The Three Millennium Development Goal Fund
ထောင်စုနှစ် ဖွံ့ဖြိုးတိုးတက်ရေး ရည်မှန်းချက်သုံးမျိုး ရန်ပုံငွေ

COLLECTIVE VOICES:

UNDERSTANDING COMMUNITY HEALTH EXPERIENCES

Stage 1 Completion Report - August 2015

Community Driven Development and Capacity Enhancement Team
(CDDCET)

3MDG IS MANAGED BY UNOPS

CONTENTS

1. BACKGROUND

The Three Millennium Development Goal Fund (3MDG) supports the provision health services in Myanmar and contributes towards the country efforts to achieve the three health related Millennium Development Goals. In March 2014, the 3MDG Fund announced the launch of a US$1.5 million initiative in partnership with six organizations to improve the understanding of the social factors limiting access to health care, and to support a meaningful participation of community members for better services and consumer satisfaction.

This initiative, called "Collective Voices: Understanding Community Health Experiences", comes in support of the vision of the Government of Myanmar to reach Universal Health Coverage by 2030 and the Constitutional objective of ensuring that every citizen shall have the right to health care.

The "Collective Voices" initiative is to be implemented in two stages, and furthers the 3MDG Fund'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 the capacity of local organizations to support the health sector now and in the future.

Community Driven Development and Capacity Enhancement Team (CDDCET) is one of the six organisations selected to receive funding to increase health information and community voices to empower community access to maternal, newborn and child health (MNCH) services in Bilin township of Mon State. CDDCET is partnering with four Community Based Organisations (CBOs): Lanpyapyesin, Paungku, Ahlinyaung and Lanpyakye. Stage 1 commenced in March 2015 and was completed in August 2015, and this report is based on the findings from the first stage.

CDDCET

In September 2013, a range of development experts and implementers who previously worked on a UNDP Human Development Initiative (HDI) and Community Development for Remote Township (CDRT) program decided to continue community based poverty reduction and development in line with the national poverty reduction framework by establishing a Civil Society Organisation (CSO).

CDDCET runs Participatory Learning and Action processes, provides capacity building and outsources funds. It has 28 members who are agricultural, livestock, health and gender specialists, who have worked on disaster recovery, conflict affected poor, and with internally displaced ethnic minorities in semi-insurgent and self-administered regions such as Kachin, Mon, Kayin, Kayah, Chin and Rakhine.

CDDCET holds registration under Yangon Region. The members possess transparent and accountable records of managing US$3-400,000 township budgets during the last decade.

The project

This is a new project for CDDCET based on the identified gaps between services and access to family planning derived from discussions of the FP2020 Seminar on Family Planning Best Practices, 7 July 2014, in Nay Pyi Taw with inputs from ten Myanmar townships, including Obstetrics and Gynaecologists, Paediatricians, Township Medical Officers, Township Health Nurses, Health Assistants, Midwives and Auxiliary Midwives.

Led by the Reproductive Health Section of the Department of Health, UNFPA, FP 2020 and Pathfinder International, the workshop looked at seven key barriers from ten chosen project sites around Myanmar, including social barriers such as varied and limited health Knowledge, Attitudes, Practices and Behaviours (KAPB) amongst communities, and gaps in supply chain management. FP 2020 is the global partnership which supports the right of women and girls for reproductive health (RH) and family planning (FP). It aims at more than 120 million people using contraceptives by the year 2020.

Using the information from this workshop, CDDCET decided to focus its Collective Voices project on increasing access to health information around MNCH, including RH and FP, thus increasing the demand and identifying strategies to improve existing service delivery of the township hospital and basic health services in Bilin.

Bilin is a medium size township with an urban population of 15,975 and a rural population of 136,034. Of the 79 villages in total, 20 villages from 12 village tracts (N = 50), 1606 household of 7,868 population were selected as project beneficiaries for Collective Voices. The range of distance from the township to the above villages is three to 21 miles.

The planned villages for this project are in Kazai, ShweYaungPya, Maelan and Kadipu zones. There are no health sub-centres, many auxiliary midwife (AMW) posts are not filled, and visits often take place after two months. Present TB malaria control activities result in a lot to do and the rate of child deaths is high. The proportion of one doctor or health assistant is to 16,451 people and of one nurse are 6,909. A total of 1,250 malaria, 738 diarrhoea, 149 TB, 433 dysentery, 184 hepatitis and eight HIV cases were identified and treated with total of 11 mortalities in 2013. The fertility rate was 0.08, 16.5 live births per thousand with 1.1 maternal mortality rate. Neonatal deaths were 16.1 per thousand with 2.1 per cent abortion.

Our partners

CDDCET is the lead organization for this project. Our partner CBOs are as follows:

	Organization	No. of Villages	Name of Village
1	LanPyaKye Sin	5	Ma Yan Chaung, Nae Char YaeZaLote, BilinKyoe, KyetChayKhat
2	Ah Lin Yaung (L)	5	Phar Ka Du, KyaungYwar, AshayYwar, KyarKwin, Yan Pyay
3	Paung Ku (B)	5	Oat Pho,MiChaungAeing KhaLaukInn,Ma Yan Kone, Inn Phyar
4	LanPyaKye (S)	5	Ban BweKone, ChaungPyant, Da NyinKone PhaYarSeik (West), Ah Hone Wa (West)

Lanpyakyesin are a CBO, specifically a Self-Reliance Group/Township Leading Group. They are a women's group including members of traditional villages, cluster and village tract committees, who also undertake tasks in township and village development assistance committees led by the Department of General Administration and Rural Development.

The CBO was involved with the National Census 2013 and has been intermittently involved with Save the Children, Myanmar Health Assistant Association and IOM to implement malaria projects in Mon and Kayin State. The majority of members are female (353:3). Women's groups have been a catalyst of community plans and managing financial assets such as revolving loan funds and seed banks in many townships of Myanmar, and remain active after completion of programs.

LSB is the umbrella organisation for itself (LanPyaKye) and two additional CBOs, including PaungKue, and Ah Lin Yaung. This CBO Cluster (federation of three) remained after completion of the CDRT project in 2013. They have also provided periodic UNICEF, PSI, World Concern, Nippon Foundation community assessments and services on a short-term basis.

Areas of work experience include child nutrition and health, TB, malaria, HIV, community development, human trafficking, livelihoods and income generation. It has a proven record of managing Revolving Loan Funds in agriculture, livestock and income generation opportunities for the villages of Bilin, Kyaikhto, Kyaikmaraw, and Paung townships. It has a total of 76 members at present and executive membership is 66 per cent male and 33 per cent female (18:9).

Goal

The goal of this project is to increase community awareness and accurate utilization of family planning services in Bilin Township, then extend to other townships in Mon State.

Purpose

All stakeholders and beneficiaries are committed to and participating in identification and promotion of social barriers relating to maternal, child health and family planning issues as prioritized during the Stage 1 participatory learning process.

Strategies

- Socio-mobilization, advocacy and promotion of family planning practices at grassroots level
- Capacity building of partner CBOs, volunteer/community health workers
- Awareness raising on sexual and reproductive health/HIV and facilitation of access and utilization of basic health services
- Community health workers and volunteers assist basic health staff by helping communities identify gaps in family planning services utilization while having dialogue with direct beneficiaries

Thematic Area

Proposals for Collective Voices funding were required to fit within at least one of five thematic areas identified below. Proposals had to demonstrate how the project would contribute to greater understanding of the key issues within these broad themes.

- Theme 1: Gender and health
- Theme 2: Cultural dimensions of health seeking behaviour
- Theme 3: Conflict and Health
- Theme 4: Age, disability and health challenges
- Theme 5: Health information

This project focused at Thematic Area 5: Health information.

Theme 5: Health Information

CDDCET decided to explore the following issues under thematic area five:

- The usefulness of current health information and education sources in decision-making and advocacy.
- Understanding levels of awareness amongst individuals/communities/populations of key health policies on family planning and maternal and child health services.

The project aimed to establish a community feedback process through a series of participatory community meetings, to correctly understand and identify gaps in accessing family planning and MNCH health services in Bilin Township. The root causes, problems, needs, strategies, and action plans were driven by community itself with help from CBOs in collaboration with township committees and township medical officers and basic health staff.

2. OUTCOMES AND OUTPUTS

Outcome

The primary outcome for Stage 1 was for communities to identify social, cultural and gendered gaps in access to family planning and reproductive health services. This will lead to Stage 2, in which communities will be informed, educated and supported to make good choices on family planning options.

Outputs

1. Civil Society Organizations (CSOs) with technical assistance from the Reproductive Health Department conduct social mobilization advocacy to village committees, Non State Actors and local authorities in Bilin Township.
2. Local CSOs recruit volunteers/community health workers trained on awareness raising and peer education on sexual and reproductive health to understand community members choices, gaps and barriers on family planning.

Activities for Output 1

Advocacy

The Reproductive Health Unit of the Department of Health led an advocacy event on 1 April 2015 with all stakeholders of Bilin Township, including the Township Medical Officer (TMO), the Township General Administration Department (GAD), and representatives of 20 village committees/health committees. A total of 48 participants attended.

Photo 1: Advocacy Workshop in Bilin Township

As a result of the advocacy event, CDDCET received agreement from 17 township government officials that RH is an issue requiring greater attention to facilitate increased access to health services, and requested the TMO to lead a township committee to oversee the project. All representatives of cluster villages attended (24 participants) and committed to their existing CBO membership duties and responsibilities, in addition to this Collective Voices project. CDDCET regarded this township coordination as important to the success of the project, and appreciated the participation of township stakeholders as active and justified.

Strengthening the Working Committee[1] for community health

On 1 April 1 2015 a project management body was established, called a "Reproductive Health and Family Planning Working Group" with 28 members, including representatives from the Health Department, CDDCET, partner CBOs, and 20 Village Development Committees, led by the Township Medical Officer. The work group committed to share information, work together and if necessary, accept project volunteers to link with existing basic health staff and identity means to mainstream reproductive health, family planning and birth spacing measures as complementary to existing facilities of township, station hospitals and rural health sub-centres. Five monthly meetings were held, often including capacity building sessions. The working committee also developed selection criteria for the 20 volunteers to support the CDDCET project.

Photo 2: RH and FP Working Group Meeting

Building partnerships and community linkages

CDDCET and its four partners recruited the 20 volunteers (one from each village) to assist and participate with midwives (MWs) and auxiliary midwives (AMWs) to create awareness on family planning including explaining options and encouraging health choices and women-led decisions from amongst the selected 20 project villages. Selection priority was given to zone and area facilitators who worked for UNDP projects in the past. The basis for the partnership is a win-win basis as mutual financial, human resource and advocacy options were equally used.

Local CBOs were also kept as project volunteers in the project, responsible for the majority of project-community interactions while continuing mainstreaming livelihood activities. The project honorarium covered direct costs and person times giving modest living conditions on site. As local people are involved in the project and they speak, act, believe, and trust the same as the communities, there was no problem discussing barriers in culture, religion, language etc. The CBO partners, once they signed the contract, agreed to collaborate in the timeframe of two years.

[1] During the time that CDDCET was funded for a UNDP project, Village Development Committees worked with project staff and led communities at planned activities. At the end of the project, these committees remained active, thus the CDDCET project continued using members of VDCs (while some have been members of SRG Self Reliance Group), and these groups were steered by township level working body under the name of Township RH and FP working group. VDCs are thus understood as Village Health Committees though they continued identification and planning of village development needs.

Activities for Output 2

Strengthen the capacity of volunteers and village health committees

CDDCET engaged an independent consultant who began staff training on participatory approaches and development concepts on 28-29 March 2015 (seven participants from CDDCET and 24 participants from four partner CBOs attended, 15 male and 16 female) to serve as a refresher and fine-tuning of existing community mobilization skills of ex-UNDP field staff. It fine-tuned facilitation skills of staff in terms of assisting villagers to visualize their family and locality information.

On 2 April 2015, the Reproductive Health and Family Planning Working Group had its first monthly meeting at the Township Administrative Department Meeting Hall. The TMO, Consultant, Chairman of CDDCET and staff, along with 24 members from villages attended the meeting. During April 2015, CDDCET assisted with the establishment or strengthening 20 Village Health Committees (VHC) at 20 project villages. At the first visit to the village, CDDCET provided the community with criteria for the formation of a VHC. They then followed up a few months later to see how the VHC was functioning and to provide support to strengthen this where needed. A total of 20 community volunteers or community health workers were selected by the community leaders and village administrative officers (30% of them are female), while project staff and representatives from four CBOs supported/facilitated the selection process.

On 18 June 2015, further training was conducted by Dr Kyaw Myint Oo, Project Coordinator of CDDCET on Reproductive Health and Family Planning to CDDCET staff and four CBOs, including 12 participants (five male and seven female) from CBOs and four from CDDCET. The purpose of the training was to strengthen the understanding of RH & FP.

Photo 3: Staff Training in Bilin Township

On 3 August 2015, the Reproductive Health and Family Planning Working Group held its fifth monthly meeting, including the Chairman of CDDCET, consultant and staff, and 17 members from villages. For the benefit of the village attendees, the Project Coordinator provided presentations and explanations on birth spacing and contraceptives (types, effects, advantages and disadvantages of contraceptive type, counselling and right choice), family planning, nutrition, vitamins, communicable diseases such as DHF, Diarrheal manifestation, reproductive organs and functions of both male and female (body mapping), menstruation, menarche and adolescence, menopause, fertilization and conception (signs of pregnancy, problems in pregnancy).

The Township Health Nurse (Bilin Hospital) attended monthly CDDCET meetings twice and trained the CBOs by presenting real cases in town and health related issues and mapped the far off villages in terms of need and presence of midwives. She clarified that some villages could not reach to the sub-centre due to a range of health knowledge and social barriers.

Community meetings led by CBO partners

The four partner CBOs led community meetings for community-based participatory planning to understand the family planning practices of communities, by extracting social barriers relating to reproductive health issues out of other prioritized health problems. The CBOs rolled out pilot participatory meetings at three villages on 9-11 April 2015 respectively in three village tracts, for villagers to discuss RH issues and start identifying possible needs for interventions.

The CBOs supported health needs assessments on behalf of the three village clusters. Cluster meetings on 24-25 April with the CBOs fixed the dates and potential invitees. There was relative reduction in the participation of village administrators and elders because of time limitations. The meeting was attended by men and women (including pregnant women), youth (both boys and girls including migrants), other vulnerable groups, village elders and village authorities. The table in the Annexes section shows the number of participants.

Photo 4: Cluster Advocacy Workshop

Tools were used in accordance with the context of the villages. Basic health staff, village administrators and leaders watched the drawings, diagrams, tables, and offered advice. Visual aids such as flipcharts, pamphlets available in the literature and those distributed from UNFPA, JOICFP, and Pathfinder were used. Consultants facilitated the flow of the sessions and reviewed the outputs with village tract administrators and elders. Project volunteers and basic health staff separated the identified problems into user and service aspects.

Tools used in participatory community meetings were:

- Social Map
- Resource Map
- Seasonal Calendar
- Venn Diagram
- Trend Line
- Causal Diagram
- Ten Seeds Method
- Wealth Ranking
- Problem Tree

- Key Informant Interview
- Body Map
- Village Profile
- Pair Wise Ranking (Antenatal)

Volunteers and four CBOs held community meetings, reporting and collecting voices at the selected 20 villages to identify family planning issues and social barriers. At monthly meetings with representatives from Township Health Department, partner villages and CDDCET, the video clips of live community events and case stories were shown to CSOs and other stakeholders. Township and cluster level advocacy and consultations were well participated by community beneficiaries, facilitated by CSO/CBOs.

Photo 5: PLA Exercise at Village

CBOs create linkages between recruited volunteers and midwives

The CBO partners worked to create linkages between recruited volunteers and midwives AMWs working in the area to and assist during their visits at the villages and likewise with Village Health Committees.

Recruited volunteers shared project information with the MWs and AMWs working in the area, and with village health committees together with village administrators. Project villages proposed village level needs and wants, while volunteers tried to understand the duties of midwives and tried to facilitate their visits during routine health activities such as DHF prevention, and assisted with travel of pregnant mothers.

Volunteers participated with MWs to create awareness on family planning including explaining options and encouraging health choices and women-led decisions to communities. The involvement of males in the health assessment meetings motivated the importance of bilateral decisions on pregnancy, birth spacing and paternal education on childhood care and development. It was found that MWs could be linked with project activities depending on their busy schedules and commitment with early and end of month meetings.

Volunteers facilitate the transport of mothers and children to health services

Volunteers facilitated the transport of mothers and children to antenatal care, postnatal care and other outpatient visits as required helping build knowledge, attitudes and behaviours during the first stage of the project. Volunteers identified locally available transportation means for those who planned to use hospital delivery, those who had been pregnant more than three times and those with risky pregnancy such as hypertension and anaemia. They arranged neighbours cars and trailers for a possible lift to the Rural Health

Centre and Bilin Hospital in case of emergency. Early Child Care and Development (ECCD) advice was also given by the township nurse and female health visitors.

3. RESULTS

Overall Findings

CDDCET compiled the findings of 20 villages' voices, four CSOs, and other stakeholders such as township and rural health centre staff. Results were captured in meeting records and in a short video clip, with interesting scenes and historical/religious institutions, faces of volunteers, community voices and discussions, comments reflecting the salient socioeconomic situation such as working in Thailand, early marriage and the life situations of people from the project villages.

Communities from the selected 20 villages identified problems and gaps around sexuality, puberty, reproduction, marriage, pregnancy and delivery, birth spacing and family planning while project volunteers and basic health staff assisted the process.

Service or supply-side issues that came up were:

- Capacity building of Auxiliary Midwives
- Strengthening of sub-centre or establishment of new one
- Keeping stock of delivery kits and essential drugs and instruments

Social Factors around MNCH included:

Most of the village participants were middle-aged pregnant mothers and mothers of children. They considered Adolescent Sexual and Reproductive Health issues, mapping of sex organs, puberty and reproductive organs as less discussed, due to existing traditions not to exchange understanding within families and between siblings. Target villages are increasingly aware the signs of dangers during pregnancy, and of the reasons why regular care at a basic health centre is deemed necessary. Other issues raised included:

- Lack of exposure to information on pregnancy, antenatal care and risky pregnancy.
- Poor levels of Knowledge, Attitudes and Practices (KAP) on RH & FP especially amongst youth, compounded by low levels of knowledge and lack of paternal involvement on deciding the number of children, type of contraception, mode and place of delivery, father's intimate care and support to both mother and children.
- Early marriage, big family and poverty.
- Many people do not know how genital organs function, but a few do as of previous training exposure, and most villagers were not used to talking about information around reproductive health openly.
- Inevitable abortion (miscarriage) and multigravida (multiple pregnancies)
- The majority of female respondents use oral and injectable ampoule for contraception, locally costing Kyat 200-500 and 500-2,000, without proper understanding of options; and have fear of social taboos to discuss these issues in depth.
- Labour burden of women continues until pregnancy, and pregnant women have to work until term in labour-intensive jobs such as extracting palm leaves used for roofing.

Other issues were:

- Distance and ex-insurgency of villages affecting the transport of pregnant mothers, together with travel constraints during rainy season.
- Access to health services is difficult.
- There is no drug pharmacy in the villages (drugs available only at MW), and essential drugs are hard to reach.

- No skilled injector for minor illnesses, side effects to drugs experienced and many villagers would not like to face immediate effects such as vomiting, fainting.
- Drugs are not affordable if many are to be bought.
- The decision to use contraception is usually dual decision of couple.
- Lack of regular antenatal care (ANC).
- Anaemia and hypertension during pregnancy.
- Delivery of baby is mainly with MW, with pressure and heat applied to lower abdomen and groin to stop bleeding and retraction of uterus, when facing emergencies, delivery usually takes place in Bilin Hospital.
- Shortage of money for emergency care, medicine and nutrition.
- Intra-partum haemorrhage and retained placenta.
- Under five and neonatal mortality.

Suggested Solutions

- More attractive health education
- AMW selection and training in villages where there is no AMW, and capacity strengthening of them
- Facilitate the Early Child Care and Development, nutrition and school enrolment of children
- Outpost to focus on care of mothers
- Establishment of mother care groups
- Replenishing delivery kits
- Easier access to contraception
- Income generation activities possibly to support pregnancy and delivery
- Founding a health fund
- Village loan fund to support poorest livelihoods, collect six monthly saving box and interest to support logistics of pregnant cases. Regular money saving at the saving box by married couple and getting casual donations or setting up revolving loan funds to invest at livelihood and generate interest, use for pregnancy and delivery cases
- Renovation of sub-centres and MW home
- Renovation of roads
- Vehicle for emergency hospitalization
- Adopting the solutions by nearby villages - one community with facilitation from township health nurse, assistant surgeon under supervision of township medical officer led to the strengthening and expansion of existing RH working group into community led initiative towards sustainability. Thus the villagers and health stakeholders thought of forming a community collaboration, which will mainstream some identified activities from the above observed needs and translate these into community solutions for the rest of the sites.

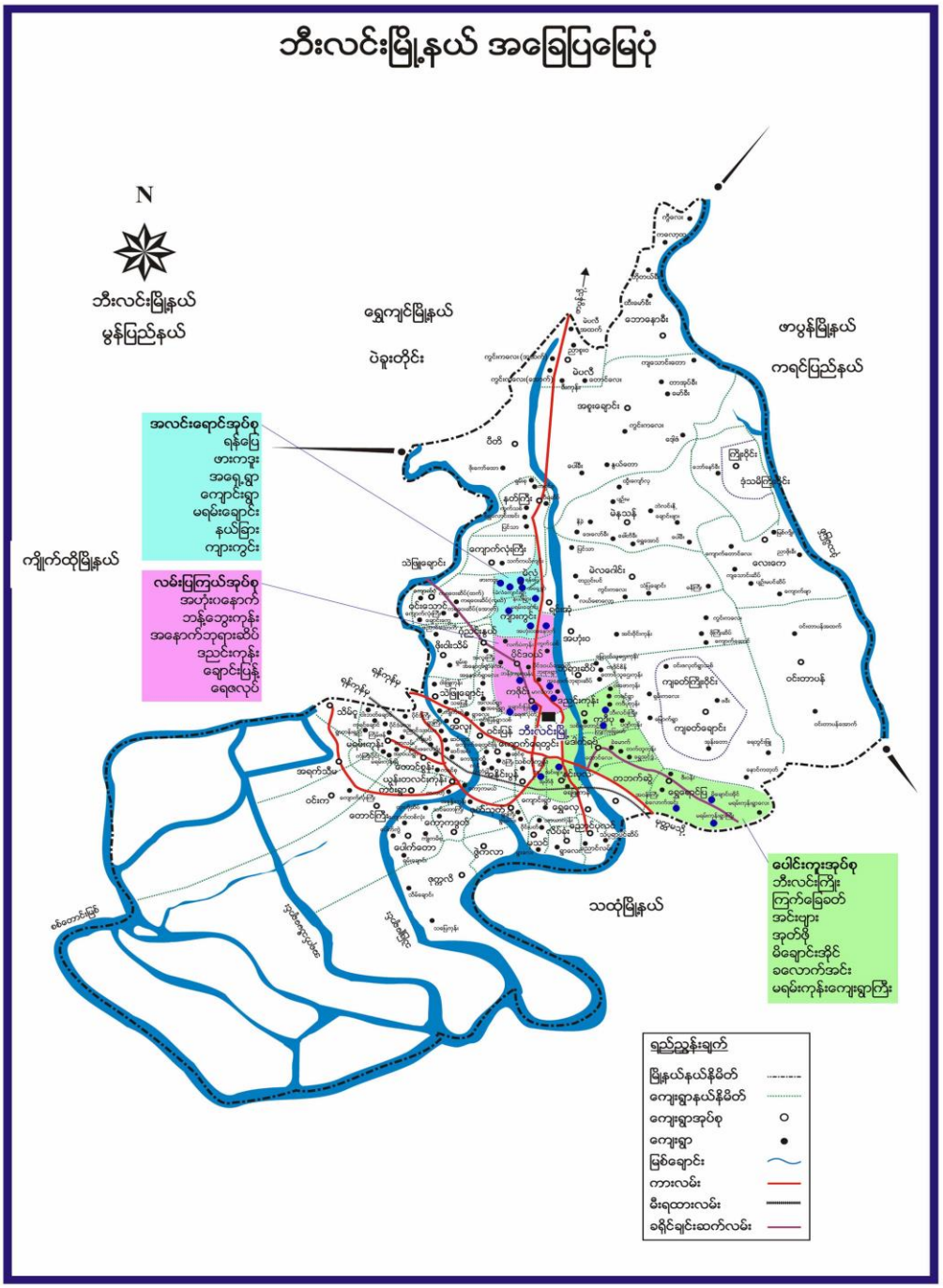
4. GOOD PRACTICES & LESSONS LEARNED

- The signing of the contract and disbursement of the Stage 1 3MDG funds to CDDCET incurred some delays which affected timing, acknowledgment and participation of project stakeholders.
- The CBOs value their participation with the project and requested long-term measures to acknowledge that CDDCET will continue to fund them.
- By receiving the commitment and collaboration of the TMO and township general administration, it was regarded that the ground advocacy was successful.
- The rapid assessment disclosed many family members of households working overseas, occasionally returning home, delivered children and left with the relatives, thus labour migration is relevant in this area. Extended families and children in the range of 2-5 were found as common. The maternal and infant mortality rate is moderate amongst the other townships in Mon State.
- Four CBOs were requested to continue their past commitment to their livelihood and microcredit assistance including agriculture loans, in addition to participating in the Collective Voices initiative.
- The township health nurse responded to the village voices about their need of a MW and sub-centre for each village, by explaining that the current distribution of midwives are part of the existing budget and policies of the Ministry of Health. It helped the community to understand that the midwife covers a specific number of villages, supported by BHS. Villages covered by BHS will not have a budget for new facilities in the near future. The MW also gets help from project volunteers for other hardship villages where there are no midwives nearby, or it takes some distance. Seasonal roads serve as barriers to ANC and health literacy access.
- The Township Medical Officer would also like to design a responsive mechanism to promote or strengthen health services and the GAD indicated the presence of different ethnicities such as Kayin, Mon, Shan and PaO, and there are few Hindu and Muslims in the locality. She also indicated that assessment in the district would achieve evidence to policy advocacy and solutions for community led assistance for World Bank Group (WBG) and Japanese International Cooperation Agency (JICA).
- It was good to learn about the ongoing activities and achievements of other partners at collective meetings and to gain insights, advice and comments from 3MDG partners. The program should also encourage a bilateral exchange study tour between players in the different States to learn experiences for cross fertilization.
- While UNICEF is conducting a socio-economic survey for development planning, except in the area of health, CDDCET also believes that creating a community response mechanism in Stage 2 will serve as a good practice, showing how township heath facilities use community engagement strategies.
- Currently, the WBG has already tapped into border areas, autonomous regions and State Townships and provided some funds to community led, participatory decision and collective planning, but has only involved a few of players and part of the residents. This would be of interest to the CDDCET Bilin Community Response Mechanism to serve as a platform to develop the comprehensive township health plan and further assist to roll it out in the future.

5. ANNEXES

Annex I – Bilin Township Map

Annex_ I

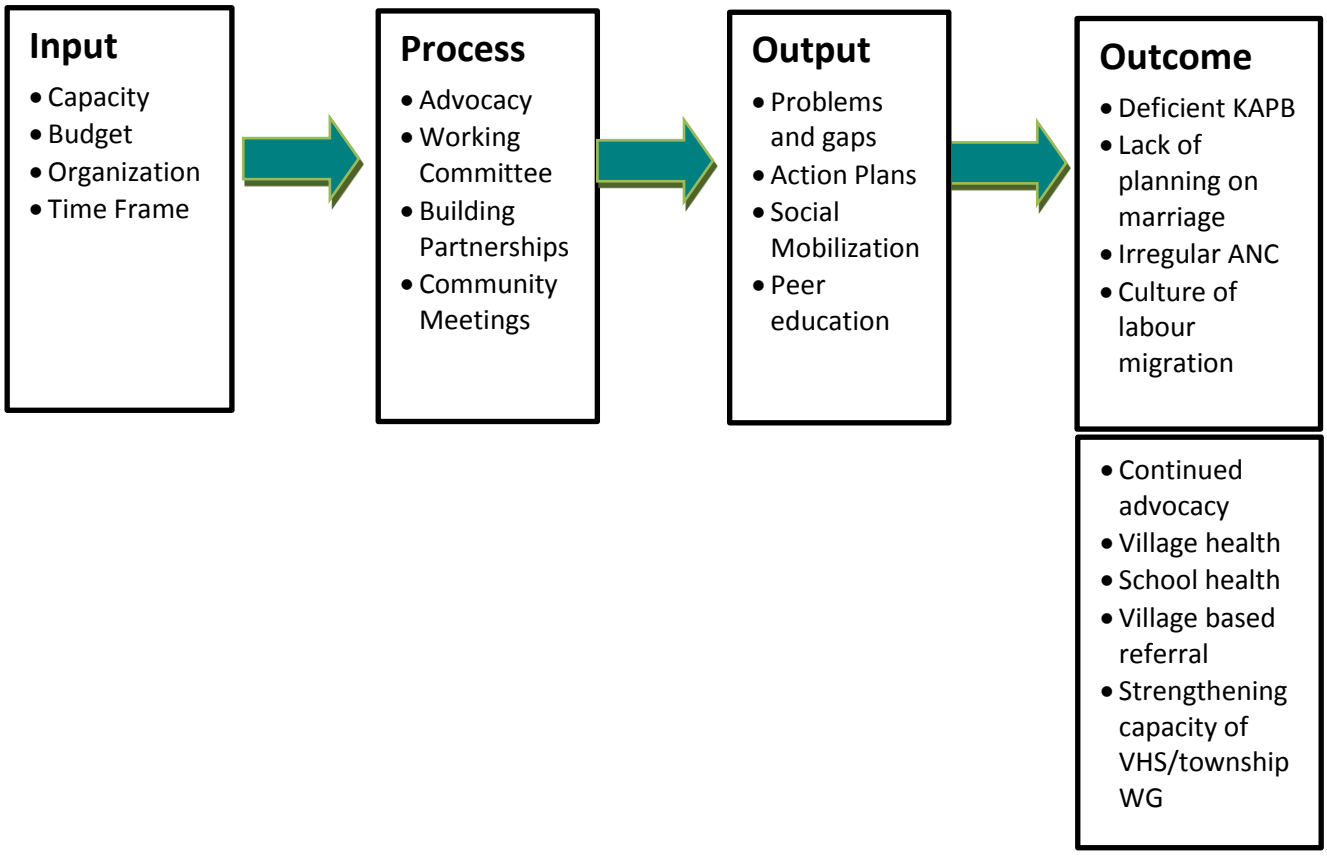


Annex II – Project Villages

Population and Household Status at 20 Project Villages in Bilin Township

Sr No.	Village Tract	Village Name	Wealth Ranking Status						Population		
			A	B	C	D	E	Total HH	Female	Male	Total
1	Me Lan	Kyaung Ywar	2	8	24	18	4	56	130	119	249
2		Ashay Ywar	5	11	26	24	3	69	155	145	300
3		Phar Ka Du		3	9	61	5	78	152	149	301
4		Yan Pyay	8	25	72	56	5	166	358	396	754
5	Kyar Kwin	Kyar Kwin	3	16	70	70		159	583	551	1134
6		Ah Hone Wa (West)	4	16	26	20	4	70	213	193	406
7		Ma Yan Chaung	4	8	8	10	1	31	78	68	146
8	Kazai	Chaung Pyant	2	11	35	70	2	120	265	226	491
9		Ban Bwe Kone	2	12	42	42	1	99	241	179	420
10		Yae Za Lote	1	19	31	18	4	73	164	305	469
11	Da Nyin Kone	Da Nyin Kone	1	33	67	23	7	131	291	268	559
12		Pha Yar Seik (West)	4	10	33	21	3	71	178	163	341
13	Yin Ohn	Nae Char	10	20	65	67	5	167	359	389	748
14	Kadipu	Bilin Kyoe	1	8	12	8	2	31	110	99	209
15		Kyet Chay Khat	1	18	58	42	6	125	281	243	524
16	A Naing Pwun	Oat Pho	7	10	45	54	10	126	256	345	601
17		Inn Phyar	4	10	21	62	2	99	257	197	454
18	Shwe Yaung Pya	Mi Chaung Aeing	1	15	15	36	5	72	193	175	368
19		Kha Lauk Inn		8	28	39	3	78	224	238	462
20		Ma Yan Kone	1	9	13	42	2	67	200	166	366
		Total	**61**	**270**	**700**	**783**	**74**	**1888**	**4688**	**4614**	**9302**

Annex III – Flow Chart of Community Voices



Footnotes:

Input
Capacity: Match and align organization strength in line with granted project
Budget: US$ 50,000
Organization: Lead and partner CSOs
Timeframe: 6 months

Process
Advocacy
The working committee for community-health strengthened. Capacity building sessions held with five monthly meetings.

Building partnerships and community linkages
Four CSOs lead community meetings for community-based participatory planning to understand family planning practices by extracting social barriers relating to reproductive health issues out of other prioritized problems.

Output
Communities from selected 20 villages identify problems and gaps around sexuality, puberty, reproduction, marriage, pregnancy and delivery, birth spacing and family planning while project volunteers and basic health staff assist the process.

Project volunteers and basic health staff separate these problems into user and service aspects and integrate actions into existing community development actions plans and township health plans.

Civil Society Organizations (CSOs) with technical assistance from Reproductive Health Department conduct social mobilization advocacy to village committees, Non State Actors and local authority.

Local CSOs recruit volunteers/community health workers trained on awareness raising and peer education on Sexual and Reproductive Health to understand community members choices gaps and barriers on family planning.

Outcome

1. General community with deficient Knowledge Attitudes Behaviours Practices (KABP) on Health, Reproductive Health, and deciding options on Maternal and Child Health services, aggravated by cultural and traditional barriers.
2. Youth's lack of planning on marriage, gap at Adolescent Sexual & Reproductive Health knowledge and access of family planning services; especially long acting methods associated with early school dropping out and labour migration.
3. Big proportion of poor pregnant mothers accessing irregular ANC (tend shifting to MW AMW from TBA), sharing burden of heavy seasonal labour progressing into risky pregnancy (malaria, hypertension, anaemia), resulting at complicated delivery (haemorrhage, retained placenta, sepsis) due to late arrival (50%) to skilled attendant while assigned AMWs are vulnerable to job opportunities, marriage and are in need of space with facilities and capacity for care at village.
4. Breadwinners partially involved with ANC and dual decision on family planning options, passively follow the consequences of culture of labour migration.

<u>Continued advocacy:</u>
Continued evidence based advocacy to what was known as Township RH Working Group committee (where TMO chairs), engaged with project findings; community inputs and voices into planning, decision, implementation of MNCH plans.

<u>Village health:</u>
Promotion of health literacy, using existing audio-visual IEC documents and video clips with interactive mentoring sessions and awarding followed by door to door visits and education at same 20 villages. Organization Development of 4 partners CSOs, continued community capacity enhancement to 20 VHCs, contributing to their participation at Township RH and FP Working Group.

<u>School health:</u>
Targeted ARSH and life skill sessions to teen students (G8-11) in 8 Belin and 2 KyaikHto State High Schools in collaboration with township education officers, school principals and class room heads. Continued sessions on school health such as WASH water and sanitation, CRC child rights convention, PE paternal education, HIV & AIDS, disaster risk reduction.

<u>Village based referral:</u>
Establishment of sustainable community based referral mechanism, ownership to VHC with micro income generation initiatives.

Strengthening the capacity of CBOs and township RH and FP WG:
Support CBO partners in dialogue on social determinants with BHS. Participation at district and state level MNCH events in collaboration with counterpart, MWAF, MNCWA and NSA partners.

Annex IV – Village Health Committee, Focal Person and VHEC List

Health Committee (1. Oat Pho Village)
Date Formed: 1.4.2015
Follow up: 24.6.2015

Sr	Name	Position
1	U Yay Hmwe	Chairman
2	U Saw Mya Chit	Secretary
3	Daw San San Maw	Book Keeper
4	Daw Yee Yee Win	Book Keeper
5	U Soe Kyi	Key Holder and Focal Person
6	U Myint Kyaw	VHEV
7	Daw Htwe Htwe Mar	Member
8	Daw Hla Win	Cashier
9	Daw Hla Wine	Member
10	U Shwe Htoe	Member
11	Daw Than Than Zin	Member
12	Daw Mu Aye	Member
13	U Kyaw Myint	Member

Health Committee (2. Inn Phyar Village)
Date Formed: 1.4.2015
Follow up: 2.7.2015

Sr	Name	Position
1	U Tin Hla	Petron
2	U Tun Wai	Chairman
3	U Tun Win	Secretary
4	U Phyu Lay	Book Keeper and Focal Person
5	Daw Yu Wah	Key Holder
6	Daw Than Than Myint	Cashier
7	Daw San San Htwe	AMW and VHEV
8	Daw Aye Mar	Member
9	U Thein Nyunt	Member
10	Daw Mi Aye	Member

Health Committee (3. Kha lauk Inn Village)
Date Formed: 4.4.2015
Follow up: 25.6.2015

Sr	Name	Position
1	U Tar Tu	Chairman
2	U Aung Kyaw Myint	Secretary
3	U Thaung Sein	Book Keeper and Focal Person
4	Daw Ma Bae	Cashier
5	Dae Ma Mi	Key Holder
6	Daw Mya Khinn	AMW
7	Daw Nwe New Oo	VHEV and CHW
8	U Maung San	Member
9	U Saw Kay	Member

Health Committee (4. Ma Yan Kone Village)
Date Formed: 5.4.2015
Follow up: 26.6.2015

Sr	Name	Position
1	U Aung Yee	Chairman
2	U Maung Naing	Member
3	U Aye Lwin	Member and Focal Person
4	U Aung Moe Khing	Secretary
5	Daw Aye Aye Mu	Book Keeper
6	Daw Ei Phyu Naing	Member
7	Daw Sandar Win	Key Holder and VHEV
8	Daw Yee Pyone	Member
9	U Maung Zaw	Cashier

Health Committee (5. Mi Chaung Aeing Village)
Date Formed: 7.4.2015
Follow up: 27.6.2015

Sr	Name	Position
1	U Pan Phyu	Chairman
2	U Nae Nae Lay	Secretary
3	Daw Mi Thet	Book Keeper
4	U Mya Maung	Cashier
5	Ma Sanay Ma	Key Holder and VHEV
6	Daw Naw Thay	Member
7	U Ba Cho	Member
8	U San Thaung	CHW
9	Daw Ma Mee	AMW and Focal Person

Health Committee (6. Ban Bwe Kone Village)
Date Formed: 6.4.2015
Follow up: 26.6.2015

Sr	Name	Position
1	U Shwe Thaung	Chairman
2	U San Oo	Secretary
3	U Aung Tin	Member
4	Daw Khin Shwe	Member
5	Daw Nyunt Yee	Member
6	Daw Sandar Win	Member
7	Daw Nwe Lay	Member
8	Daw San Myint	Member
9	Daw Win Thri Kyaw	VHEV
10	U Thaung Shwe	Member
11	U Kyaw Swar Min	Focal Person
12	Daw Khing Oo	Member
13	Daw Shwe Than Nu	Member

Health Committee (7. Da Nyin Kone Village)
Date Formed: 7.4.2015
Follow up: 27.6.2015

Sr	Name	Position
1	U Htun Myint	Chairman
2	U Than Htay Naing	Secretary and Focal Person
3	Daw Than Htay	VHEV and AMW
4	Daw Nwe Yee	Member
5	Daw Mar Oo	Member
6	Daw Moe Thein	Member
7	Daw Sabai	Member
8	Daw Thu Zar	Member
9	Daw Khine Than	Member

Health Committee (8. Chaung Pyant Village)
Date Formed: 5.4.2015
Follow up: 25.6.2015

Sr	Name	Position
1	U San Aye	Chairman
2	U Thaung Shwe	Secretary
3	Daw Than Aye	AMW and VHEV
4	Daw Aye Kyi	Member
5	Daw Shwe	Member
6	Daw Pain Pain	Member
7	Daw Maw Maw	Member
8	Daw Aye Nwe	Member
9	Daw Kyi Moe	Member
10	Daw Zar Zar Win	Member
11	U Aung San	Focal Person

Health Committee (9. Pha Yar Seik West Village)
Date Formed: 8.4.2015
Follow up: 7.7.2015

Sr	Name	Position
1	U Than Aye	Chairman
2	U Min Naing	Member
3	U Than Oo	Secretary and Focal Person
4	Daw Myint Myint Thein	Member
5	Daw Mee	Member
6	Daw Khin Htwe	VHEV
7	Daw Yee Htwe	Member
8	Daw Ya Min Khing	Member
9	Daw San San Aye	Member
10	Daw AyeThan	Member
11	Ma Kyar Nyon	Member
12	U Maung Dee	Member
13	U Ohn Twin	Member

Health Committee (10. Ah Hone Wa (West) Village)
Date Formed: 8.4.2015
Follow up: 6.7.2015

Sr	Name	Position
1	U Aung Thein	Member
2	U Khin Aye	Chairman
3	Daw Chaw Su	AMW and VHEV
4	Daw Nwe Win	Member
5	Daw Hla Win	Member
6	U Khin Moe Aye	Member
7	Daw Yin Aye	Member
8	U Maung Win	Secretary and Focal Person
9	Daw Sandar Oo	Member

Health Committee (11. Bilin Kyoe Village)
Date Formed: 2.4.2015
Follow up: 6.7.2015

Sr	Name	Position
1	U Tun Kyaw	Chairman
2	U Htay Aung	Secretary
3	U Htay Kyaw	Book Keeper and Focal Person
4	Daw Mi Pyo	Cashier
5	Daw San Nwe	Key Holder And VHEV
6	U Hla Than	Member
7	U Maung Oo	Member
8	U Htun Myint	Member
9	Daw Kyi Kyi Myint	Member

Health Committee (12. Kyet Chay Khat Village)
Date Formed: 3.4.2015
Follow up: 7.7.2015

Sr	Name	Position
1	U Kyar Ni	Chairman
2	U Than Chaung	Secretary
3	Daw Naw Phaw Aye	Book Keeper
4	Daw Yin Nu	Cashier
5	U Than Tun	Key Holder
6	Daw Aye Mying	Member
7	U Baw Lon	Member
8	Daw Kaw Lar	Member
9	Daw Ma Yi	Member
10	Daw Kye Kyi	Member
11	U Kyaw Moe	Focal Person And VHEV
12	Daw Ae Mwe Htoo	AMW

Health Committee (13. Ma Yan Chaung Village)
Date Formed: 6.4.2015
Follow up: 27.7.2015

Sr	Name	Position
1	U Min Win	Chairman
2	U Thein Tin	Secretary
3	Daw Than Aye	Book Keeper
4	Daw Nilar Moe	Cashier
5	Daw Sandar Win	Key Holder
6	U Thaung Han	Member
7	Daw Nan Aye	Member
8	Daw Thein Htay	Focal Person
9	U Than Tun	Member
10	Daw Than Than	VHEV
11	Daw Pi Pi	Member

Health Committee (14. Yae Za Lote Village)
Date Formed: 4.4.2015
Follow up: 25.7.2015

Sr	Name	Position
1	U MAung Soe	Chairman
2	Daw Myint Myint Htay	Secretary
3	Daw Aye Maw	Book Keeper
4	Daw Tin Zar Lin	Cashier
5	Daw San Aye	VHEV
6	Daw Ma Lone	Key Holder
7	U Maung Saw	Member
8	U San Myint	Focal Person
9	U Phoe Cho	Member

Health Committee (15. Nae Char Village)
Date Formed: 5.4.2015
Follow up: 26.6.2015

Sr	Name	Position
1	U Aung Hmwe	Chairman
2	Daw San Yi	Secretary
3	DAw Hla Aye	Cashier
4	U Soe Naing	Focal Person
5	Daw Kyi Htay	VHEV
6	DAw Mu Kyi	Key Holder
7	U Tun Yi	Member
8	Daw Aye Myaing	Member
9	Daw Sabai	Member
10	Daw Moe Moe San	Member
11	Daw Aye Thein	Member

Health Committee (16. Yan Pyay Village)
Date Formed: 4.4.2015
Follow up: 26.6.2015

Sr	Name	Position
1	U Yan Sein	Chairman
2	U Ba Tun	Secretary
3	U Aye Tin	Cashier and Focal Person
4	U Thein Zaw	Book Keeper
5	U Saw Htee	Auditor
6	U Than Pyo	Key Holder
7	U Hla Sein	Member
8	Daw Naw Aye Aye Myint	Member
9	Daw Naw Thet Thet Mu	VHEV
10	Daw Ta Souk	Member
11	Daw Kyi	Member
12	Daw Ma Pyo	Member
13	Daw Ngwe Khin	Member
14	Daw Khin Tha Zin Tun	Member

Health Committee (17. Kyaung Ywar Village)
Date Formed: 4.4.2015
Follow up: 5.7.2015

Sr	Name	Position
1	U Tin Shwe	Chairman
2	U Saw Han	Cashier
3	U Kyaw Tin	Member
4	U Naing Soe	Book Keeper and Focal Person
5	U Soe Thein	Secretary
6	U Kyaw Sann	Member
7	U Sein Kalar	Auditor
8	Daw Thae Nu Wah	VHEV
9	U Than Shwe	Member
10	U Zaw Min	Member
11	U Myo Win	Member
12	U Saw Wahh	Member
13	U Maung Gyo	Member
14	U Khin Maung Zin	Member
15	Daw Hnin Kyi	Member

Health Committee (18. Phar Ka Du Village)
Date Formed: 3.4.2015
Follow up: 6.7.2015

Sr	Name	Position
1	U Kyauk Lone	Chairman
2	U Aung Mya Sein	Secretary
3	U Shwe Lin	Book Keeper
4	Daw Hnin Si	Key Holder and VHEV
5	U Ye Win Naing	Auditor
6	U Zee Yo	Member
7	Daw Taw Phoe	Cashier
8	Daw Mi Tu	Member
9	Daw Aye Khine	Member
10	Daw Myint Yee	Member
11	U Maung Aye	Focal Person

Health Committee (19. Ashay Ywar Village)
Date Formed: 3.4.2015
Follow up: 4.7.2015

Sr	Name	Position
1	Daw Pe Net	Chairman
2	Daw Chaw Pyo	Secretary
3	Daw Than Tin	Cashier
4	Daw Myint Thu Zar	Book Keeper
5	U MAung Gut	Key Holder
6	U Kyaw Win	Auditor
7	U Hpar Pu Lo	Member
8	U Tun Nyunt	Member
9	Daw Phyu Phyu Win	VHEV
10	U Maung Chaw	Member
11	Daw Mi Htay	Member
12	U Mya Than	Member
13	U BA Oo	Member
14	U Than Tun	Focal Person
15	Daw Tin Nan Moe	Member

Health Committee (20. Kyar Kwin Village)
Date Formed: 7.4.2015
Follow up: 27.6.2015

Sr	Name	Position
1	U Par Nuu	Chairman
2	U Thar Gi	Secretary
3	Daw Mya Aye	Cashier
4	Daw Mi Cho	Book Keeper
5	U Soe Hlaing	Member
6	U Poe Mae	Member
7	U Maung Shwe	Member
8	Daw Win Kyi	VHEV
9	Daw Thu Zar Oo	Member
10	Daw Nin Khine	Member
11	Daw Naw Chit	Member
12	Daw Naw Ta Luu	Focal Person
13	U San Yu	Member

Annex V – PLA Exercise at Project Villages

PLA Exercises at project villages

Sr. No.	Period	Conducted by	Village	Participants*		
				Total	Male	Female
1	7-9/5/2015	A Lin Yaung	Nae Char	30	7	23
2	13-15/5/2015	LanPyaKyae	Ban BweKone	30	12	18
3	17-19/5/2015	Paung Ku	Inn Phyar	30	9	21
4	20-22/5/2015	Paung Ku	MiChaungAeing	30	15	15
5	20-22/5/2015	LanPyaKyae Sin	Da NyinKone	30	4	26
6	23-25/5/2015	A Lin Yaung	KyarKwin	30	5	25
7	23-25/5/2015	Paung Ku	Ma Yan Kone	30	8	22
8	26-28/5/2015	A Lin Yaung	Phar Ka Du	30	10	20
9	26-28/5/2015	LanPyaKyae	ChaungPyant	30	9	21
10	26-28/5/2015	LanPyaKyae Sin	BilinKyoe	30	10	20
11	26-28/5/2015	Paung Ku	KhaLauk Inn	30	13	17
12	29-31/5/2015	LanPyaKyae	KyetChayKhat	30	18	12
13	3-5/6/2015	A Lin Yaung	AshayYwar	30	7	23
14	3-5/6/2015	LanPyaKyae	PhaYarSeik (West)	30	8	22
15	3-5/6/2015	LanPyaKyae Sin	YaeZaLote	30	8	22
16	5-7/6/2015	A Lin Yaung	KyaungYwar	30	9	21
17	6-8/6/2015	LanPyaKyae Sin	Ma Yan Chaung	30	10	20
18	7-9/6/2015	LanPyaKyae	A Hone Wa (West)	30	9	21
19	8-10/6/2015	A Lin Yaung	Yan Pyay	30	5	25
20	8-10/6/2015	Paung Ku	Oat Pho	30	5	25

*[Remark: Headcounts do not overlap]

Annex VI – Summary of PLA Results

Summary Activities of PLA Results from (20) Project Villages

Activities	KY	AY	PKD	YP	KK	AHW	MYC	CP	BBK	YZL	DNK	PYZ	NC	BK	KCK	OP	IP	MCA	KLI	MYK
1. IEC/ Health Education on RH and FP, Adolescents, Pregnant	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
2. Establishment of Health Revolving Fund	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
3. Income Generation Activities	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
4. Vehicle for Patient Transfer							√	√	√	√	√	√		√	√		√	√	√	
5 Technical Assistance To Current AMW and Health Educators	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
6. Instruments For AMWs					√	√			√							√			√	√
7. Selection and Training to new AMW							√	√	√			√	√	√	√	√		√	√	√
8. Medicine for Pregnant Women			√		√	√	√	√	√	√	√		√	√	√	√		√	√	√
9. Contraceptives	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
10. Building For Health Activities	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
11. Construction / Renovation of Roads/ Bridge	√	√									√	√					√			

KY (Kyaung Ywar), AY (Ashay Ywar), PKD (Phar Ka Du), YP (Yan Pyay), KK (Kyar Kwin), AHW (W) (Ah Hone Wa (West), MYC (Ma Yan Chaung), CP (Chaung Pyant), BBK (Ban Bwe Kone), YZL (Yae Za Lote), DNK (Da Nyin Kone), PYZ(W) (Phar Yar Seik (West) , NC (NAe Char) , BK (Bilin Kyoe)KCK (Kyet Chay Khat), OP (Oat Pho), IP (Inn Phyar), MCA (Mi Chaung Aeing), KLI (Kha Lauk Inn), MYK (Ma Yan Kone)

Annex VII – TMO, THN Discussion Note

Discussion Note

On the eighth of this month (8/7/2015) Dr. Kyaw Myint Oo of CDDCET had met with Dr.Thuzar Win, Township Medical Officer and Daw Nwe Nwe Kyu, Township Health Nurse both of them are from Bilin Township hospital, to find out some matters concerning with health activities in the township and also about the situation of Bilin Hospital attended delivery cases. The TMO and the Township Health Nurse had provided some data in health status of the Township and also gave some suggestions.

Activities of INGOs and NGOs in Bilin Township

- "Marie Stope" had entered Bilin but it is just preparing to start its activities. The TMO has not been informed about these.
- "World Vision" had started functioning in Bilin but, the TMO said she have not been informed about its activities as yet.
- "PSI" had opened "Sun Clinic" and is treating TB and Malaria patients.
- "World Concern" is implementing its activities concerning with TB, Malaria, Nutrition and Health Education.
- "Myanmar Medical Association (MMA)" is implementing a Malaria Programme.
- "Global Alliance (Garvi)" is giving financial aid and supervision to package tours made by the Health Department. It is also supporting financial aid by delivering cash to hospital referred cases.
- An organization called "ARC" is making an implementation in Lay Kay village area but, the Health Department of Bilin does not know about it as yet.
- The activities being conducted in Bilin Township by the Health Department are (1) Malaria and Dengue Hemorrhagic Fever Project (RYE), (2) TB eradication Programme, (3) Prevention of the Mother to Child Transmission of HIV/AIDS Project (PMCT), and (4) Birth Spacing Project (WCHT)

Health Strength in Rural Area of Bilin Township

Sn.	Description	No.	Remark
1	Township Hospital	1	
2	Station Hospital	3	
3	Sub Centre Rural Health Centre	8	
4	Sub Rural Health Centre	34	
5	Midwife	42/54	Under Training – 19
6	Auxiliary Midwifes	100	
7	Community Health Workers	76	

Number of Births – In January to May, 2015 in Bilin Hospital there were 322 births and outside hospital there were 76.

Death Rates (According to data valid from January to May, 2015)

New born (under 7 days)	4.9/1000
Under 1 year	10.5/1000
Under 5 years	13.3/1000
Maternal Death Rate	0
(Maternal Death Rate in 2014	0.6/1000)

Problems of Childbirth Cases

There were about 40 delivery patients in the Bilin Hospital last month. 50% of patients are of normal delivery and the rest of 50% of these births is of difficult problem cases. The problem was mainly of (1) Eclampsia, (2) Post-Partum Haemorrhage, (3) Heart Attack or Heart Failure, (4) Liver Insufficiency, (5) Septicaemia and (6) Septic Abortion.

This year there is no death out these cases but in 2014 the death rate of mothers during child birth was 0.6/1000.

Suggestions given by the TMO and the Township Health Nurse are:

(1) In the problem cases, which are 50% of all delivery patients, it had been found that they arrived at the hospital very lately. They had spent a very long time in trying to deliver in villages by "A Yat Let Thae" (TBA), the TMO said. She and the THN said if there is an ambulance in the hospital, these patients can be helped to a large extent. The THN also said that Bilin Hospital is the only one in Mon State which has no ambulance.

(2) The TMO said, Health Education, easy to reach the hospital promptly, care and nutrition aid to pregnant women and children under five, prevention of Dengue haemorrhagic fever and sanitary latrines are required in villages.