Lessons learned from nimble adaptations to organisations' responses to the sexual and reproductive health (SRH) needs of adolescents in the context of the COVID-19 crisis

Country: Myanmar

Burnet Institute

The Burnet Institute is an international, non-profit, non-political, and non-religious entity and a leading Australian medical research and public health organization focused on improving the health of disadvantaged and marginalized groups. The Burnet Institute (The Macfarlane Burnet Institute for Medical Research and Public Health) was established in 1986 while the Burnet Institute in Myanmar (BIMM) has been operational since 2003. BIMM's current programs are reproductive, maternal, neonatal, child, and adolescent health, in addition to health security, disease elimination and health system strengthening.

Were you delivering services to young people before the COVID-19 crisis?

Building on the findings of a formative study in 2016, we commenced a program titled Integrated Multi-Sectoral Approach (IMSA) to improve adolescent health and well-being in Myanmar. We implement the program in collaboration with the School Health Division, Ministry of Health and Sport, and the Departments of Educational Research, Planning and Training, and Basic Education at the Ministry of Education, in addition to the Magway Regional Monastic School Supervisory Committee. The IMSA program reaches the students from eight monastic schools[1] and ten state schools in the Magway and Tanintharyi regions. The IMSA program established Project Advisory Committees (PAC) which were composed of head monks and nuns, teachers, school health teams of regional and township health departments, community leaders. They provided overall guidance to the project design and implementation in order to ensure cultural sensitivity and to promote local ownership.

IMSA delivers sexual and reproductive health (SRH) education delivery, menstrual hygiene management (MHM), life skill education (LSE), adolescent and youth-friendly health services (AYFHS), human papillomavirus (HPV) vaccination promotion, in addition to mental health and wellbeing promotion for students. Teachers are supported for comprehensive sexuality education (CSE) training, the establishment and functioning of teacher core groups and are provided with teaching aids. The trained teachers conduct training on SRH and gender rights education to mothers, fathers, and guardians of students.

IMSA provides Basic Health Service Professionals (BHSP) with AYFHS training, logistic support for school health team visits, and infrastructure to improve the physical clinics' environment. To ensure a healthy school environment, the program established health corners, youth groups, and provided menstrual hygiene kits and facilities (changing rooms, disposal bins, and pits).

Additionally, Burnet Institute led a study on the burden of disease among adolescent health in Myanmar, a national research prioritization workshop on adolescent health, and private sector engagement in adolescent health, and assisted the Yangon Regional Health Department to establish a health-promoting school program.

What new approaches did you use to respond to and overcome the barriers created by the COVID-19 pandemic to still reach young people?

The COVID-19 pandemic response measures caused the closure of schools, travel and movement restrictions, and limitations to the gathering of people. To overcome these barriers, we conducted virtual meetings and trainings using tools such as Zoom, Google Meet, and Facebook messenger. They included small group sessions, distance learning activities, and home visits by teachers. We also conducted virtual trainings and meetings for PAC members, teachers, and BHSPs. We used small in-person group sessions to train parents and guardians, teachers, and youth groups. Students were enabled to learn regularly and continuously about SRH and communication skills through distance-learning sessions via correspondence and monthly supervision home visits conducted by teachers.

Nutrition packages and masks were distributed to students in small group sessions in order to boost resistance and prevent disease transmission. Students were able to either go to teachers and take MHM kits if needed or receive MHM kits during the home visits conducted by teachers.

Why did you decide to use these approaches?

COVID-19 pressed families into poverty and financial hardship. Students had to work outside their household to contribute to the family income. Moreover, schools were closed and the pricing for one-on-one home tuition was unaffordable. As a result, education discontinuity, social disconnection and susceptibility to mental unwellness occurred. Since there were no classes for teachers during COVID-19, monastic schools could not support even the minimum salary for teachers. There was a high risk of losing trained teachers as they were likely to seek another job. Teachers were given the opportunity to receive small incomes in return for using their resources in the continuation of student education.

Case stories were collected from students, teachers and BHSPs. Based on findings from the case stories, the consultation with PAC members, teachers, BHSPs and school principals were done via telephone, in-person and virtual meetings. We developed teaching methodology,

modules, session plans, learning materials, teaching aids, and assignments in cooperation with the teachers.

Students and their families usually do not have smartphones, laptops or computers and are not able to afford internet fees which presents a barrier to the introduction of distance learning activities. Most of the teachers, on the other hand, have access to smartphones. All teachers had access to school projectors provided by the Burnet Institute. After the IMSA program conducted virtual trainings, the virtual literacy of teachers, principals and BHSPs improved.

Small group in-person sessions were conducted in monastic schools because they have open air and spacious rooms. Distance learning activities and home visits were carried out in the IMSA areas of implementation thanks to therelationship teachers have with both students and parents. Therefore, we applied the "new normal" approaches of virtual meetings and training, distance learning activities, small group sessions and home visits in order to continuously implement IMSA activities.

The first COVID-19 positive case in Myanmar was detected on 23rd March, 2020. As the first wave was not severe, we conducted in-person meetings and trainings in small group sessions. The second wave began in September 2020. Due to the severity of the second wave, in person small group sessions were discontinued but other approaches remained. These innovative approaches will be used until the COVID-19 situation is stable.

How are you working to find out if these approaches are in fact having the desired impact?

We used two approaches: tele-monitoring and supportive supervision via phone calls and home visits conducted by trained teachers to monitor distance learning activities. We collected feedback using two main methods: (1) in-person sessions (one-on-one) to collect feedback from teachers, principals, and students and (2) phone calls and messenger groups to get information related to distance learning activities and parents' training. We assessed the functioning of virtual communication tools during and after each session. These innovative approaches were reviewed and adapted in our BIMM team meetings and will be evaluated in the mid-term review.

We ensured learning continuity for students, teachers, and parents in efficient ways taking into account the scarcity of time and money. The success factors of our implementation were: having a daily schedule, social outreach and connection, creating a sense of accomplishment and responsibility, and sustained relationships with teachers, students, and parents. There was an improvement -though limited- in teacher, principal, and BHSP virtual literacy skills such as using applications and software for virtual communication. IMSA continues in compliance with MOHS guidelines for prevention of COVID -19 in communities.

The challenges we faced were poor internet connection speeds, low availability of smartphones, high cost of internet fees, unfamiliarity with virtual communication tools initially, and some students dropping out from distant learning due to families' financial hardship and concerns about their own health and that of family members.

1. To learn more about monastic schools, please see: https://www.jstor.org/stable/j.ctv13xprwx.9

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