IV Community Support System

(1) Preface

First of all, we have to say this section of *Part 3 –Chapter IV "Community Support System"* is different from other sections in the "Implementation Guide," because it doesn't show any procedures or "how-to steps" to formulate community support system. This section mainly aims to share the Project experiences related to the supportive activities in the community for the promotion of MCH; to introduce good examples practiced by community people in the Project sites, which was consolidated from the interviews with community stakeholders and presentations by community people at 2 time-Experience-Sharing Workshops in 2008 and 2009.

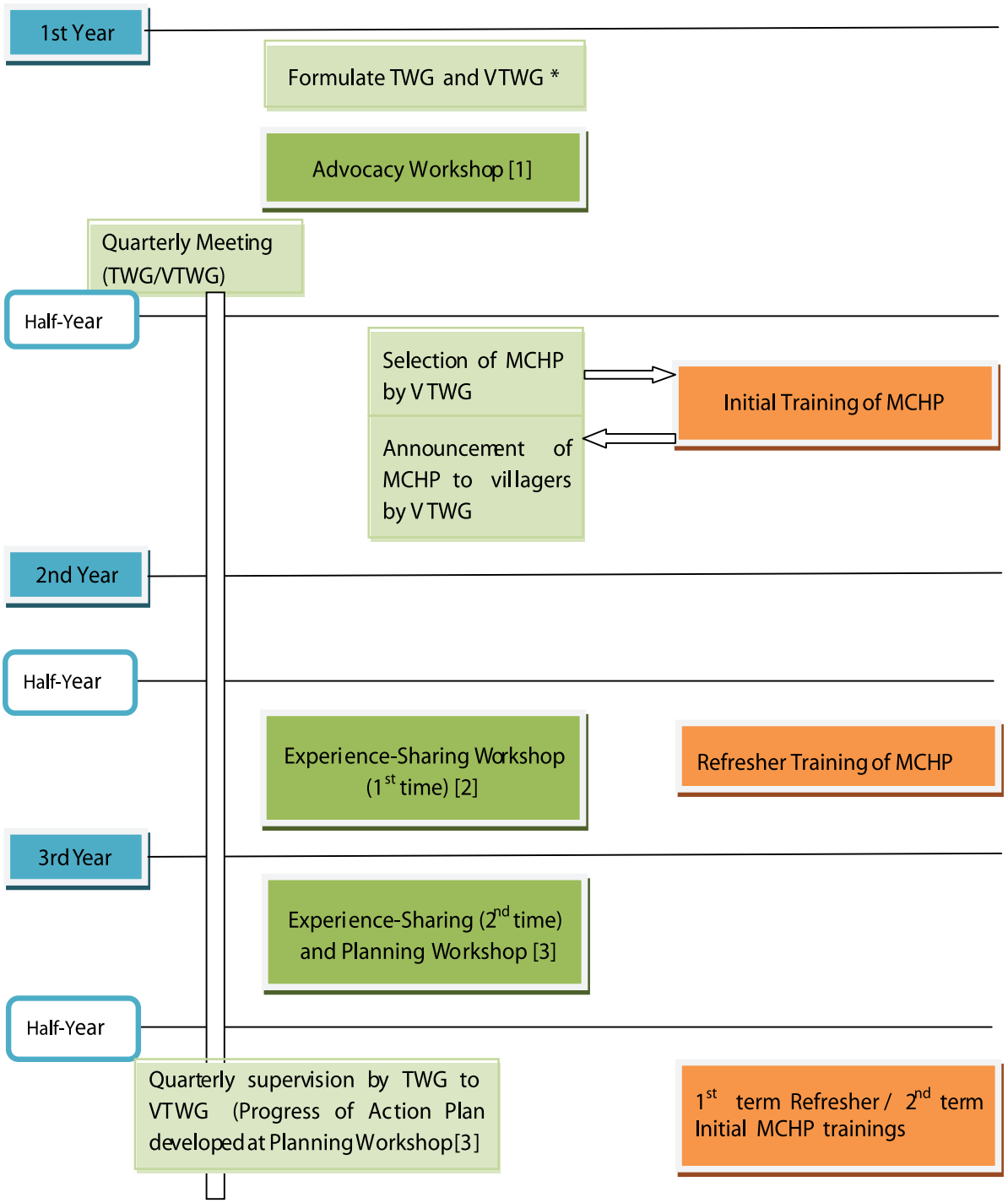
However, we think that this "Experience-Sharing" approach without any solid guidance or frameworks given by outsiders, leads to foster the community ownership and initiatives in Project sites. Through the 5-year-Project period, the Japanese experts and counterparts at central office are concentrated on the "facilitator's role" in the field of "community support system," and try to share with community stakeholders (including health staff), about the practical experiences and good practices initiated by themselves, based on the ideas that the majority would follow the innovative approach or good practices after they know it is good, and this type of approach would be better in the viewpoint of "sustainability."

In fact, after the "Community-Oriented Reproductive Health Approach" was introduced in the 2 Project Townships (especially after the introduction of MCH Promoters), we found the community people has become more knowledgeable on MCH issues and more supportive to health-related activities. Then, community people started to take actions and work together for MCH promotions mainly by their own initiatives, with the facilitative support from the Project (such as workshops).

The following chart 4-1 is a model for fostering community ownership which helps to create supportive environment for conducting MCH activities under the "Community-Oriented RH Approach." And taking this opportunity, we would like to share some of the good examples and real voices from the villages of the Project areas,with the appliers of the "Community-Oriented RH Approach" for their easy understanding on what was happening in the community.

(2) Model Steps for Creating Supporting Environment through Experience-Sharing under "Community-Oriented Reproductive Health Approach"

Chart 4-1 Model Steps for Creating Supporting Environment



*Possible members and roles and functions of TWG and VTWG are mentioned in Box 4-3 "Organizational Set up of CWG/TWG/VTWG" on pages IV-14~16.

Outline of the Workshops

[1] Advocacy Workshop

Major Objectives:

To make the TWG/VTWG members understand on

(a) the RH/MCH status in Project areas *(Problem identification/ if baseline survey conducted, results of survey could be shared)*

(b) the CORH Approach and future perspectives *(Purpose/ Expected Outcomes)*

(c) the TOR (roles and functions) of TWG/VTWG *(Actions to be taken)*

Participants: TWG members, VTWG chairpersons and BHS

[2] Experience Sharing Workshop (I)

Major Objectives:

(a) To share good practices on community support system (through the presentations by community stakeholders themselves (such as community leaders, BHS, AMW and MCH Promoters))

(b) To discuss about applicable practices by each VTWG

Participants: TWG members, VTWG chairpersons, BHS and Presenters (2~3 groups/workshops: Presentation group would be composed from VTWG chairperson, BHS, AMW and MCH Promoters)

[3] Experience Sharing (II) and Planning Workshop

Major Objectives:

(a) To share good practices on community support system (through the presentations by community stakeholders themselves (such as community leaders, BHS, AMW and MCH Promoters))

(b) To discuss about applicable practices by each VTWG

(c) To develop action plans for establishing community support system by each VTWG

Participants: TWG members, VTWG chairpersons, BHS and presenters (2~3 groups/workshops: Presentation group would be composed from VTWG chairperson, BHS, AMW and MCH Promoters)

(3) Good practices in the Community

(i) Community Welfare Fund (CWF)

In this section, the "Community Welfare Fund (CWF)" is defined as "the fund donated and managed by community people, and utilized for health-related activities." In the Union of Myanmar, many of the PDC (Peace and Development Council) Offices at Township/village tract/village levels, have their own "community fund" which is mainly used for small-scale infrastructure (such as renovation of PDC office or roads etc). "The Community Welfare Fund" described in this section is different from those "general-purpose" community fund.

As described in the following table 4-1, we identified the total number of 11 Village Tract Working Groups with "Community Welfare Fund", among which 10 VTWG started "CWF" after the introduction of CORH Approach. Out of 11 cases, PDC Chairmen of That Yet Kone Village Tract and Ohnma Kar Village Tract in Naungcho Townships mentioned that they were inspired by workshops for experience sharing or planning (from the Key Informant Interview conducted in 2008 to 2009).

The listed CWFs varied in many points how to collect the fund (e.g. voluntary donation or compulsory collection/fixed amount or unfixed amount/how frequently collect the fund from whom etc), how to manage and how to use it. One of the CWF was established with the purpose of "lending the money in emergency cases" and it proved that the community people themselves try to sustain the Fund without any external resources. It is same for others, all these good practices shows community people in Kyaukme and Naungcho Townships established the CWF, taking the community situation into account.

Therefore, the implementers of "Community-Oriented RH Approach" are recommended to facilitate community stakeholders decide the outline of CWF, according to their community needs and situation, and give them minimum necessary guidance only such as transparency in the fund management etc.

Table 4-1 Village Tract Working Groups which had "Community Welfare Fund (CWF)" in the Project Areas

Name of Village Tract	Initiator	When Started	Accumulated Amount	Main Purpose	Fund Collection	Management
Kyaukme Township						
Naung Pain	N/A	Before CORH Project		・To help poor patients	Donation from community people (no fixed amount)	by PDC Chair
Narr Pein	Discussion among PDC, MW and AMW	Early part of 2007	K120,000 (as of 2009 January)	・To assist referral cases ・To help poor patients	Quarterly collect the donation from community people (no fixed amount/as much as they wish)	by Health Committee
Kho Mone	N/A	2008 October	K143,000 (as of 2009 January), K200,000 (as of 2009 May)	・To assist referral cases ・To help poor patients	4 monthly collect the donation from community people (no fixed amount/as much as they wish)	・Kept at Myanmar Economic Bank account with 3 account holders (when draw the money, at least 2 signatures are necessary). ・If emergency cases happen, some of the rich persons agreed to rend money (pay back from bank later on).
Man Kyaung	Discussion among PDC, MW and Village Head	2009 April	N/A	・To supply minimum necessities to MCHPs' activities (such as stationary) ・To assist in emergency cases	Quarterly collect K 600 from every household (K200/month) (fixed amount/collect money according to the agricultural season (majority of villagers are farmers))	・Money was collected by 12 MCHPs in 4 villages under Man Kyaung VT, and kept at 4 assigned MCHPs by each Village Head. ・4 MCHPs are responsible for record keeping and under the supervision of Village Head.
Naungcho Township						
Kyauk Taw	N/A	2006	N/A	・To help hospitalized patients ・To help poor patients ・To arrange emergency transportation	Collect from all households in the community	by Village Head

Name of Village Tract	Initiator	When Started	Accumulated Amount	Main Purpose	Fund Co llection	Management
Kangyi	PDC Chair	2007	K200,000 (as of 2008 January) K1,000,000 (as of 2009 Sept.)	・To assist referral ・To assist those need financial help	Donation from well-off villagers (no fixed amount)	・Managed by PDC Chairperson and Health Committee (8 members incl. MCWA etc). ・Try to increase the amount of fund by loan-interest (borrow the fund to business-persons and get interest).
Naungcho Gyi	PDC Chairperson (in consultation with Health Assistant in Kangy RHC)	2008 October	K50,000 (as of 2009 Sept.)	For MCH promotion only ・To assist referral	Donation (K10,000) from newly wed couples (Collect K100,000 for general purpose and 10% of which is for MCH purpose).	・Kept by MW in Naungcho Gyi Sub-RHC. ・For utilization, MW consult with PDC Chairperson, PDC Secretary and MCHP.
Nyaunt Taw	N/A	No exact information (in 2008)	K50,000 (as of 2009 January)	For MCH activities	Donation from well-wishers (no fixed amount).	・Try to increase the amount of fund by loan-interest (lend the fund money to business-persons and get interest).
Loi Pan Sub-RHC Ye Dwin Gyi Village Tract	Discussions at Village Tract Meeting	No exact information (in 2008)	K100,000 (as of 2009 January)	・To assist referral cases	Collect K500 from all household	・Lend the fund money to those who is referred to money. ・The lended money should be paid back to the CWF (without any interest).
That Yet Kone	PDC Chair (inspired by "Experience-Sharing Workshop II")	2009 January		・To assist referral	Start from "no-interest loan" to referred patient (or patient's family)	by PDC Chair
Ohnma Kar	According to the "Action Plan" developed at Planning Workshop in 2009 May	2009 July	K100,000 (as of 2009 Sept.)	For MCH activities	4 monthly collect K500 from each household (total 300 household)	・ Collected by Village Chairs and MW ・ Kept by VT PDC chair ・ Managed by health committee (VT Chair, 10 village chairs, 1 LHV (from responsible RHC), 1 MW (in Ohnma Kar Sub-RHC) and 1 CHW in Ohnma Kar village)

(ii) Referral Support System

In the rural areas of Myanmar, some form of "referral assistance" exists commonly, because most of the referral cases from village to primary level hospital or health unit are conducted by community people (including residing BHS). Through the 5 year Project period, we try to expand the good examples of "Referral Support" in the community, in other words, try to establish "systematic referral support" in the community. Following 2 cases are one of the good practices in each Project areas (Some other village tracts/villages are practicing this kind of "roaster system" in similar way).

Box 4-1 Case 1- Referral Support (Man Kyaung)

Man Kyaung Sub-RHC (Kyaukme Township) ~From the interviews with Village Tract Chair, U Sai Myint Thein~

Since 2008, they systemized the transportation arrangement for referral cases (from Sub-RHC to District Hospital).

1. The Midwife (at Man Kyaung Sub-RHC) receives the request for emergency referral (from AMW, MCHP and community people)
2. The MW requests Village Tract PDC Chairman to prepare necessary transportation
3. The VT PDC Chairman requests the roasted owner alternately, to lend their trawlorgy.
4. The roasted owner lends the trawlorgy free of charge. Only fuel cost should be covered by the patient's family, if they can afford it.
5. If the cost is not affordable for patients, VT PDC Chairman and MW pay the amount from the Community Welfare Fund.

Box 4-2 Case 2- Referral Support (Naungcho Gyi)

Naungcho Gyi Sub-RHC (Naungcho Township) ~From the interviews with Village Tract Chair, U Sai Tun Oo~

Since 2005, they started the rotated utilization of trawlorgy for public purpose (not only for health but also for education purpose, like sending the school teachers to monthly meeting venue etc.)

1. The PDC Chairman and PDC Secretary are in charge of management of the trawlorgy rotation.
2. The roasted owner lends the trawlorgy free of charge based on the request from PDC Chairman. Only fuel cost should be covered by the borrowers.

Concerning the "Emergency Referral Support", we would also like to show some good practices achieved under the good collaboration and teamwork among community leader, MW, AMW and MCHP. It is essential for timely referral to establish the collaborative and functioning network among above stakeholders in the community. In the "CORH Approach", the MW is expected to take the central position of this community network, and newly introduced MCHPs are expected to act as the bridges between

community people and MW (or AMW). The following cases are some of the good practices which show the good cooperation among community stakeholders, which result in the successful emergency referral.

Narr Pyein Sub-RHC (Kyaukme)

(from the presentation at the Experience Sharing Workshop II in 2009 January)

a) Daw Nan Wah So Oo, MW of Narr Pyein Sub-RHC

…I have been working here since December 2005. I found many difficulties in my work for 2 reasons; poor health awareness of community people as this is the new sub-center and little work experience of me as this is my first posting.

However, CORH Project trained MCHPs and AMWs and we got good assistance from them. The chairperson of village PDC helped us by means of arranging the CWF and trawlorgy for referral cases. I also got chances of attending refresher trainings and other health related trainings, thanks to the Project. Therefore, I can perform my duties better now.

Because of cooperation among us, we got better coverage in our activities namely antenatal care, delivery with SBAs, postnatal care, care of miscarriage mothers, newborn care, routine children immunization, national immunization day (NID) activities and de-worming and provision of Vitamin A.

Let me recall one of my experiences. **In March 2008, I informed to health committee about one pregnant mother who is less than 18 years old with first pregnancy and of short stature. I requested health committee to help the mother for hospital delivery. In April 2008**, this pregnant woman got labour pain and I informed to the village PDC chair. **Chairman arranged the trawlorgy. He also supported 50,000 Kyats for pregnant woman. MCHP and I accompanied with the pregnant woman to the hospital**.

As she was a pregnant woman with some risk, hospital staff welcomed us warmly and **medical officer on duty conducted the delivery successfully. Because we were united and cooperated, we could save both the mother and baby. I, alone, could not do so, unless I got cooperation of community people**.

In conclusion, I'd like to stress that every pregnant mother will enjoy safe motherhood only when there is cooperation among all stakeholders namely village PDC, community people, volunteers and BHS.

b) Nan Shwe Myint Han, AMW of Narr Pyein village tract

…I attended AMW training in 1997 and refresher training in 2006. **Once I finished my AMW training, I cooperated with MW in providing health care to community people**. I attended to 10 deliveries per year.

Now, as we have MCHPs in our area, more pregnant mothers take AN care than before. Health knowledge of community people also improved. It is easier to refer pregnant women to hospital as they have more health knowledge. Because we explained them about danger signs by using Home-Based Maternal Record (HBMR), we can know health problems in our area early. The Clean Delivery Kit (CDK) is also very useful for delivery.

Let me share one of my experiences. **One day in April 2008, I was asked for conducting home delivery. Pregnant woman was 23 years old with her 1st pregnancy (primigrarida). When I checked the HBMR, I found out that MW had referred the patient to hospital for non engagement of head into pelvis. Then, I promptly informed to the MW and arranged for transportation to hospital with MCHP**. Then I accompanied with the woman to hospital. When we arrived at the hospital, medical officer on duty examined her and then informed to OG specialist. **OG specialist came and after seeing the patient, explained about the need of operation. Then operation was done successfully**.

In conclusion, I would like to say that I am very happy whenever I think about our timely referral which could save both the mother and baby.

c) Ma Ma Aye, MCHP from Lwe Sar village

I attended MCHP training in 2006. Once I finished the training, I participated in maternal and child health activities as much as I can.

I encouraged pregnant women to take AN care, to deliver with SBAs, to eat various kinds of food as usual and to get children immunization. I also explained about taking care of neonates. I explained about the facts from our MCHP Handbook to pregnant mothers. I always help MW for her activities whenever she comes to our village. I also ask MW about what I want to know.

Let me share one of my experiences. **One of the pregnant women in my area suffered bleeding per vagina in 7th month of pregnancy. She was having 10th pregnancy. As I knew that this is one of the danger signs, I informed to MW of Narr Pyein promptly. I also gave reassurance to mother. MW and AMW came and saw the patient without delay and we arranged for referrals. We took HBMR, CDK and accompanied with family members to hospital**. We were treated warmly in the hospital. After some preparation, operation was

done successfully. Mother was asked to submit sterilization form and sterilization was done concurrently. **Both the mother and baby are well now. When we arrived back at my village, MW congratulated me for my timely referral. Villagers also recognized me as a MCHP more than before**.

In conclusion, happiness gained from this experience encouraged me to continue working as a MCHP.

Bant Bwe RHC (Naungcho)
(from the presentation at the Experience Sharing Workshop II in 2009 January)

a) Daw Khin Kyaw Win, MW of Bant Bwe RHC

…We have 47 MCHPs trained by the Project. Altogether we had 4 MCHP trainings between 2006 and 2008. After introduction of MCHP System in our area, our MCH activities achieved more success. We could find more AN cases. We also got better coverage of immunization for children as well as mothers. MCHPs sometimes took the children with them to immunization center. Even if they cannot take the children with them, MCHPs encourage mothers and children to get immunization and refer to us. They also visit post delivery mothers and check whether they are well or not. If mother or baby is not well, they will inform us and ask for home visit to those mothers.

(Let me share one of my experiences.) **At 5:20 a.m, on October 28, 2008, the 23 years old pregnant woman suffered fits and unconscious. AMW, Daw Kyu Kyu Myint, and MCHP, Daw Htay Lwin, brought the patient to me with trawlorgy**. I examined the patient and found out that she needed to be transferred to higher health facility. So, **we arranged for transportation to Pyin Oo Lwin Hospital. Forceps delivery was done and male baby was delivered alive at 9:20 a.m. on the same day. Because of cooperation among us we could save the lives of both the mother and baby**. Patient was discharged from the hospital on November 3, 2008.

In conclusion, I would like to inform to all of you that we will continue those good habits of cooperation among all parties for safer motherhood.

b) Daw Kyu Kyu Myint, AMW from Gant Gaw village

…I first attended AMW training in 1997 November. Now, I have got 10 years service. I attended refresher training in February 2006. I have about 10-12 delivery cases per year.

After introduction of MCHP System, there are more cases of antenatal care. I conducted 2 deliveries in January 2009. I used HBMR and CDK in these deliveries. I meet with MW monthly and she discusses and gives me necessary advice.

On October 28, 2008, one MCHP, Daw Aye Lwin, informed me about one pregnant woman with labour pain. She suffered fits and unconsciousness. I informed to village PDC chairperson. Then we arranged for transportation and took her to Bant Bwe RHC.

Then MW saw the patient and informed to village tract PDC chair and we took the patient to Pyin Oo Lwin Hospital. At 9:20 a.m. the patient delivered a baby with assistance of forceps. On October 3, 2008, the mother was discharged from the hospital. Because of cooperation among us we can save both the mother and baby.

We thank those persons concerned from the Project for assisting us in our activities.

In conclusion, I would like to say that we will continue cooperation among all parties for safer motherhood.

(iii) Other Community Support (Incentives for MCH Promoters)

In this part, we would like to introduce some of the good practices initiated by community people for supporting the MCH Promoters. As described in other sections, it is important to provide health volunteers with some kind of incentives (not necessary means financial incentives) in order to sustain the volunteer system in the community.

During the Project period, the implementers didn't give any solid guidance to community stakeholders but tried to foster the ownership from community side, through the regular TWG meeting and various kinds of workshops. The followings are the good practices related to the incentives for MCH Promoter, initiated by community people. The information was collected through the situation analysis (2008 June, July and October) and monitoring of health centers (including key informant interviews with community stakeholders) (2008 October to 2009 September) conducted by Japanese expert on Community-based Organization Activities.

[1] Arrangement of the transportation
< Shwe Nyaung Pin Village and Taung Ta Lone Village in Naungcho and others>

[2] Exemption from other volunteer (labor) work
<Mai Ngwat RHC, Pone Woe Sub-RHC and Man Kyaung Sub-RHC in Kyaukme>

[3] Provision of perdiem (when attending the training)
<Ohnma Kar Sub-RHC in Naungcho>

[4] Awarding of outstanding MCH Promoters*
<Naungcho Township, in collaboration with Maternal and Child Welfare Association>

Note: As for the example no. [4] "Awarding of outstanding MCH Promoters", it needs to be carefully conducted, especially in the selection procedures. In some cases, awarding the best performer enhances the motivations of other volunteers, but in other cases, it could result in demotivating non-selected volunteers.

(iv) Behavior Change

This part introduces the "health-seeking behavior change" in the Project area, which are observed and presented by community people. All those information were collected from the presentations at Experience-Sharing Workshops and the key informant interviews conducted from October 2008 to September 2009.

[1] Harmful Traditional Custom

Traditional custom on dieting in postpartum period and delivery room at home

…For example, changed in dieting or nutrition. Before MCHP, women take only ginger and salt, after delivery. They didn't eat meat after delivery. But, we tried to explain about nutrition, and they have changed. Now, they take more nutritious and balanced food, including meat. Another example about change in the community. Before the introduction of MCHP, women stay in the dark room with bad ventilation for 7-8 days after delivery *(In their traditional custom, they make a delivery room within the house, and cover all windows with blanket (or clothes etc). So it makes the delivery room dark and mal-ventilated)*. This custom has now changed.
(Daw Khin Mar Yee, MCHP, That Yet Kone Village, Naungcho, interviewed in September 2009)

Traditional custom on dieting in postpartum period

Before MCHP, there was a traditional custom that women eat only rice and salt, not eating meat and vegetables for 7 and 8 days after delivery. Now, there is no more such kind of custom. Because MW trained MCHPs, and giving health education to MCHPs, and in turn, MCHPs give health information to village people. By our efforts, first, a few women understood the importance of balanced diet, and tried to take meat and vegetable, and others observed what happened to them. Then, nothing bad happened. So that, they began to understand eating meat and vegetable after delivery was not harmful. Therefore, other people also followed. Like this, gradually the situation is changing.
(From Focus Group Discussions with 8 MCHPs, (3 from Man Kyaung Village, 2 from Man Wei Village, 2 from Chaung Tha Village and 1 from Hae Pu Village), under Man Kyaung Sub-RHC, Kyaukme, interviewed in September 2009)

[2] Seeking for Health Services

Behavior change in AN care-seeking

…Before I became MCHP, pregnant women in my area were very much ashamed to receive AN care. Therefore, I always accompanied pregnant women to go to health center for their first time of AN care. Then, they gradually go to health center by themselves, after 2nd time and 3rd time.
(Ma Sai Sar, MCHP, Par Hatt Village, Kyaukme, interviewed in September 2009)

Behavior change in delivery attendance

…After MCHP training, there are some changes. Local people began talking more about health. They seem to have more awareness on health. Incidence of infant mortality declined. Previously, there were more cases of delivery with TBA. It becomes less and less now. Now, pregnant women deliver with MW (and, TBA helps MW in attending the delivery).
(U Shwe Hla, Village Tract Chairperson, Kywe Gone Village Tract, Kyaukme, interviewed in October 2008)

Behavior change in attending health meeting

…Remarkable changes have taken place in the village after MCHP. In the past, people were not interested in the (health) meeting. They ignored invitation. Now everybody comes to the meeting willingly. During the last two years, there was no death of pregnant women and children under 5 years old. Before that time, I found deaths of 3 to 4 years old children and of mothers during childbirth occurred.
(U Sein Thein, Village Tract Chairperson, Kone Thar Village Tract, Naungcho, interviewed in October 2008)

Box 4-3 Organizational Set up of CWG/TWG/VTWG

When applying the Community-Oriented Reproductive Health Approach in new areas, it is recommended, based on the Project experiences, to establish the following organizations and management mechanism for the effective management, planning, implementation and monitoring and evaluation. It ensures participation of various stakeholders at different level and strengthens sense of ownership towards the sustainability of the activities.

1. Central Working Group (CWG)

During the Project period (2005 -2010), the Project Steering Committee (PSC) was established as the highest decision making body of the Project. The PSC convened biannually. For the future application of "Community-Oriented Reproductive Health Approach" in the country, the following Central Working Group (CWG) need be formulated for overall management and coordination.

Members

1. Chairperson – Deputy Director General (Public Health), Department of Health
2. Member – Director (Public Health), DOH
3. Member – Director of Central Health Education Bureau, DOH
4. Member – Director of State/Division Health Department
5. Members – District/Township Medical Officer
6. Members – Supporting or funding agencies (if there are)
7. Secretary – Deputy Director (Maternal and Child Health), DOH
8. Joint Secretary – Assistant Director (Maternal and Child Health), DOH

Roles and responsibilities of the CWG

1. To oversee overall management of CORH Approach
2. To review and authorize annual plan of operations in accordance with the overall framework of the CORH Approach
3. To guide the overall activities
4. To discuss issues raised in relation to the CORH Approach application at the central level
5. To provide political, moral, logistical, and technical support for smooth implementation of the related activities at the request from State/Division or District/Township level
6. To monitor and analyze the overall progress at the central level
7. To ensure close collaboration among the relevant member agencies
8. To evaluate the activities at District/Township levels from the viewpoint of Department of Health at the central level
9. To compile all the information related to the CORH Approach at the central level
10. To disseminate information about application/expansion of CORH Approach to relevant agencies and organizations at the central level

2. Township Working Group

During the Project period (2005 -2010), the Township Working Group (TWG) was established in the respective Project townships and worked closely with the PSC. Each TWG convened quarterly and whenever necessity arose. For the future application of CORH Approach, the similar management body should be formulated for the practical management and implementation of "CORH" approach activities at township level.

Members

1. Chairperson – Chairperson of Local Authorities
2. Members (3) – Representatives from District/Township NGOs
3. Member – Township Education Officer
4. Secretary – District/Township Medical Officer
5. Joint Secretary – Reproductive health-focal staff from District/ Township Hospital assigned by DMO/TMO

Roles and responsibilities of TWG

1. To plan and organize activities at the township level and develop the plan of operations
2. To review CORH Approach-related activities at the township level
3. To guide and monitor the progress of the activities in the township
4. To discuss issues raised in relation to CORH Approach at the township level
5. To provide political, moral, logistical, and technical support for smooth implementation of the activities and social mobilization for sustaining CORH Approach in the township
6. To compile statistics related to the CORH Approach activities at the township level
7. To monitor and analyze the progress of the activities at the township level
8. To compile all the information related to the CORH Approach at the township level
9. To report to the CWG, biannually, and whenever requested
10. To ensure close collaboration among the relevant agencies and organizations under the supervision of CWG
11. To disseminate information about activities of the CORH Approach to relevant agencies and organizations at the township level under the supervision of the CSG

3. Village Tract Working Group

During the Project period (2005 -2010), the Village Tract Working Group (VTWG) was established in every village tracts (or wards) where the RHC, Sub-RHC or MCH Center is located. The VTWG covered all the villages and village tracts according to the jurisdiction of each health centers. The VTWG principally convened quarterly and whenever necessity arose. For the future application of CORH Approach, the similar working group should be established with following roles and responsibilities.

Members

1. Chairperson – Chairperson of Village Tract PDC (or Local Authority) where RHC, Sub-RHC or MCH Center is located
2. Members – Chairperson of other Village Tract PDC (Local Authority) under the jurisdiction of above RHC, Sub-RHC or MCH Center
3. Members – Representatives from local NGOs/Community Leaders
4. Secretary – SMO/HA/LHV/MW (Health Center's BHS)

Roles and responsibilities of the VTWG

1. To review the CORH Approach-related activities at the village tract level
2. To plan and organize the activities at the village tract level under the supervision of TWG
3. To guide and monitor the progress of the activities in the village tract
4. To discuss issues raised in relation to the CORH Approach at the village tract level
5. To provide political, moral, logistical, and social support for smooth implementation of the related activities especially by the RHC or Sub-RHC's BHS and MCH promoters
6. To mobilize community people for promotion of RH in the villages
7. To accept monitoring visits by the TWG and assist the team for smooth implementation
8. To ensure close collaboration among the relevant agencies and organizations under the supervision of the TWG
9. To report to the TWG whenever requested
10. To disseminate specific information about the activities related to the CORH Approach to the community people under the supervision of the TWG

IEC/BCC Manual

For conducting Community-Oriented Health Education focusing on Safe Motherhood
~Good Practices from Kyaukme and Naungcho Townships

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Raising awareness and knowledge on safe motherhood by providing the appropriate information is significant. However, the information alone does not necessary change the behaviour of the community people.

This manual is a tool to support Basic Health Staff (BHS) to conduct the health education sessions effectively at MCH Center, RHC/Sub-RHC, or in the community, as Information Education Communication/Behaviour Change Communication (IEC/BCC) activities. It is developed, based on the experience from the *"Healthy Mother Project ~ Community-Oriented Reproductive Health Project" in* Kyaukme and Naungcho Townships.

Aiming at behaviour change among the community people, this manual incorporates several new communication methods that can easily be utilized by the BHS in conducting health education sessions, focusing on safer motherhood.

Documentation of the Project activities provides suggestions for the BHS, with references for community health education sessions, directed for pre-pregnancy, pregnancy, and post-natal period. It also presents hints on practical steps to conduct the sessions, with tips for developing community-based IEC/BCC tools, and sample formats.

Introduction

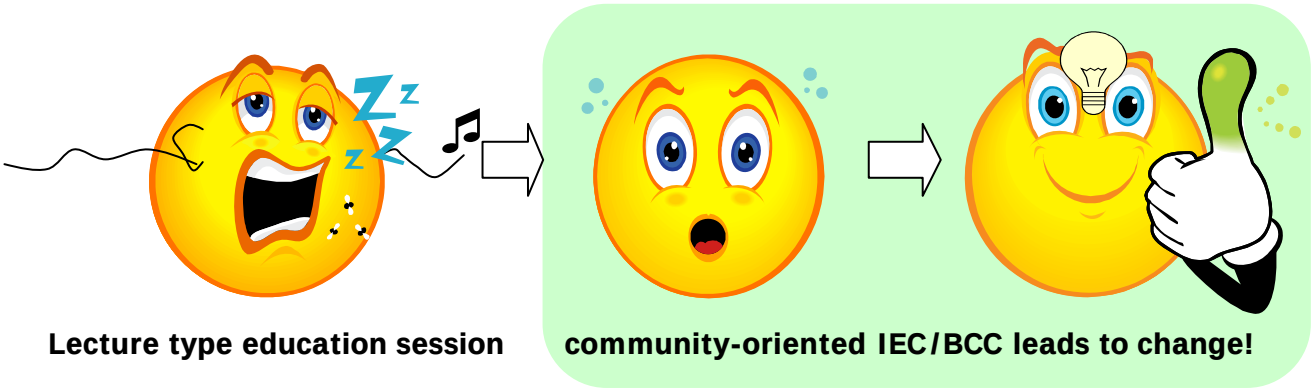
The Reproductive Health Policy in Myanmar has always given priority to women's health promotion services with special focus on safe motherhood. Ensuring mother's health to directly links to child survival and improvement of the health of the whole family. *"Community-Oriented Reproductive Health Project"* also known as *"Healthy Mother Project"* has been jointly implemented by the Department of Health, Japan International Cooperation Agency (JICA), and Japanese Organization for International Cooperation in Family Planning (JOICFP), in two model townships of Kyaukme and Naungcho in the Northern Shan State. In order to promote the health of mothers and children, improvement of awareness and knowledge on reproductive health issues among community people has been one of the outputs under the Project.

Under the Project, trainings of IEC/BCC has been undertaken to enhance the capacity of BHS, including LHVs and midwives to conduct the health education sessions focusing on safe motherhood at the MCH Center, RHC and Sub-RHC in the Project sites. Effective utilization of the Information Education Communication/Behaviour Change Communication (IEC/BCC) materials was also taught and encouraged.

This IEC/BCC manual is an accumulation of good practices from the "Healthy Mother Project". This is expected to support BHS in the Project sites to maintain and sustain its IEC/BCC activities as well as directing non-project sites to help conducting the health education sessions to bring about changes in safe motherhood the community.

1. Necessary Components for Effective Community-Oriented IEC/BCC

It is time for the BHS to conduct education sessions that are more suitable for the community people by directing the content of the session to suit the people's daily lives. For this, there is a need to shift from "knowledge-oriented lecture type" education sessions to participatory sessions that will remain in the minds of the community people and thus influence their attitude and behaviour.



Lecture type education session **community-oriented IEC/BCC leads to change!**

To conduct an effective community-oriented IEC/BCC session, it is always very important that the situation portrayed by the messages is directly linked to what is happening in the community. Thus the BHS always need to be sensitive to people's needs, and to what is happening in the community.

Teamwork building for safer motherhood community activities in Kyaukme and Naungcho Townships

Before the Project started, it was identified that AMWs did not receive sufficient supervision by the midwives, and due to some limitations, MCH services could not reach to the community people. In order to tackle this issue, the Project promoted teamwork building among midwife, AMW and MCH Promoters for strengthening MCH activities and improve provision of MCH services to the community people especially pregnant women in the Project areas.

TMO/DMO(HA/LHV)
CME (Continuing Medical Education)

RH Service Provider
Provides quality Safe Motherhood Services as Skilled Birth Attendant (ANC/PNC/Delivery).
BHS (eg. Midwife)

Health Volunteer
Provides complementary Safe Motherhood Services under the supervision of MW.
AMW

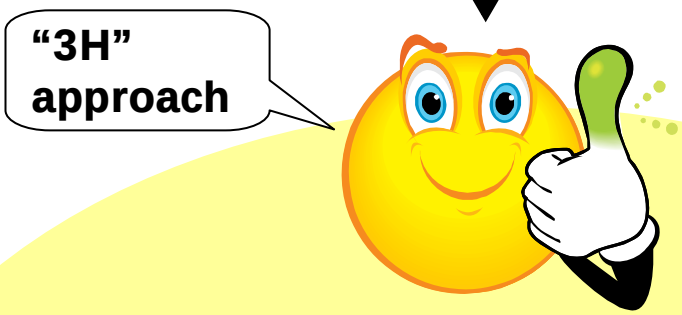
Health Volunteer
Acts as a BRIDGE between the health service providers and the community people according to MCHP Handbook.
MCH Promoters

Provision of knowledge is very important. Thus, “knowledge communication - HEAD” must be ensured in the session. However, most people can learn better when they can “hear” things that are related to their daily lives (situations) and “see” what they are learning about.

In an attractive session, setting the scene related to people’s lives with stories through “emotion communication – HEART” is just as important. In addition to “Head and Heart”, use of tools such as “visual communication - HANDS” can make people to learn better.

To conduct effective community-oriented education session, there is a need to balance the three components (Head, Heart and Hands).

Transition from Lecture type education



Practical and realistic community-oriented session

Head

Knowledge Communication by incorporating information based on scientific facts (refer to IMPAC for PHC trainer’s manual, Magnel Kit manual, etc.)

- Pinpoint information to message (mechanism of menstruation, pregnancy, fetus development)
- Danger signs
- Birth spacing methods (contraception)

Heart

Emotion Communication by incorporating an introductory scene and setting a scene or story based on the real lives in the community

- real stories/events that happens in the community
- BHS can refer to information directly from the community through MCHP/community volunteers

Hands

Visual communication by using effective RH tools

- Ready-made IEC tools (Magnel kit, pregnancy simulator, etc)
- Handmade low cost visual tools (drawing, glove puppets, doll, etc.)
- Existing IEC materials (pamphlets/leaflets, posters, etc)

2. Strategy for organizing community-oriented IEC/BCC ~ the 6 STEPS ~

To design effective community-oriented IEC/BCC session, BHS can refer to the following 6 STEPS. BHS can sit together as a team and discuss starting from Step 1.

Step 6 . Assessment plan
Step 5. HOW (3H facilitation notes)
Step 4. WHAT (Message)
Step 3. Desired change in attitude and behaviour
Step 2. WHO (Target audience)
Step1. WHY (Identify issues in the community ~purpose)

Sample format

Community-Oriented IEC/BCC Session
Model Action Plan Format

Plan title:_____ Township/name of RHC/Sub-RHC:_____

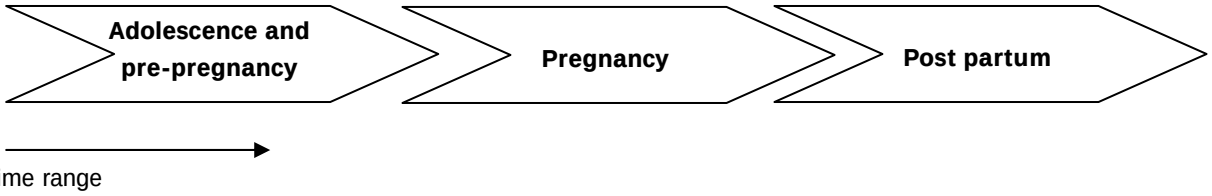
Date	
Place	
Step 1. WHY (Identify issues in the community ~purpose of the session)	
Step 2. WHO (Target audience)	Fill in
Step 3. Desired change in attitude and behaviour	
Step 4. WHAT (Message)	
Step 5. HOW (3H facilitation notes/ tools/ team)	

STEP 1: WHY (Identify issues in the community ~ purpose)

BHS in daily life face various issues related to safe motherhood. Gathering information at the grassroot level is the starting point for planning an educational session.

What is the situation and needs of women, focusing on safe motherhood? Which in other words, is to understand and identify the situation in the community.

Safe motherhood is not only about pregnant women. When considering the life cycle of women, issues surrounding young people and post delivery women should also be looked into (as part of "continuum of care").



STEP 2: WHO (Target audience)

Based on step 1 which is to identify the issues in the community, to whom will you try to reach? Target audience may not be only the pregnant woman when considering "continuum of care." When looking from reproductive health life cycle point of view, the audience can be young people or women after delivery. The education sessions should also change according to the type of audience i.e. ethnic groups, level of literacy, inclusion of men, etc.

STEP 3: Desired change in attitude and behaviour

Considering the current status of the target audience, "expected change" should be specified.

ie.) Men to care more for his wife during pregnancy and be aware of the importance of health checkups and danger signs. Pregnancy simulator is used for male to participate.

ie.) Breast-feeding women to be prepared for birth spacing back-up methods six months after the delivery.

STEP 4: WHAT (Message)

What is the most important message that you want the session to convey to the audience? Messages should be developed, based on the desired change in attitude and behavior (STEP3).

- Messages should be:
  - ✓ **Clear**: convey the same meaning to everyone; it should not be necessary to understand the written words.
  - ✓ **Simple**: one or two basic ideas.
  - ✓ **Easy to understand and follow**: matches the local culture in style and language.
  - ✓ **Action oriented**: message linked to attitude and behavior.

STEP 5: HOW (3H facilitation notes)

Discuss and develop facilitation notes to direct the team. The notes should include schedule, venue, team member, tools used, etc. Incorporate 3Hs in the session flow:

- ✓ **HEART**:
  Dramatize (role play) the introductory part of the session by setting the scene.
- ✓ **HEAD**:
  Confirm the technical part of the information by referring to manuals and textbooks.
- ✓ **HANDS**:
  Prepare necessary IEC/BCC materials (puppets, development of the materials, pamphlet, flipchart, etc) – refer to Part 5. “Tips on the development and use of community-oriented IEC/BCC tools”(p. V-12-16).

ie.) Conversation by puppets at the beginning of the session can attract attention of the audience and set the scene (issue).

ie.) Multi-purpose visual tool to support the session to ensure that the information adequately reaches the audience.

See Annex 4 for “Five Tips for Effective Health Education Session” of this IEC/BCC manual.

Sample format

Community-Oriented IEC/BCC Session Facilitation Note Format

Plan title:_____**Name (township/ RHC/ Sub-RHC):**_____

Team member:_____

Date: _____

Place (venue): _____ **Time:** _____

Time	Topic	Content	Tools to be prepared
	Fill in		

** Refer to Annex 1 for sample facilitation notes*

STEP 6: SEE (Assessment plan)

Checklist, interviews, feedback on the session tool is important for continuous improvement and sustainability of the IEC/BCC activities. After the session, set a meeting among the facilitators to review the session. BHS can share the feedback and comments to consider what is indicated in the checklist. Discuss on themes that went well, and others that did not go so well. Discuss reason for this and how it should be improved. Practical recommendations will be useful for future session.

Reporting

Using a report format (Annex 2) and the check list on the next page for health education session, revie and evaluate the session to record the activities and share valuable experiences with other BHS. The report format and check list are to be submitted to the supervisor.

Community-Oriented IEC/BCC Health Education Session

CHECKLIST ON HEALTH EDUCATION

1 Township : . . . . . .

2 Name and title of facilitator: . . . .

3 Number of the participants: Female:_____ Male: _____

4 Date of observation: . . . . / . . / . .2010

5 Location of observation:. . . . . .

6 Start time:. . . . . End time:. . . . .

7 Monitored by: . . . . . .

		Activity	YES/NO	Comment
(A)	**Role and responsibility of the facilitators**			
	A1	Greet the participants in a friendly manner		
	A2	Explain clearly the objective of the session		
	A3	Make the participants understand the flow of the session		
	A4	Use simple words familiar to the participants		
	A5	Good teamwork among the facilitators		
(B)	**Utilization of the IEC/BCC materials**			
	B1	Use IEC/BCC materials (Magnel Kit, Pregnancy Simulator, DVD)		
	B2	Distribute the IEC/BCC materials (Pamphlets)		
	B3	Explain the topic on each IEC/BCC material clearly		
(C)	**Participatory Discussion**			
	C1	Create a comfortable health education session space		
	C2	Encourage the participants to speak out and raise questions		
(D)	**Participant's feedback**			
	D1	Participate in the discussion		
	D2	Enjoy the demonstration and session		
	D3	Participants give feedback/questions to the facilitator		
(E)	**Wrap-up**			
	E1	Tell the participants the schedule for the next session		
	E2	Invite the participants to come at any time if any problem occurs		
	E3	Thank the participants for coming		
(F)	**Self-assessment (in team/group)**			
	F1	Read through all feedbacks from the audience (review and analyze)		
	F2	Modification of the script (overall framework)		
	F3	Planning for next session (schedule dates for preparation, session)		

3. Good Practices from Kyaukme and Naungcho Townships

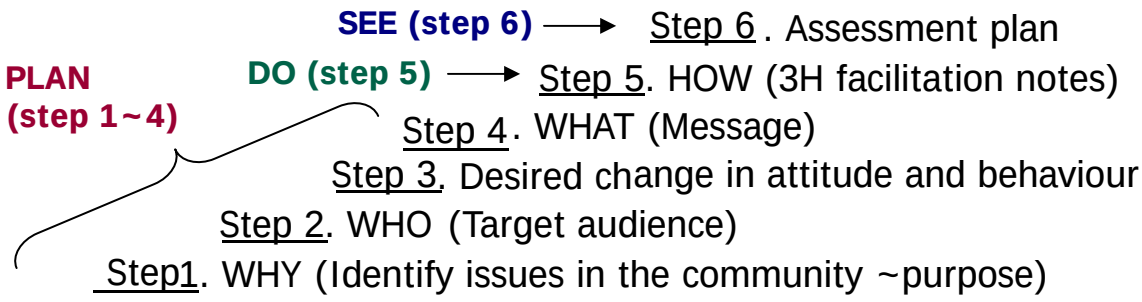
Possible content for health education focusing on safe motherhood at each stage of **"continuum of care."**

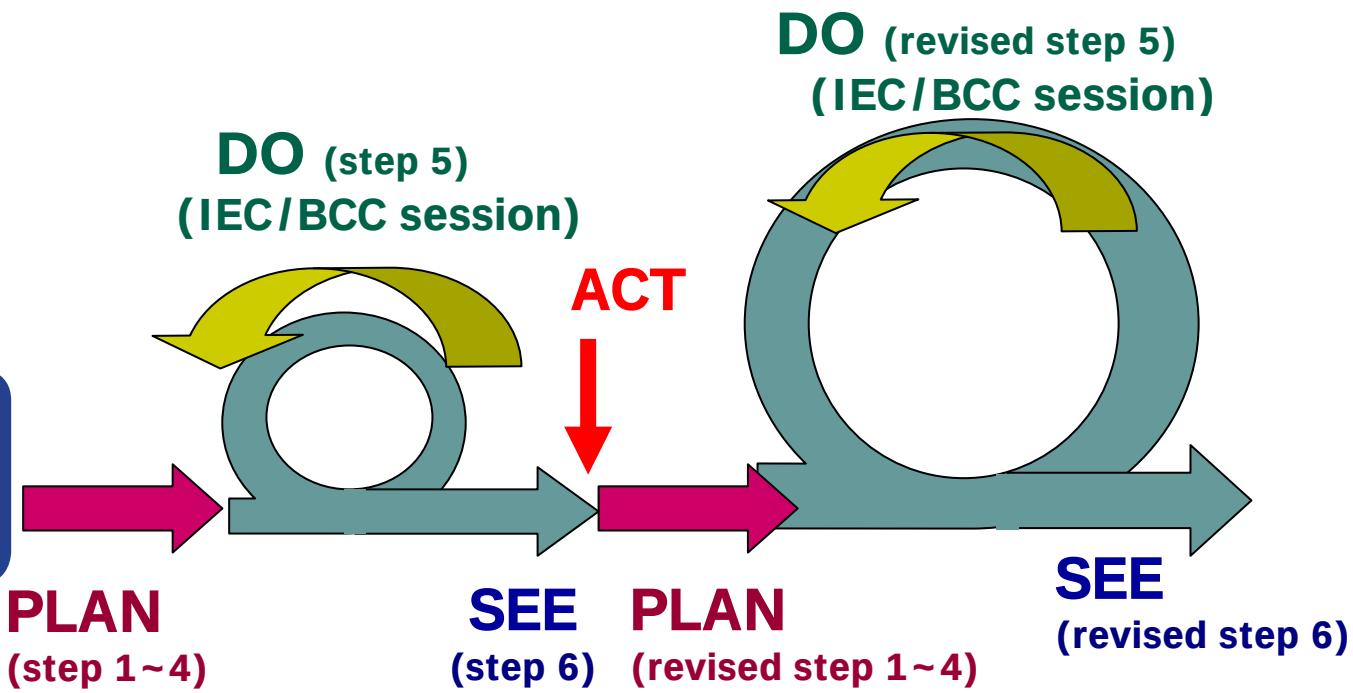
STEP	Adolescence & Pre-pregnancy	Pregnancy/childbirth	Post partum (after delivery)
Step 1: WHY (Identify issues in the community ~purpose):	Increasing number of young people are facing risk of unwanted pregnancies and termination of pregnancies by unsafe induced abortion. Further, STI cases are also observed.	Many pregnant women do not fully understand the importance of receiving at least four regular checkups (antenatal care) during pregnancy. This is especially seen in remote areas. to avoid risks during pregnancy, pregnant women (couples) need to know more on what should be done in case of appearance of any danger signs during pregnancy.	Many breast feeding women believing in "LAM method (breast feeding contraceptive method)" even after six months post delivery. Unexpected pregnancies soon after childbirth should be avoided by being informed on postpartum contraceptive methods, postpartum health care, and the need to value one's body.
Step 2: WHO (Target audience):	✓ Adolescents (age 10~15 years or above) ✓ Premarital women	✓ Pregnant mothers (and husband/relatives)	✓ Post partum women (or husbands may join-in) depending on the social context.
Step 3: Desired change in attitude and behaviour:	Young people should be taught to value themselves, their life and accept themselves as they are. Girls should acquire positive feelings and attitude to menstruation, to value one's body, and positive aspect of secondary characteristics.	To receive at least four times AN care (antenatal checkup) before delivery even if the RHC/ Sub-RHC is far away. ✓ To identify risk conditions during pregnancy and take immediate action.	Create attitude on the importance of preparedness for contraceptive methods to backup LAM (lactational amenorrhea method) when necessary. ✓ Nurture positive image of contraceptive methods. ✓ Understand that one's body is important and need to be cared and protected.
Step 4: WHAT (Message):	The theme "Happy to be a girl~ Secret of the navel" can be taught to children (age 10~15 or above/depending on the social context) and is directly linked with this theme of learning on the importance of life. The session aims at developing feelings and attitude to value one's body, positive aspect of secondary characteristics among girls. This session will introduce young girls on the mechanism of menstruation and that they possess a body that can carry new life (pregnancy). It is aimed for young people to acquire capability to live lively, by valuing one's own body and by protecting it. ⇒ Nurture bondage and love to parents and those around them. ⇒ Create feelings on the importance of life and that they are irreplaceable being thus nurture self-confidence ⇒ Nurture positive image of menstruation. ⇒ Care and protect one's body	✓ It is vitally important for pregnant woman to receive at least four regular checkups during pregnancy even if the RHC is far away. Through the regular AN care, you can enjoy a safe and healthy pregnant life. By understanding the danger signs one can avoid risks during pregnancy.	The theme "Happy to be a mother ~ avoid pitfalls of contraceptive myths after childbirth" talks about how to • avoid consecutive unplanned pregnancy after childbirth to protect the mother's health. • Provides information on postpartum contraceptive methods to avoid misconceptions related to methods focusing on the postpartum period. • Introduces on the benefits of contraceptive methods after childbirth to be prepared for spacing childbirth. ✓ To realize that their body after delivery will soon be ready to become pregnant. ✓ Create awareness on the importance of backup birth spacing methods to avoid unplanned consecutive pregnancies ✓ Care and protect one's body
Step 5: HOW: (3H Facilitation Notes)	✓ Refer to Annex 1-1	✓ Refer to Annex 1-2	✓ Refer to Annex 1-3

4. Important Components for Sustaining Community-Oriented IEC/BCC ~ Ensuring the PLAN-DO-SEE

The cycle of the PLAN-DO-SEE should be in mind of the BHS to ensure the continuity of the IEC/BCC session at the community level. As a perfect session never exists, one needs to always make sure what was good, what went well, and what did not go well, and why.

The 6 steps for designing the session can be plotted on the PLAN-DO-SEE cycle as follows:





"Act" part becomes very important to step-up to the next cycle. In Kyaukme and Naungcho Townships, monthly CME meetings are utilized as a regular site for BHS to conduct IEC/BCC session to exchange good practices among the BHS from MCH Center/RHCs/Sub-RHCs.

To make sure that ACT will take place:

- Positive attitude within the team members (start self-assessment by discussing what was good about the session. Praise each other).
- Constructive suggestions to what needs to the improved (not just to criticize).

5. Tips on the Development and Use of Community-Oriented IEC/BCC Tools

People learn better when they can see what they are learning about.

First part of this section (5-1. “Effective use of Ready-made IEC tools (Magnel Kit, Pregnancy Simulator)”) introduces on the use of ready made IEC tools that were effectively used in Kyaukme and Naungcho Townships.

For effective IEC/BCC, using HANDS as one of the three “H’s” are very important. One can utilize versatile reproductive health IEC/BCC tools such as “Magnel Kit” and “Pregnancy Simulator.” Even if such IEC tools are not available, one should not limit its motivation in conducting the session. In this section (5-2. “Tips on the development of handmade IEC/BCC tools”), some examples on how ready made IEC tools can be used and on how to make simple hand-made materials for those who do not have access to ready made tools. Furthermore, the session can be supported by various good IEC materials (leaflets and handouts) produced by the Central Health Education Bureau, Ministry of Health (as listed in 5-3. “Utilization of existing IEC/BCC tools by Ministry of Health”).

5-1. Effective use of Ready-made IEC tools (Magnel Kit, Pregnancy Simulator)

(1) MAGNEL KIT (versatile magnetic board RH education tool to demonstrate menstruation, pregnancy, fetus development, contraceptive use)

- Make full use of all the magnetic parts of the kit by understanding the mechanism of the kit.
- Use ovum/sperm in a mobile manner for demonstrating fertilization.
- Use of the tool should be linked to/with the issue of the session.
- Magnetic sheets can be placed on top of each other in layers i.e. demonstration of fetus development
- Be prepared in advance for the parts to be used to avoid searching for the parts during the session.
- Refer to the manual and make sure that all participants are seated where they can view the tool.

(2) PREGNANCY SIMULATOR (jacket weighing approx. 13kg to simulate the weight of the belly of full-term pregnant woman)

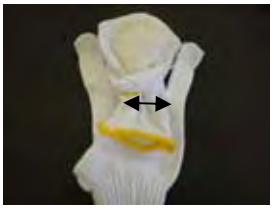
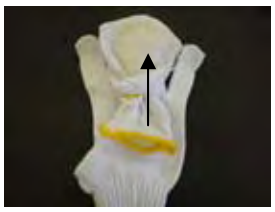
- This is a participatory tool. It is best used for and by male participants.
- Make sure that the participant is fit enough to bear the weight of the tool (do not have problems in the knees and back).
- Invite the participant to pick up tiny particle on the floor.
- Invite participant to lie down to feel the weight during sleep (small carpet or cloth can be prepared).

5-2. Tips on the development of handmade IEC/BCC tools

There are several ways to use “HANDS” to create effective tools for the session. Following are some examples from Kyaukme and Naungcho Townships.

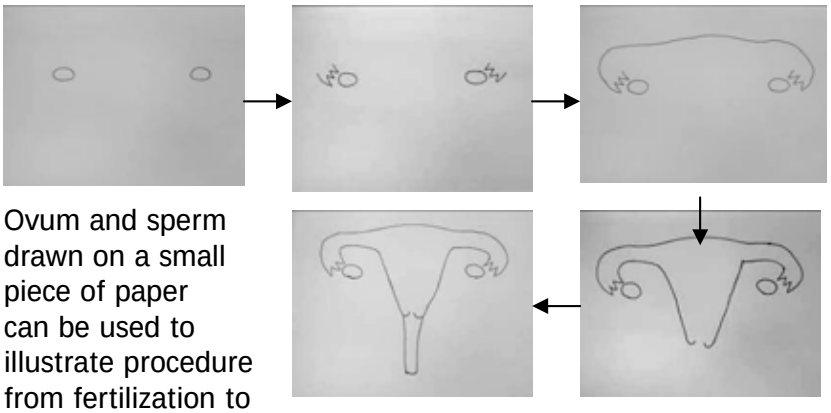
(1) Puppets (puppet made of gloves)

Conversation between the puppets (role play) can be used to demonstrate real stories and set the scene at the beginning of the session.

 1. Prepare a pair of cotton gloves.	 2. Pull the thumb inside (one glove).	 3. Reverse inside out (other glove).	 4. Place 3 in between the four fingers of 2.
 *(View from behind)* 5. Tie at the back leaving the outer two fingers.	 *(View from behind)* 6. Pull the rim of the glove over.	 *(View from behind)* 7. Cover the head part.	 8. Completed glove puppet.

(2) Illustration of uterus

Use blackboard or large flipchart paper and marker. Draw with thick clear line. Following steps can be of guidance to draw uterus.



Ovum and sperm drawn on a small piece of paper can be used to illustrate procedure from fertilization to implantation.

(3) Handmade sperm and ovum (used in facilitation note 1-1)
(this tool can be used to demonstrate process of fertilization)

1) Ovum and Baby

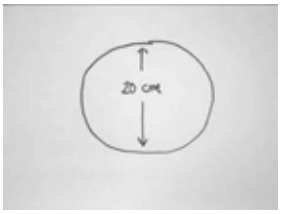
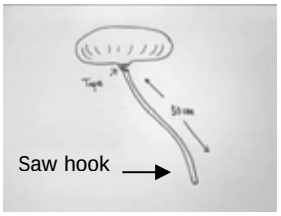
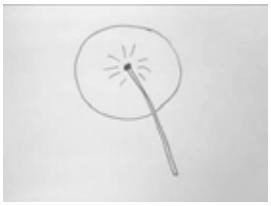
		
1. Fold A4 paper into half the size, draw circle of 15cm.	2. Cut and tape a straw of chopstick in between the paper.	3. For baby, draw face on it.

2) Sperm

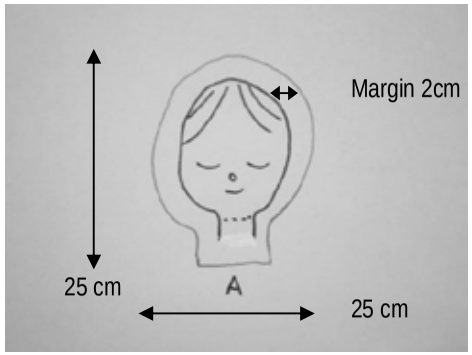
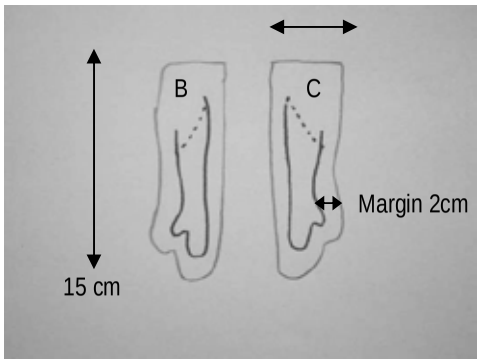
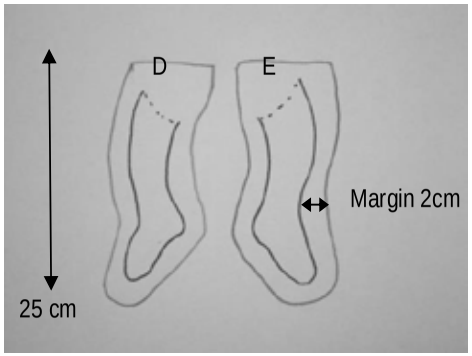
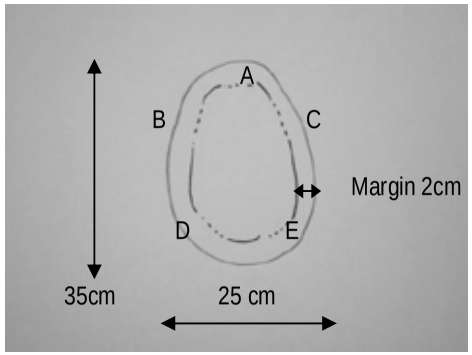
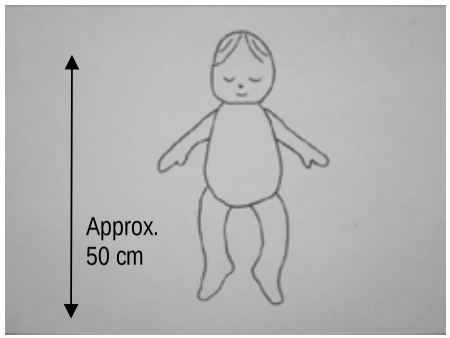
		
1. Fold A4 paper in half, draw sperm head of 7cm and tail.	2. Cut and tape a straw of chopstick in between the paper.	

(4) Handmade baby and placenta (used in facilitation note 1-1)

1) Placenta

		
1. Cut card board of 20cm (two pieces).	2. Put beans or pebbles (approx. 500gm) in plastic bag and tie.	3. Place bean bag in between the 1. (two cards) and tape.
		
4. Place 3 inside a plastic bag and tie.	*(View from side)* 5. Tape a rope of 50 cm long with a hook sawn on the end.	6. View from above.

2) Baby doll

Head	Arms	Legs
		
1. Head part: Cut the material leaving margin of 2cm. Sew and stuff with cotton wool. Add beans of 1.0kg (or 1000gm). After stuffing, sew the opening (dotted line).	2. Arms: Cut the material leaving margin of 2cm. Sew and stuff with cotton wool. Add beans or pebbles of 0.4kg (or 400gm) - 200 gm for each arm. After stuffing, sew the opening B & C (dotted line).	3. Legs: Cut the material leaving margin of 2cm. Sew and stuff with cotton wool. Add beans or pebbles of 0.4kg (or 400gm) – 200 gm each leg. After stuffing, sew the opening D & E (dotted line).
Body		
		
4. Body part: Cut the material leaving margin of 2cm. Sew, leaving the A~E open and stuff with cotton wool. Add beans or pebbles of 1.0kg (or 1000gm).	5. Join the parts: Join head part to A, arms to B and C, and legs to D and E. After connecting the parts, sew the opening (dotted lines A~E).	

5-3. Utilization of existing IEC/BCC tools by Ministry of Health

Annex 1-1: "Happy to be a Girl~ Secret of the navel" (Adolescence/ Pre-pregnancy)

STEP 1: WHY (Identify issues in the community ~ reason why is it important to conduct the session)

Increasing number of young people are facing risk of unwanted pregnancies, and termination of pregnancy by unsafe, induced abortion. Further, STI cases are also observed.

STEP 2: WHO (Target audience)

Adolescents: Girls aged 10~15 years or above

STEP 3: DESIRED CHANGE IN ATTITUDE AND BEHAVOUR

Young people (girls) must learn to value themselves, their life and accept themselves as they are. Girls must acquire positive feelings and attitude towards menstruation, to value one's body, and think of the positive aspect of secondary characteristics.

STEP 4: WHAT (Message)

The theme "Happy to be a girl~ Secret of the navel" can be taught to children (age 10~15 years or above/depending on the social context) and is directly linked with this theme of learning on the importance of life. The session aims at developing feelings and attitude to value one's body, positive aspect of secondary characteristics among girls. This session will introduce young girls on the mechanism of menstruation and that they possess a body that can carry new life (pregnancy). It is aimed for young people to acquire the capability to live lively, by putting a value on one's own body and by protecting it.

⇒ Nurture bondage and love to parents and those around them.
⇒ Create feelings on the importance of life, and that they are irreplaceable, thus, this could nurture self-confidence.
⇒ Nurture positive image of menstruation.
⇒ Care and protect one's body.

STEP 5: HOW (Date, place, tools, facilitation notes)

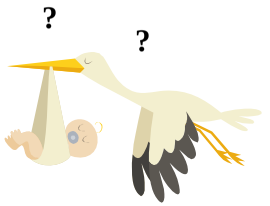
Sessions can be held at school settings, health facilities, etc.

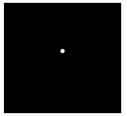
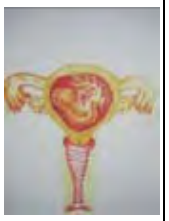
Facilitation note as attached

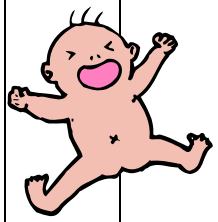
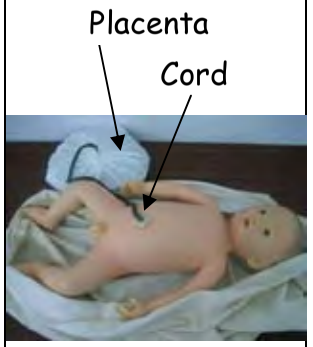
STEP 6: SEE (Assessment plan)

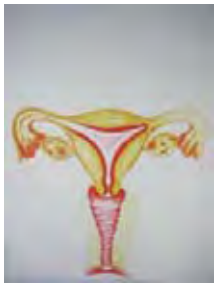
⇒ Ask students to write on a small blank sheet before the session: 1) Where do you think babies come from?
⇒ After the session: 2) Any impression (new findings)

Facilitation note: "Happy to be a Girl~ Secret of the Navel"

Time	Topic	Content	Things to prepare
5 min.	**Opening**	Conversation between a boy and a girl (puppets): Puppet A: Hello, are you well? Are you worried about something? Puppet B: I have been wondering where I came from. Mother says that the stork brought me. I might have been delivered by mistake. Puppet A: I don't know either. I once asked my mother and she said that I came out from my mother's abdomen. Puppet B: What?! Oh, no! I am confused….. I know what, let's ask the audience. Hello there, do you know were you are from? Puppet A: Where do babies come from? Puppet B: I know what! Let's go and ask the MCH Promoter.	Glove puppets (refer to page V-13) 
		Health staff (not puppet): I am here to tell you where you come from and a bit more about your life and body. Every part of our body has a purpose. Why do we have eyes? (ask students) Nose? Mouth? Now, why do we have the navel? (ask students) What can you see in the picture? (ask students) Sample picture -1 There is a baby inside. Babies grow inside the mother's tummy for almost 9 months. You were inside there too. Would you like to have a look inside?	picture -1 
10 min	**About fertilization, baby's growth and birth of the baby**	This is the room in which babies grow. It is called uterus (picture -2). It is a nice warm room with very soft, cushion-like walls. In here the baby grows for 9 months. Baby is not here yet. Now let us see how babies come into the uterus. Man and woman are made of a beautiful body. When the body of boys and girls gradually	picture -2 

		develop, they will be able to have particles (sources of life) in the body. When a girl's body grows up, source (or a particle) for the new life (baby) called "ovum" is being developed inside those two small round shaped organs. Because source of life is so important, it is kept safely inside the body. Once a month, the ovum or a particle for new life is released. Babies cannot be created only by the particle inside the woman's body. For a baby to be created, both particles from man and woman must meet and join together. Here you can see the sperms approaching the ovum (picture -3). When they join together… that is the beginning of a baby. It is called the fertilization. Let us look at how fertilization happens (tool -1). Only one particular ovum is fertilized by just one sperm out of billions of sperms. Just one strongest and the most powerful sperm compete to get into the ovum. In that sense, you are the single person on earth formed by a particular ovum and sperm. Your existence is truly miraculous and irreplaceable. It is a miraculous probability to become your self. Actual size of the beginning of life is very small. Have a look how small it was (tool -2: black card with pin hole of 0.2mm). This is the size which you began from. Even the school headmaster began the same. It moves gradually towards the tube, and towards the uterus for the baby to grow. The wall of the uterus (bed for the baby to grow) is soft like a cushion and ready to have the fertilized ovum to stay comfortable and grow. This is how the baby looks like inside the mother's womb about 3-4 months (picture -4). The baby inside the mother's womb is floating in the water like fluid. Even if the mother slightly bumps her belly, the baby is protected. Even when the weather is hot or cold, the baby is	picture -3  tool -1 (refer to page V-14)  tool -2  picture -4 

 		protected under the same comfortable temperature. Inside, it is very comfortable and fully protected by the mother. Then how does the baby breathe floating in the fluid? Or eat to grow? Baby and the mother are closely connected with this rope like cord called the umbilical cord (tool -3). When the mother eats food, like meat, vegetable, and drink milk, all the good nutrition is passed through the placenta and then through the cord for the baby to grow. When the mother breathes air, the baby receives oxygen through this cord. So the baby does not breathe with mouth and nose inside the mother's belly, but breath through the cord. So, you can see that the umbilical cord is like a life line for the baby to grow. Can you see where the cord is connected to? - It is connected to the belly button. When the baby is born, the cord is cut off. The belly button is the remaining stump of where the cord was connected. The baby begins to breathe through the nose and starts to be fed with breast milk through the mouth once they are born. Some of you may not be living with your mother. But here is a reality that your mother carried you inside her tummy for 9 months. You also took nutrition that fed you through the umbilical cord. Here, the baby is about to be born. Can you see that the baby's head is heading down ward? (picture -5). As you can see, there is a special passage that the babies are born from. It is a small opening between the openings for the urine and the feces. Because the passage is small, it will take time. With sufficient time, the passage gradually enlarges so the baby will come out (the baby will be turning and twisting meticulously to come out). Of course, you may not remember but your effort in coming out was just as hard as your mother, but with	 tool -3 (refer to page V- 14~15) picture -5 

		teamwork, you made yourself out to the world. Sometimes, there are difficult cases for babies to be delivered. In such cases, the doctor may need to operate on the mother's belly to have the baby out (caesarian section). Even after being born, babies can not talk, walk or find food to eat. There were many people around you that took good care of you up to today. Because the baby's passage is such an important part of the body, girls should keep it clean. Do not touch with dirty hands. Explain to the girls how to wipe off after defecation (to do it from the back).	
5 min	**What is menstruation?**	Now, let us have a close look at a girl's body at the age of 15 years old. As the girl's body matures, every month, the uterus waits for the fertilized egg to come into the room (picture -6). The room is ready with thick soft cushion like wall. When the ovum does not meet the sperm (not fertilized), the tiny ovum will be diminished within the body. When uterus finds out that the fertilized egg did not come, uterus will refurnish the soft velvet wall to a new one, to be ready for the next ovulation. So, the wall or the inner lining of the uterus gradually falls off and come out from the passage. This is menstruation. Menstruation is closely linked with the mechanism of having a baby. It is a wonderful thing. Menstruation is a normal bodily function. For those who have not yet experienced menstruation, very often your first sign is a slight stain on your panty. *In case it happened at home, inform your mother or people at home. If at school, consult your teacher, but in case you cannot consult anyone, place folded tissue inside your underwear. You can purchase sanitary napkins for use.* Just before menstruation, one can be feeling dull pain in the lower abdomen, slight irritation. During menstruation, some can feel slight headache and dull pain. If it is too strong, please consult health staff.	picture -6 

		Take good rest and eat well during menstruation. Otherwise, there is no need for you to change your lifestyle. There is basically no limitation for you.	
3 min	**wrap up**	Do you now understand why menstruation occurs? Menstruation means that your body is physically ready to become pregnant. If there is something that worries you, don't worry alone. Come and meet the health promoters and health staff. (Puppets) Puppet A: I now know that menstruation is a normal and a wonderful development of the woman's body. Puppet B: Life is so miraculous. I should take good care of myself. I am Happy to be a girl.	puppets
5 min	**Q & A and feedback by the audience**	Please write your impression/feeling on the session. This is not an exam. Have you learnt anything new? Please feel free to write any new findings from this session. If you have any questions, you can write them here too. Woman and man have beautiful bodies. We all should be proud of them. Do not be shy. If you have any worries or problems you should always ask for help. Also, when you go home, ask your parents on how they felt when you were born (show the leaflet to your parents). What kind of things your parents were careful of while your mother was carrying you (during pregnancy), etc.	leaflet

*Following messages can be added for older age groups:

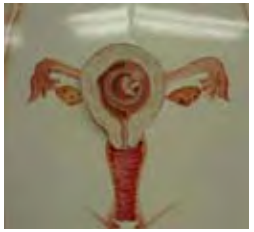
- Because fertilization or having a baby is so precious and miraculous, it is very important that women and men discuss very well with each other, whether they want to have a baby or not.
- Ovulation occurs about 14days before the next menstruation. It is almost impossible to predict next menstruation especially among young girls while their rhythm is not yet stable. Cycle can change for many reasons: worries over friendship, studies, etc. There is no "safe period." Sexual contact for the first time may cause pregnancy.

Annex 1-2: "AN Care ~ Distance is not the Matter" (Pregnancy)

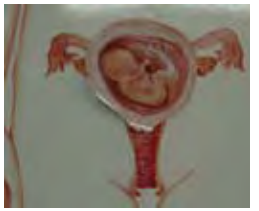
STEP 1: WHY (Identify issues in the community ~ reason why is it important to conduct the session)
Many pregnant women especially in remote areas, do not fully understand on the importance of receiving at least four regular checkups (antenatal care) during pregnancy, to avoid any risks during pregnancy. Pregnant women (couples) need to know more on what should be done to identify any danger signs during pregnancy.
STEP 2: WHO (Target audience)
Pregnant women (and husband/relatives)
STEP 3: DESIRED CHANGE IN ATTITUDE AND BEHAVOUR
To receive AN care (antenatal checkup) at least four times before delivery even if the RHC/Sub-RHC is far away. To identify risk conditions during pregnancy and to take immediate action.
STEP 4: WHAT (Message)
It is vitally important for pregnant woman to receive at least four regular checkups during pregnancy even if the RHC/Sub-RHC is far away. Through the regular AN care, you can keep safe and enjoy a healthy pregnant life. By understanding the danger signs one can avoid risks during pregnancy.
STEP 5: HOW (Date, place, tools, facilitation notes)
At MCH centers, RHCs/Sub-RHCs. Facilitation note is as attached.
STEP 6: SEE (Assessment plan)
MCHP or community volunteers can interview the participants informally to collect information and observe whether the session was favorable or not.

Facilitation note: "AN Care~ Distance is not the Matter"

Time	Topic	Content	Things to prepare
5 min.	**Opening** **Introduction on the session (What this session is all about and why it is important for the audience)**	Welcome to the session. This session is for you to learn on the importance of regular health checkup during pregnancy. Even if the rural health center is a bit far from where you live, we believe that it is necessary for you to receive at least four checkups before your delivery. In this session, we will explain to you on what kind of health checkups are performed, and for what reason. Furthermore, the session will describe to you some of the danger signs, and what should be done for each of the cases, so that you will be able to feel secure during pregnancy.	
		Conversation between pregnant woman and a friend-she is MCH Promoter (MCHP) Puppets: Puppet MCHP: Hello, are you well? Puppet Pregnant woman: I have not been eating much since I feel like vomiting these days and feel very low and fatigue. Puppet MCHP: It is a natural thing to happen during pregnancy. However, if you don't take enough nutritious food, you will be anemic. There are things we need to be careful of, during pregnancy. Have you gone for AN care? Puppet Pregnant woman: No, RHC is too far to go. Puppet MCHP: Yes, I know RHC is far. But let me tell you that a friend of mine was diagnosed as anemia and had other problems during early period of pregnancy. After she had taken regular AN care, she was OK. She was able to keep healthy during pregnancy and delivered a healthy baby. If she hadn't gone for AN care, she could have been in trouble. Puppet Pregnant woman: What is anemia? What kind of problems are there? Puppet MCHP: I am a MCHP. I know a midwife at xxx RHC! I will introduce you to her, so that	puppets

		you can get to know your health condition. Let's go to see her for AN care! End of puppet	
15 min.	**Midwife explains how a woman's body changes and fetus develops, the checkup during each AN Care to inform women that receiving AN care is important even if RHC is far in distance.**	Midwife (not puppets): Welcome to the RHC. I will tell you what AN care is today. We will explain what kind of service we provide, how your body changes and fetus develops, and on the danger signs during pregnancy. AN Care is to check your health conditions and your baby through examination of your body and your abdomen. In order to have a safe and healthy pregnant life and delivery, it is important for the mother to take regular AN care- at least 4 times. If anything is found which needs closer examination, she will refer the mother for further care. Please bring the home-based maternal record if you have one, to the AN care. It is important to keep records on your health condition, as it will give useful information for pregnant woman as well as the midwives. If you don't have one, please ask, so that you will be provided with one. **During the 3rd ~4th month pregnancy:** Look at the picture of the 3rd month of pregnancy. Some of you may feel morning sickness at the beginning of pregnancy. At the 4th month, morning sickness gradually ceases. Size of fetus is about the size of lemon (picture -1). After becoming pregnant, you will feel some changes in your body. Full term pregnancy is 9 months. During the early stage of pregnancy, you might feel dizziness, or sleepy and may vomit. This is usually normal, although that condition may differ with different individuals. I will explain on some of the danger signs later so that you will be able to identify what is OK and what is not.	picture -1 

		To make sure that your pregnancy is sound, it is best to receive the **1st AN care visit** within first 4 months or as early as possible. I will now explain on what will be performed at the AN care: ➢ Take history such as age, date of the last time you had period, the experience of pregnancy, etc. ➢ Perform physical examination including vaginal exam, height, weight, blood testing, blood pressure, etc. ➢ Look for clinical signs of anemia from blood testing. ➢ Test urine for bacteriuria, protein. If you are found that you have protein in your urine, there might be some trouble with your kidney. ➢ Screen for syphilis to check STDs. ➢ Give tetanus toxoid for prevention, and iron tablets. Lack of iron may cause the anemia. ➢ Advise on individual birth plan, healthy lifestyle. ➢ Information on danger signs. ➢ Complete clinic & home based records. For example, screening of syphilis is done by taking small amount of blood sample to check syphilis virus. Syphilis is a disease which can be transmitted to the baby. A baby born with syphilis might suffer from blindness. If a pregnant woman is found to have syphilis, she must be taken care of with treatment. By detecting the problem at an early stage, early treatment can be conducted for you to have healthy baby. So, through the AN care, if something is found, you will be referred to the hospital and can consult a doctor for further examination and treatment.	

		During the 6th ~7th month pregnancy: By 6~7 months, the size of the fetus is about the size of durian, and the woman can feel the movement of the fetus (picture -2). Colour of the nipple gradually begins to darken. It is most advisable that the woman visits the rural health center for her the **2nd AN care visit** during this 6~7 months. ➢ Perform physical examination. ➢ Listen to baby's heart sounds. ➢ Test urine for bacteriuria, protein. ➢ Give iron tablet and de-worming drugs to protect from anemia. ➢ Review individual birth plan, advise on healthy lifestyle. ➢ Complete clinic & home based records. Let me tell you by taking one of the checkup item during this period and explain how important it is to see your health condition. There are several types of anemia that may occur during pregnancy. During pregnancy, the fetus uses the mother's red blood cells for growth and development, especially in the last three months of pregnancy. If a mother has excess blood (red blood cells) stored in her body before she becomes pregnant, she can use those stores during pregnancy to help meet her baby's needs. Women who do not have adequate iron stores can develop iron deficiency anemia. This is the most common type of anemia in pregnancy. It is important not to become anemic since anemia avoids distribution of oxygen from the lungs to tissues in the body and for the baby's growth. Good nutrition before becoming pregnant is important to help build up these stores and prevent iron deficiency anemia.	picture -2  

		<u>During the 8th month pregnancy:</u> By 8 months, most body organs of the baby are now developed with the exception of the lungs and if the baby kicks, you will not only feel it but also be able to see it from the outside. The pregnant woman starts to feel more fatigued now, and breast milk may leak a little. The **3rd AN care visit** will be at 8 months gestation. ➢ Perform physical examination. ➢ Listen to foetal heart sounds. ➢ Test urine for bacteriuria, protein. ➢ Check haemoglobin and give iron folate. ➢ Give tetanus toxoid (if 4 weeks from first dose). ➢ Review individual birth plan, advise on healthy lifestyle. ➢ Complete clinic & home based records. It is important for pregnant women to take tetanus toxoid immunization to prevent from tetanus. Tetanus is a serious disease caused by bacteria. People of all ages can get tetanus but the disease is particularly common and serious in newborn babies. Neonatal tetanus can be prevented by immunizing women during pregnancy, this protects the mother and through a transfer of tetanus antibodies to the fetus. It is also important to deliver with clean practices to prevent neonatal and maternal tetanus. **<u>During the 9th month pregnancy:</u>** The **4th AN care visit** will be after 8 month gestation ➢ Perform physical examination. Check fetal lie and presentation. ➢ Listen to fetal heart sounds.	

		➢ Test urine for bacteriuria, protein. ➢ Give iron folate. ➢ Tell her about signs of labour. ➢ Review individual birth plan. Also plan about what to do if the baby is not delivered by end of week 41. ➢ Complete clinic & home-based maternal records. It's time to give a birth! The pressure on the stomach is relieved due to the lowered position of the fetus. Frequent urination may occur. Fetus becomes 50 cm and 3,000 gm, and the physical development is complete. The mother cannot eat much at one time, because of pressure of fetus on the stomach. ➢ Pregnant woman needs to take T/T immunization in time and complete the course for 2 injections before confinement. ➢ Avoid hard work, do daily moderate exercises, and eat balanced nutritious food and get enough sleep. ➢ Pregnant woman should not smoke or drink alcohol. ➢ Apart from the medicines given by health institutions, other medicine should not be taken.	
	Inter-medial message	Through the regular check up during the AN care, you can check the conditions of your health and your baby through examination of your body and your abdomen. I hope that by now you know that even when the RHC is a bit far away, it is very important to receive AN care to make sure that you and your baby will be in good health. From here, I would like to inform you about some conditions which can be dangerous if you are not taken care of by the health staff. Let me invite Mr. and Mrs. XXX to describe some of the danger signs.	

10 min.	**Danger signs during pregnancy**	**Case 1: Vaginal bleeding** Conversation between pregnant woman and husband (Mr. and Mrs. XX) Puppet Pregnant woman: Oh, I have a vaginal bleeding… What shall I do? Puppet Husband: Really? I don't know what to do…. Somebody help, my wife is bleeding from the vagina. What shall I do. Midwife: In case something like that (what happened to Mrs. XX) happens, when a woman is beginning to bleed from the vagina, please urgently contact MW at your nearest health center. You need the diagnosis and treatment (urgently) as soon as possible. For the husband, he can help to arrange transport, money, and care for other children. Also, he can accompany the woman to health center/hospital. Bring home-based maternal record and a referral form. **Case 2: Severe headache with blurred vision, convulsions** Conversation between pregnant woman and husband (Mr. and Mrs. XX). Puppet Husband: Look at that little bird up there in the tree. Puppet Pregnant woman: Where? I cannot see it. Nowadays I sometimes cannot see well. Something is wrong with my eye sight. Also, I have a severe headache…. Puppet Husband: What? You mean things are blurred? Please tell me what to do. My wife has blurred vision and has severe headache. Midwife: In case something like what happened to Mrs. XX occurs. When a woman is cannot see well and have severe headache, please urgently contact MW at your nearest health center. Convulsion/fits, severe headache with blurred vision, are signs of pre-eclampsia or eclampsia, a potentially dangerous problem during pregnancy. Please urgently contact MW. She will give	puppets pamphlet 

		an intramuscular injection of a magnesium sulphate. For the husband, again you can help to arrange transport, money, and care for other children. You can accompany your wife to health center. Also, you can keep your wife calm, quiet and away from bright light. **Case 3: Fever** Conversation between pregnant woman and husband (Mr. and Mrs. XX). Puppet Husband: Why are you still sleeping? Shall we go out to eat? Puppet Pregnant woman: I have a high fever…. Cannot get out of bed. Puppet Husband: Wow! I think you have a fever. My wife has high fever. What shall I do…. Midwife: In case a woman has fever like Mrs. XX, someone should urgently contact MW at the nearest health center. There are several different causes of a high fever with weakness, such as a urine infection or malaria. Please consult with MW. She will provide appropriate medicine such as the first dose of antibiotics or malaria medicine. For husband, again you can help to arrange transport, money, and care for other children. You can accompany your wife to health center. **Case 4: Severe abdominal pain** Conversation between pregnant woman and husband (Mr. and Mrs. XX). Puppet Pregnant woman: My due date is after three weeks, but I have severe pain in my stomach… Puppet Husband: My wife has severe abdominal pain. Who shall I call? What to do? Midwife: In case a woman has severe abdominal pain and is not about to deliver, like Mrs. XX,	

		someone should urgently contact MW at the nearest health center. She needs urgent diagnosis and treatment. Please contact MW as soon as possible. Depending on her stage of pregnancy, the cause of her pain may be due to such conditions as ectopic pregnancy, abortion, or appendicitis. If she has a high fever, giving antibiotics and malaria medicine may help prevent more serious illness or to save the woman's life. **Case 5: Fast or difficult breathing** Conversation between pregnant woman and husband (Mr. and Mrs. XX). Puppet Pregnant woman: Darling, I think I have fever and it is difficult for me to breathe. Puppet Husband: My wife has a high fever and seems difficult breathing. What to do? Midwife: If a pregnant woman has a high fever, breathlessness and/or chest pain it may be due to pneumonia. Please contact MW as soon as possible. We will provide medication if the fever is more than 38°C. Thank you Mr. and Mrs. XX for describing some of the danger signs during pregnancy. By now I hope that you know more about some symptoms which can be dangerous. Whenever you happen to encounter such cases, please contact the midwife. MCHP can assist you to call the midwife.	
	Message for husband	During pregnancy, many women feel morning sickness in the early stage, and it is important for husband to care and support your partner in doing household work. Help her not to carry heavy things and heavy work so that you can avoid danger cases. Pregnant women often feel nervous so that you can also attend the health education classes together and giving mental support is also important.	

3 min	**Concluding message**	Physical examination of your body can show what illnesses you had and how it can affect your baby and how to manage them through the early detection for safe delivery. If there is something that worries you, don't worry alone. Seek for support from the MCHP. She will assist you to come to see us at heath center. Puppet Pregnant woman: In order to have safe and healthy pregnant life, I should come for regular AN care! Puppet Husband: I now know more about danger signs. I will ask help from MCHP and seek for help from the midwife.	puppets 
	Q&A	Please feel free to ask questions. Please share your impression/feeling on the session.	

Annex 1-3: "Happy to be a Mother ~ avoid pitfalls of contraceptive myths after childbirth" (Post delivery)

STEP 1: WHY (Identify issues in the community ~ reason why is it important to conduct the session)
Many breastfeeding women believe that "LAM method (breastfeeding contraceptive method)" is fully effective even after six months after delivery. There is insufficient information for post partum women. Such situation can lead to inappropriate or ineffective choices of contraception, crucial for women to decide exactly when to begin a post partum birth spacing.
STEP 2: WHO (Target audience)
Post partum women (or husbands may join-in) depending on the social context.
STEP 3: DESIRED BEHAVOUR (Desired change in attitude and behaviour)
Create attitude on the importance of preparedness for contraceptive methods to backup breastfeeding method (lactational amenorrhea method) when necessary. Nurture positive image of contraceptive methods. Understand that one's body is important and need to be cared and protected.
STEP 4: WHAT (Message)
The theme "Happy to be a mother ~ avoid pitfalls of contraceptive myths after childbirth" is directly linked to the theme of avoiding consecutive unplanned pregnancy during post partum period and protecting the mother's health. This session aims at providing adequate information on post partum contraceptive methods and avoiding misconceptions related to various methods focusing on the post partum period, especially focusing on breastfeeding method (LAM). This session introduces mothers on the benefits of contraceptive methods after childbirth, to prepare them to space for their next planned sound pregnancy and childbirth. It is also important for the women to realize that their body after delivery will soon be ready to become pregnant. It is aimed for women to acquire capability to live lively, by valuing one's own body and by protecting it through avoiding unplanned consecutive pregnancy within a certain short period after childbirth. This session aims at providing accurate information on post partum contraceptive methods, value one's body, and postpartum health care.
STEP 5: HOW (Date, place, tools, facilitation notes)
Sessions can be held at immunization settings, PNC checkup, health facilities, etc. Facilitation note as attached.
STEP 6: SEE (Assessment plan)
At PNC checkup, immunization

Facilitation note: “Happy to be a mother~ avoid pitfalls of contraceptive myths after childbirth”

Time	Topic	Content	Things to prepare
	Opening	Welcome mothers! Congratulations to you, your partner and your newborn baby. We are here to talk to you on something very important for you to keep on with your happy life with your newborn baby. We would also like to remind you that when it comes to baby or child care, it is not only about being hygienic, immunization, and nutrition requirement for mother and baby, but health of the mother is also something very important and we should not forget it to manage our lives to go on happily with the use of family planning. Many women want no more children or would like to space pregnancy for at least 2 years after the delivery. However, only a small percentage of post partum women (after delivery women) understand fully about birth spacing method. There are birth spacing recommendations for the post partum period. In particular, it is important to note that the timing for beginning a method varies among contraceptives for breastfeeding women. At the same time, many post partum women believe in the effectiveness of breastfeeding method (LAM= lactational amenorrhea method). They believe that “while woman is breastfeeding, she will not become pregnant.” In this session, information on post partum birth spacing methods is introduced so as to prevent unwanted pregnancy.	
	Setting the scene	Conversation between two women. One with a baby and the other expecting a baby soon: (puppets) A: Hello, are you well? Are you worried about something? B: I have been wondering about Ms. Mai. I have heard that even she has just had a baby,	puppets

		she is already expecting another early next year. This means that she will be taking care of two babies with less than one year difference. My mother-in-law says that she should have taken herbal medicine, but I think breastfeeding method is a good method to prevent pregnancy. A: I met Ms. Mai yesterday and she looked very sad. She wanted to space her next baby because her husband had to go and work in the city and her mother-in-law is not so well —but she became pregnant unexpectedly. She said she was practicing breastfeeding method. B: What?! She was practicing breastfeeding method? Oh, no! I am confused…. I don't know what I should do. I am expecting my baby next month and I think I should know well enough in advance on how to space childbirth. A: Me too. My baby is still six months and I think I still want to space a little more. I know what, let's ask the audience. Hello there, do you know a good method after childbirth? B: I know what! Let's go to see the MCH Promoter. I think she will take us to the health staff or birth spacing counselor.	
		Health staff: Thank you for coming. If you are having sex and not exclusively breastfeeding your baby, you can become pregnant 4 weeks after delivery. It is not too soon to think about birth spacing methods. Waiting 2~3 years before becoming pregnant again is healthier for mother and baby. Consecutive childbirths can cause risk to mother's and baby's health. Look at this picture. How does she look? Let's keep her happiness not to have her pregnant too soon.	picture -1 

	Breastfeeding method	I think that you want to hear more about breastfeeding method. Breastfeeding method is one of birth spacing methods based on the physiology of breastfeeding. If a breastfeeding woman meets the three breastfeeding criteria, her risk of pregnancy in the first six months after childbirth is about 2% or one in 50 women. It is important for us to know that there are conditions that must be met to ensure that breastfeeding method is effective. There are three criteria: 1. Absence of the menstruation. 2. Fully or nearly fully breastfeeding. Breastfeeding day and night on demand by the infant. Breastfeeding method is more effective during the earlier weeks and months. 3. Less than 6 months after the delivery. Breastfeeding method is very effective during the first 6 months if the woman is fully breastfeeding. Exclusive breastfeeding (day and night upon request) is a first choice method. It is a very good method up to 6 months if the three criteria are met for mother and the baby. If three criteria are met, risk of pregnancy is less than 2% in the first 6 months. However, another method (back-up methods) should be considered during the period (within the 6 months) as protection so that woman can immediately shift to other methods. It is advised that mothers practice breastfeeding method to make sure that the three criteria are met. After 6 weeks, start thinking of a method. You can then initiate the method when the breastfeeding method criteria are no longer reliable. Such methods can be Injection, IUCD, Sterilization and Condom, etc.	

	Mechanism of pregnancy	Let me firstly explain to you on how women become pregnant and then explain on some birth spacing methods, how they work. Let's have a look inside a woman's body. Hold out your fist. Hold it under your navel. This is the actual size of your uterus (the room for the baby to grow). Let us understand that every single part of our body is so important and has good meanings. Explain the position of uterus, ovary and fallopian tube. This lovely baby grew in the mother's womb for nine months. Women have the source of the new life (baby) called ovum. Men also have the source of new life called the sperms. They are very small (0.06-sperm/0.24mm -ovum). When they join together… that is the beginning of the baby. It is called the fertilization. Let us look at how fertilization happens. One particular ovum is fertilized by just one sperm out of billions of sperms. Just one strong sperm compete to get into the ovum. Baby's existence is truly miraculous and irreplaceable. Fertilized egg moves gradually towards the room for the baby to grow. The wall of the uterus (bed for the baby to grow) is soft like velvet and ready to have the fertilized egg to stay comfortable and grow. This is how pregnancy occurs. After childbirth, ovulation ceases for a while. But I would like you to remember that if the woman is not exclusively breastfeeding and have sex, she can become pregnant after 4 weeks after delivery. Even if she is breastfeeding, effectiveness of breastfeeding method decreases after 6 month. I will introduce to you some birth spacing methods possible for breastfeeding mothers. Please discuss with your husband and choose a suitable method and ask MCH Promoter to take you to the health staff or birth spacing counselor for suitable contraceptives.	

	Birth spacing method that can be considered as a backup method if the woman is fully breastfeeding but does not want to rely on breastfeeding (LAM) method	****** NOTE for BHS: ****** ***Do not try to provide too many information (all the following methods) at once. Please select 2~3 methods from the following. Too many information can cause confusion.*** **1. Condom:** Condom can be used immediately after childbirth. Condom is recommended as a temporary backup method. Following are some major tips for effective use: 1. Before using, check the date of expiry. 2. Tear the tip of the package of the condom at the marked point to avoid tearing the condom inside. 3. Slightly press air out before wearing onto the penis. 4. Unroll the condom onto the erect penis before intercourse. 5. Unroll the condom to cover the whole penis, keep space at the tip for ejaculated fluid to be pooled in. Condom works as barrier preventing sperm from meeting egg. 6. After ejaculation, hold the base and withdraw the penis before losing the erection. Avoid semen spill into the vagina. Incorrect use of condom- When condom is not covering the full shaft of the penis, the sperm can spill into the uterus to meet egg and fertilize. 7. Tie, wrap with tissue and throw it into the waste bin as garbage. 8. Each condom can only be used once. **2. Sterlilization:** Sterilization can be performed immediately after childbirth. Sterilization can be performed preferably within the first seven days after delivery. Tube where sperm travel is blocked (tied) so that the ovum and sperms do not meet each	

		other. Since this is a permanent method and it is very difficult to reverse, woman needs to be very sure that she does not want to become pregnant again. **3. IUD:** IUD can be inserted immediately or should delay at least after four weeks. IUD is an option that does not interfere with breastfeeding. IUD can be inserted immediately after childbirth (within 10 minutes) or should be delayed at least 4 weeks to reduce the risk of expulsion. Or in other words, if IUD is not inserted within 10 minutes after childbirth, IUD should be inserted after 6 weeks.	
		For exclusive breastfeeding women, non-hormonal method is most suitable as it does not affect the quantity and quality of the breast milk. Injection and pills should be of a certain type (progestin-only) so that it does not affect the amount of breast milk. **4. Injection (Progestin-only)/Contraceptive pills (Progestin-only):** They can be used from after 6 weeks. Advantages are that they do not directly affect to the amount of milk production of the mother. Pills are said to reduce risk of uterus cancer or reproductive infection. • Usage: please refer to the trainer's manual. **5. Norplant Implants:** It can be used from after 6 weeks. This is the method by inserting a small capsule under the skin on the arm. If the mother chooses to rely on the breastfeeding method, Norplant can be inserted when her menstruation return or when the mother is no longer fully or nealy fully breastfeeding, or at 6 months after delivery, whichever comes first.	

		• If the mother is fully breastfeeding but does not want to rely on breastfeeding, ideally wait until at leat 6 weeks post partum to initiate Norplant. • Usage: please refer to the trainer's manual.	
	Wrap up	I would like you to remember that if the woman is not exclusively breastfeeding and have sex, she can become pregnant after 4 weeks after delivery. Even if she is breastfeeding, effectiveness of breastfeeding decreases after 6 months. Birth spacing is very important after childbirth. If there is something that worries you, don't worry alone. Come and meet the MCH Promoter to take you to see the midwife or birth spacing counselor. A: I now know that breastfeeding method is only effective under certain condition. Three criteria: no menstruation, exclusive breastfeeding and within 6 months after delivery. B: My baby is 6 months old. Although I am exclusively breastfeeding, it is time to consider birth spacing methods. My baby is so precious. So will be my next baby. I will discuss with my husband and I shall take good care of myself and plan my next pregnancy.	
	Q & A and feedback by the audience	Learned anything new? If you have any questions, or any worries or problems you should always ask for help through MCHP.	leaflet

When to begin postpartum birth spacing methods for breastfeeding mothers

Postpartum condition of breastfeeding mothers	Birth spacing methods
Immediately	Condoms
	Sterilization
	IUD (immediately or delay at least 4 weeks)*
Delay at least 6 weeks	Progestin only methods (POPs pills)
	Progestin only methods (injectables)
	Norplant

*IPPF Family planning handbook for health professionals.

Annex 2: Report Format for Health Education Session

Date:	
Township:	
Name of RHC/Sub-RHC:	
Name of the facilitator:	
Name of the reporter:	
Theme:	
Number of the participants: Total number (male/female)	Total: _____ (Male: _____, Female: _____)
Activities:	1. Role Play 2. Demonstration 3. Health Talk 4. DVD/Video Show 5. Other ( )
IEC/BCC materials:	1. Magnel Kit 2. Pregnancy Simulator 3. Pamphlets 4. Poster 5. Flip Chart 6. DVD/Video 7. Maggie Apron 8. Puppet 9. Other ( )
Discussion point:	
Request to focal point person:	

***The report will be submitted to your supervisor after the session.**

Annex 3: Model Action Plan for Health Education Session *(SAMPLE)*

Township/Name of RHC/Sub-RHC : xxxx Township, xxxx RHC/Sub-RHC, Month/Year:

	Date	Place	STEP 1 WHY	STEP 2 WHO	STEP 3 CHANGE	STEP 4 WHAT	STEP 5 HOW	
			Identify issues in the community ~purpose of the session	Target audience	Desired change in attitude and behaviour	Message	Necessary IEC/BCC materials	Facilitating Team
1	1st week of May	Rural Health Center (RHC)	**Many pregnant women do not come for ANC because of distance from the centers.**	Pregnant women and husbands	To take regular AN care at least 4 times.	Importance of regular AN care	Magnel kit or Illustration Puppets, Pamphlet	BHS AMW MCHPs
2	2nd week of May	RHC	**Delay of referral of risk cases.**	Pregnant women and husbands	To understand the danger sign and action to be taken.	Early detection of danger sign and safe delivery	Magnel kit or Illustration Puppets, Pamphlet	BHS AMW MCHPs
3	3rd week of May	RHC	**Many women face unwanted pregnancies believing that breast feeding prevents pregnancy even after six months after delivery.**	Women for PN care and husbands	To create attitude on the importance of preparedness for contraceptive methods after delivery.	Accurate information on Birth Spacing	Magnel kit or Illustration Puppets, Pamphlet Contraceptives	BHS AMW MCHPs
4	4th week of May	Community Learning Center	**There are cases of teenagers being carried into MCH center from unsafe abortion. Increasing cases of STI among young people because they do not know how to protect themselves.**	Adolescent/ Pre-pregnant	To nurture bondage and love to parents and those around them. To create feelings on the importance of life and that they are need to be cared and protected. To nurture positive image of menstruation	"Happy to be a girl" Positive feelings and attitude to menstruation, care and protection is important	Magnel kit or Illustration Puppets Pamphlet Handmade tools (i.e. doll/ placenta)	BHS AMW MCHPs

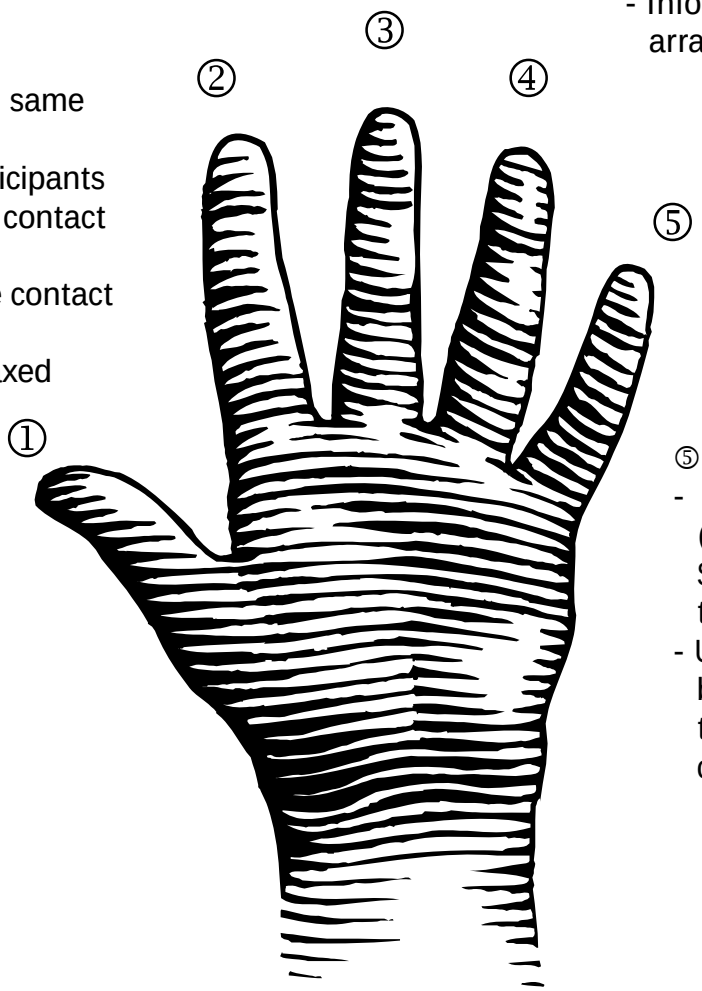
Annex 4: Five Tips for effective health education session

To run an effective health education session, starting from preparation to the point of delivering the session should be considered in advance.

③ Watch your point:
- Use simple / easy to understand words
- Inform the participants clearly

④ Watch your time:
- Manage the time well
- Always arrives before time
- Prepares the session in advance
- Inform participants on time arrangement

② Be open and friendly:
Set a friendly, informal atmosphere so that participants can ask questions; share the same emotion
- Welcomes the participants
- Maintain good eye contact
- Energizers
- Maintains good eye contact
- Smiles
- Facilitators are relaxed (good teamwork)



⑤ Be creative:
- She uses visual aids (Magnel Kit, Pregnancy Simulator, handmade tools, etc)
- Use actual tools that can be seen and touched for the participants (i.e. contraceptives, etc)

①Good planning:
Clear issue, vision with firm grasp of the whole session

VI Skills on Data Collection by MWs, AMWs and MCH Promoters

(1) Background

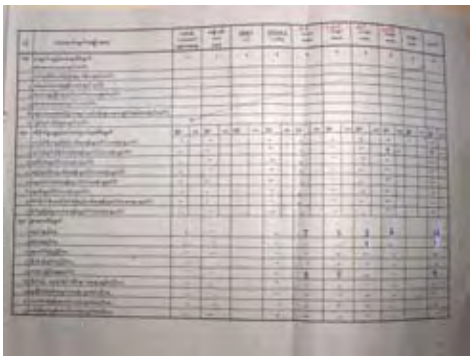
Recording and reporting daily activities is one of the important duties for MW. The data reported from MW are the essential information for the supervisors and decision-makers to learn about her performance and health-related situation in the community. Yet it is not easy to collect reliable data from the existing reporting systems. There are several reasons why it is difficult to gather accurate information using the current reporting systems.

(i) Scarcity of BHS at RHC and Sub-RHC

There are not sufficient number of BHS assigned to RHC and Sub-RHC. That is why significant share of MCH services such as pre- and post-natal care and birth attendance is provided by AMW and TBA. People living in a remote village have difficulty in reaching to the MW at the health center, therefore, rely on AMW or TBA nearby for their services. Since most of AMW and TBA do not record their activities, they tend to be neglected in the reports. In addition, in case lone MW at a health center is on leave or transferred to another center, there is nobody to prepare monthly reports. Entire records in her assigned villages are excluded from the township reports in that month.

(ii) Heavy workload for MW

MW not only covers a large assignment area, but also carries numerous duties and responsibilities. Immunization, birth attendance, and pre- and post-natal care have high priority in her daily work and recording and reporting tend to become secondary. Or she is so busy doing other things that there is not enough time to write down all of her activities. MW usually has only 1 or 2 days for report preparation. In case she finds out that some information needed for the monthly reports are missing (c.f. AMW did not report the number of delivery cases she attended for the month on time), she may not have enough time to collect them from the field. As a result, she may submit reports with incomplete information.



(iii) Large amount of data collection and reporting

Main reporting systems are HMIS and RH-MIS. MW has more than 500 items in HMIS and 120 items in RH-MIS to report to the township every month. Many countries opt for not collecting so much data from periodical reporting system. Instead, they utilize surveys, which require far less resource. A survey can be conducted at any time when data in particular topic are needed and well-designed one can provide reliable data to the decision-makers and scholars.

(iv) MCH services provided by AMWs and TBAs

AMWs and TBAs are more likely to be active at village where the services of MW are hard to reach. Few AMWs keep records of their MCH activities in writing and some report them to MW at their respective area. As a result, the number of their delivery and AN/PN care cases in the monthly report are incomplete and inaccurate. With respect to TBA, many MWs have no or little information of their activities.

(2) Inputs by the Project for Challenging the Issues

The following interventions have been carried out by the Project.

(i) Various attempts to understand the monitoring situation at the Project site

The situation of data recording and reporting was assessed in several ways – interviewing key informants at central, district/Township and village tract levels; observing health facilities in the Project sites; reviewing the data collected from RHCs and Sub-RHCs; and collecting opinions using questionnaires. The major information collected is:

- Registers, record books and report formats used at the health facilities
- Storage and management of files and documents
- Working and training experiences of health personnel
- Daily activities of the health personnel
- Flow of data in the reporting systems
- Competency of health personnel on recording and reporting work
- Recording contents in the registers, record books and reports
- Consistency among related indicators
- Accessibility of assigned villages from the health facility
- Use of CDK, HBMR and newly-introduced formats
- Working relationship among MW, AMW and MCH Promoter
- Availability of the Project indicators in the reporting systems

(ii) Introduction of recording and reporting formats

The Project introduced AN record for AMW (Annex 1) and activity sheet for MCHP. The AN record was intended for AMW to keep the records of all her MCH activities and report them to MW accurately and thoroughly. MCHP Activity Sheet was distributed to all the MCH Promoters in order

to keep track of their activities and MWs collect it monthly. These formats were introduced at the beginning of 2009.

(iii) Monitoring training for BHS

Half-day monitoring workshop was conducted in Kyaukme and Nauncho Townships in December 2008 and January 2009, respectively. The workshop covered the explanation of existing and newly-introduced recording formats, analysis of report data, and discussion of issues regarding to monitoring work. Another workshop was conducted for one day each for the two Townships in September 2009. It focused on the explanation of HMIS reporting formats and an exercise to check the coverage of each MW in her assigned area (see the annex 2).

(3) Outputs by the Project including Achievements and Lessons Learnt

Major output should be the improvement in the competency of BHS on recording and reporting work and reliability of the report data, which are difficult to measure or verify. In fact, it requires some time to improve the recording and reporting work before the data show steady trend or movement. For the mean time, some irregularities may appear in some of report data. For example, reported maternal and infant mortality are more likely to increase in spite of the improvement in the MCH situation in the Project areas. This contradiction is caused by the fact that previously unreported cases of the mortality may become available to MW through the effort of MCH Promoters and be reflected in the monthly reports, which create apparent growth in mortality. Some MWs also learned proper recording and reporting methods during the monitoring workshops. Previously misunderstood indicators and computations may be corrected, which may cause in sudden ups and downs in the report data.

Through the field observation, it is found that some MWs are not able to cover all the assigned villages with their services. In a case of a MW in a Sub-RHC, there are 15 births at a remote village in her coverage area in 2008 and her delivery register shows no record of delivery at the village. It turns out that the MW was able to capture only 36 percent of all the births in her 14 villages in spite of her effort. In the Project areas where some of the MWs cover many remote villages, there are villages the services of MWs cannot reach and the situation of those areas is not reflected in the reporting.

With respect to the AN record for AMW and MCHP Activity Sheet, BHS answered their opinions on the use of the formats in a questionnaire. According to the questionnaire, more than 90 percent of BHS think that AMW use the AN record format. Almost 70 percent received delivery records from AMWs using the record format and only 7 percent of BHS in Kyaukme and 12 percent of BHS in Nauncho think there are problems using the AN record format. Thus, the introduction of the AN record to AMW was gone somewhat smoothly. On the other hand, 67 percent in Kyaukme and 60 percent in Naungcho find difficulty in using the MCHP Activity Sheet even though more than 90 percent of BHS said the MCH Promoters are using the record format. Illiteracy among the MCH Promoters and difficulty in communication between MW and MCHP are the main problems. Only 17 percent of BHS in Kyaukme and 35 percent in Naungcho responded that they were able to collect the activity records from MCH Promoters. Thus, it is evident that MCH Promoter's reporting in writing is difficult in the Project areas where ethnicity diversity exists and illiteracy rate is high. It is also noted that about 30 percent of BHS find that it is difficult to continue to use either the AN record for AMW or MCHP Activity Sheet after the termination of the Project. They are more likely to think that the use of the recording formats is not sustainable in case the provision and distribution of the formats is discontinued.

(4) Lessons Learnt through the Project Implementation

The current situation described earlier may not be changed easily and quickly, but it still requires some effort to change it gradually and surely. The Project may have little impact to improve the situation other than understanding the conditions in the field. Nevertheless, there were some lessons learnt through the Project implementation.

During the monitoring training, the Project made some feedbacks of the report data to BHS. They learned which indicators were mis- or under-reported and how to interpret some indicators. The training is expected to have some significant effect to improve their data collection and reporting. Thus, the feedback of report data to BHS is more enhanced and implemented.

AMWs have important roles to provide MCH services in the community, especially in remote areas where the services of MW are hard to reach. But AMW is not required to keep records of her MCH activities in writing.

The AN record the Project distributed to AMWs show some effectiveness. All the data in the reporting systems should be based on records, which is fundamental of Evidence-Based Medicines (EBM).

The Project found difficulty in gathering the activity data from MCH Promoters, which is due to the language issue and accessibility in some remote areas. It is also found that some MWs cannot cover all her assigned villages with her MCH services. MCH Promoter has key roles in remote areas since she can go around her village, find people who need MCH services and inform them to MW. As a matter of fact, the End-line Assessment Study shows that some clients visited health centers because of MCH Promoter's recommendation. Thus, the introduction of MCH Promoters in the community is expected to have some effect to improving data collection in remote areas.

Attached:
Annex 1. AN Record for AMW
Annex 2. Exercise on Finding Coverage

AN Record for AMW

Registration no. _____
Name _____
Name of spouse _____
Age _____
Address _____
Date of register _____
Last mestrual period _____
Expected delivery date _____
Date of last childbirth/abortion _____
Anaemia _____
Date of TT1 _____
TT2 _____
Use of HBMR _____

Obstetric History

Previous pregnancy	Type of delivery *(ND/ preterm/ stillbirth/ forceps/ vaccum/ suction/ cesasean/ abortion)*	Place of delivery	Assisted by	Remarks
1st				
2nd				
3rd				
4th				
5th				
6th				
7th				
8th				
9th				
10th				

Obstetric Risk Factors, eg.
(Elderly Primigravida, multigravida, presence of medical disease)

AN Care

Date	Symptoms *(severe morning sickness, leg edema, high blood pressurse, anemia)*	Referral	Remarks

Deliver

Date/time of delivery _____
Birth weight _____
Male/Female _____
Anus (Yes/No) _____
Assisted by _____
Type of delivery _____
Place (Home/Clinic) _____
Use of CDK _____

PN Care

Date	Status of mother	Status of NB	Symptoms *(fever, urinary symptoms, mastitis, uterine sub involution)*	Remarks

Name _____ Age _____
Date and time of delivery _____
Assisted by _____ Place _____
Type of delivery _____

Chapter VI - Annex 2

Exercise on Finding Coverage

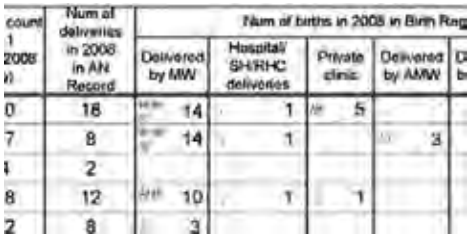
This is a simple exercise to see how much your MCH services are covering in your assigned villages. This is not a test. This exercise helps you understand where and how much your daily work is covering (and not covering). In case you find difficulty in providing immunization, delivery attendance and AN/PN care services at some villages, you may consider active participation and support from AMW and MCHP in the area.

Things you need for this exercise:

- ✦ Worksheet on Finding Coverage (attached)
- ✦ AN record book – entire records for the year 2008
- ✦ Birth register – entire records for the year 2008
- ✦ HMIS reports – from January to December 2008
- ✦ Head count records in 2008
- ✦ Map of villages in your coverage area

Step 1. Preparing the Worksheet

1. Write down names of village tracts on the worksheet. Then copy the under 1 year old population for each village tract from the head count register in 2008. If you do not have the head count data, use GAVI population for this exercise.
2. From your AN record book, count the number of deliveries for each village tract. Make sure to include only those records of which the delivery was taken place between 1 January and 31 December 2008. Then write down the number of delivery cases on the worksheet.
3. Count the number of deliveries on the birth register. This time, count them by village tract and birth attendant separately. Then calculate the total delivery cases by adding all the deliveries by different birth attendants.



	Num of deliveries in 2008 in AN Record	Num of births in 2008 in Birth Reg				
		Delivered by MW	Hospital/ SHRHC deliveries	Private clinic	Delivered by AMW	
0	16	14	1	5		
7	8	14	1		3	
	2					
8	12	10	1	1		
2	8	3				

4. From your monthly HMIS report (Form 1-A), copy the number of delivery cases to the worksheet for each village tract. Make sure to include the number of deliveries by AMW.
5. Calculate the total for each column and write it down at the bottom of the worksheet.
6. Find the ratio of (b) the head count to (a) the number of births in the birth register and write it down at the last column. The ratio is usually between 0.00 and 1.50.

Step 2. Preparing the Coverage Map

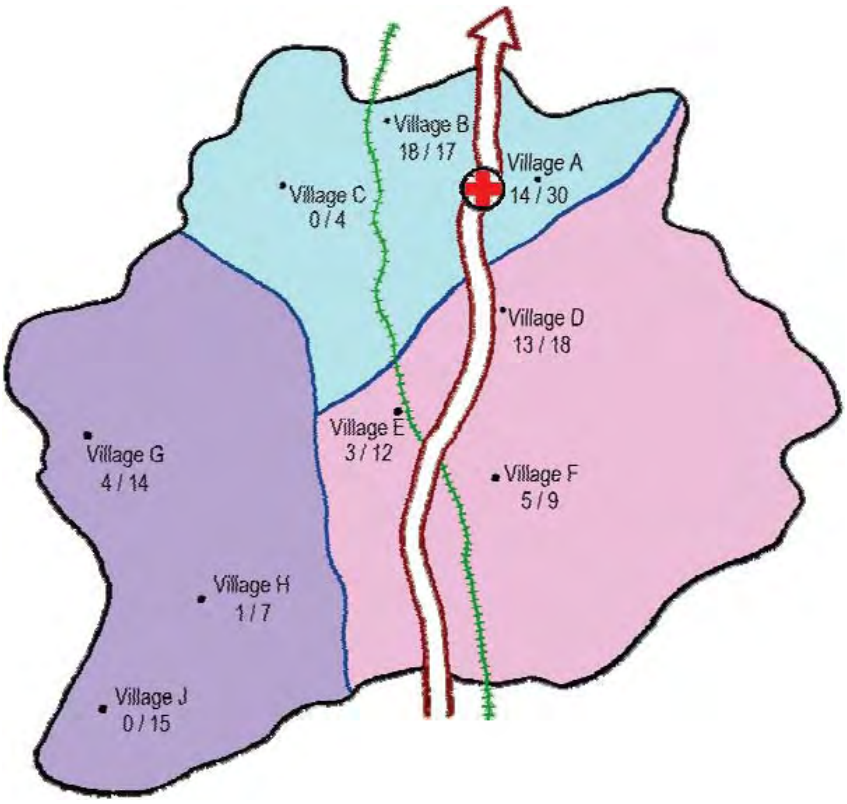
1. Draw the map of your assigned villages. Write down the village tract names at appropriate locations on the map.

2. Draw major roads connecting villages, rivers and train tracks. Add the locations of your health center and private clinics (if any), residence of health personnel (MW, AMW, TBA, etc.) on the map. Then you may also indicate where some landmarks (schools, major government offices, temples, stores, etc.) are located.

3. From the Worksheet, copy (b) the number of births in the birth register and (a) under 1 year head count population for each village tract under the village tract name on the map. Follow the example below:

The number of births in the birth register	/	Under 1 year old head count

The creating the map is complete. Your map should look like this:



Step 3. Analyzing the Worksheet and Coverage Map

The key information on the Worksheet is written in the last column – the ratio of the head count to the number of births. Ideally, the head count population under 1 year old and the number of births in 2008 must be equal, meaning that the ratio is 1.00. But in realty, these two values may not be the same because of some reasons: the family of the baby moved out from the village; and the baby was born outside of your area; the baby died before reaching 1 year; and the relocation of the settlement. If the discrepancy between the head count and birth data still exists after considering these reasons, you may suspect that your data (either the head count or births) are not accurate. The ratio of the head count to the number of births tends to be relatively low in some villages because you cannot visit there often and many pregnancies and births occur when you are away and were not informed about them. Based on the observations of some RHC and Sub-RHC, the ratio is categorized in the following:

Ratio	Comment
× 1.10 ~	The head count value is too low compared to the number of births. You might miss some part of the village during the head count field work or make some mistake during the preparation of the head count report. Check the head count records and consult with the village people and officials. There is also a possibility that the number of births in the birth register is too large. Make sure there is no double entry of records or births in other villages are not mistakenly included.
○ 0.80 ~ 1.09	The head count and the number of births are the same or relatively close. You are more likely to cover the whole village and have information on most of the MCH activities in the village.
△ 0.50 ~ 0.79	The number of births in the birth register seems very low. There may be some child births taken place without your knowledge. You may check which babies are not included in the register and find the reason why. If the village is located far and it is difficult to access there, you may try to get information on delivery through AMW or MCHP in the village.
× 0.00 ~ 0.49	The number of births is too low compared to the head count value. You certainly have little information on what is happening among the pregnant mothers in the village. It is important to find out the reason why you are missing the delivery information in the village. Then, find the solutions to obtain more information on MCH situation. You may visit the village and discuss with mothers and village officials about the situation. You may want to check if the head count data is correct.

1. Rate each village with ○ (the head-count birth ratio is 0.80 ~ 1.09), △ (0.50 ~ 0.79), or × (0.00 ~ 0.49 or 1.10 ~). Write down the rating of each village on the map.

2. Discuss with other workshop participants on your Worksheet and Coverage Map. The topics of the discussion include: Is the ratio low or high compared with other participants? What are the characteristics of the villages with low ratio? What are the possible reasons you can not obtain all of the birth information in the villages? Are there any solutions to improve the situation? Is it possible that you can get information on pregnant women from AMW or MCHP in the villages?

Attachment: Worksheet on Finding Coverage

Name of the health facility:

Village Tract		Head count < 1 Dec 2008 (a)	Num of deliveries in 2008 in AN Record	Num of births in 2008 in Birth Register						Num of deliveries reported in HMIS	Ratio (b)/(a)
				Delivered by MW	Hospital/ SH/RHC deliveries	Private clinic	Delivered by AMW	Delivered by others	Total (b)		
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
TOTAL											

Attachment: Worksheet on Finding Coverage (sample)

Name of the health facility:

	Village Tract	Head count < 1 Dec 2008 (a)	Num of deliveries in 2008 in AN Record	Num of births in 2008 in Birth Register						Num of deliveries reported in HMIS	Ratio (b)/(a)
				Delivered by MW	Hospital/ SH/RHC deliveries	Private clinic	Delivered by AMW	Delivered by others	Total (b)		
1	Village A	30	18	14	1	5			20	14	0.67
2	Village B	17	8	14	1		3		18	9	1.06
3	Village C	4	2						0	0	0.00
4	Village D	18	12	10	1	1		1	13	6	0.72
5	Village E	12	8	3					3	3	0.25
6	Village F	9	3	3			1	1	5	3	0.56
7	Village G	14	1	1			3		4	1	0.29
8	Village H	7	4				1		1	1	0.14
9	Village J	15	3						0	0	0.00
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
TOTAL		126	59	45	3	6	8	2	64	37	0.51

Annex: Educational Tools and Materials Developed by the Project

(1) Background

Improvement of awareness and knowledge on Reproductive Health issues among community people is one of the project output in order to increase the utilization of quality Reproductive Health services. Based on the review of the existing IEC/BCC materials on RH in Myanmar, many kinds of pamphlets were found to have been developed with support by UN agencies such as UNFPA. However, it was found that the IEC/BCC materials were insufficient in quantity and types of the material in the Project sites. It was also found that the materials in Shan language were necessary particularly in Kyaukme District. The challenge was development or modification of the IEC/BCC materials, which are expected to respond effectively to meet the cultural and sociological needs of specific target audiences for the community-oriented IEC/BCC activities.

(2) Inputs by the Project for Challenging the Issues

Based on the review of the existing IEC/BCC materials and needs from the Project sites, several kinds of materials have been developed for target audiences in the Project.

(i) Publicity of the Project

For the publicity of the "Healthy Mother Project", Project pamphlet and DVD had been developed which include introduction of the MCH Promoter.

(ii) MCH Promoter related items

Through the establishment of the MCH Promoter System under the Project, MCH Promoter handbook, MCH Promoter Kit, and Frequently Asked Question (FAQ) booklet were developed for their effective community-oriented activities.

(iii) Promotion of AN care

To improve awareness and knowledge on safe motherhood, some existing pamphlets on reproductive health, safe motherhood, birth spacing were translated into Shan language. Also a calendar (poster size) was made. Pregnancy calendar was developed for midwives and AMWs for their effective AN care activities.

(3) Outputs by the Project including Achievements and Lessons learned

The following IEC/BCC materials were developed by the Project:

(i) Publicity of the Project

[1] Project pamphlets for community people (in Myanmar and Shan languages)

For awareness creation on the Healthy Mother Project to the community people in the Project areas, a project pamphlet was developed in Myanmar and Shan language. It was distributed to the Project steering committee and health staff. The project pamphlet also introduced the role of MCH Promoters, so that MCH Promoters could utilize it for home visit.

[2] Audio-visual material (DVD), "One Day of Nwe Nwe – Activity of a MCH Promoter"

Audio-visual material (DVD) entitled "One Day of Nwe Nwe – Activity of a MCH Promoter" was developed to introduce the Project activities focusing on the MCH Promoters as a bridge between health services and community people.

[3] Pocket size notebook with Project logo

The pocket size notebook with Project logo was developed and distributed at the meeting, workshop, training for the Project stakeholders. It includes some useful information on danger signs during pregnancy, delivery an postnatal period.

(ii) MCH Promoter related items

[1] MCH Promoter Handbook

As the Project has introduced a system of "MCH Promoters", MCH Promoter Handbook was developed as a guide for MCH Promoters. MCH Promoter Kit including a bag, notebook, pen and badge were also developed for MCH Promoters for their effective community-based activities.

MCH Promoter Handbook was revised based on the review of MCH Promoter System and comments in terms of contents, design, layout and illustration for national prototype. Based on the comments from MCH Promoters, revisions were made on the each item of MCH Promoter Kit for improved effectiveness.

[2] Frequently Asked Question (FAQ) booklet for MCH Promoter

FAQ booklet was developed as a supporting material for MCH Promoters for their activities. It contains the frequently asked questions by pregnant women and mothers with under 5 children and corresponding for MCH Promoters' reference.

(iii) Promotion of AN care

[1] Existing pamphlets, 3 kinds in Shan language

In order to improve the knowledge on RH issues, three kinds of existing pamphlets on the topics of reproductive health, safe motherhood, birth

spacing developed under UNFPA country project were translated into Shan language.

[2] Pregnancy calendar

Pregnancy calendar was developed for midwives and AMWs to support their AN care activities. It helps them to know and explain to the pregnant women on the expected date for delivery and the timing for AN care.

[3] Calendar (Poster size)

The calendar for 2009 was developed for promoting safe motherhood with two slogans developed in the Project Townships in January 2008. The calendar shows both western and Myanmar calendar which helps BHS to utilize the Pregnancy calendar. The photos from the audio-visual material "One Day of Nwe Nwe - Activity of a MCH Promoter" were included to promote the MCH Promoter's activities.

(4) Lessons Learned through the Project Implementation

Each of the IEC/BCC material was developed for different purpose and specific target audience for effective implementation of the Project. The materials were distributed during the trainings and workshops together with some explanation of how to use the materials effectively. Understanding the local needs and responding to the cultural background would be necessary when developing the effective IEC/BCC materials. Also, in order to fully and effectively utilize the materials, guidance or training for the users is essential so that important messages can reach to the designated target audiences.

Attached:

IEC/BCC materials developed in the Project

① Project pamphlets for community people (Myanmar and Shan)
② Audio-visual material (DVD), *"One Day of Nwe Nwe - Activity of a MCH Promoter"*
③ Pocket size notebook with Project logo
④ MCH Promoter Handbook 3rd edition –national prototype-
⑤ MCH Promoter Kit
⑥ Frequently Asked Question (FAQ) booklet for MCH Promoter
⑦ 3 kinds of existing pamphlets on RH in Shan language
⑧ Pregnancy calendar
⑨ Calendar (Poster size)

① Project pamphlets for community people (Myanmar and Shan)

② Audio-visual material (DVD), *"One Day of Nwe Nwe - Activity of a MCH Promoter"*

③ Pocket size notebook with Project logo

④ MCH Promoter Handbook 3rd edition –national prototype-

⑥ Frequently Asked Question (FAQ) booklet for MCH Promoter

⑤ MCH Promoter Kit

Badge

Note book

Bag

Pen

⑦ 3 kinds of existing pamphlets on RH in Shan language

(a) Safe Motherhood

(b) Reproductive Health

(c) Abortion

⑧ Pregnancy calendar

⑨ Calendar (Poster size)