ReBUILD FOR RESILIENCE

The gendered experience of close-to-community providers in fragile and shock-prone settings. Implications for policy and practice during and post COVID-19: A qualitative study report

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Executive summary

Close-to-community (CTC) providers play an important role in providing health services within communities in fragile and shock-prone (FASP) settings. They are often the first point of contact at community level. COVID-19 affected our FASP study settings of Lebanon, Nepal, Myanmar and Sierra Leone. CTC providers were part of the response to the pandemic in these settings and further demonstrated the value of CTC providers. However, there are evidence gaps, including how policy and practice (e.g. support structures) have adapted to the realities of COVID-19, and the CTC providers' experiences during the pandemic and how these are gendered.

Myanmar had its first case of COVID-19 in March 2020 and at the time of writing has gone through two waves of the disease, killing thousands and affecting many lives. In responding to COVID-19, CTC providers have been the first points of contact and main health care providers at community level. There was a range of CTC providers operating during COVID-19, including female auxiliary midwives, male community health workers and volunteers. Although we know that CTC providers have been instrumental in the prevention and control of COVID-19, we do not understand in detail their roles and responsibilities, and in particular how women and men CTC providers experienced their work and were supported during the pandemic. This study focuses on Myanmar, and the overall objective of the study is to explore the roles of CTC providers and their gendered experiences during the COVID-19 pandemic in the country.

Methodology

A qualitative study was conducted in South Dagon Township in Myanmar which has a population of over 300,000 who were was hard hit by COVID-19. A total of seven CTC providers who were actively working during the COVID-19 participated in the study. All the interviews were done over the telephone using Facebook Messenger or Viper. Using the Myanmar topic guide, which was translated from the original English guide, two researchers conducted the interviews with the CTC providers after obtaining verbal informed consent.

The data was transcribed verbatim into Myanmar language and preliminary analysis was done in the same. All the data was also translated into English for analysis which was done using a thematic framework approach by the two researchers. The researchers read the transcripts and identified emerging themes. A coding framework was developed with the other ReBUILD for Resilience member countries, using topic guides, research objectives, themes emerging from the transcripts and data whilst being informed by Morgan et al's gender analysis framework. The four main themes were: who has what (what resources were available to the CTC providers, do they have access to resources); who does what (what are the CTC providers' roles and responsibilities during the COVID-19 response); how values are defined (what are the common social norms and how do they influence the CTC providers and their work during the pandemic); who decides (what are the common rules governing the work of CTC providers, and what are the decision-making dynamics).

Findings

The findings showed that CTC providers were a bridge between the community and the malfunctioning health system during the COVID-19 period. Layering COVID-19-related prevention and control activities onto their original roles as CTC providers (antenatal, postnatal and immunization activities) made the CTC workers busier than before, but all stated that they were proud and happy to serve their communities. During the COVID-19 period they gave educational talks on mask wearing and hand washing. They helped pregnant mothers to access ante-natal care and essential medicines. They also helped fever patients get to the fever clinics and family members to quarantine centres on time. Female CTC providers were more involved in contact tracing and educating community members about preventive activities than their male counterparts. Male CTC providers were more hands-on in the transportation of COVID-19 patients to hospital and sending contacts to quarantine centres.

When looking into who has what, CTC providers were not trained on COVID-19 prevention, clinical signs and symptoms, and community-based health activities. They obtained health information informally through social media. Although they did not get basic support, such as protective masks and hand sanitizers from the health department, they did receive some supplies from INGOs for whom they were working. Little supervision by formal supervisors was reported. Financial support was irregular and out-of-pocket expenses incurred when serving the community were mentioned by some of the CTC providers.

Stigma and fear of contracting the disease by the community was also mentioned. Family members also worried that they would catch the disease. All CTC providers said that they were "givers" of moral and mental support to community members rather than "receivers". Family support and community trust were seen as their main motivation. They also mentioned that recognition from and responsibility for them from the health department was minimal.

This study has shown the value of CTC providers during COVID -19 crisis, but also demonstrates the support that they need to fulfil their critical roles. CTC providers are important health care workers in the fragile, complex and challenging situation in Myanmar.

Recommendations

The main recommendations from the study are:

- CTC providers are frontline workers and are essential in the prevention and control of COVID-19, therefore comprehensive and proper training is required.
- As preventive protective equipment, masks and hand sanitizers are supplied on an ad-hoc basis and are inadequate for the CTC providers' needs, a formal mechanism for wider, sustained distribution is recommended.

- Motivational incentives and recognition should be given for CTC providers' continued contribution, especially during crises like the COVID-19 pandemic.
- When providing COVID-19 vaccinations, CTC providers should be considered frontline health workers along with all formal health workers.

1. Background

Close-to-community (CTC) providers play an important role in providing health services within communities in fragile and shock-prone (FASP) settings. They are often the first point of contact at community level[1]. The COVID-19 pandemic has further demonstrated the value of CTC providers. It has shone a spotlight on how gender shapes vulnerabilities and responses, the importance of CTC providers' intermediary position between communities and the wider health system, the trust they enjoy, and their importance in offering support and care[2-4]. A recent review identified the critical role that CTC providers play in pandemics, highlighting the importance of role clarity, training, supportive supervision, as well as CTC providers' health and well-being, and the need for more research focusing on gender and equity[5].

COVID-19 profoundly affected ReBUILD for Resilience's FASP study settings of Lebanon, Nepal, Myanmar and Sierra Leone. CTC providers were part of the response to the pandemic in these settings. However, there are knowledge gaps, including how policy and practice (e.g. support structures) have adapted to the realities of the COVID-19 pandemic, and the CTC providers' experiences during the pandemic and how these are gendered. This study contributes evidence on gender-equitable approaches to supporting CTC providers in FASP contexts to fulfil their vital role in the COVID-19 response and future disease outbreaks and shocks.

Myanmar is a country in Southeast Asia with a fragile and weak health system. Myanmar had its first case of COVID-19 in March 2020 and up to April 2021 more than 142,610 people were confirmed as having been infected. In the same period there were 3,206 deaths. Yangon region has been the hardest hit region in the country with more than 50% of people having had COVID-19. The COVID-19 situation can be described in two waves. The first wave ran from late March to early August 2020, with a daily infection rate of around 10 people, totaling 360 infected people and six deaths. However, the second wave, which started in mid-August 2020, hit the country hard, with the daily rate of infection rapidly increasing to more than 1,000 people. The second wave overwhelmed the fragile health system which was already suffering from understaffing of health facilities and poor service delivery[6].

In Myanmar, there were 50,000 CTC providers before COVID-19, including female auxiliary midwives and male community health workers who delivered maternal and child health services and disease-control services respectively[7]. In responding to COVID-19, CTC providers have been the first contact point and main health care provider at the community level. There was a range of CTC providers operating during COVID-19, including female auxiliary midwives, male community health workers and volunteers. Although we know that CTC providers have been instrumental in the prevention and control of COVID-19, we do not understand in detail their roles and responsibilities, and in particular how women and men CTC providers experienced their work and support received during the pandemic.

2. Aim of the study

The overall aim of the study is to explore the roles of CTC providers and their gendered experiences during the COVID-19 pandemic in Myanmar.

3. Methods

3.1 Study site

South Dagon township is in the southeastern part of Yangon region, Myanmar. It is a township hard-hit by the COVID-19 pandemic, ranking third for infection rates in the region. It is one of the new settlements in Yangon and comprises 27 wards and has a population of 325,886. It has one township hospital (25 beds), one station hospital (16 beds) and one urban health centre for antenatal care, immunization services and outpatient care.

South Dagon township was one of the model townships during the second wave due to its strong social infrastructures which helped it organize and respond to the pandemic. It had one fever clinic and two COVID-19 containment and quarantine centres. The township also has many community-based civil society groups such as "Thiri Mingalar", "Shin Than Kwint", "Yu Ya, Ah Hnine Mae" and "Meit Swe Kaung" which provide and support emergency ambulance services and funeral assistance. There are CTC providers (Auxiliary Midwives (AMWs) and Community Health Workers (CHWs) who help the community with home quarantine (ensuring that family members stay at home) and provide necessary assistance, preventive activities and referrals to hospital for families with COVID-19.

3.2 Data collection methods

In this study individual interviews were conducted with CTC providers, and key informant interviews were conducted with community-level supervisors of CTC providers. We explored the CTC providers' roles, their interactions with health systems, communities and particularly vulnerable communities and individuals, the support they received, the challenges they faced during COVID-19, and how these were affected by gender.

3.2.1 Data collectors

Two experienced female researchers with qualitative research data collection methods experience conducted all of the interviews. Both researchers reviewed the interview guidelines before the interviews and together discussed how the interviews would be conducted. After every interview both researchers discussed the interview, including the questions, responses and any changes to be made to the interview guidelines.

3.2.2 Individual interviews (IDIs) with CTC providers

Sampling process and size

Purposive sampling was used to select CTC providers in the study township. These included: AMWs - unpaid female volunteer workers whose main role was maternal and child health - and CHWs - male unpaid volunteers whose main role involved environmental sanitation and disease control activities. As there are more AMWs in the township, four AMWs and one male CHW participated in the study.

Recruitment of participants

The AMWs and CHW were recruited through personal contact as they had all worked with Burnet Institute in other projects during the 2012-16 period. They were contacted via telephone, details of the project explained and asked to participate in the interview. If they agreed and were willing to participate, they were sent the participant information sheet and consent form to read at least one day ahead of the interview.

Data collection process

All of the interviews were conducted over the telephone using Facebook Messenger or Viper. Using the Myanmar topic guide, which was translated from the original English guide (Annex 1 – opens new tab), the two researchers conducted the interviews with the CTC providers. As both researchers had good insight into the topic guide and the project objectives, there were no difficulties during the interviews with the participants.

Each participant had the opportunity to discuss the information sheet with a member of the research team and ask any questions. All participants were informed that their participation was entirely voluntary and that they retained the right to withdraw from the process at any stage. Each participant provided verbal consent and also sent a message of consent which was screen shot and stored as proof of consent. The interviews lasted between 45 minutes and one hour. Reimbursement for telephone usage was provided to all participants (around 3 US$). The interviews were recorded following consent from the participants.

3.2.3. Key Informant Interviews (KIIs) with local-level supervisors

Sampling process and size

We purposively selected two local-level supervisors, who have good knowledge and experience of CTC providers' work and worked with CTC providers during the COVID-19 pandemic.

Recruitment of key informants

We recruited the supervisors after interviewing the CTCs. Both supervisors had good knowledge of the COVID-19 response in the community and had worked with many stakeholders, including CTC providers and the health department.

Data collection

Using a topic guide (Annex 1 – opens new tab), two researchers conducted the interviews with the township-level supervisors. The nature of the study and their participation were explained thoroughly using the participant information sheet, and the interviewees had time to ask any questions. Each participant provided verbal consent and sent a message of consent which was screen shot and stored as proof of consent. Both interviews were conducted virtually using Facebook Messenger. The interviews lasted between 45 minutes and one hour. Reimbursement for telephone usage was provided to both participants (around 3 US$). Both of the interviews were recorded with permission using a telephone, and verbatim notes of the interviews were taken.

3.2.4. Data management and analysis

Recordings of interviews and discussions were transferred to a password-protected computer soon after the interviews and then deleted from electronic recording devices. These recordings were then transcribed, anonymized and assigned a participant identification number. All transcripts were encrypted and stored in a password-protected document on a password-protected computer. Participant identification numbers appeared on individual consent forms along with names, with only the two main members of the research team having access to these. All data was stored on password-protected computers, in password-protected documents.

The data was transcribed verbatim into Myanmar language and preliminary analysis was conducted in the same. All the data was also translated into English for analysis and then analyzed using a thematic framework approach by the two researchers who also read the transcripts and identified emerging themes. A coding framework was developed together with other ReBUILD for Resilience partner countries using the topic guides, research objectives, themes emerging from reading the transcripts and data whilst being informed by the gender analysis framework[8]. This framework looks at four aspects of gender relations which have been used as our high-level themes:

- who has what (what resources were available to the CTC providers, do they have access to resources);
- who does what (what were the CTC providers' roles and responsibilities during COVID-19 response);
- how values are defined (what are the common social norms and how did they influence the CTC providers and their work during the pandemic);
- who decides (what were the common rules governing the work of CTC providers, and what were the decision-making dynamics).

We applied the framework to the transcripts and data and developed charts for each code. We then identified and agreed key themes across the contexts. Verbatim quotes were also used to enrich the findings.

3.2.5. Ethical considerations

Prior to data collection, ethical approval was obtained through the Research Ethics Committee in Liverpool School of Tropical Medicine (LSTM) and the Research Ethics Committee at the Ministry of Health and Sports, Myanmar. Research ethics approval from Myanmar was received on 4 February 2021 via an emailed letter.

From project inception, the team agreed on the ethical and safeguarding principles and practices to be used, using our experience of working in Myanmar and with vulnerable groups, e.g. applying the life history approach with CTC providers, safeguarding with different groups, and the methodological and ethical lessons learnt on adapting research during crises. We followed our agreed ethical norms and values to ensure confidentiality of responses and maintain anonymity and privacy for all participants during IDIs and KIIs via telephone. We shared learning about managing ethical dilemmas through our periodic project management meetings, Skype calls and email exchanges with other country team members.

4. Results

This section begins with a brief description of the study participants. We then describe the key themes that have emerged: who does what, who has what, how values are defined, who decides, and recommendations by the participants for change.

4.1 Description of study participants

A total of seven participants participated in the study. Table 1 provides socio-demographic information of the participants.

Table 1. Type of participants and characteristics

Participant	Age	Education	Sex	Marital status	Total years working	Type of participant
Community-based health workers						
A	63	10th Standard	Female	Married, 7 children	15 Years (2006)	AMW
B	51	9th Standard	Female	Married, 3 children	7 years (2014)	AMW
C	46	10th Standard	Female	Married, 2 children	7 years (2014)	AMW
D	53	10th Standard	Female	Married, 5 children,	36 years (2085)	AMW
E	31	10th Standard	Male	Single	7 years (2014)	CHW
Supervisors						
F	54	Graduate	Female	Married, 3 children	13 years (2008)	Supervisor/MRCS
G	49	Graduate	Male	Married, 3 children	37 Years (1984)	MRCS Township level supervisor

Most of the participants were native to the South Dagon township. AMWs and CHW in the study had worked as community volunteers for between seven and 37 years. The two supervisors were members of the Myanmar Red Cross Society (MRCS) and were township-level supervisors for COVID-19-related activities. From here on we use the word close-to-community (CTC) providers for both AMWs and CHWs.

4.2 Who does what? Roles and responsibilities of CTC providers before and during COVID-19

4.2.1 Routine roles and responsibilities of CTC providers

All of the participants worked for more than one organization. The majority were working for between two and four organizations involved in health-related community-level activities. The AMWs worked for tuberculosis (TB) projects under Myanmar Medical Association (MMA) and Pyi Gyi Khin (local organizations) and for maternal and child health activities under JHPIEGO and Myanmar Maternal and Child Welfare Associations (MMCWA). The AMWs' main role was to provide maternal and child health services to mothers and children, but their role had been extended to include other health services, like providing treatment for TB and antiretroviral therapy (ART) to patients with HIV. They mobilised the community for immunization, helped mothers to access appropriate and timely antenatal, intra-natal and postnatal care, and provided health education on nutrition for mothers and children. They looked after newborn babies and reported to the midwife to access necessary care. They also participated in the prevention and control of diseases such as Dengue hemorrhagic fever and diarrhoea, and engaged in contact tracing for communicable disease like TB.

There were only a few male CHWs in the township. They helped the community with environmental sanitation, health education and disease prevention activities for TB and HIV. The CHW included in the study also worked as a CHW for a TB project run by Pyi Gyi Khin (local organizations).

4.2.2 Motivations for working as a CTC provider in general

All CTC providers in the study were very motivated as volunteers. They had all lived in this new peri-urban settlement since its establishment and all of the people in their community knew them well and respected them for their work. They all spoke with pride about their work, as illustrated by the following quotes:

> *"Helping others motivated me to work as a volunteer rather than financial incentive"* (AMW2)
>
> *"I am happy when the needy people are feeling better with my help"* (AMW1)
>
> *"I always help the community with not only health-related matters but also with the necessary transportation"* (CHW)

The CTC providers explained that women were more likely than men to take on health care roles in the community. Women accepted that these were additional jobs, mostly without payment. However, they took pride in providing health care to their community.

4.2.3 General roles of CTC providers performed during COVID-19

Before COVID-19, AMWs assisted with routine maternal and child health activities within the community. In the early phase of the pandemic, midwives were reluctant to gather pregnant women and children for immunization as they were afraid of spreading the infection. Also, many routine activities stopped for nearly six months;

maternal and child health community activities were delayed and many children were not immunized. As a result, the community relied upon the CTC provider services. AMWs were the main people who followed-up pregnant and post-natal women, giving advice over the telephone about antenatal and postnatal care, and safety measures such as wearing masks and washing hands. AMW who worked at the maternity clinic reported that many pregnant women were reluctant to go to the township hospital for delivery as they were afraid of catching the disease and so there were more births at the maternity clinic.

> *"I worked for a maternity clinic and during the COVID period, pregnant women were afraid to go to the hospital as there are also COVID-19 cases coming to the hospital, so the workload at the maternity increase twice. Pregnant mother came for delivery at the clinic, and I had to work extra hours. But I feel happy as we were able to help the pregnant women during this difficult time"* (AMW 3)

During this time, CTCs also struggled with their own families because of their involvement with patients. One AMW explained that her children were afraid that she would catch the disease from a patient, but despite her family's concerns, she continued to work because pregnant women needed her care and support. The CHW mentioned that he worked with other volunteers in preparing to transport COVID-19 cases to the hospitals and contacts to facility quarantine centres. As he knew the community inside and out, people relied upon him when they fell ill, asking for opinions and referrals.

4.2.4 COVID-19 specific roles

Most AMWs explained that at the beginning of the first wave they were very scared, but when only a few people contracted COVID-19, life and work returned to normal within about a month. In the second wave, there were more people with COVID-19 and the community spread of the infection was more apparent. AMWs said that the number of people with infection close to them was increasing, and they were afraid of contracting it and spreading it to their families. Consequently, they mostly stayed home and worked via the telephone. By the second wave they were also more aware of protection and explained that they always wore a mask whenever they went out and frequently washed their hands. During the second wave many of the AMWs helped track people and family members who had travelled to ensure that they maintained the 14-day home quarantine, keeping records and reporting to the health department via the midwife. They also did community health education activities in public places, such as marketplaces and bus stops, and distributed masks. During routine antenatal and immunization sessions, they demonstrated handwashing for mothers and children. They focused on prevention campaign activities with fewer home visits, and helped collect community data for COVID-19 vaccination preparedness. As female volunteers who were trusted by the community, AMWs were contacted via telephone by community members with COVID-19 symptoms and referred them to fever clinics and quarantine centres.

Community volunteers were needed to help in the quarantine centres and fever clinics. Consequently, many young people in the township volunteered for COVID-19 activities, mostly men. CTC providers explained that men were more deeply involved in COVID-19 activities as the nature of the work better suited them, e.g. driving, escorting patients to facilities and carrying equipment and supplies to facilities and homes. Administrative roles were more likely be taken by men, whilst women were more likely to take on health education, prevention activities, and collecting lists of people with COVID-19 and their family members so that they could access quarantine services.

South Dagon township had an organized community network before COVID-19 and some of the wards have their own ambulances. These community groups became major players in COVID-19 activities, helping patients to go to fever clinics, quarantine centres and hospitals.

4.2.5 Motivations for working during COVID-19

During the first wave, most CTC providers were very scared, as was the rest of the population. They explained that their families did not like them going out and working because they were afraid that they would contract the disease. However, because the first wave of COVID-19 was limited, their routine activities restarted after a few months, with CTC providers wearing masks and regularly washing their hands. As they were volunteers, who were always willing to help in the community, nothing really changed during their involvement in COVID-19 prevention. Their main motivation for working in during the response was simply to help their community by using their skills and knowledge and connecting with the health department. One AMW said that if they can help others to be healthy, they will be healthy and happy too.

4.2.6 Impact of COVID-19 on performing roles

CTC providers performed their roles, despite the unknown nature of the disease and the fear it instilled. However, it did affect how they worked, as community members were afraid of catching the disease from the CTC providers, and vice versa.

> *"I had to help during COVID with health care activities and everyone is afraid of COVID… before COVID, everyone would greet me on the street and sometimes even call me inside their homes for a tea chat… but with COVID… No one calls you for a chat… although they say nothing, but I can feel their expression (laughing). One time I told them, I am afraid too… thus before I go out from my house I protect myself well… You're afraid of me but I am more afraid of you all as I don't know if you have the disease or not. I protect myself well but you all do not (laughing)…"* (AMW1)

4.3 Access to resources

4.3.1 COVID-19-specific training

The two township supervisors received training on COVID-19. They reported that the quality of training was good because it was organized by the National Level Central Committee and the trainers were very knowledgeable about the disease. The CTC providers reported that they had not received any formal training on COVID-19. They explained that they learnt about prevention activities, like hand washing and mask use, via social media and national TV news. This information was repeatedly broadcast and they found it very useful. During the second wave, State Counsellor Aung San Su Kyi did a national campaign on mask awareness and hand washing which was on all social media, and which CTC providers found very persuasive and informative. All CTC providers said that they would like to receive proper training about the disease process, prevention activities, quarantine rules and regulations, vaccines and when to vaccinate. One of the AMWs said:

> *"I just watch news on the TV and if I want to know something I just search on Facebook. Sometimes I talked to my supervisor and ask for the thing that I want to know…"* (AMW 3)

4.3.2 Equipment and supplies (PPE, masks, hand gels and IEC materials)

In the early phase of the pandemic, masks and hand gel were scarce and expensive. CTC providers obtained these from some of the projects that they were working on, but supplies were irregular. During the second wave, regular mask distribution was provided by the projects and the Township Health Committee. There were also mask campaigns in the township and the distribution of masks to the community was more frequent. The price of masks had also decreased during the second wave, and they were more affordable for both CTC providers and the general public:

> *"We get mask from the organization that we are working for, like the TB projects, and I also bought some as the price of the mask dropped and was more affordable in the second wave"* (AMW 1)

The two supervisors described the Township COVID-19 Coordination Committee (TCC for COVID-19) which was led by the Township Health Department and included Social Welfare, MRCS, MMCWA, township-level administrative authorities, local-level business enterprises and local charity organizations. Under the TCC for COVID-19, the MRCS played an important role in volunteer recruitment, coordination of training of volunteers, and assigning these volunteers to various quarantine centres and fever clinics (there are six quarantine centres and two fever clinics in South Dagon township). PPE was only distributed to volunteers working in these quarantine facilities and fever clinics.

4.3.3 Financial support for CTC providers

Although all CTC providers are volunteers and do not receive regular financial support, they do get financial assistance from the organizations they work for. Financial support ranges from 30,000 -150,000 kyats (20 US$ to 100 US$) per month, depending on how many organizations they work for. However, CTCs did not

get any additional financial support for doing COVID-19 prevention activities. One CTC provider worked as a driver and only occasionally received reimbursement for fuel costs. He explained that as he has a part-time paid job as a driver, he is able to manage. Some CTC providers reported that they did not receive regular financial support for their telephone bills. Most CTC providers reported that they pay out-of-pocket for telephone bills and transportation costs. All AMWs stressed that they love their work and have been working as a volunteer without pay for years, and whether they get money or not will continue working for their community. One AMW said:

> *"I don't receive or ask for anything. Sometimes the patient called us and talk so long… we have to pay on our own but there are some people who understand and gave us phone bills back… but I never ask….*
>
> *Question: Do you get any kind of incentive or money from the organizations you are working for or even moral support?*
>
> *Not really, we use our own expenses for travelling and sometimes we have to go with a motorcycle and sometimes with a bus. Compared to ordinary women, as we work for the community, we gained respect and pride of working"* (AMW2)

4.3.4 Support from the Township Health Department

All CTC providers reported that they did not receive any support from the health department specifically for COVID-19. However, some received uniforms and material support like masks and hand gel from various organizations and community support groups:

> *"To be frank, the health department is not very supportive towards CHWs. We only get the initial training and there is no refresher training at all. We get some of the knowledge by working with the health care workers… I think the health department should be more supportive towards all volunteers"* (CHW)

4.3.5 Support from other organizations

CTC providers reported that they had received support from the various organizations that they work for, such as local non-government organizations, Myanmar Red Cross Society (MRCS), Myanmar Maternal and Child Welfare Association (MMCWA), JHPIEGO and TCC for COVID-19. This support included masks, clothing, food and telephone bills. CTC providers valued this support:

> *"Tokens of appreciation and "thank you" cards from MRCS, community and health departments make us feel motivated. I feel like I got supported when I feel very tired. I am happy for that. We work not for money and not expecting we will get something in return. From MRCS, we got hats or T shirts and some other presents from the community as tokens of appreciation. I also get the "thank you" card signed by Daw Aung San Suu Kyi. Those are my motivation."* (AMW 1)

4.3.6 Mental and moral support

All CTC providers expressed that they were "givers" of moral and mental support to community members rather than "receivers". One AMW mentioned about a pregnant

woman who was worried for herself and her child because her husband was COVID-19 positive and she was sent to a quarantine centre. The AMW said that she called the pregnant woman daily and gave her moral support until her time of delivery. The supervisors reported that the TCC for COVID-19 provided some moral and mental support to CTC providers via telephone and sometimes in person. The supervisors also spoke with the CTC providers, asking about their working conditions, worries and needs. They listened to their experiences and provided support by giving advice and reassurance about how to stay safe, sometimes giving them snacks, and going to their homes to talk with their families about the important work that they do.

4.3.7 Social media

Social media played an important role for all CTC providers in the study. Facebook was mentioned as the main medium for obtaining COVID-19 information. CTCs obtained information about the signs and symptoms of COVID-19, proper hand washing and mask wearing, and the location of quarantine centres, fever clinics and COVID information call centres from Facebook. Although irregular, telephone cards were provided by the organizations for whom they worked and internet connections were quite stable before the coup.

> *"Facebook is very useful, we get most of the information from there"* (AMW 2)

The CTC providers reported that the most popular information on Facebook was a hand washing demonstration by the National Leader, Aung San Su Kyi. The national leader also held an online competition to make a cloth facemask in May 2020, aiming to increase awareness of the importance of wearing masks when leaving home to curb the spread of COVID-19. The CTC providers thought this event was very effective. One of the AMWs received an acknowledgement letter from the State Counsellor for making a handmade mask and was very proud of this:

> *"I made my own cloth mask and competed in the competition, and I received an appreciation letter and I valued it so much"* (AMW 1)

Viper also serves as a connecting media among CTC providers and the community for education, reporting and exchange of information. Viper groups were formed by CTC providers not only to distribute information but also to remind people about antenatal care and other services. Viper is also used for monthly reporting by AMWs to their supervisor midwives. For supervisors, videoconferencing with the Township Coordinating Committee is also conducted via Messenger and other media platforms for meetings and training:

> *"I have a Viper group with the pregnant mothers that I look after. From there I remind them for AN care and also give them information on where they can get a tetanus injection and other services. They also ask about information they want to know about."* (AMW3)

4.3.8 Supervision

AMWs assist with all of the midwives' activities in taking care of the mother and her children, e.g. antenatal care, childbirth, post-natal care, and providing immunization

and nutrition advice for children. Although they did not receive any training or supervision for COVID-19-related activities, AMWs combined COVID-19 prevention activity with their daily routine work as they were in close contact with the community. AMWs are normally supervised by midwives who are paid government workers, but during COVID-19 there was minimal supervision of AMWs by these midwives. They spoke to the AMWs on the telephone but did not meet them in person as they were afraid of contracting COVID-19:

> *"She (midwife) only talked to me on the phone and tell me to look after the AN patient. She is also afraid, and I can understand"* (AMW 3)

The MRCS supervisor worked with the CTC providers to conduct COVID-19 prevention activities in the community.

4.3.9 Other challenges

One supervisor mentioned that South Dagon is a unique township with a good social support structure within the community. The community, health sector and community-level workers all understand and support one another. CTC providers did not mention much about the challenges faced during the COVID-19 period, however, a supervisor who had worked in the fever clinic described the challenges faced by female volunteers working during the COVID-19 response:

> *"There is a challenge for girls, and it sometimes needs someone to accompany the girls (volunteers) on their way home from work. Sometimes, we have meetings at night. For me, my husband must come and pick me up. For girls, we may need to arrange for their return trip. For example, the Township Committee arranged a car for girls for safety. For boys, there is no problem as they can manage their own."* (Supervisor 1)

4.4 Social norms and values affecting CTC providers' work during COVID-19

4.4.1 Family support

CTC providers reported that they had full family support for their work. Family members often warned them to take extra precautions when going into the community as they worried about transmission of COVID-19, but in general all CTC providers were thankful to their families for their understanding. One woman working for the fever clinic explained that her husband was willing to pick her up from the fever clinic even late at night. She contracted COVID-19 with mild symptoms and her husband became positive too. She thought that her husband was infected because of her but he has never blamed her for working:

> *"Family members (husband and children) were supportive despite being afraid of COVID and warned me to take precautions"* (AMW 2)

All female CTC providers described the need to balance family routine, such as cooking, cleaning, and taking care of the family, with their AMW work. Some AMWs said that they had to get up earlier than other family members to finish the cooking

and washing for the family before they go out. Although the majority said their families were supportive of their work, it was apparent that women bore a greater burden than men as expressed by one of the participants:

> *"Need to adjust to have equilibrium between work and family. More sacrifice for women than men as men do not have much responsibility like women"* (AMW3)

4.4.2 Community acceptance of CTC providers

CTC providers are well accepted by the community and recognized for their contribution in helping them. They are well connected with social organizations and support groups within the township which has been positive, both for the community and the CTC workers themselves. The AMWs who took part in the study are culturally-friendly cadres who have helped not only women and children in maternal and child health activities, but they have also assisted the wider community with any health issue needing an emergency referral or support.

> *"AMWs and CHWs have been together with us for many years and they are very helpful to the community"* (Supervisor 2)

4.4.3 Mobility limits for women during COVID-19

As COVID-19 is a challenging communicable disease, social mobilization activities were important in the early phase of the disease when many of the CTC providers were involved as health educators. However, AMWs in the study said that men have more freedom than women when choosing the nature of their COVID-19-related work and working environment. Men can choose the type, location and timing of work as they have fewer worries and family responsibilities. They also feel safer working in different places and at different times.

CTC providers have experience of providing health messages to the public; they know how to speak with different community members and are accepted by those communities. One of the main roles of AMWs is health education and counselling for mothers and children. All AMWs described providing information on COVID-19 during immunization activities with mothers, which included demonstrations of hand washing and how to properly wear a mask. Occasionally they also participated in public mass health campaigns on COVID-19 organized by the Township Coordination Committee. They also gave individual psychological support and health education via telephone to women in the community.

4.4.4 Community fear of COVID-19 infection and CTC providers

Everyone, including the CTC providers, was afraid of the disease, especially when they did not understand it at the start of the first wave. People were afraid of the CTC providers, but the CTC providers were also afraid of people in the community. In the second wave, CTC providers saw the severity of COVID-19, and so were more cautious as they were afraid of contracting the disease. Despite being health care providers they were reluctant to go into patients' homes to see them, and patients were also afraid to visit them. Telephone communication became an intervening media for all:

"In the second wave people were more cautious because they saw patients and the disease severity" (AMW1)

4.5 Who decides (decision-making power)

All participants reported that there was no specific power imbalance between men and women when work-related decisions were made. Women volunteers in the study had full decision-making power for themselves and their activities. Although some mentioned that they do need to consult their husbands, they still make their own decisions.

For COVID-19-related activities, decision-making comes from the township TCCC. All the participants in the study helped one another and explained that coordination at the township level was good between all health volunteers. MRCS also plays an important role in COVID-19-related activities. A township level supervisor described:

"We work together with the women volunteers and health care providers... as you know. We are like brothers and sisters when in need we help each other" (Supervisor 2)

4.6. Recommendations by participants

COVID-19 was a new disease, and the already weak health system was not prepared and not able to respond fully. However, the CTC providers in the township responded to the emergency as there was a strong community structure. The study participants provided important and practical recommendations that will be useful for managing future health emergencies and pandemics at community level.

CTC providers actively participated in health-related activities during the COVID-19 crisis, both at prevention and referral levels. In the future, it would be more effective and productive to set up a volunteer network in every township (for disease control, pandemic situations and natural disasters). It is also necessary to empower and increase the skill and capacities of volunteers.

All participants stressed that there was no proper protocol or guidelines for CTC providers on where to send people with COVID-19 and contact tracing. There is a need for a specific focal point in the Township Health Department to whom CTC providers can report. Participants explained the MRCS had a clear reporting process, and so CTC providers knew who to contact when they found someone with COVID-19 and were then told what to do. They found this to be very helpful. CTC providers also reported that the Township Health Department did not acknowledge the work of CTC providers:

"It would be really good if the health department recognizes the community health volunteers and tries to connect and collaborate with them more" (AMW 1)

All CTC providers recognized the need for training and information on COVID-19, and in particular disease prevention, signs and symptoms, and how to conduct contact tracing. They all felt that the Township Health Department was not organized and needed to take more responsibility for training and information sharing. They explained that the COVID-19 response worked well because of the community cohesiveness rather than the Township Health Department activities.

During the COVID-19 pandemic, AMWs continued to provide services for pregnant women who needed information such as where to deliver and who to contact in emergencies, and not just COVID-19-related information. AMWs suggested establishing knowledge exchange groups of AMWs and midwives with good telephone links so that they can readily share information.

Participants also said that acknowledgement of CTC providers is important. They suggested that the Township Health Department should support the community health volunteers both financially and technically. Since they are volunteers, they need incentives like payment of telephone bills and transportation charges. Currently, CTC providers pay out of their own pockets to connect with pregnant women and community members:

> *"It would be good if the health department support and give us some role in the community rather than asking for help only when in need, so that there would be less drop-outs"* (AMW 3)

> *"It would be really good if the health department recognizes the community health volunteers and tries to connect and collaborate with them more"* (AMW 1)

CTC providers and supervisors talked with sadness and frustration about the COVID-19 vaccine. Priority for vaccination was given to healthcare workers but this did not include CTC providers. They mentioned that they are the closest to the community, and feel sad that they are not included in the vaccination list for health workers:

> *"Now that there is COVID vaccine volunteers should be considered same as health workers in getting the vaccine*" (Supervisor 2)

5. Discussion and conclusion

CTC providers listened to the voices of the community and responded to their call for support during the COVID-19 pandemic. No one forced the CTC providers to help the community. All of the AMWs interviewed said that they listened to pregnant mothers' needs and helped them to reach care. When all other health services were engaged in responding to COVID-19, pregnant mothers were still able to consult AMWs on where to go and who to contact. They counselled mothers and transported essential drugs, like iron and folic acid from midwives to women, despite the risks to their own health. They were the first responders to help the community - referring people with COVID-19, tracing contacts, organizing quarantine and educating. Although they were afraid of catching the disease, they were willing to serve the community despite their families' concerns.

COVID-19 has disrupted health systems around the world. Many health workers were infected and hospitals were overloaded with sick people. In such situations, people centeredness in service delivery often collapses, however, CTC providers responded to the immediate needs of their communities by connecting people with health care workers and facilities. As the formal health system struggled to respond, CTC providers placed people at the centre of their service delivery. They carried out various activities related to COVID-19 prevention (e.g. educating their neighbors and patients on hand washing and mask wearing) and patient care (e.g. liaising with and directing infected people and their families to treatment centres and quarantine facilities). Although they provided these services, they were not equipped with personal prevention equipment or necessary training and knowledge. As COVID-19 was a new infectious disease, little understood by communities, some discrimination was also encountered by AMWs who were seen as people who may spread the disease.

Since the late 1970s CTC providers have filled the gaps produced by a lack of skilled health care providers. These unpaid volunteers are embedded in and trusted by their communities and serve as a bridge between the health care system and the community[9]. This embeddedness was instrumental in the effectiveness of CTC providers' activities in the COVID-19 response. The good relationships that they have with their communities have not only helped those communities but also reduced health care providers' workloads. The study findings suggest that CTC providers were active agents of preventive COVID-19 activities and drivers of referrals for people with COVID-19. Since most volunteers are women, many experienced the double burden of household chores and community-based health activities, as seen in other studies.

In the study township, the health system did not respond in a people-centred way during COVID-19. This may be because COVID-19 was a new and unknown disease and health care providers did not think that it would disrupt the system as much as it did. In this regard, CTC providers were a real helping hand and a valuable asset for both the community and the health system. The community valued the CTC providers, and they respected and acknowledged the role that CTC providers played

during COVID-19. However, CTC providers in the study did not receive training, supervision and COVID-19 vaccinations as did other official healthcare workers. The health system must ensure that CTC providers are valued and provided with the same standard of protection against COVID-19 as other healthcare workers.

This study has shown the value of CTC providers during COVID-19 crisis, but also demonstrates the support that they need to fulfil their critical roles. CTC providers are important healthcare workers in the fragile, complex and challenging situation in Myanmar. This study has shown the value of CTC providers during the COVID-19 crisis, but also describes the support that they need to fulfil their critical roles. CTC providers are important healthcare workers in fragile, complex and challenging situations, such as in Myanmar. The evidence produced in this study can inform policy and practice with regard to CTC providers and can contribute to system reform.

6. Recommendations

- CTC providers are frontline workers and are essential in the prevention and control of COVID-19, therefore comprehensive and proper training is required.
- As preventive protective equipment, masks and hand sanitizers are supplied on an ad-hoc basis and are inadequate for the CTC providers' needs, a formal mechanism for wider, sustained distribution is recommended.
- Motivational incentives and recognition should be given for CTC providers' continued contribution, especially during crises like the COVID-19 pandemic.
- When providing COVID-19 vaccinations, CTC providers should be considered frontline health workers along with all formal health workers.

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