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Community Support Group

Standard Operational Guidance

Myanmar

2022

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Community Support Group (CSG) Standard Operational Guidance (SOG) was produced by UNICEF. This SOG was mainly written by Dr Kyaw Win Sein, Nutrition Specialist, UNICEF. Thanks to Dr Nay Tun Kyaw, Nutrition Officer, Mr Sanjay Kumar Das, Nutrition Manager, UNICEF, Dr Thant Zin and Dr Aung Naing Tun, Health and Nutrition Specialists, UNICEF, IYCF/IMAM technical working group members (such as Esther Matama, Nutrition Technical Lead, Save the Children International, Jenny Hilton and Dr Nang Lyan Zar, Nutrition Specialists from LIFT, UNOPS) and participants from pilot training who contributed some suggestions.

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The SOG has been adopted and adapted from (1) Community Support Group Guidelines, Dr Kyaw Win Sein and Dr Nay Tun Kyaw, 2017, (2) cIYCF training manual for community volunteers, UNICEF, 2018, (3) Community Based Health Worker Policy, MOHS, 2020, (4) Primary Health Care and Universal Health Coverage, WHO 2021, (5) Sustainable Development Goals, UNDP, 2015, (6) Community Engagement and Accountability Toolkit, IFRC, 2021, (7) A training manual on advocacy, lobbying and negotiation skills for indigenous people in climate change and REDD+. AIPP, 2013, (8) Mobilizing community for improved nutrition; A guide for community leader. USAID, PATH, IYCN, July 2011, (9) MCH handbook, 2021, (10) Toolkits for Community Case Management of Childhood Illness, ARI/Pneumonia and Diarrhoea, implementation Guide, Myanmar, MOH, 2012 and (11) Income Generation Activities Manual, Returning Profit to IGAs, USAID 2007.

ACRONYMS

BHS	Basic Health Staff
CBHW	Community Based Health Workers
CBO	Community Based Organization
cIYCF	Community Infant and Young Child Feeding
CMAM	Community Based Management of Acute Malnutrition
COVID	Coronavirus Disease
CSG	Community Support Group
DSDG	Division for Sustainable Development Goals
EHO	Ethnic Health Organization
IGA	Income Generation Activity
IMAM	Integrated Management of Acute Malnutrition
IYCF	Infant and Young Child Feeding
LMIC	Low and Middle Income Country
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MUAC	Mid Upper Arm Circumference
NCD	Non Communicable Disease
NGO	Non-Governmental Organization
OTP	Outpatient Therapeutic Programme
PHC	Primary Health Care
SDG	Sustainable Development Goal
SFP	Supplementary Feeding Programme
UHC	Universal Health Coverage
UN	United Nations
UNDESA	UN Department of Economic and Social affairs
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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Executive Summary

The chapter one explains the importance of community Support Group (CSG) and linkage with primary health care (PHC), universal health coverage (UHC) and the Sustainable Development Goals (SDGs).

United Nations Children's Fund (UNICEF) and World Health Organization (WHO) set up a vision for PHC in the 21st century: towards UHC and the SDGs in 2018. CSG is the one of the three key essential components of the PHC which provide the foundation and impetus for achievement of UHC and health related SDGs.

PHC is "a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment." (WHO and UNICEF) (2018)

UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course.

The 2023 Agenda of Sustainable Development provides a shared blueprint for peace and prosperity for people and the planet. There are 17 SDGs which can provide impetus to the Alma Ata and Astana principles (PHC) as follows.

- end poverty (SDG 1),
- equity (SDG 10),
- community participation (SDG 16), and
- intersectoral collaboration (SDG 17)

There is growing global consensus that efforts to bridge health system and community through collaboration and partnership will be key contributor to the achievement of SDG and UHC.

Basic health staff (BHS) have over-workload to cover many villages and with a lot of tasks. It is hard to reach to all villages regularly. Accessibility of the community to health center is also difficult in some areas because of geographical terrain and other conditions. Even the BHS arrive in the village, they could not meet with caregivers at all visits with many reasons. Therefore, CSG composed of villagers and voluntary health workers is essential to fill up the gap to achieve UHC and SDG.

The chapter two outlines guidance to operationalize the community Support effectively and efficiently. There are 6 Steps for setting up and operationalize the CSG in the village.

SOG 1: Advocate and Communicate

SOG 2: Form CSG

SOG 3: Build Capacity

SOG 4: Select and Implement Appropriate Interventions

SOG 5: Monitor and Provide Supportive Supervision

SOG 6: Ensure Functioning and Sustainability of CSG

There are seven action points from the above SOGs.

1. UNICEF develops the advocacy messages, and it can be adapted as per local situation.
2. Project/ Responsible Person conduct advocacy meeting.
3. Community form CSG by themselves with one month after advocacy meeting.
4. Project staff visit to village and conduct meeting with CSG ensuring formation is as per set criteria and explain the roles and responsibilities of CSG. The staff discuss with CSG members and set the date for capacity building and prepare and conduct accordingly.
5. CSG and CBHWs implement all or selected interventions according to the needs.
6. The respective project staffs provide supportive supervision, support and observe the progress of CSG. They facilitate and serve as a technical advisor and not include in decision making. They have to ensure the establishment of effective community feedback and complaints mechanism.
7. Project has to provide necessary supports for functioning and sustaining of CSG and ensure that CSG has ability to stand independently in long term.

The chapter three outlines and guides the detail implementation of each intervention. There are 13 interventions and CSG and Community Based Health Workers (CBHW) will implement all or selected interventions based on the needs of the respective community. The interventions are as follow.

1. Community Mobilization
2. IYCF counselling
3. Active Case Finding and Prevention and Treatment of Acute Malnutrition

4. Establish Referral System
5. Support Nutrition Promotion Month Campaign and Regular Nutrition Activities such as Group monitoring and Promotion (GMP), Micronutrient Supplementation and Deworming
6. Anti-Natal Care
7. Community Based Newborn Care
8. Community Case Management of pneumonia and diarrhoea
9. WASH
10. Early Childhood Development
11. Income Generation Activities
12. Data Management and
13. Others based on local needs

CHPATER 1
INTROUCITON

1.1 Importance and Background of Community Support Group

United Nations Children's Fund (UNICEF) and World Health Organization (WHO) set up a vision for primary health care (PHC) in the 21st century: towards universal health coverage (UHC) and the Sustainable Development Goals (SDGs) in 2018. Community Support Group is the one of the three key essential components of the PHC which provide the foundation and impetus for achievement of UHC and health related SDGs.

1.1.1 Primary Health Care

Definition

Primary health care (PHC) is essential **health** care made universally **accessible** to individuals and acceptable to them, through full participation and at a cost the **community** and country can afford. (1978)[1]

Primary Health Care (PHC) is "a **whole-of-society approach to health** that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment." (WHO and UNICEF) (2018)[2]

Vision and Components

PHC was launched in the Alma-Ata Declaration in 1978. At 40 years later in the 2018, UNICEF and WHO set up a vision for PHC in the 21st century: towards UHC and SDGs. It is a whole-of-government and whole-of-society approach to health that combines three core components:

1. multisectoral policy and action;
2. **empowered people and communities**; and
3. integrated health services with an emphasis on primary care and essential public health functions

A PHC approach can help countries **equitably** maximize the level and distribution of health and well-being by focusing on **people's needs** and preferences (both as individuals and communities) as early as possible along the **continuum of care** – from health promotion and disease prevention to diagnosis, treatment, rehabilitation and palliative care – and as close as possible to people's everyday environments.

Alma-Ata declaration (1978) and Astana declaration (2018) emphasized core principles of universal access to care, equity, **community participation**, intersectoral collaboration, and appropriate use of resources, as well as by stating that inadequate and unequal health care was unacceptable: economically, socially, and politically. The new Declaration recognizes the increasing importance of non-communicable diseases (NCD) including mental health issues, injuries and the health impacts of climate change.

[1] https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata
[2] https://www.unicef.org/laos/press-releases/new-global-commitment-primary-health-care-all-astana-conference

PHC and COVID

The role of PHC in the context of the COVID-19 pandemic is also very important and can help build resilient health care system. Much of the policy attention during the COVID-19 pandemic has focused on supplies and hospital capacities but less on the role of PHC. It has slowed effective response in many countries and has led to disruption of services, especially to vulnerable populations. Strong PHC-oriented systems in some countries have been able to maintain access to essential services and minimize complications (and/or death) from COVID-19. PHC is fundamental for resilient health services and is critical for care provision during and beyond the COVID-19 pandemic. Moreover, from an economic perspective, the cost of PHC is comparatively low and can reduce the need for costly interventions.

Essential Elements of Primary Health Care (PHC):

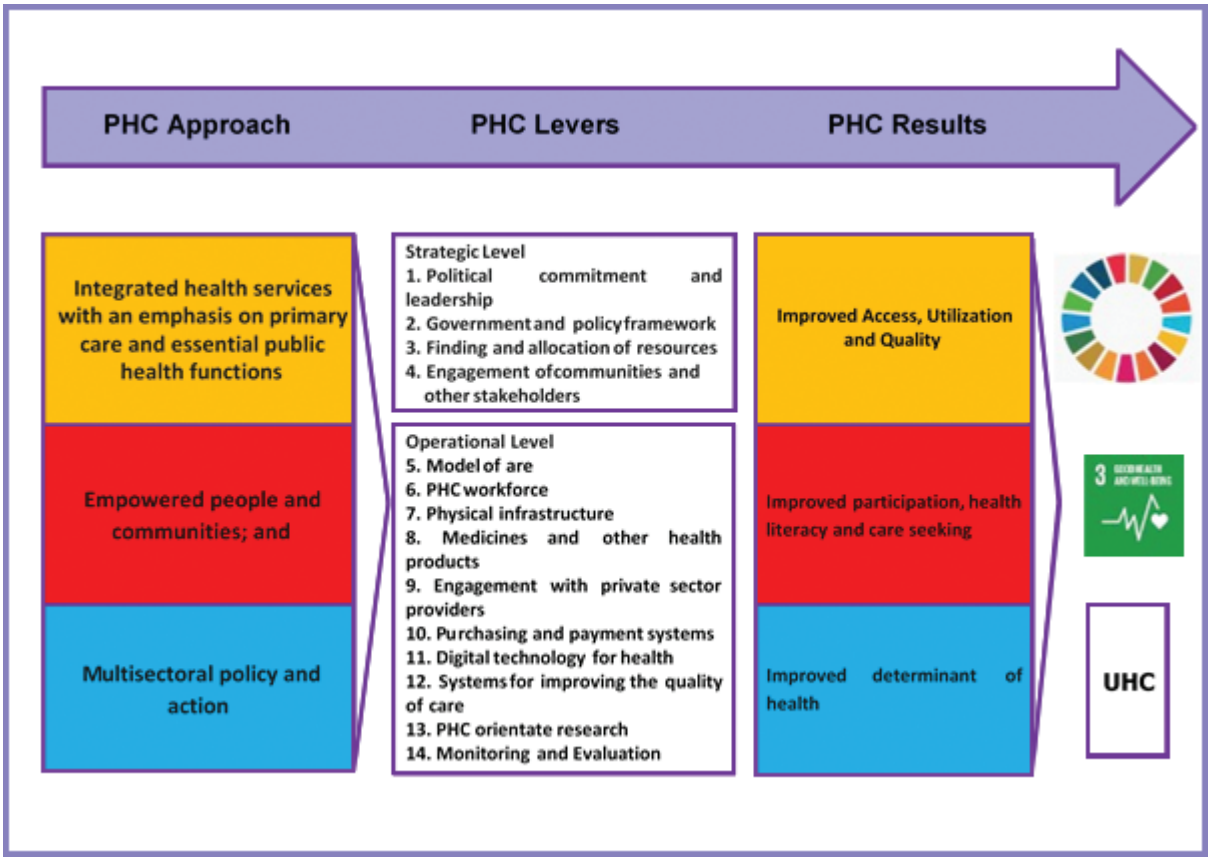
There are 8 elements of primary health care (PHC) are as follows.

- E Education concerning prevailing health problems and the methods of identifying, preventing, and controlling them.
- L Locally endemic disease prevention and control.
- E An expanded program of immunization against major infectious diseases.
- M Maternal and child health care including family planning.
- E Essential drugs arrangement.
- N Nutritional food supplement, an adequate supply of safe and basic nutrition.
- T Treatment of communicable and non-communicable diseases and the promotion of mental health.
- S Safe water and sanitation.

Extended Elements in the 21st. Century are

- E Expended options of immunizations.
- R Reproductive health needs.
- T Provision of essential technologies for health.
- P Health promotion.
- N Prevention and control of non-communicable diseases.
- F Food safety and the provision of selected food supplements.

Figure 1: PHC approach, levers and results



Depending on the setting, PHC may be provided by a nurse, family physician or other type of health worker. In 2008, the World Health Organization advocated for a renewal of PHC taking into account that globalization is putting the social cohesion of many countries under stress, and health systems are clearly not performing as well as they could and should (www.who.int/whr/2008/en/index.html).

Determinant of Health

Many factors combine together to affect the health of individuals and communities. Whether people are healthy or not, is determined by the social and economic environment, the physical environment, and the person's individual characteristics and behaviours. It depend on where we live, the state of our environment, genetics, income, education level, relationships with friends and family all have considerable impacts on health. **More commonly considered factors such as access and availability of nutritious foods, conflict, livelihoods, all use of health care services which often have less of an impact.**

1.1.2 Universal Health Coverage

Universal Health Coverage UHC means that all individuals and communities **receive the health services** they need **without suffering financial hardship**. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course. Protecting people from the financial consequences of paying for health services out of their own pockets reduces the risk that people will be pushed into poverty because unexpected illness requires them to use up their life savings, sell assets, or borrow – destroying their futures and often those of their children.

Out-of-Pocket Expenditure

OOP Protecting – OOP reduces the risk that people will be pushed into poverty.

Supply side investments –particularly in primary care facilities, human resources, and essential medicines are critical to bringing down OOP spending. By bringing quality services closer to communities, health seeking behavior can be improved, households need to spend less on transportation, spending on medicines outside the public facility can be reduced.

Out-of-pocket (OOP) spending by households remains the dominant source of financing for health in Myanmar. A recent nationally representative survey found that OOP spending comprises roughly 75 percent of total health spending (76.4 % in 2018 and 76.0 % in 2019) which is highest in ASEAN countries. For every $10 spent on health in Myanmar, $7 comes directly from people, when they go to hospitals and clinics (out of pocket spending) and less than $3 comes from government.

It is a major cause of catastrophic health expenditure (CHE) by households and can push or keep households in poverty. In addition, it prevents many from seeking necessary health care. The CHE is that health expenditure is **greater than or equal to 40% of the capacity to pay** (WHO). Some studies mentioned total health expenditure is more than 10% of annual income.

For UHC to be truly universal, a shift is needed from health systems designed around diseases and institutions towards health systems designed **for people, with people**. The delivery of these services requires **adequate and competent health and care workers** with optimal skills mix at **facility, outreach and community level**, and who are equitably distributed, adequately supported and enjoy decent work.

UHC is firmly based on the 1948 WHO Constitution, which declares health a fundamental human right and commits to ensuring the highest attainable level of health for all. Achieving UHC is one of the targets the nations of the world set when adopting the SDGs in 2015. Countries reaffirmed this commitment at the UN General Assembly High Level Meeting on UHC in 2019. Good health allows children to learn and adults to earn, helps people escape from poverty, and provides the basis for long-term economic development.

Monitoring progress towards UHC should focus on 2 things:

- The proportion of a population that can access essential quality health services (SDG 3.8.1)
- The proportion of the population that spends a large amount of household income on health (SDG 3.8.2).

Measuring equity is also critical to understand who is being left behind—where and why. WHO and World Bank have developed a framework to track the progress of UHC by monitoring both categories, taking into account both the overall level and the extent to which UHC is equitable, offering service coverage and financial protection to all people within a population, such as the poor or those living in remote rural areas.

Myanmar UHC

The health care delivery system of Myanmar has not been accorded enough attention over the years. It has led to weak health infrastructure, insufficient number of adequately skilled human resources, high out-of-pocket spending, coupled with questionable quality of health care services. For long time, specialized or tertiary care has been prioritized, mainly in urban areas at the expanse of basic essential care for the majority of the population. To overcome these issues, the National Health Plan (NHP) 2017-2021 was developed so that it helps the country move towards UHC in an equitable, effective and efficient manner.

The goal is to extend access to a Basic Essential Packages of Health Services (EPHS) to the entire population by 2020 while increasing financial protection. Intermediate and comprehensive EPHS will be next NHP (2021-26) and NHP (2026-2031) respectively.

1.1.3 Sustainable Development Goals (SDGs)

The 2030 Agenda for Sustainable Development, adopted by all United Nations (UN) Member States in 2015, provides a shared blueprint for peace and prosperity for people and the planet. There are 17 Sustainable Development Goals (SDGs), in where ending poverty and other deprivations must go hand-in-hand with strategies that improve health and education, reduce inequality, and spur economic growth – all while tackling climate change and working to preserve our oceans and forests. The process are as follows.[3]

- Agenda 21
  - In June 1992, at the Earth Summit in Rio de Janeiro, Brazil, more than 178 countries adopted Agenda 21, a comprehensive plan of action to build a global partnership for sustainable development.
- Millennium Development Goals (MDGs)
  - In September 2000, member States adopted the Millennium Declaration at the Millennium Summit at UN Headquarters in New York. The Summit led to the elaboration of eight MDGs to reduce extreme poverty by 2015.

[3]https://sdgs.un.org/goals

- Sustainable Development Goals (SDGs)
  - In 2002, the Johannesburg Declaration is adopted. It reaffirmed the global community's commitments built on Agenda 21 and the Millennium Declaration by including more emphasis on multilateral partnerships.
  - In 2012, at the UN Conference on Sustainable Development (Rio+20), Member States adopted the outcome document "The Future We Want" and decided to develop SDGs to build upon the MDGs and to establish the UN High-level Political Forum on Sustainable Development.
  - In 2013, the General Assembly set up a 30-member "Open Working Group" to develop a proposal on the SDGs.
  - In 2015, the General Assembly began process on the post-2015 development agenda. The 2030 Agenda for Sustainable Development was adopted with **17 goals, 169 targets, 3196 events, 1,322 Publications and 6,160 actions** at the UN Sustainable Development Summit in September 2015.
  - The annual High-level Political Forum on Sustainable Development serves as the central UN platform for the follow-up and review of the SDGs.
    - The Division for Sustainable Development Goals (DSDG) in the UN Department of Economic and Social Affairs (UNDESA)
    - provides substantive support and capacity-building for the SDGs and their related thematic issues, including water, energy, climate, oceans,
    - urbanization, transport, science and technology, the global sustainable development report, partnerships and Small Island Developing States,
    - plays a key role in the evaluation and on advocacy and outreach activities relating to the SDGs, and
    - facilitates engagement of strong commitment by all stakeholders to implement the global goals.
    - Every year, the UN Secretary General presents an annual SDG Progress report, which is developed in cooperation with the UN System, and based on the global indicator framework and data produced by national statistical systems and information collected at the regional level. Additionally, the Global Sustainable Development Report is produced once every four years (2019, 203) to inform the quadrennial SDG review deliberations at the General Assembly. It is written by an Independent Group of Scientists appointed by the Secretary-General.
- The SDGs can provide impetus to the Alma Ata and Astana principles (PHC) through other SDGs such as
  - end poverty (SDG 1),
  - equity (SDG 10),
  - community participation (SDG 16), and
  - intersectoral collaboration (SDG 17).

- The evidence shows that countries that reorient their health systems towards primary health care are better placed to achieve almost all of the SDGs.

Figure 2: SDG Goals

1.2 Rationale

- There is growing global consensus that efforts to bridge health system and community through collaboration and partnership will be key contributor to the achievement of a Sustainable Development Goals and Universal Health Coverage (UHC).
- Therefore, community participation is one of the key essential components of Alma Ata, Astana, SDG and UHC.
- Basic health staff (BHS) especially midwives have over-workload to cover many villages and with a lot of tasks. It is hard to reach to all villages regularly. One midwife is assigned to cover 3,000 population. Accessibility of the community to health center is also difficult because of geographical terrain and other conditions. In some hilly areas, small villages scattered around the areas and in some delta areas, it was separated by big rivers and hard to across during rainy season. Even the BHS arrive in the village, they could not meet with caregivers at all visit with many reasons.
- Therefore, Community support group composed of villagers and voluntary health workers is essential to fill up the gap to achieve UHC and SDG.

1.3 Scope of the Guidance

Target User:

Programme planners, managers, and staff working in development and humanitarian preparedness and response in Myanmar, including Ethnic Health Organizations (EHOs) United Nations (UNs) agencies, national and international non-governmental organisations (NGOs), Community Based Organizations (CBOs) and donors.

Target Population:

Primary: Under five children and pregnant and lactating women

Secondary: Adolescence, women in reproductive age, and men especially father

Goal:

To provide practical guidance on the set up, implementation and management of community support group.

Objectives:

- To set up, implement and manage the community support group for prevention, promoting, treating and rehabilitation of the health and nutrition; wellbeing of respective communities and improving overall development.
- To harmonize all stakeholders for leveraging community support group as one of key pillar of PHC approach and extending the health system to the community level
- To contribute the achievement of Sustainable Development Goals and Universal Health Coverage of Myanmar by empowering and participation of community in collaboration and partnership with health system

Overview:

- **Chapter 1** provides background information to the guideline and can be used by readers to understand the Myanmar context within which this guidance was produced and the rationale behind it.
- **Chapter 2** provides a **Standard Operational Guidance** which should be implemented by the UN agencies, NGOs, EHOs and CSOs. It provides the steps and actions that need to take place.
- **Chapter 3** describes technical interventions to be undertaken. It guides users to understand the detail procedure of technical interventions.

1.4 Community Support Group and Community Based Health Worker

Community Support Group (CSG) is the group composed of village leaders, fathers, mothers, caregivers, interested villagers, which can support basic health staff (BHS) and community based health workers (CBHWs) to preform infant and young child feeding counselling, management of acute malnutrition, micronutrient supplementation, health education, referral, and other health, nutrition and social services as per needs of the respective community.

Under the community support group, there will be many sub-groups based on the respective local situation such as mother to mother support group, youth group, social group, income generation group and farmer groups etc. CSG is overarching group which support and coordinate other groups in the respective village/villages.

Community Based Health Workers are Auxiliary midwives (AMWs) and Community Health Workers (CHWs). They are the members of PHC team and act as a bridge between local health staff and communities within the Myanmar health system. AMW provide a basic package of health services to community, similar to, the services provided by midwives. CHW provide a basic package of health services to community, similar to, the services provided by public health supervisors 2. Each AMW/CHW has responsibilities for 1,000 population or two square miles catchment areas.

The CSG has to be sustained. If the formation of CSG is in project driven approach, it cannot be sustained. Community ownership is the key driver for sustainability. Skill of the project staff on advocacy, conducting advocacy meeting and community engagement is essential parts to establish functioning and sustaining of CSG.

Platforms

There are two platforms; community based, and facility based platforms for providing the health and nutrition services to the communities.

(1) Community Based Platform

Global evidence suggests that successful community based programmes require a supportive social and policy environment for community engagement.

- **Community based services save lives**. The 21% of stillbirth, 49% of the neonatal deaths and 93% of child death can be averted by delivering currently available evidence based interventions through a community platform.[4]
- **Community based services increase access and equity**. A global review of the inequalities in maternal, newborn, and child health has concluded that community based interventions are more equitable than static facility based interventions alone.[5] The utilization of facility based services decrease exponentially as the

[4]Black RE, Levin C, Walker N, et al. Reproductive, maternal, newborn, and chid health: key messages from disease control priorities 3rd. edition. Lancet. 2016;388(10061):2811-2824. doi:10.1016/S0140-6736(16)00738-8.
[5]Barros AJ, Ronsmans C, Axelson H, et al. Equity in maternal, newborn, and child health interventions in Countdown to 2015: a retrospective review of survey data from 54 countries. Lancet. 2012;379(9822):1225-1233. Doi:10.1016/S0140-6736(12)60113-5.

household's distance from the location increases, especially if the facility is greater than 3 km or more than 30 minutes away.[6] Therefore, task shifting to CBHWs to provide outreach services in rural communities can help increase overall access to basic interventions. For examples, establishing mother MUAC programme, allowing CBHW to treat SAM without complication, providing Vitamin A and community case management of pneumonia and diarrhoea.

- **Community base services are cost effective**. Existing evidence suggests that using community health workers to deliver essential health services can be a cost effective approach for health programme in low-and middle-income countries.[7] It is most effective option to reduce mortality as well as the least expensive options we currently have to end preventable child and maternal deaths in resources limited countries by 2030.[2]

(2) Facility Based platform

- The utilization of facility based services decrease exponentially as mentioned in above paragraph.
- Achieving the same level of coverage of evidence based interventions by expanding only facility based services will take decades longer and cost much more than those of community based health care.[8,9]

[6]Tanser F, Gijsbertsen B, Herbst K. Modelling and understanding primary health care accessibility and utilization in rural South Africa: an exploration using a geographical information system. Soc Sci Med. 2006;63(3):691-705. Doi10.1016/j.socscimed.2006.01.015.
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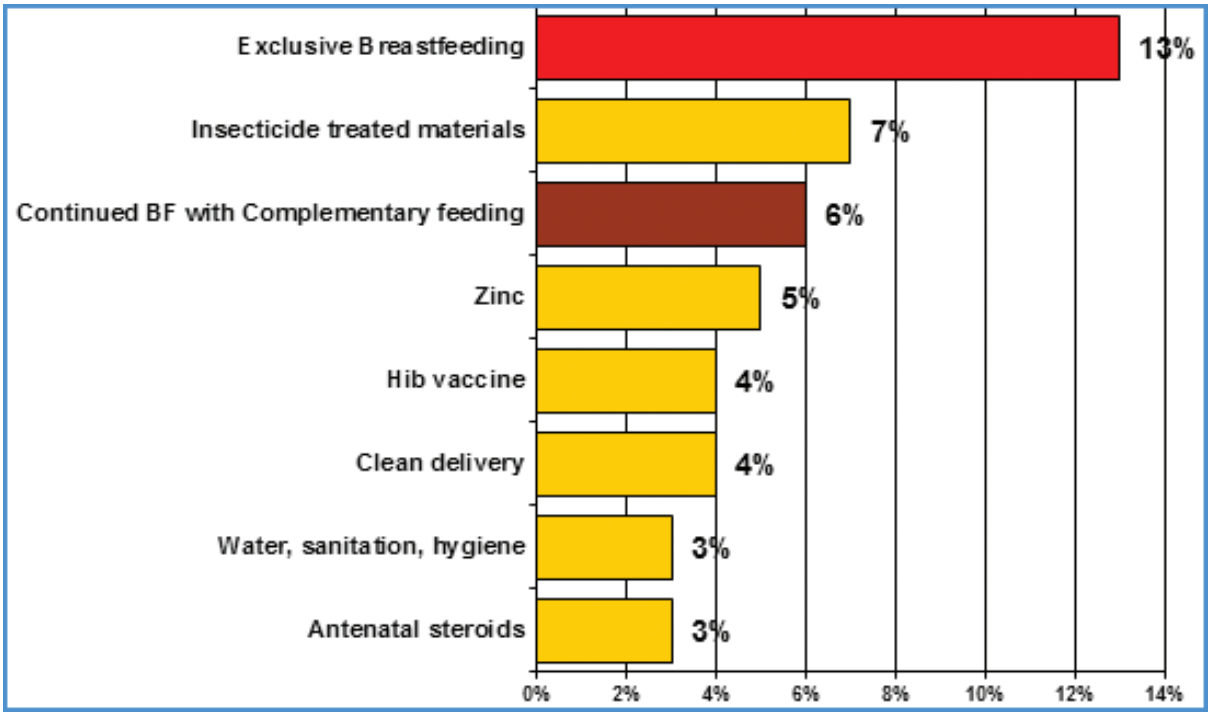
[8]Perry HB, Zulliger R, Rogers MM. Community health workers in low-, middle-, and high-income countries: an overview of their history, recent evolution, and current effectiveness. Annu Rev Public Health. 2014;35:399-421. Doi.10.1146/annurev-publhealth-032013-182354.
[9]McCord GC, Lui A, Singh P. Deployment of community health workers across rural sub0Saharan Africa: financial considerations and operational assumptions. Bull World Health Org. 2013;91(4):244-53B. doi:10.2471/BLT.12.109660.

As pre lancet series, the high impact interventions to reduce under five mortalities are as follows.

Figure 3: High Impact Intervention to Reduce Under Five Mortality



CHPATER 2
STANDARD OPERATIONAL GUDANCE

This chapter outlines guidance to operationalize the community Support Group effectively and efficiently. There are 6 Steps for setting up and operationalization of the CSG in the village.

SOG 1: Advocate and Communicate

1.1 Develop manual to be used in advocacy meeting with village authority and villagers to form CSG

The standard advocacy messages are developed by UNICEF (Annex 1). It includes

- Situation of under-five and maternal death and its causes in Myanmar
- Situation of malnutrition in Myanmar (wasting, stunting, low birthweight, iodine deficiency, anaemia, and infantile beriberi etc.)
- Impacts of malnutrition (health, education, production, income, sports etc.)
- Kind of responses to address these problems and gaps
- Importance and roles of community participation to avert under five death and malnutrition

These standards advocacy messages can be adapted as per local situation and involving of the communities in preparing is a vital way to gain credibility and bring added strength to advocacy efforts. It can be translated into local languages if required. Regularly discuss and agree with the community what the priority needs are. Ensure these discussions are reflected in wider advocacy messages.

ACTION 1

UNICEF develops the advocacy messages, and it can be adapted as per local situation.

1.2 Advocate to village authority/leaders/influential community members

During providing health and nutrition services (e.g., MUAC screening, cIYCF counselling, Micronutrient supplementation etc.), health or nutrition staff or volunteer informs village authority to have the date for the advocacy meeting with village authority/leaders.

After confirming the date from the village authority/leaders, the respective health or nutrition staff has to prepare the advocacy programme with the field project team.

The advocacy has to be conducted by project staff supported by supervisor if available in the set date. It is to ensure that both staff have experiences on advocacy. Be aware that the date of advocacy meeting should not be cancelled or postponed by the project staff. During advocacy meeting, includes village leaders, key persons, villagers, CBHW, mothers and fathers.

Firstly, explain about the messages in the advocacy tools emphasize on the roles of community participation and comparative advantage in averting maternal and child death and malnutrition. Reducing malnutrition also tend to increasing educated people and then improving capability of income. After this section, continue in formation of CSG. The following criteria has to be discussed.

- Composition: 5-7 members
- Members should be the persons who are resident of the community; interested in health, nutrition and social work; desire to stay and serve in resided village; and elected by community. Empower to include women, people with disability and people from minority communities.
- Chair: The person has the capacity to influence the villagers and manage the team such as village authority, religious leader, traditional medicine practitioners, cultural leader, teachers,
- Co-chair: The same as above
- Secretary: Suitable persons e.g., community based village volunteers or others
- Joint secretary: Suitable persons
- Members: Suitable persons
- Methods to choose the members
    - o It has to explain about strength and weakness of election and selection methods as follow and advocate to do election method.

Table 1: Differences between Election and Selection Methods

Election	Selection
a formal and organized process by which a selection is made on the basis of a choice made by population	the process of determining the appropriate entity or entities among the choices available
choice pertaining to a number of people. decision is made based on the majority of votes	Selection is often associated with an individual's method of choosing from various alternatives,
Transparency	
Represent	

After this session, the advocator has to explain and provide the roles and responsibilities of CSG and CBHW. (See in Interventions)

ACTION 2

Project/ Responsible Person conduct advocacy meeting.

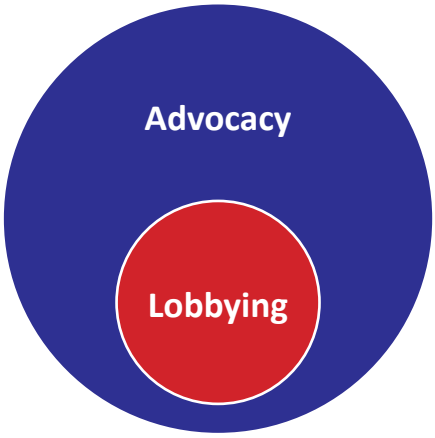
What is advocacy

Advocacy[10] is the process of raising voices in an effective manner so as to influence others. This is done by educating and creating or increasing awareness among the general public, government and policy makers, or other entities such as private corporations, on issues affecting or confronting the community and the need to align policies, laws, programs, projects to address the need.

Advocacy is a process rather than a product. A means, rather than an end.

For example, it is a means to empower the marginalized and powerless to gain a better policy environment with implications for implementation of policies. The result could be better laws, policies, programs or projects in the community that reflect the interest of the people.

Lobbying is part of advocacy and key activity to achieve advocacy. Lobbying aims to persuade or influence action of the government or policymakers or private corporations to either enact or modify legislations, policies and programmes that would benefit the interest of groups that are doing the lobbying. In simple terms, to lobby is to either oppose or support a specific issue or a specific policy or programme.



[10]A training manual on advocacy, lobbying and negotiation skills for indigenous people in climate change and REDD+. AIPP, 2013

Types of Advocacies[11]

- Lobbying or direct communication

  It involves influencing through direct, private communications with decision-makers. It can be a powerful and cost-effective advocacy tool.

- Campaigning

  It involves speaking publicly on an issue with a view to generating a response from the wider public and using a variety of techniques such as:

  - » Networking
  - » Awareness raising
  - » Media
    - opinion pieces and letters to the editor
    - newsletters
    - web-based bulletins and online discussions
    - celebrity endorsements
    - public events
    - large-scale advertising campaigns
  - » Mass Action (Awareness raising + Media, public pressure)

The choice of method will very much depend on the target audience, the message to be conveyed, the resources available, and the cultural and socioeconomic context.

Key points to check your messages during advocating.

- What you're asking for
- Why you're asking for it
- How it will benefit the community
- How it will benefit the level of government being targeted
- The consequences if the outcome is not achieved/delivered
- How people can get involved

The best way to ensure consistent messaging in community-based advocacy is to make sure everyone has access to accurate, timely, and concise information. There are 10 steps of advocacy pan as follow.

[11]NCBI.https://www.ncbi.nlm.nih.gov/books/

Table 2: 10 Steps of Advocacy Plan[12]

Steps	Examples
1. Identify an advocacy challenge or opportunity.	• To convince the school board to provide adequate time for social studies instruction and professional development
2. Determine the key audiences.	• Primary - School Board Members • Secondary - People who support the school board members, School staff, other elected leaders, legislature and the Media
3. Find out what those audiences currently know or perceive.	• Read past Board meeting minutes • Review past election materials for comments on social studies • Read newspaper coverage of Board meetings • Hold individual interviews with Board members
4. Determine how each audience receives its information.	• Interviews (based on what is discovered, new audiences may be added. For example, if members of the Board indicate that they only listen to recommendations from the superintendent then he/she is added to your audience list.)
5. Establish measurable objectives for each audience.	• E-mail or regular mail. • Each Board member will be given a copy of curriculum standard strands and performance expectations. • An article on the value of social studies will be published in the state school board association journal. • Eighty percent of the Board will attend a seminar conducted by local social studies educators. • Eighty percent of the Board will attend a social studies class in a local school.
6. Define message points for each audience.	• Social studies education is more important than ever. • Social studies education prepares students for college, career, and civic life. • Social studies hold our society together.
7. Determine the communication activities to deliver those messages.	• Prepare a cover letter and send a copy of curriculum standard strands and performance expectations. • Make a follow up phone call to assure it was received. • Submit an article to the state school boards association. • Deliver an invitation (written or verbal) to the conference. • Develop a plan with the schools to have board members observe a social studies classroom. • Deliver an invitation (written or verbal) to participate in the observation.
8. Decide what resources are necessary to complete each activity.	• Time to compose and disseminate the letters. • Postage.
9. Establish a timeline and responsible party for each activity.	• Indicate completion time for each activity
10. Evaluate whether you have reached your objectives.	• Is article published? • Do they express an interest in the curriculum standards? • Do they go on the observation?

Conducting community meeting and Focus Group Discussion are also important in establishing CSG. The details are in annex 2. Community Engagement.

[12]Creating Your Advocacy Plan; National Counsel for the Social Study, 2019, https://www.socialstudies.org/advocacy/advocacy-planning-your-10-step-plan-0

SOG 2: Form CSG

The formation of CSG has to be done by villagers within one month after advocacy meeting. Project staff has to communicate, follow up and encourage the formation of CSG. It should be election method and make sure the date and process of formation. Keep records and documents of the SCG and initiate the official launching within the community.

The composition of CSG members, the eligible criteria for each category, methods to choose the members are already explain in the advocacy meeting.

CSG chair has to explain the roles and responsibilities of the CSG and CBHWs. He / She also emphasize roles and responsibilities of each and every member in order to coordinate well between team members. Brief roles and responsibilities of the CSG and CBHW in each intervention are as follow.

Table 3: Roles and Responsibilities of CSG and CBHWs

Interventions	CSG	CBHW
Community Mobilization	Lead and organize	Support
IYCF counselling	Organize	Implement
IMAM (Active case finding and prevention and treatment of acute malnutrition)	Organize and Support	Implement
Referral	Support	Decide and manage
Other Nutrition Activities	Support	Implement
Anti-natal Care	Support	Implement
Community Based Newborn Care	Support	Implement
Community Case Management of pneumonia and diarrhoea	Support	Implement
Data Management	Lead	Support
WASH	Support	Implement
Income Generation	Lead	Support
Early Childhood Development	Support	Implement
Others based on local needs	Lead/support	Support/Implement

ACTION 3

Community form CSG by themselves with one month after advocacy meeting.

SOG 3: Build Capacity

Building the capacity of CSG members and CBHWs is necessary throughout operationalization of the programme. The quality and sustainability of CSG relies on leaders, decision makers, the availability of trained staff and supportive environment. There are different competencies required for CSG members and CBHW. The capacity building for the members and CBHW should be conducted during one month after formation of the CSG. There are different capacity building modules for CSG members and CBHWs.

The training details modules for CSG members are in the annex 2.

The topics for the training are

1. Roles and responsibilities of CSG
2. Benefits of establishing functioning CSG
3. cIYCF
   - o Importance of Breastfeeding and CF (Brief)
   - o Benefits of Breastfeeding and CF (Brief)
   - o Belief that can affect breastfeeding (Myths, all facts)
4. IMAM
   - o Why IMAM is important?
   - o Community Mobilization

     (Community assessment, community sensitization, active case finding, referral, follow up, evaluation)
5. Why micronutrient deficiencies are important and how to support in prevention and treatment (brief)
6. Danger sings of the children and pregnant women for referral
7. Mechanism of referral
8. Importance of income generation
9. Management (Basic)
10. Good governance and community leadership

For CBHW, the trainings are referred to

(a) Volunteer training manuals modules for cIYCF, IMAM, Active and Responsive Feeding and Micronutrient Supplementation

(b) Community Case Management and Community Based Newborn Care

ACTION 4

Project staff visit to village and conduct meeting with CSG ensuring formation is as per set criteria and explain the roles and responsibilities of CSG. The staff discuss with CSG members and set the date for capacity building and prepare and conduct accordingly.

SOG 4: Select and Implement Appropriate Interventions

Based on the needs of the communities, the following interventions has to be implemented in the communities. It may be one or two or many interventions as per requirement. The CHBW has key responsibilities for implementation of these interventions and CSG has key responsibilities to support it. The following are the key interventions to be carried out by CSG and CBHWs.

- Intervention 1 : Community Mobilization
- Intervention 2 : IYCF Counselling
- Intervention 3 : Active Case Finding and Prevention and Treatment of Acute Malnutrition
- Intervention 4 : Established Referral System
- Intervention 5 : Nutrition Promotion Month Campaign and Regular Nutrition Activities such as Group Monitoring and Promotion, Micro nu trient Supplementation and Deworming
- Intervention 6 : Anti- Natal Care
- Intervention 7 : Prevention and Treatment of Childhood Illness
- Intervention 8 : WASH
- Intervention 9 : Income Generation Activities
- Intervention 10 : Data Management
- Interventions 11 : Others based on local situation

The details are in chapter 3.

ACTION 5

CSG and CBHWs implement all or selected interventions according to the needs.

SOG 5: Monitor and Provide Supportive Supervision

The respective project staff monitor and provide supportive supervision and observe the progress of CSG. They will also provide suitable suggestion and supports. They will facilitate and serve as a technical advisor and not include in decision making.

The CBHWs may be the leader or members of CSG. It is a collaborative effort between a **supervisor** and a **CBHW** to help the health worker improve knowledge, confidence and skills and thereby to improve the quality of services and support CSG. The CBHW should be motivated and encouraged to continue improving their skills to promote quality of services and monitor activity and coverage.

- It should be **intensified** when new staff have been recruited or staff have not undergone full formal training in preparedness.
- The first visit for each trainee should be within **4 weeks** following orientation and/or training, after which staff should be visited according to a regular schedule (**monthly** or more).
- If access to facilities is difficult, set up **remote support measures** such as online and phone.
- Locally recruited person may themselves have been affected by the emergency; therefore, supervisors should be sensitive to the **psychosocial wellbeing** of them.
- **Records of CSG members and trained individuals** must be kept to assess how many trainees are functioning, in order to track turnover and to plan new recruitment and trainings.

Involvement of communities and Accountability

Monitoring and evaluation should regularly **involve affected communities**. Key conclusions should be distributed to all relevant stakeholders, including target population. They will collectively identify M&E criteria/indicators, who wants/needs to participate in M&E and define how they will collect and analyze the information. Sharing the results of participatory evaluations with the broader community is an opportunity for celebration and recognition of individual contributions (e.g., committed leaders, members and CBHWs) and collective achievements. Likewise, villagers will be encouraged to share their successes and lessons learned with other communities to "spread" community mobilization for health and nutrition improvement in the surrounding areas.

Aim to actively seek the views of the affected population, including through implementing **safe and responsive feedback and complaints mechanisms**[13]. Consult PLWs and other caregivers of children 0 – 23 months and others on what type of mechanism would be accessible to them and what barriers they may face in complaining. When appropriate, arrange feedback sessions with the community in order to (confidentially) share the feedback and discuss the actions being taken to address it. The service providing organization e.g., NGO has responsibility to implement it.

[13]http://feedbackmechanisms.org/resources/ . For further learning: www.disasterready.org (Beneficiary Feedback Mechanisms)

Document experiences to inform future improvement

CSG and other supportive organization are encouraged to systematically capture lessons learned from implementation, in order to strengthen and adjust these guidelines as needed.

ACTION 6

The respective project staffs provide supportive supervision, support and observe the progress of CSG. They facilitate and serve as a technical advisor and not include in decision making. They have to ensure the establishment of effective community feedback and complaints mechanism.

SOG 6: Ensure Functioning and Sustainability of the CSG

Providing the support is crucial issue for the functioning and sustainability of CSG. There are different kinds of supports needed for the CSG to work effectively and efficiently.

6.1 Capacity Support

Providing trainings and refresher training and monitoring the output, effect and impact of the training is essential part of the support to the CSG. (See with SOG 3)

6.2 Materials Support

Providing the necessary equipment and promoting materials such as T- Shirt, Coat, Cap, Bag, manuals, notebook and stationaries etc. will enhance and motivate the functioning of CSG. IEC materials (The details requirements are in annex 5)

6.3 Financial Support

Providing initial seed fund for the CSG is another key support for the functioning of CSG.

- This initial seed fund must be the revolving fund which has to be used, sustained and increased.
- They ways of sustaining (replenishing and increasing) this fund will be discussed and agreed among CSG and community e.g., donation, income generation and others. Project/staff can only provide suitable suggestions and not involve in decision making. The possible suggested ways are
    - Donation
    - Membership fees
    - Investment
    - Small business
    - Interest etc.

- Fund will be kept by three persons from the CSG agreed by CSG members based on safety precaution in place.
- This fund can be used for the expenses for meeting, referral of the patient, health and nutrition events and other necessary things agreed/set by CSG and community.
- There will be agreement from all CSG members before using the fund.
- Statement of fund has to disseminate in monthly CSG meeting.

6.4 Conduct regular CSG meeting

Conducting CSG meeting regularly (monthly or quarterly and annually) is the best way for function and sustaining of particular CSG.

In the meeting, all members will discuss on the progress, record the achievement, explain the challenges and ways of taking the corrective action accordingly and decide the way forward.

Discuss and agree the action points such as who will do what action in which time and follow up accordingly. Share the key points of discussion and agreement to the community. Progress of action points have to be presented and discussed in next meeting.

6.5 Exchange visit

Exchange visit will be organized between CSGs to share the experience, lesson learnt and strengthen the network. They can understand the different situation and different approaches which can be adapted and applied. They can also help each other if requires. It is the good opportunity between the same or different communities to improve their performance for community especially women and children.

6.6 CSG forum

National level CSG forum will be conducted to share the experience, lesson learnt, strengthen the network and update the guidelines when and if the situation is favourable. This forum has to report to nutrition cluster or IYCF TWG. A TOR for the National CSG Forum will be developed and members will be selected from the people of diverse capabilities and areas (national/international/CBOs/ CSOs/ UN/SUN CSA etc.)

6.7 Form Social Media Group

Interacting and communication among CSGs and communities through social media (e.g., viber group) when possible is another way to enhance motivation and knowledge of CSGs members. It also provides the opportunity to have real time information and appropriate/different solutions when facing the difficulties and improve the performance of CSG.

ACTION 7

Project has to provide necessary supports for functioning and sustaining of CSG and ensure that CSG has ability to stand independently in long term.

SUMMARY OF ACTIONS

1. UNICEF develops the advocacy messages, and it can be adapted as per local situation.

2. Project/ Responsible Person conduct advocacy meeting.

3. Community form CSG by themselves with one month after advocacy meeting.

4. Project staff visit to village and conduct meeting with CSG ensuring formation is as per set criteria and explain the roles and responsibilities of CSG. The staff discuss with CSG members and set the date for capacity building and prepare and conduct accordingly.

5. CSG and CBHWs implement all or selected interventions according to the needs.

6. The respective project staffs provide supportive supervision, support and observe the progress of CSG. They facilitate and serve as a technical advisor and not include in decision making. They have to ensure the establishment of effective community feedback and complaints mechanism.

7. Project has to provide necessary supports for functioning and sustaining of CSG and ensure that CSG has ability to stand independently in long term.

CHPATER 3
INTERVENTIONS

Community Support Group and Community Based Health Workers will implement all or selected interventions based on the needs of the respective community.

Brief roles and responsibilities of the CSG and CBHW in each intervention are already mentioned in SOG 2.

There are a lot of benefits of establishing functioning CSG. They are as follows.

Output

- Early treatment seeking
- Timely case finding and referral
- Increased compliance
- Minimized defaulting
- Lasting behaviour change and Create New Positive Social Norms

Outcome

- Improved Coverage
- Improved Treatment outcome
- Promoted better response to community needs and concerns
- Ensured greater sustainability, cost-effectiveness, accountability and equity

Impact

- Reduce under five children and maternal mortality and morbidity
- Reduce malnutrition
- Reach UHC and SDG goals

Intervention 1: Community Mobilization

1.1 What is community and community mobilization?

A community is a group of people who have something in common and will act together in their common interest. People can be part of a community in the place where they live, a place where they spend a lot of their time (such as school or work), or a religious group they belong to.

Community mobilization (CM) is a capacity-building process which enables community actors to plan, implement, monitor and evaluate activities in a participatory and sustained basis to improve health, nutrition and other needs, either through their own initiatives or stimulated by others.[1]

Community mobilization mean

- raising people's awareness on the importance of proper IYCF, mother's nutrition, acute and chronic malnutrition, and correct behaviour;
- encouraging community members to support women and families to feed their children in the best way; and
- helping women and caregivers to overcome common myths, beliefs, and practices that are dangerous for children.

Community mobilization is not

- not a campaign, nor a series of campaigns.
- not the same as social mobilization, advocacy, social marketing, participatory research, or non-formal or popular education.
- CM, however, often makes use of these strategies.

For example, community mobilization for CMAM aims to build the **capacity of community actors** and obtain their commitments to **support caretakers** of children with acute malnutrition access and use CMAM services, and **support community mobilization activities**, including the work of volunteers and outreach workers' activities.

Community mobilization is a combination of efforts to enhance awareness, encourage positive changes in health and nutrition related behaviour, and create a community that supports good health practices.

Correct information alone is not usually enough to lead a person to change his or her behaviour, but when combined with a **supportive environment**, it supports behaviour change. As a leader in your community, he/she can help share correct information and encourage and support people to feed their children well; in this way he/she can help prevent children from falling ill and help promote the health and development of your community.[14]

[14]Mobilizing community for improved nutrition; A guide for community leader. USAID, PATH, IYCN, July 2011.

1.2 Why community mobilization is important?

In recent years, the context of IMAM implementation has changed dramatically, from emergency and vertical programming into government– led programming or an "integrated" approach into the national health system. However, IMAM coverage and access remains low. A major factor contributing to this shortfall is the weakness of national health systems and nutrition programs to implement the community component of IMAM. Community mobilization is important as it engages local community figures and actors in supporting IMAM services in order to improve the impact and coverage of these services and contribute to their cost effectiveness, accountability, sustainability and equity.

Roles of CBHW are prominent and become critical in simplified IMAM programme and community case management of pneumonia and diarrhoea to improve the impact and coverage of services more cost effectively. In IMAM simplified approach, the roles of CBHW are critical where they are allowed to treat SAM without complications. Mother MUAC is also they key of community participation and ownership. CBHW also have the right to provide vitamin A supplementation. By these ways, the impact and coverage will be increased cost effectively.

1.3 Who needs to mobilize in the community

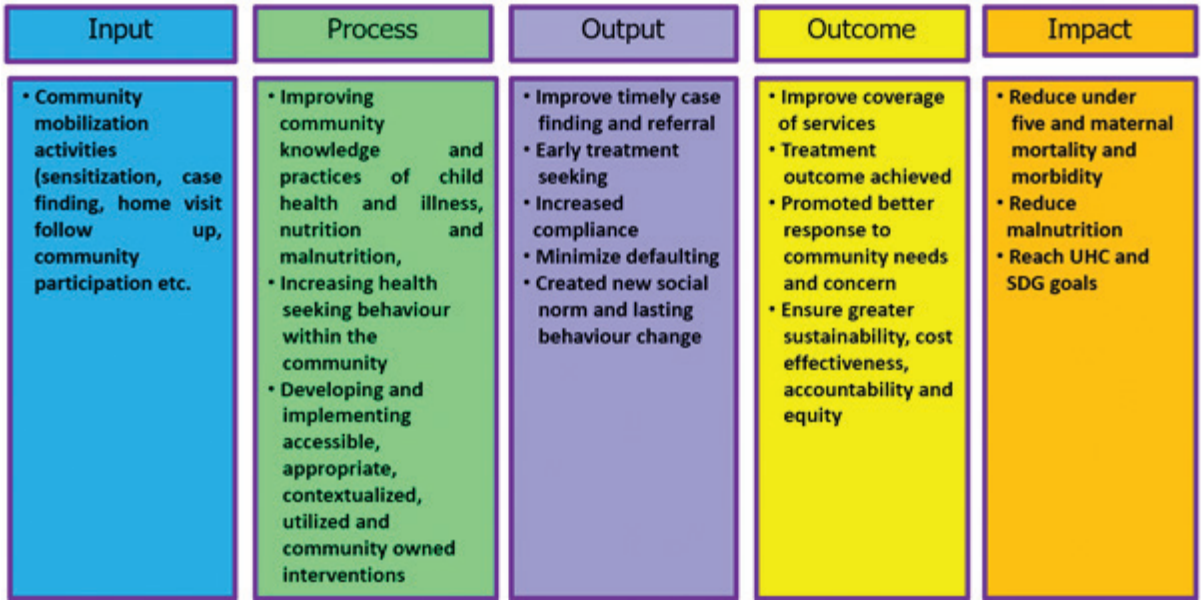
It is very important roles for **community support group** led by the person who have the most interaction and influence with the community along with caretakers (mothers, fathers, grandmothers, youth and others). The leader includes, but are not limited to:

- Political, religious and traditional leaders,
- Heath care providers (nurses, doctors, and midwives),
- Traditional healers and traditional birth attendants,
- Community health workers and volunteers,
- Community groups, local non-governmental organizations, and faith based organizations,
- Media professionals, and
- Teachers, agriculture extension workers, and social workers

As a leader in CSG, he/she have the opportunity to support good nutrition practices, help address and eliminate barriers to these good practices, and challenge inappropriate traditions.

1.4 Steps of community mobilization

Figure 4. Community Mobilization Project cycle modified from Nell Gray et. al.



With community mobilization, the role of the implementing agency shifts from a more traditional service provider to that of a facilitator. The implementing agency, such as a health facility facilitating community mobilization should guide communities through a step-by-step process.

Step 1: Community Assessment

The reasons for the community assessment are

- To understand the community knowledge, perceptions and behaviours in relation to childhood malnutrition and illnesses, and the health and nutrition services;
- To assess factors (barriers and boosters) that influence the community decision to access and use the health nutrition services;
- To explore community systems, structures, and actors, including existing networks of community volunteers which could potentially be used for community mobilization; and
- To develop a contextual community mobilization strategy and action plan.

Community assessment requires the collection of a large variety of qualitative information from community actors as follow. The CSG members have to collect this information.

(a) Identify the key actors in the community

- o Primary actors (people who have the most interaction and influence on community) such as village authority, traditional leader, basic health staff, government staff, traditional healer, religious leader,

- Local community based organizations such as social group, religious group, village health committee, parent teacher association, mother to mother support group, youth group, income generation group etc.
- CSG has to take the help from the most active and influent person and group for all process of implementation.

(b) Identify the formal and informal communication channels.

- The formal channel includes
  - Events in health facilities and schools
  - Events and community meetings organized and led by village leader
  - Markets
- The informal channel includes
  - Any places where the villages are getting together such as water fetching areas, festivals and commodity distribution areas

By knowing the exiting communication channels, the CSG can use it appropriately and effectively for the planned activities.

(c) Find out the health seeking behaviour

It is essential to find out the health seeking behaviour of the community to adjust, correct and reinforce their behaviour accordingly. It is also can help in the referral of the patient and programme on improvement health services providers.

(d) Find out the barriers and booster for the improvement of health and nutrition status of the community

By finding out and knowing the existing barriers, there will be solution which can be addressed by CSG and CBHWs. Traditional belief, health and nutrition knowledge, social economic status, food security, locally available food, and seasonally available food are the basic for these barriers.

The examples of barriers are

- lack of community knowledge and misinformation about the use and cost of services,
- lack of knowledge and misconceptions about causes and treatment of malnutrition and disease,
- sociocultural factors such as lack of support from husbands and families,
- caretaker is busy or sick,
- far distance to service points,
- poor quality and long waiting time for the services,

- stock shortages of nutrition products, and
- lack/poor community participation and outreach activities.

The examples of booster are

- community awareness about the signs and symptoms of severe acute malnutrition and that it is a treatable disease,
- community awareness about danger signs of PLW and children for referral,
- effective systems in place for referral,
- key community figures actively support the program,
- awareness that the services are available and free of charge,
- regular active case finding, counselling and micronutrient supplementation

(e) Find out barriers in accessibility of health and nutrition services

The barriers include

- physical barriers such as geographical terrain, flood, and environment factors
- social barriers such as reject by husband, culture, politics, religion, ethnic issues
- High cost
- Security and
- Poor services

Step 2: Developing Messages and IEC Materials

The standard message and materials are already developed. If needed, the respective CSG can adapt it as per community assessment.

Step 3: Sensitization

The sensitization plan has to develop in discussing with key community representatives. There are key components to include in the plan are

- Who will do it in when and where?
- What are the communication channels?
- Which materials are needed?
- What message will provide in which session?
- Who will be involved?

Step 4: Training for CBHWs

It is referred to SOG 3.

Step 5: Implementation of the community sensitization

The implementation of community sensitization is conducted as per the plan. In addition to this plan CBHWs/ project staff should conduct monthly health education sessions to all villagers. There will be one topic per each month. They will prioritize the topics based on the needs of the community and pattern and prevalence of the endemic diseases in the respective communities. The event can be alone or integrated with other events in the villages such as religious and traditional events. The examples of topics are as follows.

- Healthy Diet
- Food Group
- Wasting and stunting
- Vitamin A Deficiency, Iodine Deficiency, Iron Deficiency Anaemia, Infantile Beriberi
- Maternal nutrition
- Food safety
- Hygiene
- Dengue Fever
- Diarrhoea
- Acute Respiratory Tract Infection
- Seasonal Flu
- COVID-19
- Others

CSG has to organize and support the health education session and take necessary action for the unforeseen difficulties.

Intervention 2: IYCF counselling

CBHW/project staff will conduct the IYCF individual and group counselling (breastfeeding, complementary feeding, feeding for sick children, difficult in early initiation of breastfeeding etc.). They will also conduct "Action Orientated Group Discussion" and "IYCF supportive group discussion". IYCF counselling include maternal nutrition counselling and counselling of children from 2-5 years old children in latest modules.

The details are in volunteer training manual for cIYCF, IMAM and Active and Responsive Feeding with Care.

For the staff, it is referred to cIYCF counselling packages.

CSG members have to support in selecting and training of counsellors. They also have to arrange and support lactating mothers and or caregivers to meet with the counsellors and ask CBHW to find out the pregnant and lactating mothers and caregivers for counselling. They will also arrange "Action Orientated Group Discussion" and "IYCF supportive group discussion". CSG and CBHWs has to follow up the progress of caregivers' behaviour as per cIYCF protocol and take necessary action accordingly.

Under the supervision of CSG, the other group such as Mother to Mother Support Group can develop the IYCF key messages based on formative research to tailor the messages based on context and use of language specific IEC materials. They can so conduct cooking demonstration and home gardening.

Interventions 3: Active Case Finding and Prevention and Treatment of Acute Malnutrition

CHBWs or project staffs carry out active case finding (MUAC screening) for all under five children in the village monthly. They have to provide the MUAC training to caregivers for mother MUAC and monitor and supervise. The acute malnourished children will be treated in Outpatient Therapeutic Feeding Programme (OTP) and Supplementary Feeding Programme (SFP) by CBHWs or project staff. They will refer the severe acute malnourished children with complications to the nearest referral center. CSG has to support the referral of these patient and CBHWs has to monitor and follow up these patients such as discharge or referral to OTP/SFP etc.

In emergency duration, the IMAM programme was applied as per nutrition in emergency programming guidance during COVID-19 pandemic and other emergencies 2022. In this guidance package simplified approaches with risk reduction measures are emphasized.

The details are in volunteer training manual for cIYCF, IMAM and Active and Responsive Feeding with Care.

For the staff, it is referred to IMAM modules.

Intervention 4: Establish Referral System

For Low- and middle-income countries (LMICs) that introduce financial protection programmes and move towards UHC and careful management of the referral system can lead to improvements in the quality of care while controlling the costs of service delivery. They face challenges while moving towards universal health coverage (UHC). These include balancing an increasing demand for health services – resulting from the reduction in financial barriers to access – with maintaining the quality of care and controlling cost escalation.

4.1 Definition

A community referral system is a mechanism that enables a patient's health needs to be comprehensively managed using resources beyond those available at the location they access care from, be it in a community unit, dispensary, health centre or a higher level health facility.

The World Health Organization (WHO) defines referral as a process in which a health worker at one level of the health system connects with the same or a higher level that is better, or differently, resourced, either to provide assistance or to transfer the management of the patient to the higher level.

4.2 Process and Level

Referral is a two-way process. In principle, referral may occur from primary to secondary level for patients requiring a higher level of care and return referral from secondary to primary level where patients receive healthcare services more appropriate to their medical needs and where that provides the most appropriate use of resources. This two-way transfer is based on an understanding of patient-care pathways that acknowledge not only the role of the specialist but also the critical role of the primary health worker in coordinating patient care and giving time to the human dimension of care (Stefanini, 1994) over the longer term.

- **The first level** comprises of community health services, which lies at the foundation of the health service delivery system.
- **The second level** provides primary care services and forms the interface between the community and the rest of the health system.
- **The third level provides** primary care services but with additional services such as basic inpatient services, including deliveries and includes facilities such as nursing homes and maternity centers.
- **The fourth level** forms the first level of hospitals and provides both inpatient and outpatient services.
- **The fifth level** offers a broad spectrum of specialized curative services, and together with level four, forms the county referral hospitals. The final level comprises of tertiary level hospitals whose services are highly specialized.

Primary level referral: It is referral from community to PHC service in the health centers.

Secondary level referral: It is from primary to intermediate level of health care that includes diagnosis and treatment performed in a hospital or health center having specialized personnel, equipment, laboratory facilities and bed facilities.

Tertiary level referral: It is more specialized medical care for patients who are usually referred from secondary care centers. It includes subspecialty expertise in surgery and internal medicine, diagnostic modalities, therapeutic modalities for treating advanced and/or potentially fatal diseases (e.g., cancer). Very often, third (and/or fourth level) are linked with a university medical school.

Health care systems are often designed to encourage caretakers to seek care first at the primary level and then be referred, if necessary, to a higher level of care. If this reflects actual care seeking behavior, then health care costs for the caretaker will be minimized. In many countries, however, caretakers often bypass primary care facilities and seek care directly at referral care hospitals for illnesses that could be easily treated at the primary care facility. This can overburden the referral facility and is often costlier for the caretaker and the health care system.

4.3 Purpose

The purpose of a referral system is to provide the most effective treatment at minimal cost to both the patient and the health system. Generally, the referral occurs either

- as a result of the nature of the treatment required or
- from difficulties arising due to insufficient drugs, equipment or skills to manage the patient at the lower level.

4.4 Component of Effective Referral System (Criteria for successful referral system)

To have a successful referral system, the following criteria are essential.

(a) Present of **trained CBHWs** who can decide to refer the patient, (See with SOG 3)

(b) Present of **financial support** for referral,

The referral costs also affect the functioning of a referral system. This includes not only the costs of transportation, but also the costs of family members accompanying patients. In some cases, such costs may be subsidized through project, social health protection and insurance schemes. The cost will be supported by patient or CSG or both patient and CSG. It is also can be used from revolving fund if it is established.

(c) Ensure **timely** referral of the patient,

CSG have to arrange means of transportation with the guidelines set in the committee e.g., use of revolving fund guidelines.

(d) Refer to most **accessible referral points**,

Accessibility of provided referral services are critical. CSG and CBHWs have to have the list and qualities of referral centers.

(e) The present of **caretaker's acceptance and compliance** with a referral recommendation,

This is often determined by a variety of factors, including the perceived need of a referral (disease severity), caretaker/community experience with and impressions of the referral facility (quality). CSG and CBHWs has to convince to the patient to have confident and acceptance of referral services. CSG and CBHWs ensure that in the referral center, services must be affordable, and essential drugs, supplies, and equipment must be available.

Intervention 5: Support Nutrition Promotion Month Campaign and Other Nutrition Activities such as GMP, Micronutrient Supplementation and Deworming

There are many health and nutrition activities have been carrying out by health and nutrition staff from various sources. During conducting these activities CSG can support to completed all activities successfully and timely. For examples,

- CSG provide prior announcement before the vitamin A supplementation and de-worming campaign for children in February and August.
- During the days of event, it organizes and brings the children and PLW in the sites.

CSG can support and arrange

- vitamin A supplementation for lactating women,
- deworming for pregnant women,
- multi-micronutrient powder for under five children and
- micronutrient and vitamin B1 supplementation for pregnant and lactating women through the year.

CSG can also provide support the iodized salt testing in markets, retail shop and school, cooking demonstration and health education activities.

CBHW will conduct all these activities alone or with health and nutrition staff according to the situation of respective areas.

The details are in NIE programming Guidance 2021.

Intervention 6: Anti-Natal Care

Antenatal Care services will be done by AMWs and TBAs if there are no staff in the particular village. CSG will support the cases who need to refer to the nearest health facilities. In addition, CSG will conduct mobilization and organizing the BHS visits and managing cash transfer for pregnant mothers etc. CBHWs will perform collecting the data on PLW, abortion etc., reporting, communication with health centers and make sure all pregnant mother received ANC.

Antenatal care is essential for protecting the health of women and their unborn children. Women can learn from skilled health personnel about healthy behaviours during pregnancy, better understand warning signs during pregnancy and childbirth, and receive social, emotional and psychological support at this critical time in their lives.

By providing antenatal care services, pregnant women can also access micronutrient supplementation, treatment for hypertension to prevent eclampsia, as well as immunization against tetanus. Antenatal care can also provide HIV testing and medications to prevent mother-to-child transmission of HIV. In areas where malaria is endemic, health personnel can provide pregnant women with medications and insecticide-treated mosquito nets to help prevent this debilitating and sometimes deadly disease.

Receiving antenatal care at least eight times, which is recommended by WHO in 2021, increases the likelihood of receiving effective maternal health interventions during antenatal visits. The indicator for 'at least one visit' refers to visits with skilled health providers (doctor, nurse or midwife), 'four or more visits' refers to visits with any provider, since standardized global national-level household survey programmes do not collect provider data for each visit. In addition, standardization of the definition of skilled health personnel is sometimes difficult because of differences in training of health personnel in different countries.

Equity of access to and utilization of healthcare across socio-economic groups is important to achieve universal health coverage. Although the utilization of antenatal and delivery care has been increasing in low- and middle-income countries, inequities in the utilization of antenatal and delivery care have been reported in many countries.

The details are referred to the cIYCF modules and MNCH handbooks and National Guidelines for Antenatal Care for Service Providers

Intervention 7: Community Based Newborn Care

Community Based Newborn Care (CBNC) services will be done by AMWs and TBAs if there are no staff in the particular village. CSG will support the cases who need to refer to the nearest health facilities. In addition, CSG will conduct mobilization and organizing the BHS visits and managing cash transfer for lactating mothers etc. CBHWs will perform collecting the data on newborn care etc., reporting, and make sure all lactating mother received PNC and CBNC.

The first month of life is the most vulnerable period. Globally, deaths in the first month of life, which are mostly preventable, represent 47 per cent of total deaths among children under five in 2020.

In Myanmar, deaths in the neonatal period represent 48 per cent of children. The causes of death were prematurity (36 per cent) followed by birth asphyxia (26 per cent), neonatal jaundice (15 per cent) and sepsis (12 per cent) as per MOH, 2003 survey. The majority of neonatal deaths were due to preventable causes. Therefore, targeting the time around birth with proven high impact interventions and quality care for small and sick newborns may prevent close to 80 per cent of newborn deaths. Investment in care with targeted high impact interventions during pregnancy, childbirth and the first month of life is the best investment, with a quadruple return: saving mothers and newborns; preventing stillbirths; reducing disabilities; and paving the way for optimal child development and lifelong health and well-being.

As per UN IGME 2021 report, the under-five mortality rate (U5MR) for Myanmar is 44 per 1000 live births for 2020 (range from 29-64 per 1000 live births) with the annual rate of reduction (ARR) of 3.2 per cent from 1990 to 2020. As per UNICEF state of world children report, the infant mortality rate (IMR) fell from 76 per 1000 live births in 1990 to 37 in 2018. The neonatal mortality rate declined from 41 per 1000 live births in 1990 to 23 in 2012.

The details are referred to the MCH handbooks and Community Based Newborn Care Modules.

Intervention 8: Community Case Management of Pneumonia and Diarrhoea

CBHWs will conduct the community case management of ARI/pneumonia and diarrhoea and refer them if it is needed as per criteria. CSG will support the cases who need to refer to the nearest health facilities.

One or more villages or communities with difficult access to a health facility receive health care provided by volunteers who is trained and supervised by health care providers to handle common childhood illnesses specifically non-complicated pneumonia and diarrhoea without severe dehydration among under-five children (2-59 months).

1. Intervention package

The package for under-five children delivered by CBHW comprising following key components;

- Provision of treatment for non-complicated cases of pneumonia and diarrhoea
- Referral of cases with danger signs or cases with complications
- Communication for behavior change with special reference to home care and care seeking of a sick child

It would also be important for CCM volunteers to keep recording and reporting of the interventions delivered as per guideline.

2. Delivery of CCM package

CBHW primarily operate from their home. Regarding hours of operation, they do not work full-time. They have to attend their own business/professional activities but dedicate part of their time to CCM activities. It should then be discussed with the community to agree on the hours in which they can be contacted.

3. Medicines and Supplies Management

Medication management is one of the pillars that support CCM implementation since without them; health care becomes impossible at the community level.

- List of List of medicine and supplies for CBHW
  - Medicines
  - Paracetamol 500 mg/100 mg tablets (or) Pediatric oral solution 125 mg per 5 ml
  - Amoxicillin 250 mg tablets (or) Pediatric oral suspension 125 mg per 5 ml (or) 125 mg dispersible tablets
  - Cotrimoxazole 480 mg tablets (or) Pediatric oral suspension 240 mg per 5 ml
  - ORS (Oral Rehydration Salts) Low Osmolarity sachets
  - Zinc Sulphate 20 mg tablets
  - Supplies
  - Respiratory Timers

- Digital Thermometers
- Plastic Drug Box for easy carriage of medicine
- Plastic Bags for dispensing medicine
- Standard Patient register book (See Technical Supplement 1)
- Standard Patient treatment record form (See Technical Supplement 2)
- Standard Medicine stock record book (See Technical Supplement 3)
- Standard Monthly reports forms (See Technical Supplement 4)
- Information, Education, Communication (IEC) materials(See Technical Supplement 5)

Ensure CCM Volunteers learn how to fill out various management tools/supplies included on the list

- Support of medicines and supplies
  - Annual stock of medicines and supplies are made available at the project township level at the start of training sessions for the following reasons.
  - There is a long lead time for some supplies
  - There are supplies and equipment to which the CBHW should be familiar from their training session
  - There shouldn't be a gap between the end of the training session and the start of actual activities, otherwise the CBHW would lose the newly acquired knowledge and skills for taking care of sick children.
  - Generally, on a two monthly basis supplies are collected based on
  - The population of less than 5 years expected at the site
  - The number of episodes of illness per child per year (2.5 for diarrhea and 0.438 for pneumonia)
  - The utilization rate of health care at the CBHW estimated initially at approximately 50%
  - The total dose of tablets to be administered for each episode of illness.
  - Monthly consumption and minimum stock level for their responsible areas, the facilitators can demonstrate the necessary calculations during the training session. (Refer to CCM training)

It is strongly prohibited CBHW from treating children under two month old as they are very liable to change and need skilled care. They are also not trained to manage over five year old with ARI/pneumonia as well as adult.

Based on local situation (e.g. difficult geographical terrain, heavy rainy season interfering transportation) 4-5 months quota can be provided to avoid stock out with simplify drug dispensing and drug consumption recording. Provide stock of Amoxicillin and Co-trimoxazole in a ratio of 4: 1 where amoxicillin is the first choice in treating under-five with suspected pneumonia while co-trimoxazole will be used in children with increased respiratory rate with diarrhoea.

- Receipt and storage of medicines

Upon receipt of medication, CBHW has to

  - Count the amount of medication received
  - Check the expiry date and
  - Check the external appearance of each product (color, smell, shape ...)

Medications should be kept:

  - Clean and well maintained: regular sweeping and dusting of storage space and keep the medicines off the floor as well
  - Ventilated: the ted: room or the storage box must be ventilated so as not to expose the medicines to high temperatures and keep them away from direct sunlight
  - Dry: the storage place should be dry as moisture can affect product quality
  - Secure: Secure: the medicines Secure: box should always be locked to prevent losses…
  - Well-organized: i.e., a good medicines organization which makes them easier to find at the time of distribution.

- Physical inventory of medicines
  - CBHW will perform each month to ensure that the quantities recorded match those they have physically counted.
  - Expired medicines or the medicines affected or damaged must be delivered to supervisor and returned to project office for destruction. In such a rare event these medicines can be recorded as losses.
- Dispensing of medicines

When medication is given, it is important that the patient receives:

  - The appropriate medication with its name
  - The correct information on how to take the drug, i.e.: - The exact dosage of the medicine - How many times per day the drug is to be taken
    - The number of days of treatment
    - How to administer the drugs to sick child

    The detail are referred to CCM volunteer manual.

4. Training

The following three types of trainings are intended for the CCM implementation in cascade:

(a) Training of trainers (3 days)

(b) Training of supervisors (3 days)

(c) Training of CCM Volunteers (5 days)

(a) Training of trainers

- Trainers will facilitate training of supervisor and the CBHW in the selected townships. They are also responsible for advocacy and effective program management.
- Selection of Instructors to be trained as trainers
- Trainers are selected among government professionals and health care providers who have patients' health care in their basic training e.g., paediatricians, medical officers, nurses, health assistants etc.
- The following Myanmar specific training materials have been developed, field tested and evaluated for training of trainers in Myanmar.
    - Trainer's guide
    - Volunteer guide
    - Volunteer job-aids
    - Video
    - Instructions on the selection of villages and volunteers
    - Assessment tools for the Volunteer during the training session
    - Supervision tools and the data processing form for evaluating the quality of health care provided by volunteers.
- Conduct TOT
    - Train all potential trainers at central level and then they in turn will train staff in township level. The following events are described at the training session:
    - The training of trainers (TOT) schedule is enclosed in Technical Supplements 6

(b) Training of supervisors

- Supervisors are responsible for proving supportive supervision on regular basis to CCM Volunteers operating in their responsible areas using a standard checklist.
- Selection of supervisors
    - BHS, project staff,
- Training materials
    - CCM Volunteers' Handbill
    - CCM Volunteers' Guide
    - Vinyl sheet on management of common childhood illnesses
    - Photo Album
    - Video
    - Treatment record form
    - Patient register book
    - Drug stock book
    - Supervision check-list

- Instructions on the selection of villages and volunteer

- Conduct training for 3-day

(c) Training of CBHW

- The Role of CBHW

The Volunteers are responsible to deliver CCM package for under-five children comprising of following key components in their resident/assigned areas;

- Provision of treatment for non-complicated cases of pneumonia and diarrhoea without dehydration for the children aged 2-59 months
- Referral of cases with danger signs or cases with complications or less than 2 months old
- Communication for behavior change with special reference to home care of a sick child and recognizing danger signs for sick children
- Keep recording and reporting of the interventions

- Selection
  - Existing CHBW or person having health knowledge or experience
- Training materials
  - CCM Volunteers' Guide
  - CCM Volunteers' Handbill
  - Photo Album
  - Video
  - Treatment record form
  - Patient register book
  - Drug stock book
  - Monthly reports forms
  - Respiratory Timers
  - Digital Thermometers
  - Life-saving medicines (samples of each product used by CCM volunteers)
- Conduct training
  - Trainer : township training team or project staff
  - Duration : 5 days
  - Place : Zoom of face to face
  - Methods :
    - » Brief presentation
    - » Group work and discussion using handbill, vinyl, photos and video, and
    - » Individual exercise using treatment record form with the support of facilitators;

        - » Case examination and skills such as
- History taking,
- Looking for the danger signs,
- Taking the temperature,
- Counting the respiratory rate using respiratory timer,
- Checking the signs of dehydration and
- Checking the signs of severe pneumonia.
- CCM Volunteer' Guide (MOH)
    - o The subjects covered in the training of CCM Volunteer are
        - » Simple Case Management component,
        - » Danger signs and symptoms and make early referral of complicated/severe cases
        - » Medicine prescription
        - » Communication to mothers for adequate home care and recognizing danger signs for sick children
        - » Patient registration, record keeping and reporting (not included in CCM Volunteers' Guide)
- Training Evaluation and Follow up
    - o This is the knowledge and skill based training.
    - o Assess minimum levels of knowledge and skills are achieved on a daily basis. If those who have gaps are required to be given additional "tuition" on the specific areas.
    - o There is the final examination after 5 days. Low scores or mistakes in diagnosis and treatment are marked unsatisfactory and volunteers who fall in this category will receive an additional 2 days of intensive training followed by a repeat examination using different simulation exercises.

It is also critical to organize annual refresher training to update their knowledge and skill as well as to share experiences among themselves.

5. Supervision

The supervision of Volunteer, in the first place is the responsibility of the sub-rural and rural health center staff; midwife or project staff. Supervisor team are from township level and stat/region/central level.

5.1 Supervision Checklist

It covers five key areas as per the Tanahashi Model mentioned below in order to assess both quantitative and qualitative indicators.

1. The availability of life-saving medicines and supplies

2. The availability of trained providers
3. The utilization of the services of volunteers by community
4. The complete utilization of services by community through involvement in the strengthening of referral of severe cases and follow up visits to child treated
5. The quality of services including record review for diagnosis and treatment consistency and interview with a few mothers who have utilized the service to verify their knowledge about danger signs and home care.

5.2 Supervisors' Tasks

The key tasks during their routine visit are as follow.

- Review of all treatment record forms filled by the CCM Volunteer, with immediate individual feedback.
- Observe management of cases of illness by the CCM Volunteer and individual feedback. (Only in case a sick child is present)
- Review record and register filled by CCM Volunteer
- Check the availability of medicines, charts and other supplies at CCM Volunteers
- Verify medicine preservation conditions
- Build capacity of the CCM Volunteer in health care and medicines management
- Interview with some mothers who have utilized and who have not utilized the service for verification of their knowledge about danger signs and home care, and to get a sense of their awareness, perceived satisfaction and relevance of the services.
- If required meet village authority, village leaders etc) on the utilization of CCM Volunteer's service, ↔ visits to monitor children treated by CCM Volunteer and problems faced. ↔ Collect data/reports required for processing and analysis.

5.3 Frequency of supervision

- The RHC/Sub-RHC level staff or project staff must supervise the Volunteer once a month. At the beginning of the implementation at least for 3 months, it should be weekly to ensure adequate skills and to help with local problem solving. The frequency will be reduced gradually up to monthly as the volunteers build up their capacity.
- Supervision by the township level staff will be done on quarterly basis.
- Supervision by the central, state/region level will be on annual basis.

6. Recording and Reporting

6.1 Recording

(a) Patient Register and treatment record by using Patient Register Book and Treatment Record Form

(b) Medicine and supplies stock related by using Drug Stock Book

6.2 Compilation of data and Reporting

The data are picked up from the above records. It was compiled and prepared a monthly summary on patient treated and drug utilization at the end of each month will be done by CCM volunteers. RHC level supervisors/project staff will then compile monthly report collected from volunteers. RHC compiled report will be compiled to be township report and submitted to state/region/central level accordingly.

Data compilation and reporting needs to be undertaken by implementing partners with health system at various levels from village to central level on the lines of national Health Management Information System (HMIS). The suggested reporting format are in CCM guidelines.

6.3 Monitoring and Use of data

- The implementing partners could contribute valuable inputs to the monitoring process. Monitoring is primarily concerned with aspects of the programme and whereas supervision deals with performance of health volunteers including giving them support and assessing conditions in the health facility.
- Monitoring activities would help TMOs/ project staff to track progress and to identify and solve problems before they cause further delay in implementation. It is also important for to give feedback to staff involved on the findings of monitoring. The monitoring data needs to be summarized and indicators require to be calculated. Calculating indicators involves identifying the correct numerator and denominator, determining a current value for each from the data, and doing the mathematical calculation. When indicators are calculated, analyze the progress by making comparisons, such as
    - o For all indicators for which targets were set, compare the level of achievement for the indicator to the target.
    - o Compare levels of achievement to a past level, such as last month or last quarter, or last year.
    - o Determine trends over time.
    - o Compare the level of achievement to that in other facilities or areas.

Data from various reports both monitoring and supervision will be collated to draw conclusions on the objectives pursued by the implementation of community case management. Data will be also used to take evidence-based decision and fine-tuning day-to-day operation at grassroot level as well as to improve programmatic action at higher level.

Referred to CCM supervisor and volunteer guidelines.

Intervention 9: Water, Sanitation and Hygiene (WASH)

WASH activities such community led total sanitation, WASH in health facilities, WASH in schools and WASH in emergency are also very important for the prevention of some diseases and reduction of malnutrition. CSG will support these activities and CBHW will implement in collaboration with projects.

Growing up in a clean and safe environment is every child's right. Access to clean water, basic toilets, and good hygiene practices not only keeps children thriving, but also gives them a healthier start in life.

Despite COVID-19 putting the spotlight on the importance of hand hygiene to prevent the spread of disease, three billion people worldwide, including hundreds of millions of school-going children, do not have access to handwashing facilities with soap. People living in rural areas, urban slums, disaster-prone areas and low-income countries are the most vulnerable and the most affected.

As per UNICEF 2019, five million children in Myanmar live without sufficient water supplies at home, and 25 per cent of children (over 4 million) live in households that do not use improved toilet facilities.

In Myanmar, since work to improve WASH services began 20 years ago, around 82 per cent of households have access to at least basic drinking water, and 41 per cent are using a safely managed service. But nine million people—including three million children—still have no access to a basic drinking water service.

- Around one in four schools have a limited or no basic drinking water supply.
- Four in 10 schools have limited or no basic sanitation and hygiene facilities.[2]
- WASH provision is also a challenge at health facilities, adding to the risk of neonatal deaths.
- With a 20-litre bottle of water costing is soaring, the urban poor are finding clean drinking water increasingly hard to afford – households, especially in informal settlements can spend most of their monthly income on clean drinking water.

The details are referred to the WASH and Community Led Total Sanitation guidelines, Volunteer Training Manual for IYCF, IMAM and Active and Responsive Feeding with Care.

Intervention 10: Early Childhood Development

ECCD programme is one of the key vital programs for child survival, protection and development. By expanding the investment in ECCD services, the country will benefit from lower costs for health and nutrition care, welfare, and child protection services, and especially from a reduction of the high costs of educational inefficiencies, such as overage primary school entry, high levels of grade repetition and school drop-out, special and remedial education services, and low rates of timely school completion and progression to the next school level.

Culturally and linguistically appropriate ECCD services will enable all children across the country to succeed in school. As abundant research has demonstrated, the benefits will produce savings that will more than pay for the original investments that were made to develop, expand and improve ECCD services, and national economic productivity will be greatly increased.

Children with developmental delays, disabilities, atypical behaviours and chronic diseases are unable as yet to access individualised and intensive early childhood intervention services that they require to achieve their full potential. CSG can initiate and implement child friendly spaces and ECCD centres in public places.

ECCD vision of Myanmar

From birth to 8 years of age, all children of the Republic of the Union of Myanmar will receive holistic, high-quality and developmentally-appropriate care from their parents, caregivers and service providers to ensure they will be happy, healthy, well nourished, socially adept, emotionally balanced and well protected in conditions of freedom, equity and dignity in order to contribute positively to their families, communities and the nation.

The details are referred to volunteer training manual for cIYCF, IMAM and Active and Responsive Feeding with Care and MNCH handbook.

Intervention 11: Income Generation

Definition

Income Generation Activities (IGA)

- An activity which imparts vocational skills or provides capital or commodities that enhance the capacity of individuals or groups to generate income.

Microcredit

- The lending of small amounts of money to individuals or groups who would not normally qualify for loans from conventional financial institutions.

Microfinance

- A term encompassing the provision of a broad range of financial services, including microcredit loans as well as savings, insurance, and fund transfers, to those who traditionally lack access to banking and related services.

Vocational skills training

- Training or education to prepare for jobs or microenterprise based on manual or practical activities.

Introduction

Income generation activities attempt to address poverty, unemployment, and lack of economic opportunities to increase participants' ability to generate income and secure livelihoods. These activities can take a wide variety of forms as follows.

- **microcredit programs** that provide small loans to individuals or groups who would not normally qualify for loans from conventional financial institutions. Microcredit is one form of microfinance, which involves the provision of a wider range of financial services, such as access to savings, credit, and insurance to poor people.
- **business and vocational skills training** for participants, either for positions within existing industries or to develop small businesses of their own.
- **Both microcredit and vocational skills training** programs may include additional components not related to income generation, such as health education, women's empowerment, critical thinking, and communication skills. Many also have strong social support components.

One of the key activities is to assist women in the sustainable establishment of income generating activities. It should be undertaken in or near the home and concern activities where women can use skills they already possess. IGAs tend to give women a higher status within the family and studies generally indicates that the greater the amount of income under women's control the greater amount devoted to their children's education, health and nutrition.[15]

[15] https://www.fao.org/3/x0206e/x0206e03.htm

It should come from a bottom up approach. It is more appropriate to focus on planning, organizing and supporting IGAs than to give a list of activities. The Participatory Rural Appraisal (PRA) with women to identify problems, elaboration of a negotiated development programme and group promotion should be carried out using participatory methods. During the process, the following facts are to be avoided.

- spent no more than a few hours in the villages and several meetings were hold with only a few women who were not always representative of the community's women at village level,
- women were not aware of the objectives of the meeting,
- the presence of many official responsible (most of them male) at the meetings did not participate the discussions,
- only' a few villages were visited in the project areas.

Potential Income Generation Activities

Rural women have skills to do small-scale plant and agricultural and animal production, processing and preservation. Potentialities are various according to the specific conditions of the village. Marketing must be careful and considered before undertaking any of these rural enterprises since lack of marketing expertise is the major weakness of this kind of programme.

1. Home gardening

Women can carry out home gardening for production of vegetables, flowers, fruits, tree nurseries, aromatic and medicinal plants, herbs. Vegetables and medicinal plants should be linked with processing and packaging activities. Different groups of women could implement these activities according to their own interests and skills, one specialized in production, the other in processing and packaging.

2. Food drying, processing and preservation

In many rural households, women are seasonally involved with these activities. They preserve surplus production for household consumption and for marketing when the family needs more cash.

- dried fruit, vegetables and herbs
- processed fruit and vegetable (jams, pickles, vegetable pastes, fruit juices)
- packaging is probably important in attracting consumers for local products

3. Preparing and marketing of dairy products

Small-scale milk processing enterprises could be established in villages where there is a surplus of milk (yoghurt). The main needs are to mobilize women to produce hygienic products of consistent quality and to match their output to local markets.

4. Livestock and poultry raising

Project has to provide credit facilities and technical assistance. The animal health problem is also considered and managed.

5. Other activities related to agricultural and animal production
    - Mushroom cultivation
    - Silkworm breeding
    - Beekeeping
6. Handicraft
    - These are items made by artisans like
        - pottery,
        - handwoven blankets,
        - handmade jewellery and
        - quilts stitched by hand
        - Sewing, knitting and embroidering
        - Bamboo/wood make utensils
    - There is a gap between domestic handicrafts and those aiming at marketing, which needs business skills and of course entrepreneurship development will not be appropriate for all women. Handicrafts are IGAs but it is not easiest to came out the income.
    - Studies should be carried out to know the potentialities of marketing: contracts with public or private sector, direct sales to consumers etc.
    - It is recommended to set up of micro and small-scale enterprises, develop this activity at self-help groups level, the final objective being to establish a sustainable women's group which would be able to manage and run itself its own small enterprise.
7. Shopkeeper Activities
    - Grocery Store,
    - Fruits & Vegetables Vending Shop,
    - Electronics, Mobile and Accessories Store,
    - Fertilizers & Seeds Storage Store,
    - Clothing Store,
    - Pharmacy

Establishing and Running of Small Scale IGA[16]

There are four steps to establish and running the IGA in the rural areas as follow.

Step 1: Conducting the workshop
Step 2: Conducting the training and development of IGA
Step 3: Implementation of IGA within the community structure
Step 4: Monitoring and evaluation

Step 1. Conducting the workshop

The purpose is to provide individuals and communities with a set of tools to find out potential business activities, while considering crosscutting issues, such as the environment, gender relations and exposure to gender-based violence. Community workshop intended the participants should have an income generation activity in mind. TOTs, on the other hand, should focus on the process of sharing the methodology.

The IGA methodology encourages brainstorming, discussion and debate on the risks and benefits of potential IGAs. Issues should be addressed with respect for participants' comfort levels, and the degree of risk individuals are willing to take will depend on personal circumstances.

Participants may need to be introduced to the concepts of gender and gender mainstreaming. Some IGAs may be identified as highly profitable, they can increase an individual's risk of exposure to violence. The following are definitions summarize the most commonly applied terminology related to gender dynamics and gender-based violence.

Sex: Biological and physiological differences between women and men. Biological attributes are passed on from generation to generation – through sexual reproduction.

Gender: Gender does not refer to men and women. It is social differences between the two (masculine vs. feminine) including roles and responsibilities that are learned, and, although deeply rooted in a culture or society, are malleable and change with time. Differences can vary widely within and between communities, societies and cultures.

Gender dynamics: Socially defined relationships established between men and women within a community, or between societies, which define power relations based on gender-related social differences.

Gender discrimination: A form of social discrimination within society that emphasizes inequality based on gender relations. Every culture has social institutions (whether cultural, social, political, economic and/or religious) that perpetuate discrimination. Employment opportunities, for example, are generally not the same for women and men.

Gender-based violence (GBV): An umbrella term for any violent act carried out against a person's will that is a result of gender-based power inequities. It is an abuse of power, which involves force and/or threats and coercion may be physical, economic, sexual, physical, psychological, and/or socio-cultural nature. Most of the time, gender-based violence has a greater negative impact on women and girls. A woman's increased vul-

[16]USAID. Income Generation Activity Manual. 2007

nerability to violence due to her status within society, however men and boys can also be victims of GBV. Those carrying out gender-based violence may be strangers, family, community members, and/or those acting on behalf of socio-cultural or political institutions.

Sexual and gender-based violence: Violence involving men and women, whereby the female is usually the victim and the male the perpetrator.

Survivor: An individual who has experienced violence or other forms of abuse.

Perpetrator: A person who has committed violence or other forms of abuse against others.

Equality: Recognizing that individuals are different but not unequal. The biological differences between men and women do not reflect the superiority or inferiority of either sex. Men and women are human beings, equal but not identical. Therefore, they have the same right to life and well-being.

Equity: Treating men and women in a manner that takes into consideration the specificities of each sex. Maintaining equity may require the creation of more opportunities for traditionally marginalized and disadvantaged individuals or groups. The term equity does not exclude equality between men and women. Equity introduces the notion of entitlements or rights: to a job, education, access to health care, protection under a legal system, etc. In addition, the concept implies that both sexes share the same obligations and are capable of facing the same responsibilities.

Social division of labor: Gender analysis shows that division of labor is no longer based on sex, but on social factors that try to legitimize the division by portraying it as a result of biological differences. Specific tasks and needs are allocated to men and women based on socio-economic and cultural contexts. In most societies, due to gender discrimination that favours men, women carry out the least profitable activities, in particular domestic activities. Their contribution to the economy (often informal) does not receive proper recognition.

Access and control of resources: The social division of labor attributing subordinate roles to women reduces their access to resources and/or benefits derived from those resources. Frequently, women have the right to use a specific resource, but not assert control over the nature of its use. In other cases, they have access to resources, but only limited decision-making power, such as the use of agricultural land without control or ownership. Achievement of equal access to, and control of resources is one of the main objectives of gender mainstreaming. Power in decision-making processes will guarantee access to resources and their benefits.

(For detail refer to SGBV programme)

Preparing and conducting the Workshop (Refer to how to conduct community meeting)

- Duration: half day
- Workshop participants and facilitators should be selected based on program-specific requirements and representation by both men and women, and people living with disabilities and lesbian, gay, bisexual, and transgender (SGBT) plus, taking into consideration socio-cultural backgrounds.
- Use the local language. If facilitators do not speak the local language, close collaboration with interpreters will be required.

Step 2. Conducting the Training and Development of IGA

- Duration: 6 days
- Number of participants: 10 – 15
- All participants should receive an agenda outlining the tentative schedule and planned activities at the beginning of the workshop.
- Tools and templates will have to be adapted to accommodate local languages, dialects and knowledge.

Sample agendas

Day 1		
Time	**Topics**	**Facilitator**
09:00 – 09:30	Registration	
09:30 – 10:00	Self-Introduction	
10:00 – 10:30	Market Analysis: introduction (Handouts, market analysis checklist)	
10:30 – 11:30	Market Assessment Questionnaire exercise	
11:30 – 12:30	Group Work Case 1, Presentation and Discussion	
12:30 – 13:00	Lunch	
13:00 – 14:00	Group Work Case 2, Presentation and Discussion	
14:00 – 14:30	Market Analysis Conclusion	
14:30 – 15:00	Gender Analysis	
15:30 – 16:30	Group work on business plan, presentation and discussion	
16:30 – 17:00	Overall Discussion	

Day 2		
Time	**Topics**	**Facilitator**
09:00 – 09:30	Introduction of Cost/Benefit Analysis	
09:30 – 10:30	Introduction of the concepts and profit margin templates (Templates, flip charts, markers)	
10:30 – 11:30	Group Work Case 1, Presentation and Discussion	
11:30 – 12:30	Group Work Case 2, Presentation and Discussion	
12:30 – 13:30	Lunch	
13:30 – 14:30	Group work on business plan, presentation and discussion	
14:30 – 15:30	Wrap up	

Day 3		
Time	**Topics**	**Facilitator**
09:00 – 09:30	Introduction of Marketing (Handouts and checklist)	
09:30 – 10:00	Marketing skits	
10:00 – 11:00	Group Work on Marketing skit, presentation and discussion	
11:00 – 12:00	Group Work on case 1, presentation and discussion	
12:00 – 13:00	Group Work on case 2, Presentation and Discussion	
13:00 – 14:00	Lunch	
14:00 – 14:30	Introduction of Bookkeeping (Handouts, bookkeeping templates, flip charts, markers)	
14:30 – 15:30	Group Work on case 1, presentation and discussion	
15:30 – 16:30	Group Work on case 2, Presentation and Discussion	
16:30 – 17:00	Group work on business plan, presentation and discussion	
17:00 – 17:30	Wrap Up	

Day 4		
Time	**Topics**	**Facilitator**
09:00 – 10:00	Introduction of Market Niche (Handouts and checklist)	
10:00 – 11:00	Group Work on case 1, presentation and discussion	
11:00 – 12:00	Group Work on case 2, Presentation and Discussion	
12:00 – 12:30	Group Work on business plan	
12:30 – 13:30	Lunch	
13:30 – 14:30	Group Work on business plan continue	
14:30 – 16:00	Presentation on business plan	
16:00 – 16:30	Wrap Up	
16:30 – 17:00	Training Evaluation and Conclusion	

Participants are introduced to a **general business cycle** that is divided into five small steps:

(a) market analysis /assessment,

(b) cost / benefit analysis,

(c) production & marketing,

(d) basic bookkeeping, and

(e) strategies for continued success at the market (establishing a market niche).

The training package can be modified to meet the needs of illiterate participants. Literacy is not a prerequisite for carrying out successful income generation activities.

(a) Market Analysis

Market Analysis/Assessment

It is the process of collecting information about goods and services that may or may not be available at the market in order to determine how a business can participate in a profitable way and fill market gaps.

Before starting a business, it is essential to know about the quality and quantities of goods and services available on the market. In addition, understanding the buyers/potential consumers of goods and services is equally important, in order to fill market gaps. What would buyers like to see that isn't available? What can they afford? It helps determine whether a business will find sufficient demand for goods or services. There are two main components to a market assessment:

- Physically going to the market to observe what is bought and sold, discussing with the merchants.
- Talking to people who are likely to visit the market (potential buyers), which does not need to happen at the market itself.

Common Mistakes

» Assessing the market, but not talking to potential buyers.
  - (Talk to people on the streets and in their homes)

» Assessing only one market without visiting others.
  - (Go to as many markets as possible)

» Assessing only a limited number of social and/or age groups.
  - (Talk with both men and women, the elderly and youth)

The purpose is to develop a picture of whether/how a proposed business activity can fill existing gaps for particular goods or services at the market. To do so, preferences of potential buyers must be understood, together with their socio-economic and cultural status and the needs of men and women. In addition, it should also focus on the socio-cultural and environmental impact of an activity.

- Is the activity culturally appropriate?
- Will significant risks to personal health and security arise, and if so, how can they be minimized?
- What tensions might be generated within a community? Between men and women?
- How is the environment affected?

The facilitator has to ask participants to identify IGAs that carry a negative socio-cultural or environmental impact.

- What are the risks involved in these activities?
- Do they increase chances of being exposed to violence?
- What alternatives exist?
- How do risks vary between conflict and post-conflict settings?

Market assessments last for months conducted by many people or few days involve one person talking to ten potential buyers and visiting three markets. The following formula can help these efforts.

Figure 5: Formula for market assessment

WHO?
- Customers
- Buyers
- Producers
- Clients
- Suppliers

WHAT?
- Products
- Goods
- Materials
- Services

WHEN?
- Daily
- Weekly
- Monthly
- Annually
- Seasonally

(local, city or international)

WHERE?
- Fairs
- Shops
- Supermarkets
- Markets
- On demand

HOW MUCH?
- Competition
- Availability
- Quantity
- Demand
- Quality

Informal Market Assessment

1. Facilitators explain that you are going to conduct a market assessment to understand what kind of business has potential for success in the area. The facilitators are planning on opening a small shop across the street from the training venue and expect participants to make up the majority of potential buyers so that the participants are interviewees. If participants are homogenous, fictional identity cards should be distributed at the beginning of the exercise. Identities should rep-

resent a broad spectrum of individuals from diverse socio-economic and cultural backgrounds.

2. Ask the interviewees a series of questions and write down results. Avoid asking more than 15 total. The following questions can be used or adapted.
   (1) How many interviewees are male / female?
   (2) How many interviewees are between 20 and 35 years old?
   (3) How many interviewees are between 36 and 45 years old?
   (4) How many interviewees are between 46 and 60 years old?
   (5) How many interviewees are married?
   (6) How many interviewees have fewer than 3 children?
   (7) How many interviewees have 4 or more children?
   (8) How many interviewees are from the area?
   (9) How many interviewees are employed and receive regular financial incentives?
   (10) The household monthly income of how many interviewees is below 200,000 MMK?
   (11) The household monthly income of how many interviewees is between 200,000 and 500,000 MMK?
   (12) The household monthly income of how many interviewees is above 500,000 MMK?
   (13) How many interviewees live together with more than 5 other family members?

3. After information has been collected, analyze it.

The following example shows how information collected from 39 participants was analyzed based on answers the set of questions above.

Sample Results:

1. 13 participants were male and 26 were female.
2. 31 participants were 20 – 35 years old.
3. Six participants were 36 – 45 years old.
4. Two participants were 46 – 60 years old.
5. Seven participants were married.

6. Five participants had fewer than three children.
7. Six participants had 4 - 5 children.
8. 18 participants lived in this village and 18 came from other places.
9. All participants were employed.
10. Monthly HH income of 21 participants did not exceed 200,000 MMK.
11. Monthly HH income of four participants was between 200,000 and 500,000 MMK.
12. Monthly HH income of five participants was above 500,000 MKK.
13. 10 participants lived together with more than five family members.

Sample Analysis:

- Based on **age**, the store should carry many goods targeting **young people**, such as trendy watch belts for men and inexpensive handbags or purses for women. It should possibly carry some makeup and perfume to attract the female participants.
- It should also carry sweets for **the children** in case family members (sisters, aunts, etc.) want to buy treats on their way home.
- Since half the participants came from **outside of the village**, the store should carry something very special and distinctive to village, which can then be taken away as a souvenir.
- Based on the household **income**, the store should focus primarily on cheaper goods that will be affordable for the majority of participants.
- The store should also carry some basic stationery so that participants who have lost or forgotten their notebooks and pens could easily pick up the necessary items.

> The analysis should identify gaps in the market. If so, this is a good opportunity to emphasize the importance of understanding preferences of potential buyers to fill market gaps. However, preferences do not reveal whether people are actually able, based on their household income, to purchase the goods or services of which they are in need.

Market Assessment Checklist

The following checklist can be used as a guide to asking the most relevant questions.

(1) The Market (Physical Place)

- What types of goods / services are available at the market?

- What is not available, but has potential demand (i.e. something people are willing and able to buy)?
- Who are the current consumers/buyers of goods and services at the market?
- What are the prices and what influences them (seasons, geographical location, availability, security, environment, etc.)?

(2) Potential Market (Demand)

- Who (if any) are the potential consumers/buyers of the goods or services to be made available?
- What are the individual, social and cultural preferences of current and potential buyers?
- Are the needs of men and women similar?
- Are these preferences currently satisfied at the markets? If not, how can you satisfy demand in the most effective/efficient way?

Case Study

It is important to encourage discussion on the impact a certain business activity may have on an individual/family/community and the environment.

- Will sensitive sociocultural practices influence success?
- Is the activity traditionally limited either to men or women?
- Might the activity place certain groups in danger's way?
- How can risks be minimized?

Divide participants into small groups and distribute the first case study. Move between groups and address issues that may not have been fully understood. Discuss findings together with all participants. Next, distribute the remaining case. It takes one hour to complete it. Cases should then be presented on a flipchart or whiteboard, followed by discussion.

Case Study 1: Leather Crafts

A group of 25 women in IDP Camp want to start a leather business in A town. (Wallets, belts, bags, etc.). They are not registered officially as a group. Some of the women have experience in handicrafts (baskets, mats, etc.), but none have ever worked with leather. Most of the women are illiterate. It is their intention to sell the final products at (A) market.

- Advise these women how to carry out a market assessment.
- What larger issues should be taken into consideration for this particular project, be it socio-cultural, rapports between men and women, environmental, etc.?

Case Study 2: Brick Making

A group of 10 IDPs and host community members (five men and five women) want to start a business making bricks in (B) town.

- Advise this group how to carry out a market assessment.

- What larger issues should be taken into consideration for this particular project, be it socio-cultural, rapports between men and women, environmental, etc.?

Case Review and Conclusions

There are no right or wrong answers to these case studies. Business activities have to respond to market fluctuations, which are influenced by the socio-political environment and economic status of buyers. People move, household income changes, the environment changes, and competitors come and go. A good idea today may not be a good idea next month. In case reviews, only focus on how carefully the market assessment was conducted. The quality of this process should be emphasized in discussions. Facilitators should refer back to the market assessment checklist during each presentation.

- Did participants remember to visit more than one market?
- What questions did they ask?
- Who asked the questions?
- Which questions were missing?
- Who did they talk to?
- Would it have been better to talk to other people?
- Did participants identify potential risks that activities may pose to personal security, family/community relations, or the environment?
- Did they consider the roles that men and women play in the community?
- Furthermore, did they propose ways to minimize these risks?

Reassure that their market assessments will be successful, if they keep a few things in mind (F,O,S) as follow.

Flexible: People change, Markets change, Environment change,

Ongoing: Assess markets on a regular basis,

Simple: Do not need extra forms, do not have to be literate and talking to people is all you need to do,

(b) Cost Benefit Analysis

Cost Benefit Analysis

It is the process of quantifying anticipated costs, revenues, and profits involved in a particular business activity in order to determine whether that activity will generate profit or loss.

Profit is the central goal of any business activity. Without carefully studying the cost and revenue of an activity, it is difficult to know whether that activity will generate profit. A bakery in one town may be profitable, but this does not mean that bakeries will necessarily be suc-

cessful in every other town. Once a market assessment has been conducted, and a favourable activity identified, a cost/benefit analysis can help determine whether it makes sense to start an IGA from a financial viewpoint. A cost/benefit analysis also gives a good indication how much capital will be required to do so.

- Cost: Money spent on raw materials, labor, and additional items.
- Revenue: Money received.
- Profit: Money received minus money spent.

Profit Margin Template

The profit margin template follows three steps as follow. Always take into consideration the permits, necessary authorization, taxes or duties that may need to be obtained for a given IGA.

Cost

Raw Materials				
Sr	**Items**	**Unit Cost**	**Quantity**	**Total**
1				
2				
3				
4				
5				
	Total cost for raw materials			
Labour				
1	Wage for production			
2	Wage for sale			
3	Wage for others			
	Total labour cost			
Additional Cost				
1	Transportation			
2	Other Cost			
3	Taxes			
	Total additional cost			
	Total Cost			

Revenue

Sr	Items	Unit Price	Quantity	Total
1				
2				
3				
	Total Revenue			

Profit

1	Revenue	
2	Cost	
3	Profit	

Case Studies

- Prepare as per instruction from market analysis.
- Participants are expected to come up with market prices for the final products, costs for transportation and taxes, etc.

- Figures used below were only serve to guide facilitators through the template.

Case Study 1: Leather Crafts

Your women's group has conducted a market assessment and established a network of suppliers for raw materials and other needs (vocational training, equipment, etc.). The production process is set up and you have identified 3 shops at A market willing to accept your products. Each goatskin costs 50,000 – 60,000 MMK. Out of each skin, the group can make 2 bags, 3 wallets and 4 belts. Is it a profitable business? There are 25 women working on production during one business cycle.

Case Review and Conclusions

Cost

Raw Materials				
Sr	**Items**	**Unit Cost**	**Quantity**	**Total**
1	Goat Skin	50,000	5	250,000
2	Thread	5,000	25	125,000
3	Needles	2,500	50	125,000
4	Buckles	10,000	20	200,000
5	Leather Punch	20,000	10	200,000
	Total cost for raw materials			900,000
Labour				
1	Wage for production			
	Leather bag	50,000	10	500,000
	Wallet	20,000	15	300,000
	Belt	30,000	10	300,000
2	Wage for sale			
3	Wage for others			
	Total labour cost			1,100,000
Additional Cost				
1	Transportation	5,000	10	500,000
2	Other Unexpected Cost			50,000
3	Taxes			
	Total additional cost			150,000
	Total Cost			**2,200,000**

Revenue

Sr	Items	Unit Price	Quantity	Total
1	bag	200,000	10	1,500,000
2	Wallet	60,000	15	900,000
3	Belt	70,000	10	700,000
	Total Revenue			**3,100,000**

Profit

1	Revenue	3,100,000
2	Cost	2,200,000
3	Profit	900,000

Analysis – The business is profitable

Case Study 2 – Brick Making

You have conducted a market assessment for brick making. Given that many returnees have to reinforce their houses, a need and market exist for this income generation activity. You have identified a piece of land where you can produce bricks and made all necessary arrangements with the landowner. Your group is ready to start production. Cost of renting land: 300,000 per month, Water: Free, Firewood: 150,000 per bullock cart, Grass: 300,000 per bullock cart Other? Is it a profitable business? There are 10 people working on production during one business cycle.

Cost

Raw Materials				
Sr	**Items**	**Unit Cost**	**Quantity**	**Total**
1	Firewood	150,000	5	750,000
2	Cow dung	30,000	5	150,000
3	Metal frame	20,000	10	200,000
	Total cost for raw materials			1,100,000
Labour				
1	Wage for production			
	Brick	4,000	1,000	4,000,000
2	Wage for sale			
3	Wage for others			
	Total labour cost			4,000,000
Additional Cost				
1	Transportation	25,000	2	50,000
2	Land lease	300,000	1	300,000
3	Taxes			
	Total additional cost			350,000
	Total Cost			**5,450,000**

Revenue

Sr	Items	Unit Price	Quantity	Total
1	Brick	6,000	1,000	6,000,000
	Total Revenue			**6,000,000**

Profit

1	Revenue	6,000,000
2	Cost	5,450,000
3	Profit	550,000

Analysis – The business is profitable

In concluding, a cost/benefit analysis assumes 100% of the products were sold at a set price. In reality, this is rare. The real profit margins depend on more than planning. They will be influenced by fluctuating sales prices and the number of goods sold – factors affected by the behavior of competitors and buyers. Even if determined profitable, an activity may be socially unacceptable and/or increase the risk of exposure to violence.

(c) Production and Marketing

Successful production needs adequate technical training and skills for quality, and sufficient equipment. The risks involved in production such as occupational health, personal safety or the environment should be considered as well. Facilitators can open a brief discussion on production, but it is not part of the training, per se. It will be link with vocational training programme.

Marketing

It is ways of presenting and promoting goods or services that help increase sales at the market.

Success in selling goods or services depend on a number of factors in addition to the quantity and quality produced. Marketing techniques include the manner in which goods are displayed or packaged, the location where they are sold/offered, and how a seller interacts with customers.

Marketing Tips:

- Target various age and socio-economic groups.
- Take into consideration women and men needs.
- Explore new locations and market venues.
- Pay careful attention to presentation and packaging.
- Provide high quality customer service; be available to serve the customer with a smile.
- Include additional goods & services that increase convenience for customers. Example: sell baskets for transportation in addition to the main products being sold.

Role Play

Make visual demonstrations of good and bad marketing by role-play exercises. Facilitators lead the exercises with assistance from volunteer participants. The key here is improvisation. The skits lasting just a few minutes and do not require extra props. Skits should encourage movement and laughter. The participants work in small groups to develop and present their own skits, so they become familiar with the process of facilitating role-play exercises.

Skit 1: Marketing Soft Drinks

- Two stands are selling soft drinks – one on each side of the road. A potential buyer has approached the first stand and is interested in buying a drink.
- At stand A

- The seller is seated behind the table, talking on the phone with a friend.
- Soft drinks are scattered across the table, and some have fallen to the ground.
- So much dust has collected on the containers that it's difficult to see whether bottles contain Fanta, Coca-Cola, or water
- When the potential buyer asks about the price and types of drinks available, the seller looks angry. However, she stops talking on the phone long enough to say: 500 MMK.
- Out of the corner of his eye, the potential buyer sees another stand across the street. Unimpressed by stand A, he crosses the road, hoping to have better luck there.

- At stand B
  - The seller immediately stands up from behind the table to greet the buyer.
  - She introduces the drinks (nicely arranged by type and size), apologizing that she doesn't have Coca-Cola, but that all drinks cost 510 MMK. When the buyer asks for a discount, she smiles and says that's not possible, but offers him a drink that is cold and a seat in the shade. The buyer happily accepts.

Skit 2: Marketing Tomatoes

- Two stands at the market are selling vegetables next to one another. A potential buyer has approached the first stand, looking for tomatoes.
- At stand A
  - Vegetables are not sorted: eggplant, cucumbers and tomatoes are mixed on the table.
  - The seller is busy weaving a basket and doesn't look up when the customer pauses in front of her stand.
  - When the potential buyer points out that some tomatoes are no longer good, and asks about the price, she replies - everything is 1,000 MMK/Viss. The buyer moves on to the stand next door.
- At stand B
  - The seller is weaving a basket but looks up to greet the customer with a smile and ask what she is looking for.
  - Vegetables are neatly arranged. There is one pile of perfect tomatoes and another with slightly damaged ones. The seller quickly apologizes for the quality of some tomatoes, which were damaged during transport, and offers a 50% discount on the damaged ones if the customer takes the same amount of good tomatoes at 1,000 MMK/Viss. When the potential buyer asks whether there would be a way to transport a large amount of tomatoes, the seller smiles and offers one of her recently woven baskets for free, if the customer takes at least 5 viss of tomatoes.

Case Studies

Each team receives the same case study and is given approximately 15 minutes to discuss marketing techniques for the specific scenario. Next, distribute the next case for discussion in small groups. Cases should then be presented on a flipchart or whiteboard, followed by discussion.

1: Leather Crafts

Your women's group produced 10 leather bags, 20 wallets and 10 belts in one week. How are you going to market these items? If you sell them directly, how will you display and store the products?

2: Brick Making

Your group has managed to produce 500 bricks in one week. How will you sell them, especially during the raining season?

Case Review and Conclusion

There are no set answers to these case studies. Important is that participants pay attention to details. For example,

- products should be stored in an orderly manner, in a clean, dry place.
- When on display, a selection of different samples should be neatly arranged so buyers can see the options available.
- Social specificities and needs of different groups (both men and women) should also be considered.
- Participants should be encouraged to consider alternative strategies for the cases. If a group decides to build a small shelter from local materials to keep bricks dry, discussion might follow regarding other options that could have been chosen. For example, rather than incurring costs for shelter, the price of bricks could be dropped, or they could be sold at another location.

Common Mistakes

- Trying to market inappropriate items to various socio-economic groups.
- Forgetting the degree to which marketing techniques can affect sales

At the end of session, draw participants' attention back to the importance of quality. Only with quality goods and services, which satisfy customers, can marketing strategies be successful.

(d) Bookkeeping

Bookkeeping:

It is a way to record and keep track of expenses and revenues.

Bookkeeping includes

1. How much has been spent.
2. How much has been sold.
3. How much has been earned.

Common Mistakes are not considering all labor costs involved and time spent on transportation and sales. All transactions need to be registered as accurately as possible, including dates, type, monetary value, and its effect on the balance.

Cost/benefit analysis is a tool for planning – an educated guess of anticipated costs and revenues (including the risks involved), which helps decide whether to engage in a certain business activity.

Bookkeeping is the process of registering income which recording all transactions in a simple and accurate way.

Basic Bookkeeping Template

Date	Transection	Money In	Money Out	Balance
Week 1				Register Initial Balance
Week 1 total				Register final balance for the week
Week 2				Register the balance of week 1
Week 2 total				Register final balance for the week
Week 3				Register the balance of week
Week 3 total				Register final balance for the week
Week 4				Register the balance of week 1
Week 4 total				Register final balance for the week
Monthly Balance				**Register total balance of the month**

- Number of cells have to modified as per needs.
- Balance = (Total) Money Received – (Total) Money Spent
- Monthly Balance = Balance (Week I) + Balance (Week II) + Balance (Week IIII) + Balance (Week IV)
- Balance from each month is transferred to the next month on line 1 as “Money In”.

Case Studies

1: Carpentry in A Camp

- A group of 5 carpenters is currently producing chairs, beds, tables and benches to be sold inside the camp.
- Cost
  - Each board of wood costs 30,000 MMK
  - The group already had most tools, but needed to buy some additional tools during this month (total cost = 300,000 MMK)
  - They spent 200,000 SDD on basic materials (glue, nails, etc.)
  - The selling price of a chair is 70,000 MMK
  - The selling price of a table is 250,000 MMK
  - The selling price of a bench is 100,000 MMK
  - The selling price of a bed is 350,000 MMK
- During July
  - 50 boards of wood were purchased
  - 30 chairs were sold
  - 5 tables were sold
  - 7 benches were sold
  - 3 beds were sold

Please complete the bookkeeping template, using the information above and any other information that may be required but is not provided.

2: Pottery

- A group of 10 women in A town started a pottery business. They had the skills needed for the business. With income generated from sales, they managed to pay for machinery and assume responsibility for all aspects of the business, from purchasing raw materials to selling the products.
- Cost
  - Each wheelbarrow has 50 kg of clay soil and costs 750,000 SDD
  - Water is free
  - All 10 women participate in the production process

- Only five women sell pots at the market
- Each pot is sold for 50000 MMK at the market
- From each wheelbarrow of clay soil, they can produce around 150 pots

- During July
  - One wheelbarrow of clay soil was purchased
  - 125 pots were sold

Please complete the bookkeeping template, using the information above and any other information that may be required but is not provided.

Case Review and Conclusions

Date	Transection	Money In	Money Out	Balance
Week 1				Register Initial Balance
02/07/2022	Wood Boards		50x30,000= 1,500,000	- 1,500,000
04/07/2022	Glue, Nail etc.		200,000	- 1,700,000
05/07/2022	Tools		300,000	- 20,000,000
Week 1 total				- 20,000,000
Week 2				- 2,000,000
07/07/2022	Sale of chairs	30x70,000 = 2,100,000		100,000
11/07/2022	Sale of tables	5x250,000 = 1,250,000		1,350,000
Week 2 total				1,350,000
Week 3				1,350,000
19/07/2022	Sales of benches	7x100,000 = 700,000		2,050,000
Week 3 total				Register final balance for the week
Week 4				2,050,000
21/07/2022	Sale of beds	3x350,000= 1,050,000		3,100,000
Week 4 total				3,100,000
Monthly Balance				**3,100,000**

Outcome: The group's balance at the end of July is 3,100,000 MMK. It is successful.

Note: Instructions for the case do not include labor and transportation costs. If groups come up with these costs on their own, they should be praised. Otherwise, it is important to point out that the profit of 3,100,000 MMK does reflect revenue. Labor and transportation costs should be deducted in order to assess the actual profit.

Date	Transection	MoneyIn	MoneyOut	Balance
Week 1				Register Initial Balance
02/07/2022	Clay		750,000	- 750,000
04/07/2022	Firewood		1,000,000	- 1,750,000
Week 1 total				- 1,750,000
Week 2				- 1,750,000
07/07/2022	Sale of 50 pots	350x 50,000 = 2,500,000		750,000
Week 2 total				750,000
Week 3				750,000
19/07/2022	Sales of 75 pots	75x50,000 = 3,750,000		4,500,000
Week 3 total				4,500,000
Week 4 total				4,500,000
Monthly Balance				4,500,000

Outcome: The group's balance at the end of July is 4,500,000 MMK. It can be considered successful.

Note: If groups come up with additional costs (transportation, extra labor costs), they should be praised. Otherwise, it is important to point out that the figure of 4,500,000 MMK does not reflect the group's actual profits.

In ending this section, participants should be reminded to register all expenditures and income after each transaction, update the balance daily, and verify the balance on a weekly/monthly basis.

(e) Market Niche

Market Niche:

It is a condition (or set of conditions) that allows a producer/seller and their competitors to continue making enough profit to justify costs.

There are factors or conditions that need to be paid attention to once a business is up and running, in order to assure having continued profit.

Market assessment is an activity. Market niche is a condition.

Maintaining a market niche requires regular market assessments. Because the market is constantly changing, especially in conflict and post-conflict affected areas, including the cost, availability and demand for particular goods or services, an IGA is always at risk of becoming redundant. Finding and maintaining a niche in the market requires continuous monitoring of changes that may:

(1) threaten a business activity or

(2) allow for increase in profits by introducing new products or services.

There are many ways to establish and maintain a market niche, but solutions to individual situations must be identified on a case-by-case basis. Some strategies are introduced below:

(a) Identify new products that are not available on the market, which a sufficient number of people would be willing and able to buy

Example: The people in A IDP Camp were using plastic bags to collect their garbage and transport fruits and vegetables. Palm leaves were available but were only used to produce mats and tightly woven baskets. One day, women realized they could produce loosely woven baskets (as was traditionally done in the countryside, but not in A camp), and market them for garbage collection and transport. They introduced the baskets with success.

Ask participants to share ideas and experiences. Are there similar success stories from local markets? Which products might help establish a market niche?

(b) Change the business activity to respond flexibly to market supply & demand

Example: A well-established baker in town discovered that sales had started dropping, not long after a new bakery opened in town. He visited the new bakery and discovered significantly higher prices, but also a much better selection. The baker decided to start experimenting with new types of bread as well. He kept general prices the same, selling only specialty items at a higher price. Sales began to increase again.

(c) Lower prices

Example: A brick maker discovered that he had a surplus of bricks just before the rains were to start. He calculated that dropping the sales price and selling bricks quickly would be more profitable than investing in material to keep them dry.

(d) Reduce production costs

Lower labor costs: Labor can either be paid based on unit, total output or time. Calculations should always be made in advance to see which option makes more sense, depending on contribution and output required.

Example: Women are being paid to weave grass mats. Labor costs should be compared for the following methods of payment:

(1) weaving one grass mat,

(2) weaving 30 grass mats, regardless of the time it takes and

(3) one hour of weaving grass mats, regardless of the number of units.

As a rule:

- Production of items requiring high technical skills (e.g., crafts, clothing, etc.) should be paid per unit.
- Delivery of a certain amount of work requiring a flexible amount of time (e.g., construction of a building) should be paid based on the total output.
- Providing services that are used occasionally (e.g., vaccination of animals) should be reimbursed based on time.

Purchase goods wholesale rather than retail:

Cost estimates for materials vary depending on the quantities being purchased.

Example: A baker is purchasing individual, 500 gram bags of flour from the supermarket next door. With time, he discovers that the price of flour can be reduced by 40% if he buys as least 100 kg in bulk.

(e) Change markets / target other customers.

Example: She grows and sells tomatoes and finds herself with a surplus at the end of the season. There are so many tomatoes, that they can never be sold before rotting. After some consideration, she decides to produce sun-dried tomatoes to sell once the season has ended.

Market Niche Checklist

1. What types of goods or services do you currently offer?
2. What is the level of current demand?
3. How many other people are offering the same goods/services at the same market?
4. How does this influence your position at the market?
5. What is the quality of the goods/services you offer in relation to those of your competitors?
6. What is the price of the goods/services you offer in relation to those of your competitors?
7. How can you diversify the types of goods/services offered, in order to attract more clients and/or generate more profit?
8. How can you successfully cooperate with other businesses to offer goods/services that are currently not available?
9. What other factors should be considered (acceptance, (in)security, mobility, gender dynamics, etc.)?

Case Studies

Divide the participants into small groups, distributing the first case study. Move between them to monitor whether the concept of market niche has been understood and address any remaining questions. Discuss findings with the participants. Next, distribute the remaining case and have participants return once more to small groups for 20-30 minutes. Afterwards, every team should present its findings on a flipchart or whiteboard, followed by discussion.

1: IDP Camp

Ma Ni lives with her children in A IDP Camp and recently became a widow. Before her husband died, she was assisting him in his tailoring business. She now has the option of taking over the business or joining other women in the collection and sale of firewood. Which market niche strategy would you recommend to her and why?

2: Urban Area

While visiting relatives in A town, Ma Ei saw nice leather handbags, engraved with palm leaves. She learned that the bags are produced at an INGO women's center in B Camp and sell quite well in A town. Upon returning home, she decides to produce the same bags as an income generation activity. She contacts 4 other women to join her in the business venture. What market niche strategy has Ma Ei used?

Case Review and Conclusions

There are no solutions to the case studies, as such. By now, participants should be able to explain the purpose behind each step of a business cycle. During group presentations, facilitators can pose the following questions to help tie the concepts together:

- Would a market assessment need to be carried out first? Why / why not?
- Would a cost/benefit analysis need to be carried out? Why / why not?
- Are the technical skills for production in place?
- What market techniques might maximize chances for success?
- Might a niche be found in the market? Why / why not?

Facilitators should also foster discussion on issues related to the socio-cultural / environmental impact of an activity. Following are points that can provide a framework for discussion:

- Will personal safety be compromised? How can this be avoided / minimized?
- Can this activity be conducted both in rural and urban areas? In IDP camps?
- Can this activity be conducted in conflict-affected areas?
- How will success of the activity be influenced by family / community / inter-ethnic relations? What kind of mediation might be useful to overcome obstacles?
- How will culturally constructed relations between men and women influence this activity? Will potential tension increase / decrease? Will the risk of exposure to gender-based violence increase / decrease? o Will the activity have a positive / negative impact on the environment? If negative, how can this be avoided / minimized?
- Will the activity have a negative / positive impact on health? Routine market assessments, cost/benefit analysis, quality production, marketing and bookkeeping are all prerequisites for establishing and maintaining a market niche.

A successful business will respond to changes in the market with flexibility and creativity.

Step 3. Implementation of IGA within the Community Structure

Specific IGA group:

It is a group of 3-10 people, engaged in an income generation activity on a regular basis. They do not need to be registered and management structure. Members must assure the roles and responsibilities are distributed amongst them, and that individuals are able to look after all aspects of the business, including production, procurement, bookkeeping and marketing/sales. Each group should be received support for three production cycles, including raw materials and facilitation of market access.

They worked closely together, sharing skills and ideas. They provided each other with a social support structure, sharing life experiences while carrying out daily work together. If in IDP camp, they are coming from different ethnic and cultural backgrounds, the women were able to share intricate patterns and weaving styles with one another, increasing the success of goods at the market.

The profit distribution template below provides a simple way of doing so. Once a group has covered its labor costs, it can decide how to use the remaining profit. Distributing profits in an organized manner can increase chances for sustainability. When dealing with illiterate people, use measurements that group members will easily understand, avoiding percentages.

Table 4: Profit Distribution

Sr	Items	Percentage	Number
	Net Profit	100%	Refer to the estimated profit calculated
1	Profit to be distributed among members	In addition to the labour cost	
2	CSG fund	Determine % based on type activity and risk involved	Calculate based on the figures of net profit
3	Emergency Fund*	Determine % based on type activity and risk involved	Calculate based on the figures of net profit
4	Depreciation Fund**	Determine % based on type activity and equipment required	
5	Further Investment***	Determine % based on ability and willingness of member to expand business	

* The emergency fund might also be used as a social support fund for this women's groups.

** Funds that will be used for repairs and/or purchase of new equipment.

*** Not all businesses need to expand. While making a decision about expansion, it is important to consider the social needs of the group members (i.e., family and household responsibilities) and fluctuations of the markets.

For example, when one woman's shelter burned, the group used its emergency fund to support the victim with basic necessities. The depreciation fund provided necessary production supplies for her to restart business activities. Being able to anticipate their expenditures and profit, the women felt more confident about the future of their businesses.

Supporting Specific IGA Groups

Organizations and CSG have to support IGA groups such providing necessary fund, training including profit distribution template and others for an extended period of time. Depending on progress, support provided by an organization can gradually be reduced with each business cycle, as the following example illustrates.

Cycle 1: Groups are provided with raw materials and basic business trainings that ideally include modules on other crosscutting issues introduced in this manual. The organization acts as a link between the Specific IGA group, suppliers and the markets. At the end of the cycle, profit is distributed according to the distribution template.

Cycle 2: During the second cycle, 50% of the necessary inputs should be provided by the organization. Groups assume responsibility for maintaining contacts with suppliers and merchants/sales agents. Organizations should monitor these exchanges. Further business and management trainings are offered according to specific needs.

Cycle 3: Groups are responsible for all aspects of the business, receiving only technical advice and supervision from the donor organization. Depending on the specific activities and needs, additional trainings and/or technical consultations may be needed before the group can work independently.

Role of Community Support Group

Community Support Group is already established. CSG coordinate and support all groups such as IGA, women to women, youth etc. in the respective village.

There will be many IGAs based on the situation and needs. This will depend on resources available too. Each IGA will need to complete a separate profit distribution template. When combined, these templates will form a business plan, illustrating the degree to which other social activities of CSG can be supported by profit generated from IGAs. Profit obtained through IGAs should cover 30% of CSG operational costs. CSG should have a strong management structure.

The profit channelled towards other CSG activities will not be adequate to sustain quality programs and cover administrative costs. Therefore, fundraising activities for CSG is needed. (See in sustainability of CSG) Refer to sustainability of CSG for detail.

If possible, organization can support to set up the CSG center to conduct the trainings, meeting, community celebrations, gatherings and others.

Supporting CSG

Before a CBO can stand and function on its own, it should be able to secure funds independently. An organization should be prepared for a commitment of at least one year.

Profit Distribution

The profit distribution template for CSG is a tool for managing and developing programs, which can also assist in the process of resource mobilization.

Table 5: Sample percentage of profit distribution

Sr	Items	Percentage
	Net Profit	100%
1	Profit to be distributed among members	70% (In addition to the labour cost)
2	CSG fund	20 - 30% (administrative cost and revolving fund)
3	Emergency Fund*	5%
4	Depreciation Fund**	5%
5	Further Investment***	0 - 5%

CSG does not distribute profit amongst its members. Incorporating IGAs into programming significantly increases a CSG chances for long-term success because it is:

- Less vulnerable to fluctuations in the funding pipeline.
- More likely to appeal to donors, given its proven capacity to manage and generate funds.

Writing an IGA Proposal

The structure will depend on a donor's rules and regulations. A generic framework is as follow.

1. Executive Summary
2. Introduction
3. Goal and Objectives
4. Proposed Activities
5. Expected Result
6. Monitoring, Evaluation and Reporting
7. Budget

Checklist for writing IGA proposals

1. Why is this project / IGA necessary?

2. Who are the direct beneficiaries / target population and the indirect beneficiaries?

   a. Justify the choice.

   b. How will the IGA improve the target group's socio-economic situation?

c. In which way this IGA correlates with the mandate of the organization?

3. Where will implementation of the activity / project / IGA take place? Why? Justify the choice.

4. What is being proposed? Specify and justify the type of activity selected.

5. Is it a complete business cycle?

a. Attach results of market assessment; cost/benefit analysis, and marketing strategy.

b. Describe M&E mechanisms that will be used.

6. How are larger issues addressed / considered in this proposal?

a. Protecting personal health and safety

b. Incorporating gender mainstreaming

c. Assessing environmental impact (positive / negative) d. Assessing potential socio-cultural impact (positive / negative)

Step 4. Monitoring and Evaluation

Individuals evaluate their potential business options and must constantly monitor conditions of the market to maintain their market niche: both social and economic. Specific IGA and CSG have to monitor their performance in order to improve chances for success. Project has to support the monitoring and evaluation and gradually handed over to the IGAs and CSG when they have the skill and experiences to fully manage the programme independently.

3.1 Monitoring and Evaluation Tools for training

For training and workshop, we have to conduct pre and post-test. Daily evaluation can also be conducted based on the needs. At the end of the training, the evaluation will be conducted by using the following form.

Sample Workshop Evaluation Questionnaire

I. Content

1. Overall, how useful did you find the content of this workshop?

Very Useful	Useful	Indifferent	Not Useful	Not Useful at All

2. How useful did you find specific presentations?

Session	Very Useful	Useful	Indifferent	Not Useful	Not Useful at All
Market Analysis					
Cost-Benefit Analysis					
Bookkeeping					
Marketing					
Market Niche					

3. How useful were the case studies?

Very Useful	Useful	Indifferent	Not Useful	Not Useful at All

4. How useful was the group work?

Very Useful	Useful	Indifferent	Not Useful	Not Useful at All

5. What session did you like the most? Why?

6. What session did you like the least? Why?

II. Pace of the training?

Too fast	Fast Normal	Slow	Too Slow

III. What topics that would be useful for your group were not covered?

Additional Comments:

Thank you very much.

3.2 Monitoring and Evaluation Tolls for Specific IGA group

IGA Monitoring Sheet

Name of Group:

Location:

Members:

Start Date:

I. Implementation

	1st Cycle	2nd Cycle	3rd Cycle
Input Provided (Fund, raw materials etc.)			
Goods produced (# of items produced)			
Goods sold (# of items sold)			
Cost (Total cost covered by the group including labour)			
Revenue (All money received after the sale of products)			
Profit (Net profit generated by the group)			

II. Capacity

On a scale from 1 to 5 (one being the lowest and five the highest), evaluate the following categories per each cycle:

Utilization of the Profit Distribution Template

1st Cycle	2nd Cycle	3rd Cycle

Bookkeeping Practices

1st Cycle	2nd Cycle	3rd Cycle

Capacity to work with suppliers

1st Cycle	2nd Cycle	3rd Cycle

Capacity to function independently

Comments

IGA Evaluation Sheet

Name of Group:

Location:

Members:

Start Date:

End Date of the Third Cycle:

Part I. Program Impact on Individuals

1. Percentage increase in household income (PIHHI) of the participants at the end of third cycle.

   PIHHI = (final HH income - initial HH income) * 100%/initial HH income

   Accurate calculation requires initial data of the household income of the participants.

2. Changes in psycho/social conditions of the participants (qualitative).

Part II. Group's Capacity to Function Independently

On a scale from 1 to 10 (one is the lowest, 10 is the highest), assess whether the groups are capable of functioning on their own (i.e., without any external assistance).

1. Ability to work with suppliers: ☐
2. Ability to produce quality goods: ☐
3. Ability to sell the goods produced at the market: ☐
4. Ability to track expenditure and revenue (bookkeeping): ☐
5. Ability to generate profit: ☐
6. Ability to recycle profit: ☐
7. Ability to distribute profit generated: ☐

Comments

3.3 Monitoring and Evaluation Tools for CSG

CSG Monitoring Sheet

Name of CSG:

Location:

Members of Management Committee:

Date Established:

Project Start Date:

Part I. Implementation

A. IGAs

	Description	Month 1	Month 2	Month 3	Month 4	Month 5
IGA 1	Input Provided (Fund, raw materials etc.)					
	Individual involved in production (#of individual involved)					
	Goods produced (# of items produced)					
	Goods sold (# of items sold)					
	Cost including labour					
	Revenue					
	Profit (Net profit)					
	Description	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**
IGA 2	Input Provided (Fund, raw materials etc.)					
	Individual involved in production (#of individual involved)					
	Goods produced (# of items produced)					
	Goods sold (# of items sold)					
	Cost including labour)					
	Revenue					
	Profit (Net profit)					
	Description	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**
IGA 3	Input Provided (Fund, raw materials etc.)					
	Individual involved in production (#of individual involved)					
	Goods produced (# of items produced)					
	Goods sold (# of items sold)					
	Cost including labour					
	Revenue					
	Profit (Net profit)					

Note: The assumption is that a CBO will be supported for a period of one year, with a midterm evaluation in month six and final evaluation in month 12.

B. Providing health and Nutrition and other Social Assistance

	Description	Month 1	Month 2	Month 3	Month 4	Month 5
Activity 1	Input Provided (Fund, material, training and stationaries etc.)					
	# of individuals participating in activity)					
	# of beneficiaries received supports)					
	Description	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**
Activity 2	Input Provided (Fund, material, training and stationaries etc.)					
	# of individuals participating in activity)					
	# of beneficiaries received supports)					
	Description	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**
Activity 3	Input Provided (Fund, material, training and stationaries etc.)					
	# of individuals participating in activity)					
	# of beneficiaries received supports)					

C. Fund Raising

	Month 1	Month 2	Month 3	Month 4	Month 5
In kind contribution from donors (List all inputs including trainings, stationery, etc. received from donors)					
Cash contribution (List all cash contribution from donors)					

Part II. Organizational Capacity

On a scale from 1 to 5 (one being the lowest and five the highest), evaluate the following categories each month.

Capacity to provide services (IGAs and Health and Nutrition and other social assistance)

Month 1	Month 2	Month 3	Month 4	Month 5

Utilization of profit distribution template

Month 1	Month 2	Month 3	Month 4	Month 5

Financial Practices (Bookkeeping for IGAs and financial reports to donors)

Month 1	Month 2	Month 3	Month 4	Month 5

Capacity to address organizational issue

Month 1	Month 2	Month 3	Month 4	Month 5

Capacity to comply with rules and regulations as a subgrantee

Month 1	Month 2	Month 3	Month 4	Month 5

Capacity to mobilize resources from donors

Month 1	Month 2	Month 3	Month 4	Month 5

Comments

CSG Evaluation Sheet

Name of CSG:

Location:

Members of Management Committee:

Date Established:

Project Start Date:

Part I. Program Impact on Individuals

1. Percentage Increase in Household Income (PIHHI) of participants at the time of evaluation (i.e., within a period of six to 12 months).

   PIHHI = (final HH income - initial HH income) * 100%/initial HH income

   Note: Accurate calculation requires initial data of the household income of participants. In case the number of members is high, interviewing and monitoring 10% of the participants in each IGA should be sufficient.

2. Changes in psycho/social conditions (well-being) of the participants in IGAs (qualitative). Interview at least one participant in each activity

Part II. Organizational Capacity

On a scale from 1 to 10 (one is the lowest, ten is the highest), assess whether the association in capable of functioning on its own (i.e., without any external assistance).

A. Capacity to Function Independently

IGA

1. Ability to work with suppliers ☐
2. Ability to produce quality goods ☐
3. Ability to sell the goods produced at the market ☐

B. Utilization of profit distribution template

1. Ability to generate profit ☐
2. Ability to recycle profit ☐
3. Ability to distribute profit generated ☐

C. Bookkeeping Practices

1. Ability to track expenditure and revenue (bookkeeping) ☐

D. Capacity to address organizational issues

1. Ability to coordinate all elements of the business cycle (including procurement, production, marketing and sales) for multiple activities ☐
2. Ability to coordinate PSAs and IGAs ☐
3. Ability to resolve conflict ☐

E. Capacity to Comply with Rules and Regulations as a Sub-grantee

1. Ability to report on activities taking place under the organization's umbrella ☐
2. Ability to adhere to financial rules and regulations of the sub-grant ☐

F. Capacity to Mobilize External Resources (i.e., from other donors)

1. Ability to coordinate with other agencies (Including NGOs and donor agencies) ☐
2. Ability to write grant proposals ☐

Note: This sheet can be used for conducting a mid-term evaluation (ideally after six months of implementation) as well as final evaluations.

Sample Business Plan

Project title : Production of Leather Craft

Implementing body :

Implementation site :

Funds requested :

Following an assessment carried by a group from the area, three markets in ..... were selected: (1) ....., (2) ..... and (3) ..... It was found that there is high demand and need for bricks.

1. COSTS

Raw Materials

- Goat Skin 250,000
- Thread 125,000
- Needles 125,000
- Buckles 200,000
- Leather Punch 200,000

Total cost **900,000**

Labour

- Wage for production
  - Leather bag 500,000
  - Wallet 300,000
  - Belt 200,000
- Wage for others 100,000

Total labour cos **1,100,000**

Additional Cost

- Transportation 50,000
- Other Unexpected Cost 150,000

Total additional cost **200,000**

Grand Total Cost = 900,000 + 1,200,000 +200,000 = 2,200,000

2. REVENUE

Sr	Items	Unit Price	Quantity	Total
1	Bag	200,000	10	1,500,000
2	Wallet	60,000	15	900,000
3	Belt	70,000	10	700,000
	Total Revenue			**3,100,000**

3. Profit

1	Revenue	3,100,000
2	Cost	2,200,000
3	Profit	900,000

Points to be considered before starting the project:

- Market assessment (evaluating market supply and demand)
- Cost/benefit analysis (Production)
- Profit margin
- Bookkeeping

Intervention 12: Data Management

SCG will collect and update the information related to the health and nutrition as follow.

- Village Profile
- Demographic data
- Population (Total and disaggregation)
    - Total population
    - Male and female
    - Children (0-5 months, 6-11 months, 12-59 months, 5-9 years)
    - Adolescence
    - Pregnant Women
    - Lactating women
    - > 60 years
- Occupation
- Health facilities
- Schools
- CBOs facilitated and coordinated by CSG
- IGA groups
- Others

Intervention 13: Others Based on Local Needs

There will be many interventions need to be addressed based on the local situation. The project and CSG will seek the technical, financial and programmatic supports for these particular interventions. For examples,

- PMTCT
- Malaria
- Tuberculosis
- Preschool
- Education
- Child protection
- Cash transfer etc.

ANNEXES

Annex 1. Advocacy Message

Under Five Mortality

Myanmar

	Total number of under five children death	Malnutrition is responsible for about haft (45%) of the deaths (Lancet 2013, WHO 2016)
One Year	41,000	18,450
One month	3,417	1,538
One day	114	51

Two leading causes: Pneumonia and Diarrhoea
Source: UN IGME, UNICEF, WHO, World Bank, 2021

Under Five Malnutrition

Myanmar

	Stunting	Wasting
One Year	1,136,200	302,700 (2018)
One month	94,683	25,225
One day	3,156	840

Source: JME, UNICEF, WHO, World Bank, 2021

Effect of Child Malnutrition

- Death
- Lower education level
- Poor job opportunity
- Less Income
- Low performance in sport

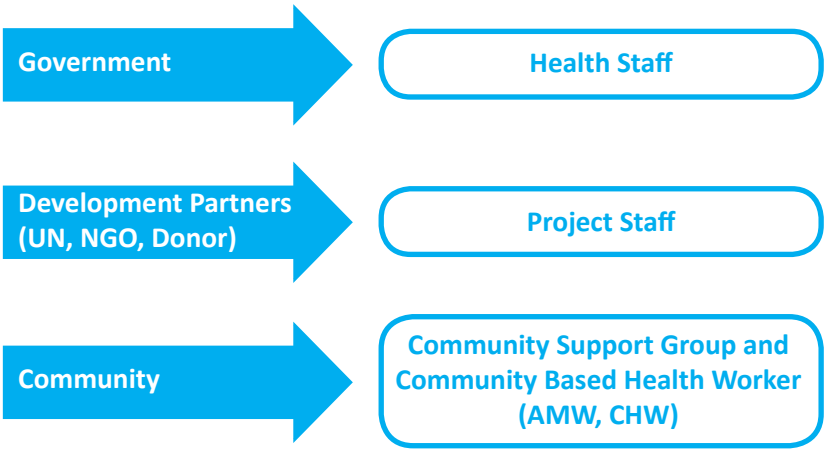
Maternal Mortality

- 250/100,000 LB (2017)
- 2.5 women die during pregnancy, during delivery and within 2 months after delivery for 1,000 livebirths

Source: MMEIG, UNICEF, WHO, UNDP, UNFPA, World Bank, 2019

Under Five Malnutrition

Who can help to overcome child death and malnutrition?



Community participation is most important in averting maternal and child death and malnutrition.

Process to Form CSG

- **5-7 members**
- **members**
  - resident of the community,
  - interested in health, nutrition and social work;
  - desire to stay and serve in resided village; and
  - elected by community
  - Empower to include women.
- **Chair and Co-chair**
  - capacity to influence the villagers and manage the team such as village authority, religious, leader, traditional medicine practitioners, cultural leader, teachers,
  - The same as above
- **Secretary**
  - Suitable persons e.g., community-based village volunteers or others
- **Joint secretary and members**
  - Suitable persons
- **Methods to choose the members**
  - Strength election method

Brief Role and Responsibility of CSG

- **Support capacity building of Community Based Health Workers.**
- **Support arranging and gathering of communities before and during providing of health and nutrition services by staff and volunteers**
- **Support patients who need to be referred to the nearest health facilities**
- **Support community health education, counselling and meetings**
- **Manage CSG daily functions**
- **Establish revolving fund system in the respective village**

Annex 2: Training Manual for CSG

Agenda

Time	Topics	Facilitator
09:00 – 09:15	Registration	
09:15 – 09:30	Self-Introduction	
10:00 – 10:30	Roles and responsibilities of CSG, Benefits of Establishing Functioning CSG	
10:30 – 11:00	cIYCF	
11:00 – 11:30	IMAM	
11:30 – 12:00	Micronutrient Supplementation	
12:00 – 13:00	Lunch	
13:00 – 13:30	Danger Sign for referral	
13:30 – 14:00	Mechanism of Referral	
14:00 – 14:30	Importance of Income Generation	
14:30 – 15:00	Basic management	
15:00 – 15:30	Overall Discussion	

(1) Roles and responsibilities of CSG and benefits of establishing functioning CSG

Roles and Responsibilities of CSG

Activities	CSG	CBHW
Community Mobilization	Lead and Organize	Support
IYCF counselling	Organize	Implement
IMAM (Active case finding and prevention and treatment of acute malnutrition)	Organize and Support	Implement
Referral	Support	Decide and manage
Other Nutrition Activities	Support	Implement
Anti-natal Care	Support	Implement
Community Case Management	Support	Implement
Community Based Newborn Care	Support	Implement
Data Management	Lead	Support
WASH	Support	Implement
Income Generation	Lead	Support
Other based on local needs	Lead/Support	Support/Implement

Benefits of establishing functioning CSG

Activities

- Early treatment seeking
- Timely case finding and referral
- Increased compliance
- Minimized defaulting
- Lasting behaviour change and Create New Positive Social Norms

Outcome

- Improved Coverage
- Improved Treatment outcome
- Promoted better response to community needs and concerns
- Ensured greater sustainability, cost-effectiveness, account ability and equity

Impact

- Reduce child and maternal mortality and morbidity
- Met SDF goals

မိခင်နို့တိုက်ကျွေးခြင်း၏ အကျိုးကျေးဇူးများ

ကလေးသူငယ်အတွက်အရေးကြီးပုံ

- ♦ တစ်နှစ်အောက်ကလေးများ၏အသက်ကို ကယ်တင်သည်။
- ♦ ကလေး ပုံမှန်ကြီးထွားစေရန်အထောက်အကူပေးသဖြင့် အရပ်ပုခြင်းကိုကာကွယ်သည်။
- ♦ မိခင်နို့တွင်ပါဝင်သောရောဂါကာကွယ်သည့်ဓာတ်များကြောင့်ရောဂါများကို (အထူးသဖြင့် – ဝမ်းပျက်ဝမ်းလျှောနှင့် အသက်ရှူလမ်းကြောင်းရောဂါများ) ကာကွယ်သည်။
- ♦ ကလေးလိုအပ်သည့်ရေဓာတ်အပြည့်အဝ ပါရှိသည်။
- ♦ မိခင်နို့စုပ်ယူခြင်းလုပ်ဆောင်ချက်ကြောင့် ကလေး၏သွားနှင့် မေးရိုးများကိုပုံမှန်ဖွံ့ဖြိုးစေသည်။
- ♦ မိခင်နှင့်အသားချင်းထိကပ်၍နို့စို့ရခြင်းကြောင့် မိခင်နှင့်ကလေးကို သံယောဇဉ်တွယ်စေသည်။
- ♦ ရေရှည်ရရှိသောအကျိုးမှာ အဝလွန်ခြင်းနှင့် ဆီးချိုသွေးချိုရောဂါဖြစ်နိုင်ခြေလျော့နည်းသည်။

မိခင်နို့တိုက်ကျွေးခြင်း၏ အကျိုးကျေးဇူးများ

မိခင်အတွက်အရေးကြီးပုံ

- ♦ မိခင်နို့စို့ခြင်းသည် သားအိမ်ကိုကျုံ့စေနိုင်သဖြင့် မွေးပြီးလျှင်ပြီးချင်း ကလေးကိုနို့တိုက်ခြင်းသည် အချင်းကို လွယ်ကူစွာကျစေသည်။
- ♦ မိခင်နို့တိုက်ခြင်းသည် မွေးပြီးသွေးသွန်ခြင်းကို နည်းပါးစေသည်။
- ♦ နို့မှုန့်ဝယ်ရခြင်း၊ လောင်စာရှာရခြင်း၊ ရေနွေးကျိုရခြင်း၊ နို့ဖျော်ရခြင်း စသောအလုပ်များလုပ်ရန်မလိုသဖြင့် မိခင်အလုပ်ရှုပ်သက်သာပြီး အကုန်အကျလည်း သက်သာသည်။
- ♦ နို့မှုန့်တိုက်သောကလေးသည် အကြာခဏ မကျန်းမမာဖြစ်တတ်သဖြင့် ကုသမှုကုန်ကျစရိတ် များသည်။
- ♦ မိခင်တွင် ရင်သားနှင့် သားဥအိမ်ကင်ဆာဖြစ်နိုင်ခြေနည်းပါးသည်။

မိခင်နို့တိုက်ကျွေးခြင်း၏ အကျိုးကျေးဇူးများ

ရပ်ရွာ/ နိုင်ငံတော်အတွက်အရေးကြီးပုံ

- ♦ ကလေးများ မကျန်းမမာဖြစ်မှုနည်းပါးခြင်းကြောင့် နိုင်ငံတော်၏ကျန်းမာရေးကုန်ကျစရိတ် နည်းပါးသည်။
- ♦ လောင်စာအတွက် သစ်ပင်များခုတ်လဲရန်မလိုခြင်း၊ စွန့်ပစ်နို့မှုန့်ခွံအမှိုက်များမရှိခြင်းတို့ ကြောင့် သဘာဝပတ်ဝန်းကျင်ကို ထိန်းသိမ်းကာကွယ်သည်။
- ♦ နို့မှုန့်နှင့် နို့ဖျော်ရန်ပစ္စည်းများ ပြည်ပမှဝယ်ယူတင်သွင်းရန်မလိုသဖြင့် ပိုလျှံငွေကို နိုင်ငံတော်အတွက် အခြားလိုအပ်ချက်များတွင် ပိုမိုသုံးစွဲနိုင်သည်။

ဖြည့်စွက်စာမှန်မှန်ကန်ကန်ကျွေးခြင်း၏ အကျိုးကျေးဇူးများ

၅ နှစ်အောက်ကလေးများ ဖြည့်စွက်စာမှန်မှန်ကန်ကန်မရရှိပါက အာဟာရချို့တဲ့ လာပါမည်။ အထူးသဖြင့် ကလေးများ အရပ်ပုလာပါမည်။

အောက်ပါ အရပ်ပုခြင်း၏အကျိုးဆက်များ ရလာပါမည်။

- ♦ ၅ နှစ်အောက်ကလေး သေနှုန်းများလာခြင်း
- ♦ ပညာရေး နိမ့်ကျလာခြင်း
- ♦ ကုန်ထုတ်လုပ်မှုနှင့် ဝင်ငွေ နိမ့်ကျခြင်း
- ♦ အားကစားပြိုင်ပွဲများတွင် မအောင်မြင်ခြင်း

Myth

- It is a type of misinformation

  (incorrect information spread by people either intentionally or unintentionally)
- We are more likely to believe things that we have heard many times than new information.
- Misinformation has the potential to cause substantial harm to individuals and society.
- If caregivers base their decisions on incorrect information, they are unable to make an informed choice. This can have very bad consequences.

Myth

(a) Babies need extra water/fluids when it is very hot.

- Breastmilk provides all fluid that a 5 months old baby needs even in very hot weather.
  - about 90% of breastmilk are water and feed more often
  - When it is very hot, baby's behaviour may change, fuss and cry more because they are uncomfortable in the heat.

(b) The first milk should be discarded/not given to the newborn after birth.

- Colostrum is also known as baby's first vaccine or liquid gold or superfood.

(c) Stressed mothers cannot breastfeed.

Negative emotions such as stress are passed from mother to baby, harminf baby

- Stress may <u>temporarily</u> interfere with milk flow ("let down") but it does <u>not</u> affect milk production.
- Reduce stress for the mother, support relaxxtion and connection, keep mother and baby close together (e.g., in a sling), encourage frequent BF and skin to skin.

(d) Mother should not breastfeed their baby if they have COVID

- A mother with conformed COVID-19 can breastfeed if they want to do so with COVID-19 precaution measures

(e) Malnourished mothers cannot breastfeed

- Should continue breastfeeding
- Provide nutritional support and treatment to mother and encourage well eating.

(f) It is not safe to breastfeed while pregnant because it will harm the foetus by depriving them of nutrients or trigger early labour

- Breastfeeding will not harm the developing foetur and will benefit the older child (nutrients, closeness & comfort during time of change)
- After the new baby has arrived, she can safely breastfeed both children (tandem breastfeeding). Colostrum will be made.

(g) Once you stop breastfeeding, it is not possible to start again

- Breastmilk production can be started again, even if a woman has not breastfed for years. This is known as relactation.

(h) If mother has upset/stress/anxiety, her breastmilk is changed into sour or bitter and not suitable to feed the baby

- Can feed baby safely. Important to provide psychological support to the mother

(i) Infant formula should never be provided

- It can be provided as a last resort as part of an appropriately managed intervention for infants who cannot be breastfed.
- However, it should NEVER be included in a general distribution or provided without an individual assessment of need.
- It should ALWAYS be provided in compliance with the Myanmar IYCF SOG.

(4) IMAM

လတ်တလောအာဟာရချို့တဲ့မှု ဘက်စုံကုသစောင့်ရှောက်ခြင်း (IMAM)

လတ်တလောအာဟာရချို့တဲ့မှုဘက်စုံကုသစောင့်ရှောက်ခြင်းသည် အဘယ်ကြောင့်အရေးပါသနည်း။

- ♦ ၅ နှစ်အောက်ကလေးသေဆုံးမှု – လေးသောင်းကျော်
- ♦ လတ်တလောအပြင်းအထန်အာဟာရချို့တဲ့သောကလေး – သုံးသိန်းကျော်
- ♦ လတ်တလောအပြင်းအထန်အာဟာရချို့တဲ့သောကလေးများသည် အသက် ၅ နှစ်မတိုင်မီသေဆုံးနိုင်ခြေမှာ ပုံမှန်ကလေးများထက် (၉)ဆ ပိုများပြီး၊
- ♦ ထိုကလေးသည် အရပ်ပါပုပါက (၁၂)ဆ ပိုများပါသည်။
- ♦ ဝမ်းပျက်ဝမ်းလျှောခြင်း၊ အဆုတ်ရောင်ရောဂါနှင့် ၄က်ဖျားရောဂါ စသည်တို့ကိုခံစားနေရပါက သေဆုံးနိုင်ခြေ ပိုမိုမြင့်မားပါသည်။
- ♦ လတ်တလောအာဟာရချို့တဲ့မှု ဘက်စုံကုသစောင့်ရှောက်ခြင်းဖြင့် ကာကွယ်ကုသနိုင်ပါသည်။

လူထုနိုးထစေရန်တိုက်တွန်းစည်းရုံးခြင်း

၁. လူထုအခြေအနေကို ဆန်းစစ်လေ့လာခြင်း၊

၂. အဓိကသတင်းစကားများနှင့် အသိပညာပေးပစ္စည်းများကို ပြုစုထုတ်ဝေခြင်း၊

၃. အာဟာရဆိုင်ရာ အဓိကသတင်းစကားများ အသိပညာပေးလှုံ့ဆော်မှု အစီအစဉ်ရေးဆွဲခြင်း၊

၄. အသိပညာပေးလှုံ့ဆော်ရန်အတွက် လေ့ကျင့်သင်ကြားပေးခြင်း၊

၅. လူထုအသိပညာပေးအစီအစဉ် ကျင်းပခြင်း၊

၆. လတ်တလောအာဟာရချို့တဲ့သောကလေးများအား ကိုယ်တိုင်ရှာဖွေလွှဲပြောင်းညွှန်းပို့ခြင်း။

(5) Micronutrient Supplementation and Deworming

ဗီတာမင်များ၊ သတ္တုဓာတ်များနှင့် သန်ချဆေးတိုက်ကျွေးခြင်း

မြန်မာနိုင်ငံတွင် အသုံးပြုရန်အတွက် ထောက်ခံချက်ပေးထားသည့် အဏုအာဟာရနှင့် သန်ချဆေးတို့မှာ–

- ♦ ဗီတာမင် အေ
- ♦ ကိုယ်ဝန်ဆောင်နှင့် နို့တိုက်မိခင်တို့အတွက် အဏုအာဟာရဆေးပြား
- ♦ ဖြည့်စွက်စာကို အိမ်တွင်းအားဖြည့်ရန်အတွက် အဏုအာဟာရမှုန့်မျိုးစုံ
- ♦ ဗီတာမင် ဘီ–၁
- ♦ သန်ချဆေး (Albendazole, Mebendazole)

- ♦ ဗီတာမင်အေသည် ကလေးများပုံမှန်ကြီးထွားဖွံ့ဖြိုးရေးနှင့် ကျန်းမာကြံ့ခိုင်ရေး၊ မျက်စိကျန်းမာရေးနှင့် အမြင်အာရုံကောင်းမွန်ရေးအတွက် အရေးကြီးသည်။
- ♦ ဗီတာမင်ဘီ–၁ ချို့တဲ့ပါက သူငယ်နာဘယ်ရီဘယ်ရီ ဖြစ်နိုင်သည်။ အချိန်မီ ကုသမှုမခံရပါက အသက်သေဆုံးသွားနိုင်သည်။

အိုင်အိုဒင်းဓာတ်ချို့တဲ့ပါက

- ကိုယ်ဝန်ဆောင်မိခင်များတွင်
- ♦ သားပျက်သားလျှောတတ်သည်။
- ♦ ကလေး အသေမွေးတတ်သည်။
- ♦ ကိုယ်အလေးချိန်မပြည့်သောကလေး၊ လမစေ့သောကလေး မွေးတတ်သည်။
- ♦ ဆွံ့အ နားမကြားသောကလေး၊ ခြေလက်မသန်စွမ်းသောကလေး၊ ဉာဏ်ရည်နိမ့်သောကလေး မွေးတတ်သည်။

အိုင်အိုဒင်းဓာတ်ချို့တဲ့ပါက

- ကလေးများတွင်
- ♦ ခန္ဓာကိုယ်ကြီးထွားမှုနှေးကွေးမည်။
- ♦ ဉာဏ်ရည်နိမ့်မည်။
- ♦ ထုံထိုင်းနှေးကွေးမည်။
- ♦ လည်ပင်းကြီးမည်။

လူတိုင်းကျန်းမာကြံ့ခိုင်သန်စွမ်း၍ ကလေးများဉာဏ်ရည်မြင့်မားထက်မြက်စေရန် မိသားစုတိုင်း အသက်အရွယ်မရွေး နေရာဒေသမရွေး အိုင်အိုဒင်းဆားကို နေ့စဉ်သားသုံးရန် လိုအပ်ပါသည်။

- ♦ သံဓာတ်ချို့တဲ့ပါက သွေးအားနည်းရောဂါခံစားရမည်။
  - ကိုယ်ဝန်ဆောင်များသွေးအားနည်းပါက ကိုယ်ဝန်ဆောင်စဉ်၊ မွေးဖွားစဉ်နှင့် မွေးဖွားပြီးကာလအတွင်း အသက်အန္တရာယ်ကြုံတွေ့နိုင်သည်။ ကိုယ်အလေးချိန် မပြည့်သောကလေး၊ လမစေ့သောကလေး မွေးဖွားနိုင်သည်။
  - ကလေးများသွေးအားနည်းပါက ခန္ဓာကိုယ်ပုံမှန်မကြီးထွားနိုင်ပါ။ ပညာရေးနှောင့်နှေးမည်။ ရောဂါရလွယ်မည်။

ကိုယ်ဝန်ဆောင်နှင့် နို့တိုက်မိခင်များအား အဏုအာဟာရဆေးပြား၊ ကလေးများအား အဏုအာဟာရမှုန့် တိုက်ကျွေးရပါမည်။

- ♦ သန်ကောင်ရောဂါရှိပါက အာဟာရချို့တဲ့မည်။ သွေးအားနည်းမည်။

သံချဆေးတိုက်ကျွေးရပါမည်။ (Albendazole, Mebendazole)

(6) Danger's sings for referral

အောက်ပါအခြေအနေတစ်ခုခုဖြစ်လျှင် ကလေးကို ကျန်းမာရေးဌာနသို့သွားရောက်ပြသပါ။

- ♦ နို့စို့ရန်ငြင်းဆန်ခြင်းနှင့် အလွန်အားပျော့နေခြင်း၊
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(7) Mechanism of Referral

Mechanism of Referral

(a) Decided by trained CHBWs

(b) Provide financial support for referral,

- costs of transportation,
- cost of family members accompanying patients.
- Provided by patient/project/CSG revolving fund

(c) CSG have to arrange means of transportationensuring timely referral of the patient,

(d) Refer to most accessible referral points, CSG and CBHWs have to have the list and qualities of referral centers.

(e) Advocate and convince to have caretaker's acceptance and compliance with a referral recommendation,

- This is often determined by a varety of factors, including the perceived need of a referral (disease severity), caretaker/community experience with and impressions of the referral facility (quality).
- CSG and CBHWs ensure that in the referral center, services must be affordable, and essential drugs, supplies, and equipment must be available.

(8) Importance of Income Generation Activities

Importance of Income Generation Activities (IGA)

- Income generation activites attempt to address poverty, unemployment, and lack of economic opportunitues to incress participants' ability to generate income and secure livelihoods.
- Assist women to establish IGAs.
- It should be in or near the home and concern activites where women can use skills they already possess.
- Studies generally indicates that the greater the amount of income under women's control the greater amount deveoted to their children's education, health and nutrition.
- Rural women have skills to do small-scale plant and agricultural and animal producation, processing and preservation. Potentialities are various according to the specific conditions of the village.
- Marketing must be careful and considered before undertaking any of these rural enterprises since lack of marketing expertise is the major weakness of this kind of programme.

Details are in the establishing and running of LGA training.

Basic Management

- Art of getting things done through and with the people in formally organized groups. (According to Harold Koontz)
- Art of knowing what to do when to do and see that it is done in the best and cheapest way. (F.W. Taylor)
- Working with human, financial and physical resources to achieve organizational objectives by performing the planning, organizing, leading and controlling functions. (Megginson, Mosley, and Pietri)

Housewife

- Apprasise her household and its needs,
- Forecast hte needs for a week or a month or longer,
- Stock of her resources and any constraintson these resources,
- Plans and orgnizes her resources to obtain the maximum benefits out of these resources,
- Monitors and controls the household budget and expenses and other activites,
- In a large household, divides the work among other family members and coordinates their activites,
- Encourages and motivate them to do their best in completing their activites,
- Always in search of improvement, mentions goals, resources, and means to attain these goals.

Above are the basic functions of mangement.

Funtions

POSDCORP (Luther Gulick and LyndallUrwick)

P	Planning	
O	Organizing	activities, assign ,delegate, reponsibility
S	Staffing	JD, advertising, recruiting, selecting, orientation, training, developing, compensating, evaluation, incentive and motivation
D	Directing	insturction, delegating leading, monitoring, supervision, communication, motivation Standard performance- Establish, Measure and Compare
C	Coordination	Linking
R	Reporting	
B	Budgeting	

Some paractical section are in the income generation activites' training.

Financial Management

- Finance is the management of money and includes activites such as investing, borrowing, lending, budgeting, saving, and forecasting.
- A budget is an estimation of revenue and expenses over a specified future period of time and is usually compiled and re-evaluated on a periodic basis. It is basically a financial plan for a defined period, normally a year that is known to greatly enhance the success of any financial undertaking

Data Management

- village profile
- Csg profile
- IGA
- Meeting minutes
- Records

Annex 3. Community Engagement[17]

There are four community engagement methods such as

1. community meetings,
2. focus groups,
3. surveys and
4. online engagement

1. Community Meeting[18]

Purpose of a Community Meeting

A community meeting is the perfect setting to exchange ideas and information, grant community groups real opportunities to affect plans and make changes and gives them responsibility as part of the process so that they feel their efforts will matter.

Tips on holding a community meeting

- **Before: Planning**
  - **Have a clear purpose**

    e.g., It is to discuss next steps in the programme, respond to community feedback, share information etc.

  - **Plan with key community representatives or groups**

    e.g., community committee, community volunteers, or community leaders. They can advise on where, when, and how to organise and mobilise people to attend. This can be done through a phone call if time is short. At least a week before the meeting date.

  - **Plan the meeting at convenient times**

    e.g., at the time people are not working or engaged in household tasks

  - **Understand the context in the community in advance.**

    e.g., What is the security situation? Are there any tensions between groups that could disrupt the meeting or put people at risk? What are the power dynamics in the community, and could it lead to certain people being excluded from either attending or speaking during the meeting e.g., women or minority groups?

[17] https://www.sustainet.com/community-engagement-methods/
[18] Community Engagement and Accountability / IFRC / June 2016

- **Consider the meeting size**

  It is difficult to limit how many people attend. Large meetings are good because they reach more people and are more transparent, but they can be difficult to manage. They also make it harder to hear the views of all groups equally or even just those who are shy about speaking in public. Consider holding a series of smaller meetings with different groups, so people feel more comfortable to share their opinions

- **Meeting Place**

  Try to hold the meeting in an open space, but away from spectators or other interruptions.

- **Coordinate with other agencies**

  If multiple agencies are providing support in the same community, it is good for agencies to hold community meetings together. An added benefit is less issues for the National Society to refer on to other agencies after the meeting[19]

- **Be prepared**

  Consider what questions people are likely to ask in the meeting and come with the relevant information to respond. It can also help to have details of all the other organisations operating in the community and their contact details so questions that can't be answered can be referred accurately.

- **Advertise the meeting**

  Make sure people in the community know about the meeting in advance, including the purpose, location, date, time, and length. Unless it is an emergency and cannot be avoided, it is disrespectful to turn up in a community and expect people to make themselves available immediately.

- **During: Facilitating**
  - **Have at least two facilitators**

    One to facilitate the discussion and another to take notes and make sure you have permission from the group to take notes. Reassure people the notes are to follow up on their concerns, and people's names will not be recorded.

  - **Introduce the facilitators**

    Even if this is not the first meeting to show respect.

[19]Communities don't always know who provides which services and will often ask questions during community meetings about the services of another agency. This agency hosting the meeting will still need to log these questions and try to refer them to the relevant agency for follow-up, which can be time consuming.

- **Consider how the main facilitator will be perceived by the community**

  For example, age, gender, language spoken, ethnicity, nationality, or profession, can all affect the level of trust and respect the community have for the facilitator

- **Try to keep the discussion to an hour at most**
- **Use clear, simple, non-technical language**

  Use open ended questions as much as possible to bring out the views of participants. such as:

  - How...?, What...?, Why...?
  - Can you tell us more about...?
  - Can you tell us what happened?
  - How did you feel when…?
  - Why do you think…?

- **Encourage people to participate by asking for feedback and questions**

  This helps the meeting to be a conversation, rather than a lecture, which builds trust and ensures the hearing of people's issues and concerns

- **Encourage participation from diverse groups**

  Observe behaviours during the meeting and how people react to each other, or who doesn't attend or speak, as this can provide interesting information about the social dynamics in the community. If certain groups do not speak during the meeting, for example women or young people, hold separate, smaller meetings with these groups to ensure their views are heard.

- **Keep the discussion on track, but still allow people to express their views**

  Allow people to share their concerns and experiences, even if they fall outside of the programme's remit, as it is important people feel listened to. However, it is also important to keep the discussion focused and not allow one person to dominate. If this happens, it can help to offer to speak to the person separately after the meeting.

- **Discuss and respond to sensitive issues carefully**

  Be aware of the local culture and beliefs and if there are some topics that should not be discussed in public meetings. If people raise sensitive topics or feedback in a public meeting, such as sexual or gender-based violence, listen carefully and allow the person to speak, but do not ask for details in front of the meeting. Speak to them separately at the end of the meeting and ask their permission to follow up on the issue and take their contact details.

- **Don't take sides in disagreements or express judgements**

  Attempt to mediate and calm the situation or allow the community or community leader to resolve the issue. Try to remain positive and unbiased: do not guide the discussion toward a certain outcome or dwell on particular problems.

- **If the community are angry with organization**

  Stay calm and acknowledge people's frustrations. Depending on the issue, for example if it is delays to the programme, explain why this has happened, what is being done about the issue, ask the community for their ideas about how to tackle the issue or what more we could do, and offer to provide regular updates while the issue is being resolved.

- **If tensions are escalating, and the meeting is not going well,**

  Ask community leaders to intervene or split people into smaller groups to deal with issues separately. However, if there is any threat to staff or volunteers, apologise and close the meeting and return when the situation has calmed down.

- **Summarise the main points and any agreed actions**

  At the end of the meeting, check if the written record has reflected the main points and ensure the organization and the community have the same interpretation of next steps. This includes being clear about roles and responsibilities and action points. This can help to address any unrealistic expectations or assumptions within the community about the programme.

- **After: Next Step and Follow Up**
  - **Discuss how to act on the issues raised.**

    The issues raised during the community meeting are reviewed and discussed in team meetings, including what action can be taken and how the programme can respond to the community. If information from the meeting is not used, collecting it is a waste of time and resources.

    If community members feel their feedback is being ignored, they will lose trust which will reduce their willingness to attend future meetings or engage in programme activities

  - **Cross check and triangulate information**

    Check and triangulate against other sources, particularly if only some groups were active in the meeting. For example, is the programme receiving the same feedback through monitoring, the feedback mechanism, and community meetings, or are their differences? This helps to ensure the programme is not making decisions based only on the views of those who are most vocal during a community meeting. Use summary to identify the

information gaps and can try to fill next time your community meets to discuss these issues.

- **Refer issues the programme cannot respond to**

  If questions, suggestions, or complaints were raised about other organisations, it is important to share these with the relevant agency or pass the contact details for that agency to the community.

- **Share**

  Share the summary and findings with local leaders, community organizations, health care workers, and others in the community who can use the information to help better plan their programmes and activities.

  Share your findings with the provincial health department, your branch or HQ, and others who create policies and make resource allocations for your community.

  Response, clarification and follow-up actions (if taken, or not taken) should be communicated back to the community or affected persons.

There is not one perfect way to engage with stakeholders, and needs will change depending on the groups and issues needing to be addressed. The approaches depend on the groups of stakeholders being consulted and the intended outcomes of your initiative. Using more than one outreach method for your engagement process will pave the way to increased stakeholder participation and building of stronger relations with your stakeholder community. Issues, objectives, stakeholder mix and available resources will all contribute to determining the ideal framework for your stakeholder engagement initiative.

Strength and Weakness of Each Method

Method	Strength	Weakness
Community Meeting The face-to-face nature provides a great opportunity to demonstrate openness and transparency to stakeholders. It is important to consider what will make your event compelling to stakeholders and encourage attendance.	Opportunity to deliver information and gather feedback. It can be used effectively at the beginning of an initiative to explain processes and outcomes. Great for meeting stakeholders in person, and to demonstrate transparency. Can be useful for community outreach or to attract media attention for your project or program.	Attendance may be low. Stakeholders are not likely to attend unless they feel personally affected by outcomes related to your project or program. If an issue or project is particularly controversial, this may not be the right method for engagement. Media publicity may be negative if the meeting is confrontational or not handled well.
Focus Group It encourages discussion and work well when reaching out to smaller or marginalized stakeholder groups. The active dialogue is enhanced when asked focused questions, and a comfortable environment is created.	This small group setting is an efficient way to use resources and identify important issues. Focus groups can be planned and organized to reach a specific group of stakeholders or developed around a particular topic. If there is conflict, it can be handled more easily in a small group.	Must involve an experienced facilitator to ensure the process runs smoothly. Focus groups are not an effective method to ensure all stakeholders and perspectives are represented.
Survey Surveys Ask yes/no (or scaled) questions to groups of people in order to identify community opinion. They are useful for mass outreach.	Useful to collect and collate quantitative and quantitative data. Data can be used to compare results from another period of time or against different stakeholder groups. It is a quick and cost-effective way to communicate with large groups of people.	Surveys are not usually useful to identify reasons behind stakeholder opinions. They are not as effective in establishing community relationships or developing dialogue. Response rates may be limited.
Web Based Engagement Online public participation is a useful way to reach and engage with many stakeholders. It includes social media, web or cloud-based survey systems, and online discussion platforms.	Effective in reaching large groups of people and collecting data in an efficient way. Flexible and convenient for participants, encourages participation if time and location is a barrier. Is an opportunity to encourage discussion and reflection about complex topics.	Stakeholders without access to the internet will be excluded. A moderator should be allocated to manage the process and respond to questions promptly. Privacy concerns should be addressed to encourage participation.

Being asked to participate in a consultation, but not believing that your input will make any difference to the outcome, is a serious hazard. If intention is not genuine, people can sense it. Effective stakeholder engagement is more than a check box as all parties must value it.

2. Focus Group Discussion[20]

(1) What is Focus Group Discussion?

A Focus Group Discussion (FGD) is a method for collecting qualitative data that gathers community members together to discuss a specific topic. Questions are open-ended, with the aim of stimulating an informal discussion and investigating people's views in more detail than is possible through a survey. An FGD usually lasts for 60-90 minutes and includes between 6 to 12 participants.

(2) When FGD can be used?

It can be used during assessments, planning, monitoring and evaluation:

- **During assessment**

  It can be used to gain a deeper understanding of the context in the community including people's beliefs and values, social and cultural characteristics, power dynamics, capacities, and perceptions of the organization.

- **During planning**

  It can be used to identify and prioritize solutions with the community, agree programme outcomes, activities, roles and responsibilities, and how the organization should work with the community during the programme.

- **For monitoring**

  It can be used to find out how well the programme is meeting people needs, if it is reaching the right people, supporting self-reliance and resilience and if people are satisfied with the quality of information, participation and influence they have over the programme.

- **During an evaluation**

  It can be used to evaluate if the programme met people's needs, if support was relevant and timely, if they were satisfied with the quality of information, participation and influence they had over the programme and if there is anything they would change or improve in future programmes.

(3) How to develop FDG questions?[21]

Engagement Questions

It is to establish the topic of discussion with your participants and make them comfortable with the focus group setting and with each other. You'll only ask a few engagement questions, at the beginning of the session.

- "What's your favourite brand of cereal?"

[20]Community meeting tools, Community Engagement and Accountability Toolkit, IFRC, 2021
[21]Jefferson, Thomas Jefferson University,2022. https://online.jefferson.edu/business/create-effective-focus-group-questions/

- "What do you look for in an internet service provider?"
- "What kinds of toys do you like to buy your child?"

Exploration Questions

It is time to move on to exploration questions. Use these questions to get the information you're trying to acquire and to ensure that the discussion is useful. These are bulk of questions in this phase.

- "What's more important in a breakfast cereal: taste or health?"
- "How often do you download large files at home?"
- "What do you think a fair price is for a toy of this kind?"

Exit Questions

It is to ensure you haven't missed anything, or that there isn't anything else your focus group members would like to tell you about the subject.

- "Is there anything else you'd like to say about why you buy the cereals?"
- "Is there anything else we should know about how you choose an internet service provider?"
- "Would you like to tell us anything else about the toys you buy?

(4) Six Steps to create effective FGD questions

(i) Be clear about project goals

(ii) Know want information is already available: It should be eight to 12 questions. Know what information you can get from other methods to ensure you're not asking unnecessary questions.

(iii) Brainstorm preliminary questions: Work with a group to cover engagement, exploration and exit categories.

(iv) Solicit Feedback: Share with project stakeholders to know what are missing or needs to be adjusted or altered.

(v) Refine your list of questions: Cut less important questions, combine similar questions and refine the questions you wish to keep.

(vi) Run a test: Gather a similar number of people and run a test focus group, with the intent of finding any problems with the questions. Look for unclear phrasing or questions that lead to too much tangential discussion.

(5) Do's and Don't

Do's	Do not's
Clear, easy to understand and result in straight-forward answers.	Vague wording
Open ended language e.g., "How did you feel?" or "What problems did you see?"	Yes or No questions
	Questions that might be embarrassing or threatening
General to more specific	

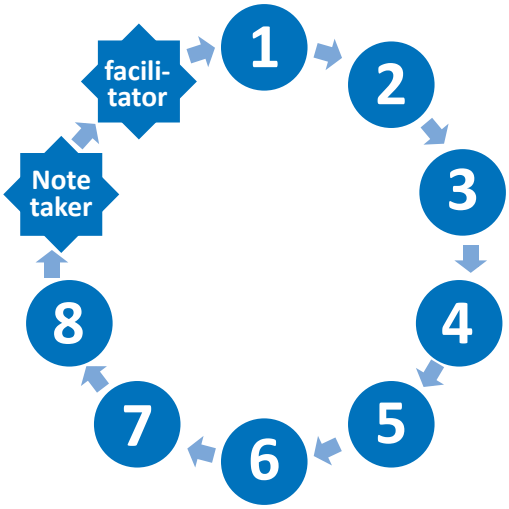
(6) How to Run a Focus Group Discussion?

Planning

- An FGD requires **a facilitator and a notetaker**. Ideally, the facilitator should have previous **experience** of facilitating FGDs.
- Ensure the facilitator and notetaker can either **speak the community language** fluently or are able to work with an **interpreter**. Always run through the questions with the interpreter **in advance** to make sure they understand them.
- **Translate** all FGD questions into the relevant local languages and test these with a native speaker to make sure they make sense and are culturally appropriate.
- It can help to **practice** in advance through a role play with the team, including the interpreter.
- Plan with the local staff/volunteer **where and when** the FGD should take place and who should participate, so they can plan this with the community. Try to avoid participants being selected by community leaders if this could lead to bias.
- Consider whether to provide **food and refreshments**, but do not pay community members to take part.

Setting up the group:

- Identify **a private space** to hold the FGD to avoid lots of people listening in.
- Limit the number of people taking part to a maximum of **12**. Ask the community volunteers or community representative to help you control numbers and offer to organise an additional FGD if more people are keen to participate so they don't feel excluded.
- The participation of a **community leader** may affect the answers people provide. A good tactic is to have another member of the team conduct a key informant interview with the community leader at the same time as the FGD.
- Have people sit in a **circle** as per the below diagram:
- The **facilitator and notetaker** should sit next to each other
- Everyone should be seated at the **same level** i.e., avoid the facilitator and notetaker sitting on chairs, with everyone else on the ground.



At the beginning:

- **Introduce** yourself and explain the purpose and duration of the FGD and allow the participants to also introduce themselves.
- Ask for people's **consent** to participate and permission to take notes.
- Explain clearly that participation in the FGD **does not guarantee** people will receive support, nor do people have to take part to receive support
- It can help to agree **ground rules** at the beginning, such as everyone has a right to speak, not to interrupt one another, there is no right answer, people can opt not to answer a question, and that anything shared should be kept confidential.

When asking questions:

- **Don't ask 'yes/no'** questions or leading questions (i.e., 'do you agree that…?).
- **Don't stick** rigidly to the questions and rush through them. An FGD is an open conversation, not a survey, so ask follow-up questions if something interesting comes up related to objecitves.
- Ask **sensitive questions** in a respectful and sensitive way and recognize when to move on if a topic is making people feel uncomfortable.
- Encourage **everyone to speak**. If someone is not talking ask for their opinion or if someone is talking too much, ask what the rest of the group thinks.
- **Do not judge what people say** - listen openly, even if you disagree and do not react negatively to people's answers.
- If people raise issues linked to **protection or sexual exploitation and abuse**, let them talk as much as they want to but do not press them for details in front of the group. Speak to them separately at the end of the FGD and ask their permission to follow up on the issue and take their contact details. You may need to refer this to a Protection, Gender and Inclusion specialist or your manager.
- At the end:
    - Ask people if they have **any questions** for you

- Explain the next steps and be careful not to make any **promises** or raise **expectations** about what comes next
- Thank everyone for their time.

After

- **Review the notes and add** any additional details so they are not forgotten.
- **Debrief** with the team to capture any additional information about group dynamics, or changes that should be made for the next FGD.
- **Analyse and use** the information collected during the FGD, otherwise it has been a waste of time and could lead to frustration in the community. To analyse:
  - For assessments, FGD findings should feed into the assessment report and will provide a deeper understanding of the community context and how to make sure the community can participate in the planning phase.
  - For planning, FGD findings should be used to inform the programme design including activities, methods and how to ensure good participation, information sharing and feedback management.
  - For monitoring and evaluations, feedback findings can be organized into what is working/worked well and what is not working well and needs to be changed either during the current programme or for future programmes.
- Don't forget to **provide feedback to the community leader, representatives, or local volunteers on the outcomes from the FGD.** Too often communities take part in FGDs and then never hear from the agency again and this affects their willingness to take part in future discussions.

(7) Focus Group Discussion with Children

Girls and boys have needs and abilities which are significantly different from those of adults and from each other. Communicating with children has some specific requirements including:

- Making sure the child and her or his parents provide consent to participate, know that they can stop participating in a session at any time, and have information to access psychosocial or protection support if they need it.
- Ensuring that all persons in contact with children have signed and been briefed on the institutional **Child Safeguarding Policy, Prevention and Protection from Sexual Exploitation and Abuse Policy, and Code of Conduct**; know how to report any safeguarding concerns, and do not commit unsafe and prohibited actions
- Being at ease with children, engaging with them in **whatever style** suits the child (e.g., by sitting on the ground, through play, going for a walk)
- Using **simple language and concepts** appropriate to the child's age, stage of development, disability status, and culture.

- Accepting that children who have had **distressing experiences** may find it extremely difficult to trust an unfamiliar adult. It may take time and patience before the child can feel enough trust to communicate openly and it is important to tolerate expressions of distress and frustration.
- Understanding that children may **view their situation in distinctly different ways** from adults: children may fantasize, invent explanations for unfamiliar or frightening events, express themselves in symbolic ways, emphasize issues which may seem unimportant to adults and so on.
- Being **sensitive to gender, culture, ethics, and the power relations** between adults and the child. For instance, including female and male facilitators when speaking with mixed gender groups; or when more appropriate to have gender specific groups, ensuring that the facilitator is of the same gender.

Examples of questionnaires

Questionnaires for Breastfeeding communication campaign

1. Have you breastfed or do you still breastfeed your child?
2. Did you refraining from eating some food during your last pregnancy? What did you refrain from eating? And why did you do that?
3. Did you breastfeed exclusively for six months?
4. What do you think are the motivations/advantages(enhancers) for you to have done so?
5. Why did you give water to your infants?
6. How did you give rice to your infants?
7. What do you know about exclusive breastfeeding?
8. What do you think would be the best person to reach mothers/prospective mothers about exclusive breastfeeding?
9. What do you think would be the best place to learn about exclusive breastfeeding?
10. What are your media consumption habits?
11. Early initiation? Within 1 hour? Within 1 day? (Why?)
12. Is there anything else you'd like to say about breastfeeding?

Questionnaires for Assessment

1. **What are the most important needs in this community right now?**
2. **What community groups and associations are active in this community?** Is anyone here a member of these groups? (Note how many men and women say)
3. **How often are community meetings held here?** When? Where? Who leads these? Who attends these? Are there people in the community who don't attend?
4. **Are the community leaders supporting you?** Would you be happy for leaders to decide who should receive support and who should not? Who else is trusted in the community? (This is a sensitive question so may need to be asked differently depending on the context and culture, and who is present in the FGD. The aim is to understand if community leaders are trusted.)
5. **How are decisions made in this community about issues that affect the community as whole?** For example, during community meetings? By the groups and associations? By the leader on their own? Do you feel like you have a say in decisions that affect your community? If not, why not? How important is it to you to be involved in decisions about your community?
6. **What is the best way to make sure people in the community can take part in planning activities?** For example, should we plan with the leaders? Through the committees? Through meetings like this?
7. **How well do people get along with each other in this community? Are there are any tensions or arguments between different groups?** This is a sensitive question so may need to be phrased differently depending on the context and who is in the FGD. The aim is to understand if people trust one another and can work together.
8. **What is the best way for us to share information with people in this community?** Which channels? Which languages? Are there people in the community who find it harder to access information? How do people share information with each other?
9. **What information would people like to receive or feel they are not getting?**
10. **What is the best way for people to share feedback, concerns or ask questions?** What if the complaint is something private? For example, about the way we have treated you.
11. **What are the different roles and responsibilities of women, men, boys, and girls in the community and at home?**
12. **Do you have any questions for us?**

Questionnaires for Planning

1.	**What are the key problems or issues you would like this programme/response to address?**
2.	**How are people coping with these problems now?** What is working well? What still needs to happen? What are the capacities and skills of different groups?
3.	**What do you think the community can do to address the problems, and what support is needed from our organization?** Which groups in the community should be involved? Are there groups who would struggle to take part? Are there issues between different groups we should be aware of?
4.	**Once activities start, what is the best way to make sure people have a say in what is happening and can participate in decisions?** How do people normally participate in decisions in this community? Is anyone excluded? Should we work through community leaders or with an existing committee(s)? Or set up a new committee for the project? If so, how should members be selected? What would help people to be able to take part in these approaches? For example, would women need childcare to attend meetings? (Questions about participation can be challenging to understand if people are not used to being involved in decisions so consider the best way to ask this question for the context and adapt the wording as needed.)
5.	**If we do not have enough resources to help everyone, what is the best way to manage that?** How should we decide who receives support and who doesn't? Can the community leader decide?
6.	**What is the best way for the project to share information about the project with the community?** Which languages? Channels? What type of information would people like to receive? How regularly should we share information? Are there groups in the community who might struggle to access information? What are the best ways to reach these people? How do people share information with each other?
7.	**If you have questions, suggestions, or complaints about the project, how would you feel most comfortable sharing these with us?** Through which channels? How would you like us to reply? What would be an acceptable time for us to reply? If the complaint is something private, what is the best way to share this? What if the complaint was about the behaviour of a member of organization?
8.	**Who else is providing services or support in this community and should they be involved in this project?** For example, local authorities? Other NGOs or community organizations?
9.	**Do you have any questions for us?**

Questionnaires for Monitoring and Evaluation

1. **How do you feel about the project activities or support provided in this community?** Are you satisfied with the support provided? Is it meeting people's needs? If not, what needs are not being met? Is support reaching the right people? Is it good quality?
2. **How have people been treated by project staff and volunteers?** With respect? Is everyone treated equally and fairly? Were you ever unhappy with how you were treated?
3. **Do you feel able participate in decisions about the project activities in this community?** Were you asked about your needs at the start? Involved in planning activities? Are you involved now in making decisions about what happens in the project? Are there groups who don't take part? If so, which groups and why? If there is a committee, is it working well? What could the project do to improve people's participation in the project?
4. **Do you understand how the project decides who receives support and who does not?** Are these decisions fair?
5. **Do you receive regular information and updates about what the project is doing in this community?** What kind of information is shared? Is it clear and understandable? Is it useful? Is there information you would like to receive that you are not getting?
6. **How is information shared with you?** Is this a good way to share information with this community? Is anyone missed out? If so, who? Is there a better way to share information with you?
7. **Do you know how to ask questions, make suggestions, or raise concerns with the project?** Are there better ways the Red Cross Red Crescent could listen to your feedback?
8. **If you shared feedback, did you get a response from the project?** Were you satisfied with the response?
9. **Do you feel the project acts on feedback they receive from your community?**
10. **Would you feel comfortable raising private complaints through the project feedback mechanism?** For example, in relation to the behaviour of a project staff?
11. **Do you have any questions for us?**

Annex 4. List of Supplies, IEC and promotional materials

(1) First Aid Kit

(2) Medicines and other required supplies for treatment of

a. SAM, MAM,
b. Pneumonia, diarrhoea

(3) IEC materials

Pamphlets for each CSG

Sr	Items	Quantity
1	Breastfeeding	100
2	Complementary feeding	100
3	Maternal nutrition	100
4	Vitamin A deficiency	100
5	Iodine deficiency disorders elimination	100
6	Iron deficiency anaemia	100
7	Infantile beriberi	100

Vinyl Poster for each CSG

Sr	Items	Quantity
1	Breastfeeding	10
2	Complementary feeding	10
3	Maternal nutrition	10
4	Vitamin A deficiency	10
5	Iodine deficiency disorders elimination	10
6	Iron deficiency anaemia	10
7	Infantile beriberi	10

(4) Promotional Materials

Sr	Items	Quantity
1	T shirt	10
2	Raincoat	10
3	Hat	10
4	Handbag	10
5	Stationaries	10

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