make sure that community can give their suggestion/feedback to RHC/SRHC which is widely known among all the villagers?
- Do you consider that this is also known very well by those from lower social group? WHY?

Do you consider that the practice of villagers suggest/feedback is functioning well at your village? WHY, if YES or NO?

Please describe us 3 recent community suggestions/feedback that have been received

- Were they actioned? WHY, if YES or NO?
- Were there suggestions/feedback among them that were relayed to other concerned persons at higher levels? Who were they?
- How were they relayed to concerned persons if considered necessary (at township level or higher)?
- Were they actioned? WHY, if YES or NO?

Were there any community feedback practices in your village 3 years ago? If YES,

- How was suggestion/feedback collected and provided to relevant service providers 3 years ago?
- Do you think the practice has been improved? WHY, if YES or NO.

Theme 2 Health Seeking Behaviours of Mothers (related to MNCH)

Please tell us where majority of mothers, especially those from lower social group, from your village go for:

- Do they go for Antenatal care? (Ask WHY?/Why not?)
- With whom do they Deliver? (Ask WHY?) (look for outliers.)

During past one year, were there any emergency referral of a pregnant mother to a hospital?

- Probe: For what reasons? Who suggested the referral? How did you/ they know it was an emergency?
- Probe: What kind of assistance (financial, transport, etc.) did VHC provide to these referrals?
- Probe: Have women been referred but did not follow the advice? Why?
- Probe: What was the patient outcome of the referral?

During the past one year, were there any emergency referrals of a child under 5 to a hospital?

- Probe: For what reasons? Who suggested the referral? How did you/ they know it was an emergency?
- Probe: What kind of assistance (financial, transport, etc.) did VHC provide to these referrals?
- Has child been referred but did not follow the advice? Why?
- Probe: What was the patient outcome of the referral?

What is your opinion in regards to children in your village having immunization?

- Probe: Did all children of your village get their immunizations? WHY?/ Why not?
- Probe: Who gives information sessions and organises the immunization events? Is it the same as it was before (last two years ago)?

Theme 3 Health Seeking behaviour of mother and children (related to personal hygiene)

Please tell us where majority of mothers, especially those from lower social group, from your village go for:

- Water sources (drink/use)? (Ask WHY?)
- Sanitary disposal (toilet/drainage)? (Ask WHY?)
- Probe: How many households from lower social group use fly proved toilets? Has the use of fly-proved toilets been improved compared to 2 years ago?

What is your opinion in regards to children receive personal hygiene practice in your village?

- Probe: Did all children of your village get education on personal hygiene? HOW, if YES or WHY, if NO?

What is your opinion on the personal hygiene of mothers and children?

- Probe: Do you think or do not think they have improved in their personal hygiene? WHY do you say so?
- What are the reasons for such improvements/non-improvements?

Theme 4 Opinions on their further improving Health Seeking Behaviours of Mothers, Community Engagement and Personal Hygiene of Mothers and Children

What suggestions would you like to give for further improving:

- Joint Information Sharing activities in future?
- Community Feedback Mechanism in future?
- Health seeking behaviours of MNCH services by mothers, especially those from lower social group, of your village?

ANNEX 5

OBSERVATION CHECKLISTS TO OBSERVE PERSONAL HYGIENE PRACTICES

The purpose of the observation checklist is to verify and expand personal hygiene related information that was obtained in study group meetings and FGDs. It also aims to get the study team/interviewees out of the typical interview setting, to triangulate information collected, and to check the new perspective on the territory, water sources (ponds, wells), supply and sanitary disposal system (toilets, drainage). The study team will randomly select from guides from the community who are more knowledgeable about the studied villages and the places to observe. The study team will use this checklist and observe at least three water sources and three toilets for each village. This will include observation on upper, middle, and lower social groups. These questions will be used to look at hygiene practices and if this has an effect on engagement and/or health behaviours in the other sections.

Under each checklist, the following features will be observed.

1. Supply and sanitary disposal system of toilet
2. Water sources (pond, well)

Name of the village:
Name of the observer/s:
Subject:
Topic:

Date:
Location:
Time Began:
Time Ended:

Observation checklist for toilet

Item to observe	Yes	No	Note
Is the toilet fly proof?			
Are hand-washing facilities with soap available?			
Has the toilet have water container to store water?			
Is water available near the toilet for hand-washing?			
Is the toilet clean? (no paper, general clean, no smell)			
Has the toilet have cover?			
Other observations			

Observation checklist for central water source (pond/well)

Item to observe	Yes	No	Note
Has the Pond/well/pump have fence to protect entering the animals?			
Is there a separate collecting container at the pond/well?			
Do the villagers wash their clothes near the pond/well?			
Other observations			

Observation checklist for water storage in individual household

Item to observe	Yes			No			Note	Item to observe
	1	2	3	1	2	3		
Do the households cover their water container?								
Is there a cup to take water out of the water container?								
Other observations								

