Collective Voices

PARTICIPATORY DEVELOPMENT OF M&E STRATEGY AND LOGICAL SOCIAL FRAMEWORK

Capacity building of CBOs to identify and address social factors limiting access by communities, especially the poor and marginalised to health services

Results in interventions that improve health seeking behaviour, community voices and engagement with health service providers

Target communities empowered to access fair, responsive and inclusive health services

Yangon, Myanmar

November 2015
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ACKNOWLEDGEMENT

Monitoring and Evaluation may be one of the most challenging areas in health and social development because it not only demands performance and results but also creativity, enthusiasm and energy from the projects themselves. I saw plenty of the latter in the nascent civil society of Myanmar who hold big dreams for their country. Now a few of them have their own M&E Strategy that will provide direction and guidance in service of the community. The twenty five organizations are a small window into the soul of Myanmar and my very best wishes to you all as you take the Collective Voices Initiative forward.

However, none of this would have been possible without the 3MDG Fund. I would like to acknowledge the Fund for providing a platform to the Lead CSOs and their CBO partners to develop a participatory and bottom up M&E Strategy. A special thank you goes to Julia Messner, 3MDG Accountability Officer for her vision, leadership and commitment in making Collective Voices the best it can be. The process ‘went off without a hitch’ for three reasons; the exemplary attitude of the Lead CSO-CBO partners towards 3MDG, an eagerness on their part to take the Initiative forward collectively and the attitude of the Health for All Team who were consummate professionals in their support to the CV partners and the Consultant.

Thank you to the hera team for giving me this opportunity. After many years in the profession, I can state with confidence that no two bespoke M&E strategies are alike. I have not only learned a lot but enjoyed the experience too.

Poonam Thapa, PhD
Global Health Consultant
Training and Evaluation
LIST OF ABBREVIATIONS AND ACRONYMS

3MDG The Three Millennium Development Goal Fund (also referred to as the Fund)  
AEI Accountability, Equity and Inclusion  
APO Accountability Programme Officer (of 3MDG)  
AYO Ar Yone Oo  
BF Bright Future  
CAD Community Agency for Rural Development  
CBOs Community Based Organisations  
CDDCET Community Driven Development and Capacity Enhancement Team  
CEDAW Convention on Elimination of All Forms of Discrimination against Women  
COM Charity Oriented Myanmar  
CSO Civil Society Organisation  
CV Collective Voices (also referred to as the Initiative)  
CfP Call For Proposal  
DAC Development Assistance Committee OECD  
ECC Early Childhood Caries  
EmOC Emergency Obstetric Care  
HCP Health Care Provider  
HSB Health Seeking Behaviour  
HSS Health Systems Strengthening  
IEC Information, Education and Communication  
INGO International NGO  
LNGO Local NGO  
LSF Logical Social Framework  
MNCH Mother Neonatal Child Health  
M&E Monitoring and Evaluation  
MoH Ministry of Health  
MSA Monitoring Supervision and Audit  
NGO Non-governmental Organisation  
PLA Participatory Learning Action  
PTE Phant Tee Eain  
SRHR Sexual and Reproductive Health and Rights
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>SSI</td>
<td>Semi Structured Interview</td>
</tr>
<tr>
<td>THD</td>
<td>Township Health Department</td>
</tr>
<tr>
<td>TMO</td>
<td>Township Medical Officer</td>
</tr>
<tr>
<td>ToC</td>
<td>Theory of Change</td>
</tr>
<tr>
<td>ToR</td>
<td>Terms of Reference</td>
</tr>
<tr>
<td>Three(3)Os</td>
<td>Objective Output Outcome</td>
</tr>
<tr>
<td>T/VHC</td>
<td>Township Village Health Committee</td>
</tr>
<tr>
<td>UHC</td>
<td>Universal Health Coverage (sometimes referred to as Care)</td>
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<tr>
<td>UNOPS</td>
<td>United Nations Office for Project Services</td>
</tr>
<tr>
<td>VHC</td>
<td>Village Health Committee</td>
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EXECUTIVE SUMMARY

1. Introduction

Myanmar is the largest country in Southeast Asia and according to the provisional 2014 census, the total population is approximately 51.4 million, divided into eight national ethnic races and 135 officially recognised groups. The Government is committed to achieve Universal Health Coverage (UHC) as part of its Vision 2030 “Health for All” policy. A roadmap to greater democracy since the elections in 2010 has provided increased space for civil society organisations (CSO) and community-based organisations (CBO) to operate, including support of the health sector.

The aim of the six-year, multi-donor Three Millennium Development Goal Fund (3MDG Fund 2012-2017) is to accelerate progress towards the health MDGs 4, 5 and 6 and UHC in Myanmar. A key component of the Ministry of Health’s (MoH) vision is to strengthen community engagement in health service delivery and promotion (Strategic Area 6), which is a key component of the 3MDG Description of Action.

Collective Voices is an innovative Initiative that reflects the notion that, in order for the objectives of 3MDG to be achieved, fundamental changes need to occur in the relationships between health care providers and the community they serve, especially the poor and marginalised, to achieve improvements in service quality, access and utilization. Hence, the eventual goal of the interventions is “target communities empowered to access fair, responsive and inclusive health services”. This goal is modified from the 3MDG programme output goal No.5 “enhanced health services responsiveness and accountability to communities” to better reflect the overarching lessons from the strategic review in 2014 and the breadth of health seeking behaviour interventions and expected changes in relationships the Initiative aims to achieve between civil society, community and health service providers.

In June 2014, 3MDG launched a new project, ‘Collective Voices: Understanding Community Health Experiences’. Through a unique two-stage project, the 3MDG Collective Voices (CV) Initiative is partnering with six CSOs who in turn are each partnering with a minimum of three CBOs (twenty-five organisations in total) to: firstly, generate better information for all stakeholders on the social factors limiting access to health care (Design Stage 1 - March-October 2015), and secondly, to empower local organizations to implement effective solutions at the community level (Implementation Stage 2 - November 2015-December 2017).

The United Nations Office for Project Services (UNOPS), who manages 3MDG, contracted a consultant through hera to develop a Monitoring and Evaluation (M&E) Strategy including a Social Framework for Collective Voices. The main inputs for developing the strategy and framework incorporated a one day training course for each of the six Lead CSOs and their CBO partners. The purpose of the course was to understand the concepts, terms and methods of M&E and generally agree on several working definitions as a basis for developing their project log frames deemed necessary to measure and analyse their results. This was followed by a two-day workshop for all CSO-CBOs and the 3MDG Health for All team to develop a bottom up and integrated Logical Social Framework based M&E Strategy for Collective Voices. The workshop reinforced the CSO-CBO learning gained from the training course, and allowed them through group work and plenary discussions to arrive at a consolidated set of outputs at the level of Collective Voices. The pre-training course and post-workshop evaluations indicated that the CSO-CBO participants were highly successful in achieving increased technical knowledge and skills, enabling them to devise an M&E strategy for their own projects and contribute to an overarching one for Collective Voices. A review of the six finalised CSO (PTE, Bright Future, COM, CDDCET, AYO and CAD) proposals and
workshop information contributed significantly to the development of the overall Collective Voices M&E Strategy.

The scope and methodology for the development of the M&E Strategy for Collective Voices comprising the formulation of a Theory of Change (ToC) flow chart, 3Os (Objective, Output & Outcome indicators) table, Logical Social Framework (LSF) and Communications Framework involved triangulation of outputs from the training courses and workshop, 3MDG information and Collective Voices publications, semi-structured interviews and CSO proposals/presentations (Annex 3). A social framework approach to ToC was adopted bearing in mind the 3MDG logical framework, particularly output 5 (enhanced health services accountability and responsiveness through capacity development) and analysis of objectives of Collective Voices with reference to Health for All to arrive at measurable output and tracking outcome indicators. An M&E Planning and Scheduling Matrix was produced linking Collective Voices Stage 1 (Design) to Stage 2 (Implementation) with formative (monitoring, supervision, audit and midterm review), final (summative) and probable 3MDG impact evaluation. Qualitative indicators to support the analysis of health seeking behaviour change and DAC evaluation criteria adapted for use by Collective Voices evaluations are greatly explored.


The overall approach to a participatory M&E strategy (see working definition Box 1) is illustrated in Annex 9. A shared understanding of 3MDG Health for All provided the starting point, from which - taking a Social Framework approach to the Theory of Change (ToC) - , CSO-CBOs rationalised the problem statement, later adapted as “Poor availability and access to basic health services exacerbated by limiting social factors in target communities, and insufficient capacity of CSO-CBOs and healthcare providers to undertake effective engagement in 6 states/regions”. The problem statement is translated into a goal statement and in turn specified the implementation strategies/main activities of Collective Voices and the underlying assumptions, which enable delivery of projects. The diagram in Annex 9 illustrates how the Health for All Team, through a monitoring pathway, will track CSO-CBO implementation work plans through agreed output indicators using regular project reporting and supervision. It also shows how, through an evaluation pathway, outcome indicators will be assessed at mid-term and final evaluations to track the change effects of implementation. The data obtained through the combination of both pathways, enables the understanding, analysis and communication (via a Collective Voices Communication Framework) of change in health seeking behaviour by type and focus of change. The end product provides Collective Voices input to the possible 3MDG Impact Evaluation measuring overall change.

The Theory of Change (ToC) embedded within Collective Voices (summarised in Figure 1 and fully elaborated in Annex 10) has been established through triangulation of 3MDG/Collective Voices publications and resources, semi-
structured interviews, the joint CSO-CBO / Health for All Team workshop and project proposals. It reflects a set of assumptions and the working definition (see Box 2) of how change will happen and includes ideas or explanations currently widely held within 3MDG/Collective Voices.

Figure 1 - Collective Voices: Theory of Change

The internal logic of the Collective Voices’ ToC is that inputs (3MDG funds & CSO-CBO resources) and activities (training and health education), lead to outputs for the Initiative (a change in the supply of products/services e.g. Village Health Committees formed/strengthened). These in turn lead to outcomes (the use or application of outputs), which reflect the Initiative/programme’s benefits and changes in behaviour, knowledge, skills and level of functioning (e.g. improved community health seeking behaviour and engagement with health services). In the longer term outcomes contribute to the goal of target communities empowered to access to fair, responsive and inclusive health services. This is summarised in the Results Chain in Figure 2.

Figure 2 - Collective Voices: Results Chain

Goal
Target communities empowered to access to fair, responsive and inclusive health services

Outcome
Improved health seeking behaviour and community engagement with health services

Outputs
Improved CBO capacity increased community health knowledge and strengthened feedback mechanisms

Activities
Lead CSO-CBO training, community IEC & gender interventions, training HCPs, create referral and health funds, community engagement in Village forums etc.

Inputs
3 MDG funds for CSO-CBO for "Community Voices" - Community design-inception (Stage 1) and Work Plan implementation - community actions (Stage 2)
The main **expected changes or outcomes** of Collective Voices as per its Theory of Change (**Annex 10**) are:

- Empowered women make personal and family health decisions;
- Improved health seeking behaviour in target communities;
- Increased engagement between health service providers and target communities; and
- Increased capacity of Lead CSO-CBOs to support health and development.

The **strategies or main activities** and associated outputs resulting from the implementation of Collective Voices to achieve the above-mentioned outcomes summarised in Figure 2 above, are:

- Training and capacity building of Lead CSO-CBOs;
- Community health information, education and communication;
- Gender awareness raising of target communities;
- Strengthening community referral and village health funds;
- Community engagement through Village / Township Health Committees and Planning Forums; and
- Training health service providers (public, private, informal) in target community on overcoming social and cultural barriers to healthcare.

The **Objectives, Outputs and Outcome (3Os)** template (**Annex 11**) of Collective Voices expresses how specific outputs and outcomes are measured and how change occurs and can be analysed as a result of programme implementation, monitoring and evaluations. Outputs and outcome indicators (quantitatively or qualitatively speaking) are SMART (specific, measurable, attainable, realistic and timely) will allow the Initiative to assess progress towards achieving the specified objectives.

The numbers of objectives were expanded from an original three to four, again to better reflect CSO-CBO project activities and results which were restructured and further codified following the M&E training sessions and workshop. In this process, specific interventions that empower women to make personal and family health decisions were expressed as distinct activities/results. The four Collective Voices objectives now also reflect the expected changes (detailed above) necessary within the ToC (**Annex 10**) to contribute towards achieving the Collective Voices’ goal. The output indicators were arrived at through review of CSO-CBO proposals and work plans, and capacity building activities to ensure compatibility with regular project data collection, measurement and reporting (**Annex 9** – monitoring pathway). The outcome indicators were selected to enable review of the effects of CSO work plans in terms of the expected changes to be assessed through Health for All-Collective Voices Midterm (formative) and 3MDG-Collective Voices Final (summative) evaluations (**Annex 9** – evaluation pathway).

A **Social Framework** is a means of describing an expected pathway of influence through a wider network of people, groups or organisations, which is relevant to the successful implementation of a programme. In terms of Collective Voices this can be illustrated in a network diagram (Figure 3) reflecting different actors involved, and their relationships.
The thick blue line represents the main pathway of interest and influence and what happens in terms of social relationships can be expressed through a Logical Social Framework (LSF).

A LSF reflects the reality that people and relationships matter if change is to be achieved. It is a way of summarizing the theory-of-change (in this case converting the social and system barriers into a health seeking behaviour change, moving from a negative problem statement to a positive goal statement), and the objective-output indicator-outcome indicator-change analysis table (Annex 11) within the 3MDG health development Initiative, in a form that is easily explained and can be monitored and evaluated. Without this combination most social frameworks by themselves remain anecdotal and immeasurable.

The LSF as presented in Annex 12 defines the problem statement as expressed within the Initiative’s ToC. This is then converted into a goal statement for expressing the long-term objective of Collective Voices interventions and key relationships as defined in the Social Fare diagram are noted.

The four objectives that Collective Voices will address in order to contribute to the achievement of the goal, together with the outcome indicators (measuring expected changes) and output indicators (measuring the change in supply of products and services) necessary to monitor and evaluate the 3MDG Initiative are summarised in Table 1. The means of verification of these indicators, for example training and Village Health Committee records and assumptions regarding the operating context, for example Township and Village Health officials and infrastructure, enabling the delivery of the programme are detailed in Annex 12.

The LSF as summarised in Table 1 expresses key relationships (it is people who make outputs and outcomes happen) necessary to achieve results and enables Health for All team to monitor CSO-CBO projects against measurable indicators and evaluate them to identify the degree to which stated objectives have been achieved in support of the Collective Voices goal. A budget for conducting M&E and communicating results is crucial for the entire Collective Voices Initiative and is highly recommended.
### Table 1 - Summarised LSF Outcome and Output Indicators with Key Relationships, Source and Verification of Indicators to Achieve Results

#### Objective 1 – Increased empowerment of women to make personal and family health decisions

<table>
<thead>
<tr>
<th>Outcome indicators:</th>
<th>1) Percentage increase in community knowledge and awareness of women’s healthcare needs (disaggregated by gender), 2) Percentage increase in female community volunteer representatives on VHCs, and 3) Percentage increase in women using local community health funds for out of pocket family health expenses. (&quot;Baseline&quot; established from Stage 1 results and inception phase review).</th>
<th>Output indicators:</th>
<th>1) Number of participants at gender and health specific training, awareness and information sessions (disaggregated by gender), 2) Number of women trained as volunteer representatives on VHCs, 3) Number of women trained to establish local community health funds, and 4) Number of local health funds established and operated by women. (Data verified from activity record and collected through monitoring form)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key relationships to achieve outputs:</strong></td>
<td>1) CSO-CBO-Target communities 2) CSO-CBO-Target communities-Township Medical Officer-PHC 3) &amp; 4) CSO-CBO-Target communities</td>
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#### Objective 2: Improve health seeking behaviour in target communities in three states & three regions

<table>
<thead>
<tr>
<th>Outcome indicators:</th>
<th>1) Percentage increase in knowledge and awareness of project-related health issues and local health services, 2) Percentage increase in timely referrals who receive health services, 3) Percentage increase in utilisation of specified local health services, and 4) Percentage increase in community satisfaction with local health services. (&quot;Baseline&quot; established from Stage 1 results and inception phase review).</th>
<th>Output indicators:</th>
<th>1) Number of Training/IEC interventions on reproductive health, personal hygiene &amp; nutrition and health care services undertaken within target communities (disaggregated by subject, language and location), 2) Number of referral mechanisms established and/or strengthened for EmOC, ECC or other emergency care, 3) Number of cases referred utilising referral mechanisms for EmOC, ECC or other emergency care, and 4) Number of health staff trained and aware of social and cultural factors limiting access to health services. (Data verified from activity record and collected through monitoring form)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key relationships to achieve outputs:</strong></td>
<td>1) CSO-CBO-Target communities 2) CSO-CBO-Target communities-Township Medical Officer-PHC 3) &amp; 4) CSO-CBO-Target communities</td>
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#### Objective 3: Improve participation and engagement between target communities and health care providers, including local health coordination and planning mechanisms in selected townships and villages

<table>
<thead>
<tr>
<th>Outcome indicators:</th>
<th>1) Percentage increase in community members participating in T/VHC and 2) Percent of community feedback that has been verified as actioned3) Number and % of Township Health Departments that have engaged communities in micro planning process supported by CSO-CBOs. (&quot;Baseline” established from Stage 1 results and inception phase review).</th>
<th>Output indicators:</th>
<th>1) Number of health staff, community members and other stakeholders trained to establish/strengthen Township/Village Committees (T/VHC), 2) Number of joint information sharing sessions with HCP involving community representatives to advocate for community health needs (session outcome briefly documented), 3) Number of participatory T/VHC established/strengthened, 4) Number of T/VHCs that establish a functioning community feedback mechanism, and 5) Number of State/Regional/Township training sessions delivered by CSO-CBOs on community engagement and listening to community voices. (Data verified from activity record)</th>
</tr>
</thead>
</table>
Box 3. Joint Brand: Working Definition

"A joint brand is the essence of 3MDG’s own unique story that includes a collection of COLLECTIVE VOICES stories".

The added value of the Communications Framework (Annex 13) to Collective Voices is that the relationships described in the LSF that help to achieve the outputs would be influenced by how the programme is perceived. This has implications given that cooperation with different actors is necessary to achieve objectives related to health seeking behaviour and engagement with health service providers, INGOs, LNGOs and beneficiary communities. The Framework is a means of ensuring coherent communication to different audiences at national/regional, township and community level of Collective Voices brand values (see working definition Box 3) and results, to enhance collaboration and partnerships to the overall benefit of the 3MDG programme.

The M&E Planning and Scheduling Matrix (Annex 14) differentiates the M&E Strategy based on the Collective Voices project portfolio/Initiative programme life cycle namely, design, implementation and follow-up. Formative evaluations were conducted during Stage 1 - Design (i.e. needs assessment and inception) and another planned for Stage 2 Implementation (i.e. Midterm Review), the latter to highlight unplanned under-over implementation, barriers that delay or prevent the achievement of objectives and inform the development of Collective Voices projects/programme. Follow-up and End of Project Stage 2 (summative) final and impact evaluations will examine the achievement of Collective Voices outcomes and qualitatively measure changes achieved.

The M&E Planning and Scheduling Matrix summarises for the benefit of CSO-CBOs and the Health for All team:

- What is to be monitored and evaluated?
• What activities are needed to monitor and evaluate?
• Who will be responsible for monitoring and evaluating?
• When monitoring and evaluation are to be planned?
• What resources are required and where they are committed?

The consolidated ToC (Figure 1 and Annex 10), the Results Chain (Figure 2), 3Os template (Annex 11), the Social Network diagram (Figure 3), LSF (Table 1 and Annex 12) and Communication Framework (Annex 13), together with the systematic M&E Planning and Scheduling Matrix (Annex 14) developed on a participatory basis with the CSO-CBOs and the Health for All team, are the core of the COLLECTIVE VOICES M&E Strategy.

The OECD’s Development Assistance Committee (DAC) in 1991 established several principles of evaluation which were subsequently developed into five to seven specific criteria (eight if impact is included) which are today widely used in development evaluation (See criteria – Box 4). During the training sessions each of the criteria was defined and during the workshop the Lead CSO-CBOs were asked to suggest questions for each of the evaluation criteria (see Annex 15) for use in future Collective Voices reviews and evaluations. Furthermore, the column on analysing change (Annex 11) can also guide an evaluator to develop more questions and qualitatively explore the type and focus of change that is being sought by 3MDG.

3. General Conclusions and Recommendations

**Conclusion 1:** Given that the CSO-CBOs proposed activities and results although containing similar elements, include substantial differences in approach, it is important to ensure their project data collection and reporting system is aligned with the suggested overall Collective Voices Logical Social Framework.

**Recommendation 1:** A meeting should be called between the 3MDG Health for All Team and the implementing six CSO-CBOs to seek further harmonisation of the Collective Voices Logical Social Framework output and outcome indicators with those of the six projects being implemented to ensure alignment, consistency and feasibility of data collection across the Initiative. Ensure that M&E component of projects are adequately resourced both at the level of Lead CSOs and Health for All.

**Conclusion 2:** 3MDG reports to a set of indicators. In turn the process for developing the M&E Strategy and Logical Social Framework has recognized this from the outset and this Report emphasizes that the signal of success of Collective Voices will not only be at their level but how they have contributed to the overall success “how their (Initiative) outcome contributes to our (3MDG) outcome”.

**Recommendation 2a:** Once recommendation 1 has been achieved the 3MDG Health for All team and M&E team should meet to establish how the Collective Voices Logical Social Framework is contributing to the overall 3MDG log frame. It is suggested that Output 5 is kept intact as there will be INGOs and LNGOs reporting towards it and that the Collective Voices goal is added, ensuring there is no duplication in reporting.

**Recommendation 2b:** There should be integration and mutual buy-in with 3MDG mid-term review and the final summative evaluation using the planning and scheduling matrix (Annex 14) as a guideline. There will be some budget and resources implication on both sides but would help increase joint activities and co-ordination between two critically important parts of 3MDG.
Recommendation 2c: In order to make the M&E Strategy for Collective Voices functional, an M&E Assistance Framework should be mutually agreed so that the 3MDG M&E unit can play the role of routine in-house support for Health for All Team and Lead CSO partners. Joint activity could be around analysing Stage 1 consolidated results and establishing “baseline”, the mechanism for data feedback from Lead CSOs, support for the development of selection criteria of a company and budgets for midterm/end of term evaluations as well as ToR for the evaluator(s) and help in formulating the table of content of the Collective Voices Annual Report.

Conclusion 3: Given that the CV M&E Strategy will soon be in place, it is expected that relationship among relevant CV partners and those 3MDG partners working in Component 1 (MNCH) will be further reinforced especially those present in the same state/region/township.

Recommendation 3a: In order to ensure that there is no dual reporting to 3MDG and data inflation, there is an imperative that the three Lead CSOs (AYO, COM and CAD) meet with C1 partners and have a discussion on the CV M&E strategy outputs and outcomes in order to bring greater clarity to the ‘joint’ intervention process, role and responsibility and contribution/attribution of each partner

Recommendation 3b: It is highly encouraged that CV organisations work with and learn from each other on how to join forces with other implementing partners and stakeholders in their project areas.

Conclusion 4: In recognition that Output 5 of 3MDG encourages community participation as part of health responsiveness, the whole M&E Strategy and the Logical Social Framework and quantitative indicator- qualitative analysis of change (Annex 11) focus on responsiveness in favour of health seeking behaviour.

Recommendation 4: Collective Voices Communication Framework that has been developed for the purpose of joint brand recognition (Lead CSO, 3MDG and Collective Voices) will need to be aligned and harmonized into the 3MDG communication framework/strategy. As Stage 2 project implementation begins this month, accelerated communication will be crucial to encourage large-scale uptake of services by the community in the coming year. This activity will have budget implications for Collective Voices and must be duly considered.

Conclusion 5: The M&E Strategy for Collective Voices including the formulation of the Logical Social Framework are following closely in the footstep of trainings on organisational strengthening of the six Lead CSOs and project cycle management but only one of the CSOs had formally integrated M&E functions into staff responsibility, sole or otherwise. There were two M&E officers who attended the M&E training course but their role and responsibility was not clear vis-à-vis the Collective Voices project.

Recommendation 5: The Health for All Team should ask the Lead CSO to formally designate a senior staff as focal point in support of implementing the M&E Strategy especially the monitoring of data collection, reporting and analysis. A ToR to this effect should be prepared and joint team meetings should be planned on a six monthly basis to discuss the findings especially quality of project data and reliability.

Conclusion 6: Trainings on a variety of relevant subjects such as PLA tools, gender and conflict sensitivity and disability, have been ongoing for the partners including CBOs and there is the same exposure to all 6 partners. Stage 1 projects have identified the need not just for MNCH but also for sexual and reproductive health and behaviour change communication. It is critical that both MNCH and SRH trainings are underpinned by gender, social inclusion and rights as many of the projects are targeting adolescent and youth, girls and women, sexual minorities and prevention of HIV.
Recommendation 6: Preferably as soon as possible, otherwise when space opens up, the Health for All Work Plan should introduce a socially inclusive, gender and rights based SRH training that also includes components such as sexuality education and behaviour change communication. In fact it would be interesting to do the training utilizing social accountability tools. If properly rationalized and justified, Collective Voices should be able to pass the budget eligibility criteria without any overlap with Component 1 (MNCH).

Conclusion 7: In order to measure effectively change from the implementation of the projects, a KAP (Knowledge, Attitude and Practice) survey will be necessary especially in relation to outcomes related to Objective 1 - women’s empowerment and Objective 2 - health seeking behaviour (to be incorporated into the Planning and Scheduling Matrix). The survey will specifically provide data in relation to the following outcomes:

Objective 1 - Outcome indicator 1 - Percentage increase in community knowledge and awareness of women’s healthcare needs.

Objective 2 - Outcome indicator 1 - Percentage increase in knowledge and awareness of 3 MDG health issues and local health services.

Objective 2 - Outcome indicator 4 - Percentage increase target community satisfaction with delivery of local services, baseline and follow-up satisfaction surveys are necessary to provide data in relation to this indicator.

Objective 2 - Outcome indicator 2 - Percentage increase in timely referrals from target communities who receive health service, the issue of countering the issue of subjectivity in relation to measuring timeliness might be addressed to some extent by defining requirements within referral mechanisms for EmOC or ECC.

Recommendation 7a: The KAP survey should be designed and implemented to be undertaken within the CSO-CBO work plans early in the Stage 2 implementation phase, with a review incorporated as part of the Mid-term review in October 2016.

Recommendation 7b: A separate baseline survey would be necessary if the community assessment (Stage 1) did not provide sufficient qualitative and quantitative information necessary to indicate current community views regarding local health services, to be followed up during the Mid-term review.

Recommendation 7c: It may difficult to define a baseline in relation to timeliness of emergency referral of cases and hence it may be appropriate to measure whether referral mechanisms operate to the access standards as defined within the referral mechanism protocol.
1 PART I: BACKGROUND AND INTRODUCTION

1.1 Health Policy and Practice in Myanmar: Civil Society Perspectives

Myanmar is the largest country in Southeast Asia, with a total land area constituting 676,000 square kilometres and divided administratively into seven states and seven regions. According to the provisional 2014 census, the total population is approximately 55.4 million, divided into eight national ethnic races and 135 officially recognized nationality groups\(^1\). The country has experienced internal conflict for more than 60 years and although this is now confined to fewer areas, basic services have yet to recover from the damage caused by earlier conflict (Box 5). Myanmar has become more democratic since 2010, when the country held national-and state-level elections, in accordance with a roadmap developed by the military junta in 2003.

The above-mentioned political development has resulted in an increased space for civil society organizations (CSOs) to operate. However, these CSOs are few and have limited capacity to represent the interests of poor or excluded groups to service providers and limited political space to advocate for appropriate policies and programmes\(^2\).

There are two types of CSOs operating in Myanmar currently: Community-Based Organizations (CBOs) and national CSOs, in addition to a large number of International NGOs (INGOs). CBOs are generally informal or voluntary associations that are formed at the village level and typically do not have paid staff. The estimated number of CBOs in Myanmar is 214,000. National CSOs who tend to originate from cities and townships, are still largely having temporary registration, and often have paid skilled staff. There is no reliable approximation of how many national CSOs are in Myanmar but estimates range from 270 to 10,000\(^3\). Several of the larger CSOs are registered with government ministries or at state level and will often work with government and/or development agencies to implement projects across a diverse range of sectors, including health care. INGOs, having entered the field significantly in 2008 after Cyclone Nargis, are largely focused on longer-term development, health and humanitarian response. In addition to national/state CSOs, prominent INGOs like, Save the Children (SCF), CARE, Population Services International (PSI), Marie Stopes International (PSI) and International HIV Alliance to name a few have provided their assistance in achieving more positive health outcomes.

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\(^1\) The Population and Housing Census, Myanmar, 2014: Summary of Provisional Results; Department of Population, Ministry of Immigration and Population, August 2014.
\(^2\) Description of Action Multi-Donor 3MDG Fund (2012-2016), pg. 1 and 4
\(^3\) ADB Civil Society Briefs: www.adb.org/countries/myanmar; www.adb.org/publications/myanmar-fact-sheet
There are several CSOs and national networks in Myanmar that also play a role in the provision of technical resource in the health and social sector\(^4\). These include Gender Equality Network, Myanmar CSO Network, Myanmar Positive Group National PLHIV Network, Myanmar Medical Association, Myanmar Red Cross Society, Myanmar Nurses Association, Myanmar Dentists Association, Myanmar Physically Handicapped Association, and Myanmar Maternal and Child Welfare Association\(^5\). Additionally, there are several noteworthy civil society capacity-building initiatives in Myanmar that seek to meet the growing demand in the development sector for skilled and trained staff. A prominent initiative is Paung Ku, a national group initiated by a consortium of INGOs to assist smaller organizations in Myanmar on training, advocacy, coordination and small grants. The initiative also plays a critical role in helping INGOs network with civil society\(^6\).

The Government has committed to achieve universal health coverage (UHC) as part of its Vision 2030, defined as ‘the provision of optimal quality of health care to everyone in the country that is accessible, efficient, equitably distributed, adequately funded, fairly financed, and appropriately used by an informed and empowered public.’\(^1\) Myanmar’s “Health for All” policy is coordinated by the National Health Committee, chaired by the Vice President of the Republic of the Union of Myanmar.

The Department of Public Health is responsible for the public health divisions and manages primary health care, nutrition promotion and research, environmental sanitation, maternal and child health services, and school health services. The National Health Plan follows a primary health care approach based on state and township and district administrative levels. The township health departments are responsible for the delivery of both urban and rural health care services.

Civil society has been playing a critical role in poverty alleviation programmes, national sanitation programs, national immunization days, health education and disease prevention, and social welfare services for a long time (Box 6). In Myanmar, approximately 79.3 percent of health services are funded by the private sector, (which includes for profit and not for profit), 13.6 percent by the government, and the remainder from international sources.\(^7\) In 2011, the Ministry of Health estimated total health expenditure per capita was roughly $28 (in Purchasing Power Parity International $) and despite current increased health budgets, the government’s ability to allocated resources to health care remains constrained\(^8\). Public institutions and civil society organizations working for the implementation of the

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\(^4\) For 3MDG, the term CSO applies to national non-profit entities and the term CSO are used to mean both CSOs and CBOs.

\(^5\) Collective Voices Lead CSOs will establish relationships with some of these larger CSOs mentioned here during the course of implementation.

\(^6\) Reflections on Myanmar Civil Society 2014, KEPA Myanmar

\(^7\) Myanmar Public Expenditure Review 2015, World Bank

\(^8\) The Republic of the Union of Myanmar Health System Review, Asia Pacific Observatory on Health Systems and Policies, 2014
Convention on Elimination of All Forms of Discrimination against Women (CEDAW), limited progress has been made, due in part to lack of resources.

Myanmar suffers from high maternal child mortality and among specific diseases; the leading causes of death are tuberculosis, malaria and HIV/AIDS. There are significant health inequalities in health status and in access to affordable, quality health care especially in rural areas, the hard to reach remote populations and the vulnerable. In the absence of health policy and programme implementation, CSOs act as a buffer often providing services and public goods where needed. In this endeavour they are supported by bilateral and multilateral agencies operating in the country as well as the 3MDG Fund (from here on interchangeably referred to as 3MDG or the Fund).

### 1.2 The 3MDG Fund

The aim of the six year, multi-donor Three Millennium Development Goal Fund (3MDG Fund 2012-2017) is to accelerate progress towards the health Millennium Development Goals 4, 5 and 6 and UHC in Myanmar. The design of the 3MDG Fund is intended to promote transformational change and a rights-based approach. In partnership with the Government of Myanmar and others, the Fund seeks to strengthen the national health system at all levels, extending access for poor and vulnerable populations to quality health services.

The 3MDG Fund aims to have a significant, timely and nationwide impact, improving maternal and newborn child health, and combating HIV and AIDS, tuberculosis and malaria (Table 2). It will also strengthen the public structures and institutions that deliver sustainable, efficient and responsive healthcare across Myanmar. Systems strengthening will also include measures to empower community voices to hold public health accountable and to build related capacity.

<table>
<thead>
<tr>
<th>COMPONENT 1, MATERNAL, NEWBORN AND CHILD HEALTH</th>
<th>COMPONENT 2, HIV, TB, MALARIA</th>
<th>COMPONENT 3, HEALTH SYSTEM STRENGTHENING</th>
</tr>
</thead>
<tbody>
<tr>
<td>108,137 Children immunized with PENTA 3</td>
<td>75,636 Women visited four times for antenatal care</td>
<td>71,131 Births attended by skilled person</td>
</tr>
<tr>
<td>71,131 Pregnancy women use emergency referrals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RESULT JUNE 2015 (4.4 MILLION PEOPLE COVERED)

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9 Civil Society Review Myanmar: Transition Process: Prospects for 2015 and Beyond, October 2014; Myanmar CSO

10 MNCH is the largest component (1) of the Fund, covering 4.4 million people with essential package and quality continuum of care through community based work and the private sector. Governance and oversight is through Township Health Plans. Additional human resource and training support is provided to the MoH.

11 The Fund works closely with Myanmar’s National Disease Control Programme to support national strategies on HIV/AIDS, TB and Malaria, integrating partner responses to the three diseases, extensive service delivery and working in conflict affected areas (component 2).

12 The Fund provides sector-wide support across a broad range of areas, especially initiatives to strengthen institutions and systems of MoH, develop health financing policy, strengthen the supply chain, improve health workforce training, renovate health facilities at primary health care level as well as provide support to strategic directions to achieve UHC coverage and community engagement (component 3).

13 Description of Action Multi-Donor 3MDG Fund (2012-2016), pg. 2

14 [www.3mdg.org](http://www.3mdg.org)
By pooling the contributions of seven bilateral donors - Australia, Denmark, the European Union, Sweden, Switzerland, the United Kingdom and the United States of America, 3MDG promotes the efficient and effective use of development funds. Donor commitment is based on support for good governance, civil society capacity building, health, education, poverty alleviation, basic needs and livelihoods for the poorest and most vulnerable populations, and environmental protection\(^{15}\). The Fund is set up to have a catalytic role in facilitating a health development process where people in communities will be provided with information to help them access health services, and the public health system will be supported in listening to the voice of the people and responding accordingly. The United Nations Office for Project Services (UNOPS) manages the 3MDG Fund.

### 1.3 3MDG Programme: Engaging Communities and Fostering Health for All

As outlined in the Government’s strategic direction for UHC, a key component of the MoH vision is to strengthen community engagement in health service delivery and promotion (Strategic Area 6). The 3MDG Fund recognizes that community engagement creates opportunities for learning from the ground up, and community views can be used to inform health policies, programmes, services and projects. It also enables health providers to be more responsive to the needs of people, which improves the quality of health services and enhances patient satisfaction. This MoH vision is also reflected in the Fund’s principles of non-discrimination, equality, participation, transparency and accountability.

3MDG has introduced a vision for health care in Myanmar. This work of the Fund, to engage communities and foster health for all, is placed within Component 3, Health Systems Strengthening, working towards the key output goal of ‘enhanced health services accountability and responsiveness through capacity development of target communities, civil society organizations and the public sector’ as stated in 3MDG Logical Framework (or log frame). It is managed by the Health for All Team that also oversees grants for the Collective Voices Initiative (explained in the next section).

In an effort to drive and promote accountability to communities (or beneficiaries) amongst its implementing partners, and address the cross-cutting, societal issues or ‘social determinants of health’ that significantly affect health outcomes for individuals and communities, in late 2013 the 3MDG Fund consolidated the main cross-cutting issues relevant to the Fund (e.g. gender, beneficiary accountability, social inclusion, community engagement and partnerships with civil society) into one strategy, calling it an Accountability, Equity and Inclusion (AEI) Strategic Framework.

An overarching lesson of a 2014 strategic review was that the 3MDG language of ‘accountability, equity, and inclusion and conflict sensitivity’ was too technical, complex, and unfamiliar to many people in Myanmar (particularly those in the field and in communities). Based on this feedback, the 3MDG Fund developed more user-friendly and context-appropriate ways of explaining these concepts, and has linked them more clearly to the Ministry’s UHC goals. While the objectives of the AEI Framework remain valid, going forward the Fund will refer to an approach to ‘Health for All’, and will use simpler language such as community engagement, responsibility, fairness, inclusion and ‘do-no-harm’ to more easily communicate the nature of its rights-based work\(^{16}\).

\(^{15}\) Description of Action Multi-Donor 3MDG Fund (2012-2016), pg. 17

\(^{16}\) Community engagement means working directly with national CSOs and CBOs. Responsibility incorporates good governance and accountability, and keeps to commitments for the people who use health services. Inclusion ensures that the voices of all stakeholders and people are considered during health planning and decision making. The Fund calls for fairness and justness to all people who use health services regardless of age, gender, ethnicity or location, and takes action to address discrimination. The Do No Harm approach stipulates that 3MDG partners ensure that health activities do not create or worsen conflict.
The Fund’s “Health for All” strategy complements the efforts of the MoH by focusing on community engagement and capacity development. The basis of the strategy utilizes the skills, strength and knowledge of local communities to fortify health services and client satisfaction. The Ministry continues to lead the way in strengthening the development of the health sector, but all stakeholders – public and private – play a role in bearing responsibility to the communities they serve (Box 7).

For example, it is expected that civil society will play a key role in independent monitoring and feedback. At township level this might include reviewing the capacity of existing structures for accountability; training for township health teams and committees; capacity building for civil society organizations for independent monitoring of service delivery; strengthening community mechanisms for voice and accountability and ensuring that these are integrated within coordinated township plans. In addition, feedback from beneficiaries and through accountability mechanisms will be collated by the Fund Manager and provided to the Senior Consultation Group and the Fund Board, to ensure that the voices of beneficiaries, communities and implementing partners at township level are heard by those responsible for 3MDG Fund management and oversight.

The 3MDG Fund provides financial support to implementing partners (INGOs, national and local CSOs, CBOs, and UN agencies) who support health services to all people in Myanmar, especially to groups who are vulnerable or have difficulty in accessing health care services.

1.4 Collective Voices: A Strategic Health Partnership with Communities

In June 2014, 3MDG launched a new project, ‘Collective Voices: Understanding Community Health Experiences’. Through this unique two-stage project, 3MDG is partnering with six CSOs to generate better information for all stakeholders on the social factors limiting access to health care and empower local organizations to implement effective solutions at the community level.

The initiative builds on the CSOs strong relationship with their local communities and excellent understanding of issues relating to gender, equity, social inclusion, community engagement and participation. The six CSOs are each partnering with a minimum of 3 CBOs each, meaning that 19 CBOs are also part of the Collective Voices Initiative (25 organizations in total).

Within the three programme components of 3MDG there are six output goals, contained in the 3MDG log frame; the fifth of these is the following:

Box 7. Fundamental Paradigm Shift in Strategic Decision Making

- 3MDG is now fully aligned with the public health system. After the sanctions were lifted in 2011, the Fund was the first to begin full cooperation with Ministry of Health. By 2014, the government had agreed to participate in the Fund’s Board which ensures that it is involved in the delivery by the Fund along with donors and independent experts.

- Universal Health Care is now an accepted principle in Myanmar. The whole Fund is a partnership at various levels and there is strategic coordination and collaboration by all three components of the Fund. 3MDG has introduced a new vision for health care in Myanmar.

- With the implementation of Collective Voices which is now happening, the cross-cutting principle of partnership in health is complete. Through our increased engagement, MoH understands that interests are mutual at various levels of implementation and this includes CSOs.

From Interviews
“Enhanced health services accountability and responsiveness through capacity development of target communities, civil society organizations and the public sector.”

According to the 3MDG AEI Strategic Framework, this output raises important issues of definition; what will an accountable, equitable and inclusive health system in Myanmar look like? Some gender-rights based approaches highlighted in 3MDG Description of Action forms the basis of Collective Voices and is well utilized to formulate Part III of this report: 1) Target delivery of an essential package of health services that will primarily benefit women and girls of reproductive age and children; 2) Implement demand-side financing that will increase access to services for poor people, in particular poor women and their children, and monitor the impact on service uptake by women; 3) Support research that improves understanding of how gender affects health, health seeking behaviour, health care expenditure and other gender-related issues, including knowledge and attitudes of men and women concerning utilization of health services.; 4) Ensure that accountability mechanisms support equal engagement of women and men and promote women’s representation and voice, and monitor the participation of women; 4) Ensure that Fund Manager and implementing partner staff have a good understanding of gender issues and that the Fund Manager has access to gender expertise; and 5) Include gender-relevant indicators in the logical framework and collect disaggregated data as appropriate.

Issues such as gender relations, social inclusion, empowerment, culture and change towards health seeking behaviour (HSB) are complex issues and changes therein are hard to measure. It is precisely for this reason that simple and straightforward gender and rights based approaches for community engagement, capacity building, partnership and learning have been introduced into the process (Box 8).

The Collective Voices is made up of six carefully selected Lead CSO partners who are focusing their work in 3 regions and 3 states of Myanmar and together with 19 local CBOs have so far held 200 plus community meetings on health seeking behaviour, promotion of MNCH, prevention of HIV and utilisation of appropriate health services (Annex 1).

The Initiative initially has two fold objectives:

1. Increase understanding of the social factors limiting access to health care (community voices); and

2. Empower local organisations to take action to address the social factors by improving understanding between communities and health service providers (community co-ordination, communication and collaboration).

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17 Fostering Accountability, Equity and Inclusion in 3MDG: From Principle to Practice, September 2013
The fulfilment of these objectives is expected to boost the utilisation of primary health care facilities through support for expanding UHC coverage and strengthening partnerships (community outcome - action). The choice of objectives also addresses the multi-faceted principles and social factors that are barriers to health in fulfilling the purpose of 3MDG.

The Initiative operates in two stages:

**Stage one**, the first six months (March-October 2015) or the inception-design phase focused on the training of CSO-CBO partners in facilitating participatory meetings around gender, culture-related behaviour and reproductive health. The CBOs also lead a series of participatory meetings in order to bring people together with the purpose of generating information people’s views and opinions on social barriers to health. It has required resourcefulness and patience by all partners as dividends start to happen. (Box 9)

**Stage two** (November 2015-December 2017) or the implementation phase, will be focused on piloting community-led projects which seek to address the barriers identified through the stage one findings. By bringing greater understanding about social factors, which limit access to health care, and by facilitating mutual understanding between communities and health service providers, COLLECTIVE VOICES also plans to share its findings in order to inform health planning and decision-making at the national level.

The Initiative is closely supported by the 3MDG Accountability Programme Officer (APO) and a three member-technical and grant management team (the Health for All Team). The APO represents the Initiative’s engagement with MoH and the three components of 3MDG Fund. The Team works closely with COLLECTIVE VOICES partners in the provision of technical assistance and is responsible for monitoring as well as coordinating all evaluations with 3MDG.

The overall Initiative budget for the 34 month projects is USD 1.5 million which is split into two parts for Stage 1: USD 300,000 (20%) for needs assessment, inception and project design and Stage 2: USD 1.2 million (80%) for project implementation.

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18 Principles: responsibility, fairness, inclusion and Do No Harm; social factors: (remoteness, hard to reach, distinct ethnicities, language and dialects, poverty and imbalance in decision making on health between genders)
1.5 Terms of Reference and Deliverables

Annex 2 provides the original terms of reference.

United Nations Operations for Project Services sought the support of Hera, a consultative group in the field of health systems development, management, financing and evaluation to help develop a Monitoring and Evaluation (M&E) Strategy for Collective Voices and a Social Framework (in place of a traditional log frame).

During the course of discussions with the 3MDG Accountability Officer, it was agreed that the Hera Consultant (also referred to as Facilitator in relation to the Training Course and Workshop) would hold one-day sessions with each of the six organisations to build the capacity of individual Collective Voices partners to develop their own project log frame, and with their inputs help design an integrative Logical Social Framework based M&E Strategy that is rationalised under the aegis of Health for All and also one that contributes to the Fund’s Performance and Results based Logical Framework (3MDG log frame) including measurable indicators for monitoring, tracking outcomes and qualitatively analysing change.

There are three sets of deliverables at the output level that form part of this report:

1. Outputs at the level of Lead CSO project: The basis for the output is the one day training course on M&E provided separately to each of the Lead CSOs and their CBO partners (also referred to as participant in relation to Training Course and Workshop) by the Hera Consultant. These included flow charts depicting community issues and contextualised theory of change (ToC), an objective formulation - output - outcome indicator table (3Os), logical modelling and a communication framework (how to communicate your evaluation results) for their project.

   Expected Outcomes: 1) The partner CSO will utilise the social framework based logical framework during their final project proposal submission to 3MDG; and 2) the completed set of M&E charts becomes a constant point of reference by the AEI team during project implementation.

2. Outputs at the level of Collective Voices: The basis for the output is the inputs provided by the six CSO partners during a two-day workshop co-facilitated by the Hera Consultant and the Health for All Team. The set of outputs arrived at the workshop includes:
   - Collective Voices theory of change;
   - M&E strategy that is integrated into the Collective Voices project cycle management and 3MDG programme impact evaluation;
   - Suggested criteria for a mid-term and final (summative) evaluations;
   - Practical understanding of the relationship between objective-output-outcome and analysis of health seeking behaviour change;
   - Collective Voices Logical Social Framework; and a
   - Pro-active communications strategy for Collective Voices.

   Expected Outcomes: 1) The Health for All Team will utilise the set of outputs as integral during grant management and reference them in a continuous process of monitoring and evaluation; and 2) 3MDG remains amenable to holding discussions with the Health for All Team to better integrate the Collective Voices M&E Strategy with that of 3MDG.
3. Outputs related to knowledge enhancement, skills development and capacity building in M&E:
The basis for this output is comparison between participant responses to the pre-training course and post-workshop evaluation questionnaires.

Expected Outcomes: 1) There will be shift in the CSOs knowledge and understanding of M&E Strategy as well as 3MDG-Collective Voices thus providing higher level of confidence in implementing their projects and promoting the Collective Voices-3MDG brand, 2) participate in the mid-term, final (summative) and impact evaluation with greater readiness and preparedness; and 3) the Lead CSO management accepts having an evaluation system as an integral part of organisational growth.

1.6 Scope and Methodology: Bottom-up-Phased-Participatory Approach to Capacity Building in M&E

Reflecting the overall principles and purpose of 3MDG’s ‘Health for All’ Strategy, the aim of the one-day training courses, two-day workshop and the pre-post evaluation was three-fold:

1. To unlock the potential of the individually funded 3MDG project by learning to measure performance and analyse the results chain;

2. Reinforce Collective Voices as a joined brand and support the Health for All Team to continuously monitor and evaluate the six lead partners by arriving at a commonly agreed set of tools to measure performance and analyse the results change; and

3. Gauge the relevance and effectiveness of knowledge transfer and skills development in M&E on capacities of Lead CSOs to develop implement projects in a sound manner.

The M&E learning process using a set of standardised tools and techniques involved project staff on the ground. It meant that training course and workshop activities were knowledge based, contextual and participatory; there was plenty of information sharing and feedback and response between Health for All Team and the Consultant. Translation was provided at all sessions by Health for All Team members.

In relation to the Terms of Reference (ToR), the Consultant’s in – country and home based assignment was divided into two phases with the completion of the desk research as illustrated in Annex 3.

The ToR required desk research of the documents for 3MDG, Collective Voices and Stage 1 Call for Proposals (CFP) documents completed by the six Lead CSOs before the training course and workshop. On return to home base the Consultant has done a thorough review of the: a) flip charts prepared by the participants to ensure their inputs are well considered, b) session notes provided by the Rapporteur (from the Health for All Team) and c) pre-training course and post workshop evaluation forms.

i) Phase 1 included six one day training course to build capacity of the individual CSO and their CBO partners. The course was designed as a set of lecture series with the purpose of clarifying M&E concepts, tools and terminologies. This was supplemented with several worksheets and example hand-outs. Time was given for questions and answers. The participants were given homework (project outputs) and asked to bring it as project inputs into the workshop. The course took place in

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19 3MDG website, Health for All, AEI Strategic Framework, 3MDG logical framework, power point, Collective Voices Coverage and CBOs, Engaging Communities: Best Practices and Lessons learned, six Stage 1 and 5 Stage 2 proposals of CSOs.
the respective CSO offices in Yangon between October 1st and 8th 2015. The topical agenda and learning objectives are provided in Annex 4a.

ii) Phase 2 included a two day workshop for CSOs and 3MDG Health for All Team on the development to social framework based M&E Strategy and Communication Framework. The workshop was designed with the purpose of reinforcing all the learning by the participants from the training course and utilising their project outputs as inputs into the workshop to arrive at a consolidated set of outputs at the Collective Voices level. There was great reliance on the preparedness and involvement of each CSO-CBO and they were exemplary especially in group work and focussed discussions but were more hesitant at plenary. The workshop took place in the 3MDG office in Yangon on 12th and 13th of October 2015. The topical agenda and learning objectives are provided in Annex 4b.

iii) Pre-post evaluations were conducted among participants to allow for comparisons before the training course and after the workshop had been completed. The pre-evaluation questionnaire was the baseline and changes in knowledge and skills were noted by the post evaluation. By using pre-post evaluation the Consultant will not overstate the influence of the event but rather is guided by it in preparing this report.

iv) Semi-structured interviews were conducted with twelve key informants in an open and informal manner, allowing for new ideas to be brought up by the interviewee to the broad questions put to them by the Consultant. Of the interviewees, eight (8) were women, seven (7) were from Lead CSOs and four (4) from 3MDG. An open thematic questionnaire set was formulated and was duly explored The themes were 3MDG’s fundamental shift in terms of engagement with government, the ways by which Collective Voices contributes to the delivery of the Fund’s strategic funding decisions, the history of the Fund and civil society in Myanmar including that of the CSO partners themselves, why the latter being primarily non-health organisations chose to engage with the health sector, what was the selection process of the Lead CSOs, views on accountability, equity and inclusion and last but not least what they thought of CSO prospects in the future.

To arrive at Part III results, three types of triangulations were made by the Consultant during the process of information collation and report writing:

- **Document triangulation** – Outputs of the training course and workshop, information from 3MDG, Collective Voices publications and presentation/project proposals from Lead CSOs-CBOs.

- **Concept/Method/tool/triangulation** – Use of social framework approach to the Theory of Change (ToC) keeping in mind Output 5 of the 3MDG log frame (Collective Voices goal); analysis and evolution of Collective Voices objectives in reference to Health for All (from two initial objectives to four) and 3MDG logical framework to arrive at measurable output and tracking outcome indicators; utilizing these two methods (ToC and 3Os) as inputs for the Logical Social Framework.

- **Phases and type of M&E/Planning Matrix triangulation**: Linking Stage 1 (Design), to Stage 2 (Implementation and follow up), with formative (monitoring, supervision, audit and midterm review), final (summative) and probably impact evaluations and then considering the time factor (schedules) along with resources and responsibilities.
In Stage 1, the participants used Participatory Learning Action tools and used loosely speaking a form of Phenomenological Analysis which nevertheless deeply describes the interactions (in presentations and proposals) and defines the essential nature, structure and profile of communities as well as needs assessment and issues to be addressed that it almost allowed the Consultant to experience the situation on the ground.

Throughout the workshop and semi structured interviews common themes emerged and Discourse Analysis has been utilized. It provided the Report with opinions of stakeholders from 3MDG and Lead CSO-CBOs within the Initiative and how they came to know their experience; the practicalities of implementing a complex partnership programme, defining community needs that must be addressed and recognizing their individual/collective potential and seizing opportunities for the future.

Limitations:

There were a number of limitations to the assignment largely resulting from:

a) The need to absorb a great amount of technical information by a group of participants that were not familiar with many of the concepts, methods, tool and techniques of M&E;

b) The need to acquire skills and capacities in a very short time and then utilize them to arrive at a Logical Social Framework based M&E Strategy in a participatory manner for the entire Initiative;

c) The constraints put upon the Health for All Team, particularly due to translation support, giving them little or no time to provide inputs into the group work and influence the quality and appropriateness of the outputs and outcomes, and

d) The 3MDG M&E unit not being engaged in the entire process especially given the fact that the Logical Social Framework will have to contribute to the 3MDG logical framework. Recognising that Collective Voices represents a very small part of 3MDG resources, it was a missed opportunity not to hear directly from the Lead CSOs-CBOs and how they could have supported the 3MDG log frame and enhanced the overall performance of 3MDG.

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20 This method of analysis describes what is the actual experience of people living in communities in the transition to democracy and relative development

21 This method of analysis generates, interprets, connects and represents stories in a coherent narrative form and contextualises experiences within broad cultural norms.
2 PART II: ONE DAY TRAINING COURSE ON SOCIAL FRAMEWORK BASED M&E STRATEGY AND LOGICAL MODELLING

2.1 Analysis of Participation by Collective Voices Partners

A total of fifty participants completed the training course. The participant numbers from each organisation ranged from four (4) to thirteen (13)\(^{22}\). Table 3 provides a disaggregation of the participants based on the attendance list, followed by other observations from the hera Consultant cum Facilitator:

<table>
<thead>
<tr>
<th>PROFESSIONAL LEVEL</th>
<th>GENDER</th>
<th>AGE</th>
<th>ETHNICITY</th>
</tr>
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<tbody>
<tr>
<td>Executive: 3 (6%)</td>
<td>F 1</td>
<td>M 2</td>
<td>&lt;25  3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt;25  3</td>
</tr>
<tr>
<td>Programme Staff: 7 (14%)</td>
<td>3</td>
<td>4</td>
<td>1  6</td>
</tr>
<tr>
<td>Project Staff: 18 (36%)</td>
<td>10</td>
<td>8</td>
<td>18  8</td>
</tr>
<tr>
<td>Finance, HR and Administration: 9 (18%)</td>
<td>5  4</td>
<td></td>
<td>9  3</td>
</tr>
<tr>
<td>Volunteers: 2 (4%)</td>
<td>2</td>
<td>-</td>
<td>1  1</td>
</tr>
<tr>
<td>Technical Consultant: 2 (4%)</td>
<td>-</td>
<td>1</td>
<td>1  1</td>
</tr>
<tr>
<td>Other: 9 (18%)</td>
<td>3</td>
<td>6</td>
<td>9  2</td>
</tr>
<tr>
<td><strong>Total: 50</strong></td>
<td><strong>25 (50%)</strong></td>
<td><strong>25 (50%)</strong></td>
<td><strong>2 (4%)</strong></td>
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</tbody>
</table>

The training course was well attended throughout the day. Generally the participants showed eagerness to learn, understand and put the knowledge to practice. Of the fifty participants who attended, forty-eight of them were staff of the Lead CSOs or their community based partners (14 - CBOs)\(^{23}\). Participants included senior executives, programme managers and project officers, finance officer/assistants, technical consultants and field coordinators. Two (2) of the programme and project staff were M&E officer/assistant. Of the six (6) Collective Voices partners, only COM included two participants who are volunteers, one of whom is a parliamentarian. It was the latter who at once grasped the critical importance of joined 3MDG Collective Voices brand and communicating evaluation findings.

Participants were equally divided between men and women (50/50). However, given that all six projects, primarily target women in reproductive age group and young people with the focus on sexual and reproductive health and adolescent health, only two (2) of the participants were under the age of 25 years and both were men\(^{24}\). Gender and age of staff as well as skills are important considerations in project delivery as it affects training receptivity, client response and results.

Community based organisations were well represented in the training. There was due recognition by Lead CSOs, that their CBOs were critical to successful implementation. Four Lead CSOs with head offices located in Yangon included a total of fourteen (14) CBO partners as participants; the only exception was

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\(^{22}\) Ar Yone Oo (AYO): 9, Bright Future (BF): 6; Community Agency for Rural Development (CAD): 4; Community Driven Development and Capacity Enhancement Team (CDDCET): 12; Charity Orientated Myanmar (COM): 6 and Phan Tee Eain (PTE): 13

\(^{23}\) Technical Consultants: 2

\(^{24}\) Further break down by 26-35 and 36-45 age categories would have provided a more realistic picture but the information was not asked at the time of the training course. Most people in the room were in these two categories.
CAD who did not include any (due to recent flooding in their project area). Bright Future (BF) which is the sixth Lead CSO is based in Mon State and did not include CBO partners.

The CBO participants represented their respective states and issues. Eleven (11) of the fourteen CBOs are based in the project areas namely Chin State, Magway and Ayeyarwady Regions. The three CBOs attached to Phan Tee Eain (PTE) were inclusive of organisations that represented sexual minorities, of these two are based in Yangon Region and one in Shan State. This added to the variety of participants who represented a small slice of the Union of Myanmar itself.

Ethnic minorities were prominent participants, twenty-three (23) out of fifty (or 46%). They hold higher posts within the project and organisation they represented. This is due to the fact that Lead CSOs such as AYO, CAD and BF identify closely with respective ethnic groups especially Chin and Mon. Other participants were Shan-Mon, Kayin and Myanmar. Sixteen of the participants are located full time in the state or region (township) where the projects are based. Sometimes states do overlap in terms of project location but townships differ as do project topics.

2.2 Session Outputs and Realisation of the Learning Objectives

2.2.1 Introductions and Expectations

The ‘Big Idea’ (or purpose) underpinning the training course was to unlock the potential of the projects in the Collective Voices portfolio by learning to measure performance and analyse results, including preparation of a project log frame. In this instance results meant improved change in health seeking behaviour. In the opening session, rather than self-introduction, which is the usual process, the participants were asked to introduce their colleagues sitting next to them and to describe him or her. The description had to be one of sentiment/feeling or professional opinion. Following the introduction the participants were asked about their personal expectation of their project (not the training course) and is conceptualised by Figure 4.

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26 AYO: Overcoming barriers to health: promoting community access to health services in southern Chin State; BF: Two ways connections project: connecting service providers and local communities for better health knowledge and access to services; CAD: Improving health access for Chin people; CDDCET: Family based health literacy promotion and community based programming in Mon State; COM: Gender equality and health service equity; PTE: Enhancing the capacity of community based organisations to strengthen community health care access.

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Achievement of Learning Objective: The participants understood two things: a) that evaluation explores the quality, characteristic and attribute of a project and b) the results of the evaluation will often reflect the general feeling of the project management team (noted in the circle). An evaluator will have expectations of the project and it will be no different than that of the participants (success on all fronts). Such an ice breaker helped the participants get over the fear factor about M&E, which not only increased their absorption power given the extensive information provided in one day. The proof of their learning is in the outputs they have produced as seen in Annexes 5 to 8.

2.2.2 Presentation of the CSO-CBOs Initiative Project

From the desk review it was clear that while the training on PLA tools and community meetings were done in conjunction with CBOs, project design and development seemed to be more the forte of the Lead CSO and Health for All Team. In preparation for developing the ‘Logical’ Social Framework for the Initiative every one of the participants had to be clear on standard concepts, terms and methods of M&E. The Lead CSO-CBOs project was the basis of these clarifications. The session started with a presentation of the project, which the Lead CSO had organised in the following manner as requested:

a) The community issues that the project was going to address;

b) The assumptions that were being made about the existence, validation of the information;

c) Major risk identification if any and a mitigation plan;

d) Contextual factors – socio-demographic-location information about the project;

e) Expected Change; and

f) Strategies and main activities.

Achievement of the Learning Objectives: It was clear to all participants that most of the required social and health information was contained within their project proposal and given this; they could easily extract the information about community issues to:

a) Arrive at a problem statement: Needs that would be addressed by the individual projects and to ascertain whether Output 5 of the AEI Strategic Framework which is the Goal statement for Collective Voices (adapted by the 3MDG log frame Output 5) was valid for their project; being sufficiently broad it was (but with the realisation that outputs for Collective Voices may differ).

b) Rationalise the Objectives: Each of the individual projects had their own set of objectives, three to five in number and sometimes what should have been different objectives were written as one. The SMART (specific, measurable, accurate, and realistic and time bound) technique for writing objectives was introduced. The participants were asked to keep the objectives to a set of three and where possible to it should contribute to the 3MDG Output 5 to which they readily agreed. However, both the participants and Consultant agreed that the Collective Voices objectives would have to be adapted and made more precise as well as expanded to reflect firstly the Collective Voices project portfolio and secondly its contribution to 3MDG results.

c) Understand the meaning of Social Framework based M&E Strategy: Each of the individual projects was underpinned by an analysis of social barriers to health and needs assessment (Stage 1). The realisation that they had participated in a critical M&E activity on behalf of a learning organisation like 3MDG made the groups keen to know about formulating a fully-fledged strategy which will be part of a wider set of activities to enhance Collective Voices approach to M&E
2.2.3 Introduction to the Theory of Change

From the desk research of the project proposals it was clear to the Consultant, that the Lead CSOs-CBOs had under difficult circumstances conducted an exhaustive assessment of the social barriers to health and identified the needs in the community. While the Lead CSO-CBOs’ proposals presented the issues in a sufficiently clear manner and identified activities, outputs and even expected outcomes (a rare sight in most proposals), it was still not a product of critical-thinking exercises that provides a comprehensive picture of the early-and-intermediate-term changes in the communities that are needed to reach the Goal of Collective Voices. Any research results which serve as inputs to proposal development whether they are quantitative or qualitative must ensure that the participants especially the project staff explicitly understand the early and intermediate steps required for long-term changes to occur; therefore, many assumptions and activities to support the change process needed to be examined to have an effective project.

Achievement of the learning objectives: There was a general agreement on the working definition of Theory of Change (Box 10). Once the step-by-step process in doing the worksheet (filling the boxes in the flow chart) was completed, there were no more blank stares from participants. This session provided an opportunity for Lead CSO-CBOs to unpack their assumptions (positive features) about the project from Stage 1 such as awareness, co-ordination-collaboration and capacity building which will contribute to success, validate the assumptions especially who will provide support, what expected outcomes they can have, and whether it is realistic to expect to reach the Goal in two years. In the post evaluation response, eleven of the participants rightfully identified the Theory of Change as a project planning tool working towards a deadline (the goal), rather than an evaluation tool and noted that it would have been more useful had it been introduced at an earlier time in Stage 1.

Some of the Lead CSOs were familiar with a SWOT analysis and it was agreed that they could use it to do their risk and assumptions. They accepted that if major weaknesses and threats were identified, there should be a mitigation plan as well as strength and opportunities (assumptions) must be validated.

Annex 5 presents the training outputs on the Theory of Change that was done by four Lead CSOs (AYO, CDDCET, COM and PTE)

2.2.4 Introduction to the Brand that is 3MDG Collective Voices and Understanding the Art of Communication and Marketing

During the desk research it was made amply clear from the project write up that 3MDG is seen no more than a funder and there is little or no mention of Collective Voices Initiative in the text. The possibility of partnership with INGOs of Component 1 is mentioned; however co-operation, collaboration and communication among Collective Voices partners themselves is not given due credence in spite of training together in Stage 1. While there may be many reasons for this, the critical fact was that the Lead CSOs while well recognized did not really consider themselves as a brand (“that is more private sector”) and so identifying with a larger brand such as 3MDG Collective Voices did not arise. However, the participants were keenly aware of the context in which 3MDG operates and that as recipients they should not worsen any situation with their health interventions. Do No Harm principle was well recognized.
For the above-mentioned reason the session began with question “What is a brand” to which most of them answered accurately and on probing did mention their organizational name, symbol and strap line and that in the project area especially in the respective states the Lead CSOs were well recognized. The discussion was followed up with another question “If I said 3MDG, Collective Voice Initiative and CSO-CBOs are a joint brand what would conjure up in each of your head.” There were several enthusiastic responses as is illustrated in Figure 5.

**Achievement of Learned Objectives:** There was a general agreement that not just Collective Voices but their own organization aspects of public relations. By using the needed a communication framework to address multiple communication matrix the participants were able to link their activities-outputs and outcomes and identify the audience/client within their project so as to make them aware or expose the project content and message, engage with stakeholders, influence target beneficiaries and become advocates on the issues for 3MDG Collective Voices and not just implementers of projects (Box 11).

Annex 6 presents the training outputs on brand development and communication framework that was done by 3 Lead CSOs (CDDCET, COM and PTE)

### 2.2.5 Why do we have to Understand M&E?

The Lead CSO-CBOs proposal speaks extensively about conducting research in Stage and how the findings provided a basis for proposal development funded by 3MDG. The proposal also contains a section on M&E, which focuses mostly on the conduct of implementation, forums, meetings and reporting.

Understanding M&E became the heart of the training course because the Planning and Scheduling Matrix for Collective Voices which would form a major output of the workshop relied on participants fully understanding a) the type of evaluations during a project life cycle (structured evaluations done during needs assessment /design/inception stage, midterm, summative/final and impact versus administrative evaluation that includes monitoring, supervision and audit) and b) the focus of the M&E process (objective-activity-outputs-outcomes).
The participants responded appropriately to the question “What is Evaluation” (Error! Reference source not found.); the pre-evaluation showed that most of them had not recently been involved in any form of M&E activity. So the participants were surprised when the Consultant-Facilitator disagreed and said that the Collective Voices project staff had been in evaluation all through Stage 1 from writing their preliminary concept for submission to 3MDG, to formulating and negotiating the initial survey, learning PLA techniques, deciding which ones were appropriate and conducting it with the community, reflecting on the findings and extracting the information for proposal development, they were all elements of M&E. Given the qualitative nature of the information in Stage 1, the participants were hard pressed on how to arrive at measurements for their outputs and outcomes. Part III of this report fills this particular gap.

Achievement of Learning Objectives: Everybody accepted that the M&E process begins with project design; and that it is the one element of M&E if done well will prevent confusion to the Evaluator. Once this was established there was more willingness to understand the role of the evaluator and that he/she cannot meet the participants’ expectations of success without their help throughout the project cycle (Box 12).

Participants found novel ways of expressing what they thought of evaluations. One participant likened the evaluator, the project and evaluation to a food critic in a restaurant; “he sits there and tastes a variety of items from the menu and then passes judgment on the quality and appeal of the restaurant”. In the mind of the participant, the customer is the donor, who reads the review and decides to visit the restaurant or not. This elaboration by a participant lowered the fear factor about M&E. To put the participants more at ease the main ‘mantra’ throughout the training course was that the focus may be on achievement of outputs and outcomes but this will also be balanced with how project activities were conducted and under what circumstances. In the post workshop evaluation, one participant noted, “Evaluation will now no longer be a shock to the system and 3MDG evaluator will be welcomed.”

2.2.6 Understanding the Logical Social Framework Model and Analysing the Results Chain

The combination of Theory of Change and Communication Matrix provided the participants with a framework for social analysis using the data and information from Stage 1 as evidenced inputs for their project proposal. During the different sessions the Consultant–Facilitator noted that there were many causal inferences within the proposals - what the projects were going to do, with whom, why, how and when. All proposals provided examples of socioeconomic plights and cultural constraints especially on poor women and young people in Myanmar and their inability to use health services not only for reasons...
of poverty but also because the public health sector was not a conducive response system in terms accessibility, availability and affordability. In spite of these causal inferences there was little understanding of how transformation takes place (change happens). Participants found the results chain concept within evaluations the most difficult “to get their heads around.” This was not surprising as most CSOs tend to be highly “projectized” in their approach to programmes.

Civil society may have values; vision and mission in a strategic plan document that provides general guidance but in reality CSOs are “doers” who may rarely reference their strategic document or make/have the time to see the big picture as most donors and academicians do. A simplified example was utilized to enhanced understanding (Box 13).

Achievement of Learning Objectives: Participants understood that the Logical Social Framework template (Table 4) is a ‘bridging’ technique as it provides:

- Problem statement (context and issues)
- Goal (the solution or benchmark)
- Objectives (the purpose)
- A social theory of change and logical framework redesigned in a form that can be monitored (output) and evaluated (outcome)?

<table>
<thead>
<tr>
<th>Title of Project</th>
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<tbody>
<tr>
<td>Problem Statement (TOC):</td>
</tr>
<tr>
<td>OBJECTIVE</td>
</tr>
<tr>
<td>GOAL (COLLECTIVE VOICES):</td>
</tr>
<tr>
<td>Expected Outcome (ToC):</td>
</tr>
<tr>
<td>Output 1.1:</td>
</tr>
<tr>
<td>Output 1.2:</td>
</tr>
<tr>
<td>Output 1.3:</td>
</tr>
<tr>
<td>Activities (ToC):</td>
</tr>
</tbody>
</table>

Annex 7 presents the 3Os table (project objective, output and outcome) that was done by 2 Lead CSOs namely CDDCET and COM and Annex 8 was completed by three (AYO, CAD and CDDCET)
3 PART III: DEVELOPMENT OF M&E STRATEGY AND LOGICAL SOCIAL FRAMEWORK FOR COLLECTIVE VOICES

The participants from the training course were involved in the workshop with the purpose of reinforcing all the learning by utilising their project outputs as inputs into the workshop. This combined with further group work and plenary discussions allowed the participants to arrive at a consolidated set of outputs at the Collective Voices level. The dual pathway for developing and implementing a Participatory M&E Strategy for Collective Voices Initiative is illustrated in Annex 9. Change is continuous and dynamic and must be understood as such during the project cycle; this message was communicated to the participants. What they needed to understand, and did was that change in the community can be documented using the monitoring pathway, something easily understood by most CSOs but that the very same change will be reinforced and sustained by the evaluation pathway. The CSOs were encouraged to integrate dual pathway in their final proposal.

The Theory of Change (ToC) brings together Collective Voices strategy to invest in capacity building of Lead CSOs-CBOs to develop interventions for communities especially the poor, vulnerable and marginalised, with specific project proposals to increase health seeking behaviour and promote improved utilisation of primary health care in Myanmar. The ToC combines information regarding the Collective Voices with the six final proposals and presentations detailing objectives, outputs and outcomes for individual CSO projects. It was extremely helpful to this report and enlightening to review the six CSO proposals (PTE, Bright Future, COM, CDDCET, AYO and CAD) and incorporate their social framework and innovative ideas within the Collective Voices ToC.

The key strategies and expected changes highlighted in the ToC are translated into the 3 Os template which specifies against four suggested objectives focused upon, 1) empowerment of women to make family health decisions, 2) health seeking behaviour, 3) community and health service engagement and 4) Lead CSO and CBO capacity building. The number of objectives has expanded from the initial two to four so that in combination they better reflect the two-pronged approach to engagement which is gender and rights based and is contained in 3MDG Health for All strategy to achieve its goal to empower target communities to access fair, responsive and inclusive health services.

The Logical Social Framework reflects the overall Collective Voices-M&E strategy developed following the review of CSO-CBOs outputs and outcomes, and provides relevant data in support of the wider 3MDG logical framework. Lead CSOs will continue to develop their M&E plans to reflect the overarching Collective Voices M&E Strategy developed at the M&E workshop.

3.1 Collective Voices Theory of Change

Collective Voices is an innovative programme that reflects the notion that in order for the objectives of 3MDG to be achieved fundamental changes need to occur in the relationships between health care providers (HCP) and the community they serve especially the poor and marginalised to achieve improvements in service quality, access and utilization. Collective Voices furthers the aims of 3MDG by contributing to the development of a “Fair, Responsive and Inclusive” health sector through a focus on community engagement, which is enhanced through strengthening the capacity of local community-based organisations. In essence, this is mainly a “demand side” Initiative which complements the “supply side” 3MDG interventions that aim to improve access and availability of essential maternal, neonatal and child health services, prevention of communicable diseases and strengthen health systems. However,
recent developments with the MoH mean that Collective Voices partners will also be supporting the “supply side” basic health staff to engage communities for health micro planning in townships.

The Theory of Change (ToC) embedded within the Collective Voices (see Figure 7) is a set of assumptions about how change will happen and reflects ideas or explanations which is widely held within 3MDG and in its AEI Strategic Framework but they are until now unexamined and with more experience maybe re-evaluated as implementation progresses.

**Figure 7 - Summary of Collective Voices Theory of Change**

The eventual change “target communities empowered to access fair, responsive and inclusive health services” reflects the demand side focus of Collective Voices on addressing identified social factors limiting health seeking behaviour in order to increase service access. It also highlights the necessary engagement with health sector providers to ensure services are planned and delivered (supply side changes) without stigma or exclusion to meet the needs of target communities. This is supported by Collective Voices extensive work to build the capacity of civil society and target communities to recognise and give voice to their health needs. Hence, the Collective Voices goal has been modified from the 3MDG programme output goal No. 5 “enhanced health services responsiveness and accountability to communities” which does not entirely reflect the breadth of Collective Voices health seeking behaviour interventions and expected changes in civil society, community and health sector relationships. However, the modified goal “target communities empowered to access fair, responsive and inclusive health services,” continues to contribute towards 3MDG logical framework output 5 and improvements in maternal and child health, and a reduction in communicable disease burden in areas supported by the 3MDG Fund.

The ToC reflects the assumption that improved health care outcomes for communities necessitate changes in the nature of relationships between township/village health services and poor and marginalised communities. This is only achieved through meaningful engagement to address social factors that mediate interactions and access to services, and facilitate effective participation in health planning and coordination mechanisms. Through a learning process communities are more empowered to advocate for their needs, health providers become more responsive and accountable for improving health care delivery, and mutual understanding increases and stigma and discrimination is reduced through promoting a dialogue between the different stakeholders.

The internal logic of the ToC and the Collective Voices design is summarized in the Results Chain in Figure 8. This illustrates in simple terms the ToC in Annex 10, namely that Inputs (3MDG-Collective Voices funds, CSO-CBO staff and resources), result in activities (e.g. training & Information, education and communication (IEC) and produce project Outputs (a change in the supply of products and services as a result of project activities e.g. number of Village Health Committees (VHC) formed/strengthened). Implementers of the projects control all these elements. These in turn result in Outcomes (the use or application of outputs), which reflect the Initiative/Programme’s benefits and changes in behaviour, knowledge, skills and level of functioning (e.g. improved community health seeking behaviour and...
engagement with health services). Outcomes typically require the cooperation of other actors to be achieved such as the Township Medical Officer and health provider staff – hence the importance of building mutually beneficial relationships. In the longer-term, outcomes are reflected in the goal of target communities empowered to access to fair, responsive and inclusive health services.

**Figure 8 - Collective Voices Results Chain**

In the ToC Annex 10, the strategies in section 6 represent the main activities and associated outputs that result from the implementation of the Collective Voices summarised in Figure 8 above, these are:

- Training and capacity building of Lead CSO-CBOs
- Community health information, education and communication
- Gender awareness raising of target communities
- Strengthening community referral and village health funds
- Community engagement through Village / Township Health Committees and Planning Forums
- Training HCP in target community social and cultural barriers to healthcare

Continuing with the Annex, section 3 details the main expected changes or outcomes of the programme these include:

- Empowered women who make personal and family health decisions (supported by developing community awareness of gender specific health needs, VHCs with significant female representation and influence over communal health funds)
- Improved health seeking behaviour (supported by training/IEC and improved community health knowledge and referral mechanisms, and social and cultural awareness of health care staff)
• Increased engagement between HCP and target communities and knowledge and awareness of their health needs (supported by formation and strengthening of Township / Village health engagement and planning mechanisms)

• Increased capacity of Civil Society Organisations and Community Based Organisations

The community issues addressed by the Initiative (i.e. social factors such as low health education, lack of gender specific health needs and health service awareness) identified by Lead CSO-CBOs during Stage 1, inform the development of Community Action – stage 2 are detailed in section 1. The programme is supported by assumptions (section 2), conditions on the ground that are necessary for success such as a Myanmar Universal Health Coverage Policy or 3MDG “Health for All” demand side components.

The Annex also provides details of the validation or evidence supporting the assumptions, and the contextual factors impacting the delivery of the project which may only be ameliorated through the project e.g. diverse ethnic groups, with over 100 languages and dialects located in remote and hard to reach areas.

3.2 Practical Understanding of the Relationship between the Three Os of Collective Voices and Health Seeking Behaviour Change

The Objectives, Outputs and Outcome template (Annex 11) of Collective Voices expresses how specific outputs and outcomes are measured and how change occurs as a result of programme implementation. Outputs and outcome measurable indicators are SMART (specific, measurable, attainable, realistic and timely) to assess progress towards achieving these objectives.

The four reconstituted main objectives (keeping in mind the modified Goal) re summarised and related to output and outcome indicators of the Collective Voices. These are summarised below:

Objective 1 – Increased empowerment of women to make personal and family health decisions

Output indicators: 1) Number of participants at gender and health specific training, awareness and information sessions, 2) Number of women trained as volunteer representatives on VHCs 2) Number of women trained to establish local community health funds 3) Number of local health funds established and operated by women

Outcome indicators: 1)Percentage increase in community knowledge and awareness of women’s healthcare needs , 2) Percentage increase in female community volunteer representatives on VHCs, and 3) Percentage increase in women using local community health funds for out of pocket family health expenses

Objective 2: Improve health-seeking behaviour in target communities in three states and three regions of Myanmar.

Output indicators: 1) Number of Training/IEC interventions on reproductive health, personal hygiene and nutrition, and healthcare services, 2) Number of referral mechanisms established and/or strengthened for EmOC, ECC or other emergency care 3) Number of cases referred utilising referral mechanisms EmOC, ECC or other emergency care 4) Number of health staff trained and aware of social and cultural factors limiting access to health services.
Outcome indicators: 1) Percentage increase in knowledge and awareness of project-related health issues and local health services, 2) Percentage increase in timely referrals who receive health services, 3) Percentage increase in utilisation of specified local health services, and 4) Percentage increase in community satisfaction with local health services.

Objective 3: Improve participation and engagement between target communities and health care providers, including local health coordination and planning mechanisms in selected townships and villages.

Output indicators: 1) Number of health staff, community members and other stakeholders trained to establish/strengthen Township/Village Committees (T/VHC), 2) Number of joint information sharing sessions with HCP involving community representatives to advocate for community health needs, 3) Number of participatory T/VHC established/strengthened 4) Number of T/VHCs that establish a functioning community feedback mechanism 5) Number of State/Regional/Township training sessions delivered by CSO-CBOs on community engagement and listening to community voices

Outcome indicators: 1) Percentage increase in community members participating in T/VHC and 2) Percentage of community feedback that has been verified as actioned 3) Number and % of Township Health Departments that have engaged communities in Micro-Planning processes supported by CSO-CBO

Objective 4 – Strengthen the capacity of Lead CSOs-CBOs to identify community health needs (Stage 1), address these appropriately and accurately through implementing a community action project - (Stage 2).

Output indicators: 1) Number of trainings in participatory approaches, gender, culture, social accountability and related behaviour and reproductive health 2) Number of participatory community meetings to identify health needs 3) Number of CSO-CBO staff trained in Community Action project & partnership development, organisational development, financial management and monitoring and evaluation 4) Number of engagement mechanisms formed with public and other healthcare providers formed with stakeholders to address target community needs

Outcome indicators: 1) Successfully implemented Community Voices Initiative to identify social factors limiting health access at the community level and 2) Successfully implemented Community Action projects to address identified barriers to healthcare access The Objectives, Outputs and Outcome template (Annex 11) of Collective Voices expresses how specific outputs and outcomes are measured and how change occurs as a result of programme implementation. Outputs and outcome measurable indicators are SMART (specific, measurable, attainable, realistic and timely) to assess progress towards achieving these objectives.

The four reconstituted main objectives (keeping in mind the modified Goal) re summarised and related to output and outcome indicators of the Collective Voices\(^{27}\). These are summarised below:

\(^{27}\) The Collective Voices initially defined two objectives, which had too many purposes all rolled together. The reconstituted objectives each states one single purpose
Lead CSO-CBOs have highlighted gender inequality within target communities, the lack of empowerment of women to make decisions regarding personal and family health, and the complexity of implementing projects to many ethnic groups with numerous languages and dialects. Both output and outcome indicators have been framed to enable Lead CSOs to include disaggregated data according to gender, age, language, location (hard to reach or conflict areas) and ethnic groups to ensure all members of the community benefit from the programme.

The objectives express different programmatic strategies to improve the health seeking behaviour of communities especially poor and marginalized. They are not mutually exclusive and act together to promote health seeking behaviour change. Objective 2 on the “demand side”, for example uses IEC to increase community health knowledge and health care service awareness. Objective 3 on “supply side” aspects, for example, supports health care staff through joint training with CSO-CBOs (in support of the ethos - train together work together), which adds to mutual understanding especially in sensitive areas and enhances the acceptability of local health services. Objective 4 through strengthening CSO-CBOs supports the effective implementation of the overall Collective Voices initiative.

It is possible to analyse health seeking behaviour change in terms of type and focus. The types of change can be illustrated through Objective 2 as follows:

- IEC interventions result in greater health awareness, knowledge and skills in target communities (Learning);
- As a result there is modified or changed health seeking behaviour (Action); and
- Also women are empowered through increased health awareness, knowledge and skills (Conditional)

The focus of change can be illustrated through objectives 1, 3 and 4 as follows:

- Women are better able to advocate for their rights through participation in T/VHC and health fund schemes (individual / client focused)
- Improved health seeking behaviours through better family/community knowledge of reproductive health, personal hygiene etc. (family and community)
- Increased engagement and participation between health providers, INGOs, Lead CSOs-CBOs and target communities (Systemic)
- Lead CSOs improved capacity to deliver community projects, and develop mutually beneficial partnerships with health providers, INGOs and CBOs (Organisational)

Contextual factors affecting target communities include geographical remoteness, language and cultural barriers. It is important that both demand and supply side determinants of health service access (the timely use of a service according to need) are addressed concurrently. These may not be mutually exclusive and may interact and influence each other.

The different Lead CSOs-CBOs implementing Collective Voices have many variations in the type of health seeking interventions and the scope of their projects (see Table 5). The matrix below aims to summarise these using some standardized categories:

**Demand side determinants** – are factors influencing the ability to use health services at individual, household and community level; and

**Supply side determinants** – are aspects inherent in the health system that may hinder service uptake by individuals, households and communities.
Table 5 - Lead CSO-CBOs: Health Seeking Behaviour Interventions

<table>
<thead>
<tr>
<th>Health Seeking Behaviour Interventions – Demand and Supply-side</th>
<th>COM</th>
<th>CDD-CET</th>
<th>AYO</th>
<th>BF</th>
<th>PTE</th>
<th>CAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demand Information, Education &amp; Communication (IEC)</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Supply Participation and coordination T/VHC, ICSO etc.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Demand Community engagement and participation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Supply Referral Mechanism</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demand Health fund / Income generation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supply Health System social and cultural sensitivity</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demand Community Volunteers</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supply Facilitating outreach services</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Note: Indicates where Lead CSO explicitly stated interventions in proposal activities/outputs

The Collective Voices addresses mainly the “demand side” but also some “supply side” aspects, as detailed below and highlighted in Table 6 in relation to a comprehensive range of health seeking behaviour interventions. These are critical factors that have been considered in developing a social framework embedded logical model for Collective Voices (or the Logical Social Framework).

Table 6 - Highlighted: Lead CSO-CBOs Interventions Addressing Demand and Supply Side Barriers

<table>
<thead>
<tr>
<th>Dimensions of access barriers</th>
<th>Geographic Accessibility</th>
<th>Availability</th>
<th>Affordability</th>
<th>Acceptability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-monetary Community Participation</td>
<td>Information, education &amp; communication</td>
<td>Information, education &amp; communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-monetary Community-based interventions</td>
<td>Social Marketing</td>
<td>Social Marketing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monetary Health equity funds</td>
<td>Accreditation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vouchers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community loan funds</td>
<td>Community loan funds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health insurance subsidies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conditional cash transfers</td>
<td>Pre-payment schemes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provision of essential services</td>
<td>Provision of essential services</td>
<td>Regulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach services</td>
<td>Regulation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity waiting home</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency transport</td>
<td>Culturally sensitive care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peripheral health units</td>
<td>De-concentration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supply-side interventions</th>
<th>Non-monetary</th>
<th>Non-monetary</th>
<th>Non-monetary</th>
</tr>
</thead>
<tbody>
<tr>
<td>De-concentration</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Improved management, including supervision and feedback mechanisms

<table>
<thead>
<tr>
<th>Monetary</th>
<th>Pay for performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Needs-based financing</td>
</tr>
<tr>
<td></td>
<td>Contracting</td>
</tr>
<tr>
<td></td>
<td>Abolishment of fees</td>
</tr>
</tbody>
</table>

Underlying Assumptions = Policy framework, Legislation, Supply running costs, essential consumables & equipment, monitoring and supervision

Demand side non-monetary
- Consumer information on health services including availability and associated cost – addresses barriers due to lack of information (availability), and household expectations and health awareness (acceptability);
- Community participation may reduce transport costs, improve information about services, reduce opportunity costs (loss of income) and enable access to cash within the community, address household expectations and cultural preferences. Also it may negatively affect embedded empowerment, effects low self-esteem and limited assertiveness and reduces power gaps between communities and health services;
- Social marketing (IEC) resources to encourage positive behaviour change, overcome stigma (acceptability) and availability of product and services; and
- Non-professional health workers or volunteers reduce acceptability barriers though interventions offered may be limited.

Demand side monetary
- Community loan funds enable the borrowing of funds at low or zero interest to pay for emergency medical or transport costs to health facilities (accessibility)

Supply side non-monetary
- Provision of outreach services – tackles location of health care providers (accessibility) although services may be limited
- Provision of culturally sensitive health care (acceptability)
- Emergency transport with associated communication system for referrals (accessibility)
- Establishing better staffed peripheral health units (accessibility and availability)
- Improved health service management including feedback mechanisms which has potential to address all four dimensions if resources are available

It is important to note that both quality of health services and capacity to absorb additional demand needs to be addressed by the Initiative if health-seeking behaviour is to be sustained. This highlights the importance of relevant Lead CSOs-CBOs continuing to work in close partnership with 3MDG partners such as I/LNGOs implementing supply side interventions, to support and enhance their health seeking behaviour initiatives. It is also important that CSO-CBOs operating in the same or nearby state/region cooperate in terms of learning and best practice to strengthen project implementation. For example, some of the projects proposals include enhanced emergency referral mechanisms but do not include reference to community fund initiatives to cover transport costs or out of pocket expenses and visa-versa.
3.3 Collective Voices Logical Social Framework

A Social Framework is a means of describing an expected pathway of influence through a wider network of people, groups or organisations, which is relevant to the successful implementation of a programme. A Logical Social Framework that was designed during the workshop reflects the reality that people and relationships matter if change is to be achieved. It is a way of summarizing the theory-of-change (in this case converting the social and system barriers into a health seeking behaviour change) and the objective-output-outcome-change table within the development initiative, in a form that is easily explained and can be monitored and evaluated. Without this combination most social frameworks by themselves remain anecdotal and immeasurable.

The Logical Social Framework uses the idea of pathways of the latter as a bridging concept, which can connect up two very different ways of thinking about the Initiative. One is the logical framework that provides a very linear view of the projects within Collective Voices, where events happen in sequential steps, in one direction. The other is a network view of project development and implementation, where change can take place simultaneously, in many different locations, in relationships between many different actors.

In terms of the Collective Voices this can be simply illustrated in a network diagram reflecting different actors involved, and their relationships (see Figure 9).

![Figure 9 - Collective Voices Initiative Network Diagram](image)

The thick blue line represents the main pathway of interest and what happens in terms of social relationships can be expressed through the Logical Social Framework (LSF). Table 7 mirrors the detailed LSF in Annex 12 but expresses in more detail the expected changes in actors’ behaviour measured within this framework.
<table>
<thead>
<tr>
<th>Expected Social Changes (Objectives)</th>
<th>Indicators Measure</th>
<th>Means of Verification</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective 1: Target communities will:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Increase in community knowledge and awareness of women’s healthcare needs</td>
<td>Changes in awareness of gender specific health needs</td>
<td>KAP survey Local health data and information Project monitoring data and reports Information dissemination</td>
<td>CSO-CBOs knowledge, engagement with poor, marginalized communities</td>
</tr>
<tr>
<td>o Increase female representation on VHCs</td>
<td>Changes in female representation on VHCs</td>
<td></td>
<td>Township health officials, committees &amp; infrastructure</td>
</tr>
<tr>
<td>o Increase women’s use of local community health funds for out of pocket health expenses</td>
<td>Changes in use women’s use of community health funds</td>
<td></td>
<td>Target communities adopt communal burden sharing approaches</td>
</tr>
<tr>
<td><strong>Objective 2 : Target communities will:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Improve knowledge and awareness of project-related health issues</td>
<td>Changes in knowledge &amp; awareness</td>
<td>KAP survey Local health data and information Project monitoring data and reports Information dissemination</td>
<td>3MDG “Health for All” supply side MNCH, communicable disease and health strengthening components UHC Policy</td>
</tr>
<tr>
<td>o Improve knowledge and awareness of local health services</td>
<td>Changes in referral and service utilisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Improve utilization of local health services</td>
<td>Changes in staff awareness and service satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Local Health Services will:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Increase awareness of social and cultural factors in target communities limiting health access</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Objective 3: Target Communities will:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Increase participation in Township/Village Health Committees (T/VHC)</td>
<td>Changes in community participation</td>
<td>Analysis of T/VHC meeting records Community participation and satisfaction survey Training participation records and feedback Analysis of Township health plans Information dissemination</td>
<td>Township health officials, committees &amp; infrastructure CSO-CBOs knowledge, engagement with poor, marginalized communities Traditional village level dialogue and decision-making forums</td>
</tr>
<tr>
<td>o Increase use of these T/VHC to engage with health providers and feedback on local health services</td>
<td>Changes in participatory forums and planning mechanisms</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Local Health Services will:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Increase engagement with target communities through strengthened/established T/VHCs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Increase community engagement within Township-micro planning processes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Objective 4: CSO/CBOs will:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Successfully implemented Collective Voices Initiative (Stage 1) to identify social factors</td>
<td>Changes in production of qualitative data</td>
<td>Qualitative data from PLA meetings</td>
<td>CSO-CBOs knowledge, engagement with</td>
</tr>
</tbody>
</table>
limiting health access at the community level

- Successfully implemented Collective Action – Stage 2 projects to address identified barriers to healthcare access

<table>
<thead>
<tr>
<th>Changes resulting from project implementation</th>
<th>M&amp;E qualitative &amp; quantitative reports</th>
<th>Information dissemination</th>
<th>poor, marginalized communities Collaboration with other CSO-CBOs, public and private sector providers, Collective Voices &amp; most importantly 3MDG ICSO partners working in Component 1</th>
</tr>
</thead>
</table>

The main changes in relationships between actors relate to target communities (including gender issues impacting the health seeking behaviour of women, children and young people), local health officials and service providers, and CSOs and CBOs working with both to increase engagement and thereby support improvements to service access. However, the assumptions column describes other relationships, which are also important because their actions (or inaction) may impact what happens to actors in each row of the social framework. For example, under objective 3, CSO-CBOs have an important role in working with a broader range of actors to develop partnerships, for example INGOs involved in the implementation of 3MDG supply side interventions. This collaboration is important due to the necessity of addressing both supply side and demand side aspects of health seeking behaviour.

The vertical dimension of a typical logical framework represents the flow of time (a continuum) from the use of inputs, implementation of activities to produce outputs, and eventually outcomes and fulfilment of goal and addressing the problem. In the social framework the vertical dimension represents a chain of actors connected by their relationships, it is the changes in these relationships between actors by which change happens. Unlike the logical framework causation may work in both directions, up and down the chain of relationships as different individuals, organisations or groups influence each other. For example, target community participation in T/VHC may increase self-esteem and empowerment to advocate for improved health services, whereas Township Medical Officers may become more aware of the social and cultural issues reducing the ability of target communities to access health services. Collaborative approaches with the support of CSO-CBOs may identify innovative solutions to improve referral mechanisms and address the costs of transport and emergency care.

The means of verification column does not just provide information regarding expected changes but also regarding who will know about these changes, because if information is not disseminated appropriately it cannot be used effectively. For example, improved communication between Lead CSO and INGOs may help to address health-seeking behaviour where significant supply side issues are creating barriers to service access.

In the Social Framework there is still a connecting logic between different rows as in a logical framework, however it is a social logic as detailed below:

- If the Lead CSO is able to provide technical assistance and capacity building to CBOs
- And Collective Voices continues to fund these Lead CSOs to implement community action projects
- Then CBOs will be able to engage more effectively with target communities

Therefore, the Logical Social Framework as presented in the Annex 12 is able to express relationships (it is people who make outputs and outcomes happen) and enable Collective Voices to monitor projects...
against measurable indicators and evaluate them to identify the degree to which stated objectives have been achieved in support of the Collective Voices goal. Budget for conducting M&E and communicating results is crucial.

### 3.4 A Pro-Active Communication Framework for Collective Voices

The Collective Voices initiative is an integral part of the 3MDG Fund which supports community based projects implemented through a CSOs-CBOs partnership for the benefit of communities, including the poor and marginalized. Together these actors operate as a joint brand, which needs to collectively project to a variety of audiences (clients) the brand values (and results) as summarised below:

- Supports Universal Health Coverage through community engagement;
- Promotes a collaborative approach to shared learning, best practice and innovation; and
- Listens to community voices to identify and address their health priorities

These Collective Voices brand values address the national objective to achieve universal health coverage for all by 2030, a desire at township level to work collaboratively with partners to innovate and achieve results, and prioritize at a community level listening to the poor and marginalized people to identify and address their health concerns. Achieving clarity regarding the values of the brand with all Collective Voices partners will ensure that they are more likely to project the brand accurately whilst communicating with a variety of audiences at national, state/region, township or community level.

The Collective Voices Communication Framework (Annex 13) summarizes the different audiences at national/regional, township and community levels. An effective communications strategy is important for Collective Voices because the relationships described within the Logical Social Framework to help achieve outputs may be influenced by how the programme is perceived and this in turn has implications, given that cooperation of different actors is necessary to achieve key objectives relating to health seeking behaviour, and engagement with local health services, INGOs and beneficiary communities. Communication with different audiences may need to be nuanced according to their concerns, priorities and interests, for example the role of civil society in the health sector may be seen very differently by Township Medical Officers and INGO staff teams. However, the core values of Collective Voices provide a platform from which dialogue and understanding can be developed. There is also a need to combine development communication language with social media perspectives. For example, as depicted in the Annex:

- The issue is not whether people are aware of Collective Voices, but what is its level of exposure in the public arena;
- Knowledge and understanding of Collective Voices by the Township Medical Officer may not be sufficient, it may be important to engage with him/her to get action;
- The health services may be interested in co-operating with Collective Voices but they will be keen to know the extent of the Initiative’s influence;
- Lead CSO-Health for All Team may wish to advocate and they may have a clear message but unless the former is clear on what kind of support it is seeking it may not be forthcoming; and
- In order to make an impact, Collective Voices has to take specific actions to call attention to itself. Annex 13 tries to answer these questions.

At the national/regional level audiences for Collective Voices includes donors, 3MDG programme, INGOs, government departments including the Ministry of Health (MoH) and the general public. A proactive
communication framework would ensure these key stakeholders understand that Collective Voices addresses social factors limiting health access, supports universal coverage through community engagement and contributes to the 3MDG Health for All strategy. Collective Voices could adopt a range of media channels:

**Communication Channels – National/ Regional Level**

- Communicating project updates and results through meetings and workshops;
- Sharing CSO-CBO information with partner agencies;
- Brochures sharing learning/best practice;
- Project updates and results using newsletters, e-bulletins, website-updates;
- Highlighting events and achievements using social media including Twitter and Facebook
- Collaborative events e.g. 3MDG partners with TV/Radio media coverage and press releases during special national and international (days) events

Key objectives of communication would be to maintain donor support, promote the value of civil society engagement, highlighting social factors and health priorities of the poor to inform forward strategies and plans, and the benefits of collaborative approaches.

At a township level (intermediate stakeholders) audiences for Collective Voices include Townships Medical Officers, health care staff, other nation/local CSO and INGOs working in the programme area. A proactive communication framework would ensure that they understand that Collective Voices builds the capacity of local CBOs and health partners, facilitates shared learning and strengthening of partners, and adopts a collaborative approach. Collective Voices could adopt a range of media channels.

At the community level (primary stakeholders) audiences for Collective Voices include a variety of CBOs especially those related to women and youth. When dealing with communities, the issues of health will have to be dealt with up close and personal and in real time. Keep the messages very simple and accurate and show empathy. Ensure that Lead CSOs-CBOs always refer to Collective Voices in any relevant publication or event.

The Collective Voices brand recognition is crucial at all levels but the more the community values the brand the greater the influence of the brand as one goes up the hierarchy and wider the support.

### 3.5 Integrating Participatory M+E Strategy into Collective Voices Initiative Project Cycle Management

Through a process of iteration at the Lead CSO-CBO level (training course) and again at the Collective Voices level (workshop) which included the 3MDG Health for All Team, a consolidated Theory of Change, Objective-Output-Outcome-Expected Change logic, a Logical Social Framework and Communication Framework was generally agreed along with a systematic Planning Matrix for scheduling and conducting a monitoring and evaluation (see Annex 14). The participatory method that was utilised ensured that relevant risks and assumptions in carrying out routine monitoring, supervision and audit under the aegis of the Health for All Team and the planned mid-term review (formative) and final (summative) evaluations is not only seriously considered but also well anticipated by the Lead CSOs-CBOs and 3MDG.

Firstly, the Planning Matrix differentiates the M&E strategy based on Collective Voices Initiative programme/project life cycle namely design, implementation and follow-up. Secondly, the matrix considers the type of evaluation that Collective Voices is already involved in or wishes to conduct in the future. **Structured evaluations** done at discrete times in the programme/project cycle are needs assessment, midterm review, final and impact. The first two evaluations are considered formative
evaluations as project adjustment and adaptations are still happening. The last two, which are final (summative) and impact tend to be more rigid and there is little room to manoeuvre. Administrative (formative) evaluations are continuous processes and apply to monitoring, supervision and audit.

The Planning Matrix is backed by a rationalised set of methods and tools (the how) as noted in section 3.1-3.4 of this Part. The matrix clarifies the following:

- What is to be monitored and evaluated?
- What activities are needed to monitor and evaluate?
- Who will be responsible for monitoring and evaluating?
- When monitoring and evaluation are to be planned?
- What resources are required and where they are committed?

In doing Stage 1 (March to October 2015) activities such as community assessment of social barriers to health, identification of community needs, project inception and proposal; the Lead CSOs-CBOs have been active in formative evaluation at the design stage. This is the first building block for Collective Voices M&E Strategy.

The second building block is during Stage 2 (which begins in November 2015). Around the end of first year of implementation (2016) there will be a midterm (formative) review, which will focus on the achievement of consolidated outputs by Lead CSO-CBOs. It will measure a) how well the projects have been implemented in relation to its design, b) if the activities were implemented in the way they were intended and c) resources were used as planned. Any form of unplanned under-over implementation will also be addressed. This form of review must pinpoint to barriers that prevent or delay the achievement of outcomes. As in all evaluations there is a need to cast a “fresh eye” hence this review should be done by an external national consultant but with the remit of shared task and duties. This means that the primary responsibility for ensuring this review takes place rests with the Health for All Team notably the APO who may participate as an active observer or Lead an evaluation steering committee of secondary and intermediary members.

A formative midterm review is highly time-consuming, as it requires familiarity with almost all aspects of the 3MDG Initiative programme-individual (6) project implementation. Given the great distances in which projects are located in Myanmar, it may be worthwhile to spread the evaluation over a month (to allow for wider scope, tools and methods to be utilised) if one national consultant is hired and two weeks if there are two. Also given the nature of formative midterm reviews, the Health for All Team must remain open to and provide assurance to the national consultant that opportunities for adaptations/adjustments exist within reason.

Formative evaluation also includes monitoring, supervision and audit (MSA). The monthly, quarterly records and all reports (including trip reports) should be readily available and must be fully utilised by the midterm review. These documents should be provided by the Health for All APO on a confidential basis.

The third building block is during Stage 2 follow up and implementation (after midterm review). There are plans to conduct a final (summative) evaluation at the beginning of the last quarter of project implementation (2017). This evaluation will focus on whether the objectives have been achieved in relation to the agreed outcomes of the CV Initiative. The Lead question that 3MDG should ask is whether the Initiative accomplished specifically what it set out to do? The midterm evaluation report especially its conclusions and recommendations will be a critical point of reference for the final evaluation. If at the time of the final evaluation there is a possibility that 3MDG Collective Voices may be extended, then this evaluation should also serve as a guide for designing and new programme/initiative. The final evaluation should be as independent as possible keeping in mind the following three options.
• Option 1: Utilise an international consultant as Lead and previous national consultant as co-Lead;
• Option 2: Utilise the 3MDG M&E unit to co-Lead with an international consultant; and
• Option 3: Utilise 3MDG Unit with a national consultant

Based on the option considered the most feasible, a steering committee should be reconstituted as appropriate.

The fourth building block is an Impact Evaluation which is usually conducted six months after all programme inputs have ended. It is normally conducted by donors/MoH. However, in the Planning Matrix the 3MDG programme is completed in December 2017, it is possible to do the final CV evaluation either before, parallel or alongside. All options should be considered for greater effectiveness and efficiency.

3.6 Suggested Criteria for a Mid-Term and Final Evaluation of Collective Voices

Drawing from donor agency best practice, the OECD’s Development Assistance Committee (DAC) in 1991 established several principles of evaluation to guide DAC member states. These principles have subsequently been developed into five to seven specific criteria (eight if impact is included), which are today widely used in development evaluation.

During the training each of the criteria was defined and during the workshop the Lead CSO-CBOs were asked to suggest questions for each of the criteria (see Annex 15). The criteria as they apply to Collective Voices are:

**Relevance:** The extent to which the Initiative’s activity is suited to the priorities and policies of the target group, recipient and donor.

**Effectiveness:** A measure of the extent to which an aid activity attains its objectives.

**Efficiency:** Efficiency measures how the outputs have been achieved in terms of the work plan and budget and if it represents value for money.

**Sustainability:** Sustainability is concerned with exploring whether the benefits of an activity are likely to continue after donor funding has been withdrawn.

**Gender Equality, Equity and Social Inclusion:** Gender in most cases refers to women and men, girls and boys and equality is about rights, responsibilities and opportunities. Equity implies that interests, needs and priorities of these groups are taken into consideration based on the extent of a problem and identified needs. Social inclusion widens the case for diversity and embraces all segments of society regardless of gender.

**Monitoring and Evaluation:** Monitoring is the systematic collection and analysis of information as project progresses. It is aimed at improving the efficiency and effectiveness of a project or an organisation.

**Analysis and Learning:** Refers to experience and ability to understand data, its context and optimal use and to discover critical information. It could also mean the person/staff involved is allowed to communicate and socially connect or attend trainings and hold technical discourses on relevant subjects.

**Impact:** The positive (and negative) changes produced by a development intervention, directly or indirectly, intended or unintended.
While the criteria is a popular tool because it is sound and simple, below are some tips and traps for the Health for All Team to be aware of while USING:

- Criteria often overlap, and the same data can be employed for different criteria.
- Eight cross-cutting themes which evaluators should always carefully consider when employing the DAC criteria are identified: local context; human resources; protection; participation of primary stakeholders; coping strategies and resilience; gender equality; HIV/AIDS; and the environment. While an evaluation need not include every theme, a rational should be considered for excluding any.
- While widely used, the DAC evaluation criteria are too often employed mechanistically. They are a valuable guide for framing questions and designing evaluation, but reliance on them should not prohibit more creative processes for evaluation.
- Feedback has shown that many evaluators employ the DAC criteria to ask questions about results rather than processes. There is, however, much room for the eight sets of criteria questions to prompt consideration not only of ‘what’, but also of ‘why’ – for example, not only “what real difference was made to the beneficiaries as a result of the activity?”, but also “why was that difference made or not made?”
4 PART IV: PRE-POST SCRIPT: MONITORING AND EVALUATION

4.1 Readiness Assessment of Partners to Participate in Collective Voices M&E Strategy

Readiness assessment is a unique addition to the many M&E models that currently exist because it provides an analytical framework to assess the Collective Voices and its partner’s organisational capacity and ‘political’ willingness to monitor and evaluate its goal and objectives. For Collective Voices this assessment is the foundation upon which it has built and will implement the M&E strategy.

A set of eight questions as elaborated in Figure 10 was put to the plenary to gauge the readiness of the participants to have a Collective Voices M&E strategy.

In the first question participants were asked about their thoughts on the motivation encouraging the need for an M&E strategy for Collective Voices. Participants responded with a breadth of answers, which corresponded with their individual experiences. Most of the participants wanted to understand whether the performance of their organisations reflected the goals and objectives of Collective Voices and also to assess the improvements in project implementation. They also wanted to know how each stage of the project was doing in relation to proposed activities and to assess for themselves as a collective how they were contributing to 3MDG. Lastly, participants wanted to better understand the voice and situation confronting the community in order to better understand their needs, and to also measure the achievements of the project.

The second question concerned the main advocates (champions) supporting an M&E strategy for their respective organizations. The responses included 3MDG, all stakeholders within the organizations, consultants and the CSO team Leaders. They also highlighted the contributions of senior management,
programme leaders, consultants, and administrative and finance staff all of whom emphasised quality and performance.

The third question related to what motivated the advocates to support an M&E strategy for the participants’ organizations. Answers included the objective of implementing projects successfully, measuring project achievements, effective project evaluations, project experience and the requests of donors. They also wanted to know how much the project goals achieved and to share it with members as part of advocacy and transparency.

The fourth question asked participants about who should own the M&E strategy, and how Collective Voices would benefit from their respective inputs. Participants wanted to ensure they could measure the achievements and successes of projects, and to be known as part of an Initiative, which is able to implement the goals and objectives of the project.

The fifth question asked participants whether they had resources allocated in support of an M&E component within their respective projects, and the answer was a unanimous yes. Two however, admitted that resources were allocated after the training course and one said a slight increase was made. Such a reaction to capacity building in M&E is not uncommon.

The sixth question asked how Collective Voices should react in case there are any negative outputs/outcomes/results generated by the Collective Voices M&E system or evaluator. Participants responded by advocating for a participatory approach, a need to re-analyse constructively, to evaluate the lessons learned, to investigate together hand-in-hand, and to work together in order to take correct action in future. This is an important consideration during monitoring visits by Health for All Team and mid-term evaluation.

The seventh question asked participants to consider where capacity should exist to support a results based M&E strategy for partners within the Collective Voices framework. They agreed that it should exist for all people implementing the project and programme, including the organisation and donor, at all levels, including the VHC, and should certainly exist in 3MDG.

The last question focused on how the Collective Voices M&E strategy should link to the 3MDG programme and National Health Sector System. Participants agreed that greater collaboration and coordination should start with 3MDG component as a requirement and extend to the township/district township health department, and that there was a need to work towards increased opportunity for collaboration within the public health sector as a whole.

4.2 Results of the Pre-post Evaluation of the Training Course and Workshop

The one day training course participants included representatives from all six CSOs that make up Collective Voices. A total of fifty participants completed the training course and forty-seven completed the pre-training course evaluation form.

Results of the Pre-Training Course Evaluation Questionnaire

Three quarters of the fifty participants noted that the series of training and workshops was relevant to their engagement with the current national health development agenda (Figure 11.1). They felt that the training (using the phased approach and reinforcing the learning) was not only good for their academic and professional career but that their institution would gain tremendously (Figure 11.2).
Two thirds (60-64%) of the participants thought the training course was somewhat timely and it would have been more so had it come a little earlier when the CSO-CBOs were still engaging with communities, local and regional government (Figure 11.3 and 11.4). However, a little over one third (36-40%) of participants thought it was still timely in terms of proposal writing and starting implementation.

As expected, familiarity increased as one went from 3MDG programme, to Collective Voices, to CSO-CBO project. However, the Monitoring & Evaluation log frame of 3MDG was not sufficiently known to over two thirds of the participants (Figure 11.5).
Nearly three quarters of the participants thought the logical framework (44%) and theory of change (30%) was the most relevant in terms of their proposal writing. However, of the 26% who emphasized the importance of communication, most of them seemed to be the younger (25-35 years) participants (Figure 11.6).

Approximately half (49-57%) of the participants were familiar with participatory M&E tools (Figure 11.7), proposal development (Figure 11.8) and the M&E section within it (Figure 11.9). They had participated in skills and capacity building in M&E, although it was a long time ago, and are currently more involved in monitoring. Nevertheless, these were all critical facilitating factors in their quick grasp and producing outputs (homework) after just one day. Only 3 of the 50 participants had recently partaken in an evaluation.
Participants understood the purpose of the training course. Of the 70% who answered the question “What do you expect to gain most from this training course?”, the most common answer was to gain greater understanding of the various terms, concepts, tools and type of evaluation. Other relevant answers included: To do more for Collective Voices; Update project design based on M&E information; Enhance training of trainer skills to be better able to interact with the community; Understand the M&E protocols and procedures and how they apply to CSO project in terms of type and timing; Application of M&E tools to proposal development; Better prepare the M&E selection of the proposal.

Results of Post-Training Course Questionnaire

A total of twenty-seven participants attended the workshop and twenty-five completed the post-workshop evaluation form. On the whole, participants were satisfied and very satisfied with the workshop content (76% and 17%), and the method of combining the presentation with participatory discussions, focus group work, plenary discussions and worksheet exercises were equally received with high levels of satisfaction (Figure 12.1).
The most useful and effective sessions were those that dealt with theory of change (80%) and logical modelling (68%). However, participants’ also noted sustaining M&E strategy was critical (64%). Eighteen of twenty-five participant/respondent commented on whether additional topics should have been covered. Of these, 74% said that the course was sufficiently comprehensive and it was important to just focus on M&E.

The development of communication framework was a necessary side-track (14%). However, 56% of the participants wished there was more time for the facilitator to have actually helped integrate the log frame into each of the proposals.

Participants’ understanding and knowledge of 3MDG and Collective Voices programs increased as a result of the workshop. The pre-training course questionnaire highlighted that participants were largely familiarly with the programs, but 4-30% of respondents indicated having very little or no familiarity (see Figure 11.5).

As a result of the workshop, participants all indicated showing familiarity with the programs as a result of the training. The percentage of participants with no knowledge at all decreased to zero, and familiarity to a good extent increased from 35% to 50% on average across all six CSOs (Figure 12.2)

Mixed group work was highly appreciated, and an overwhelming majority (92%) said utilizing mixed groups was an effective way to consider the commonalities among them. This fostered a good relationship among them as well as allowing an opportunity to learn from each other. However, 8% of participants found the process time consuming.

While three quarters of the participants felt that the workshop greatly expanded their technical knowledge on M&E (83%), especially theory of change and logical modelling, over half of them (all from Lead CSO) felt they were ready to apply their skills, but needed more practice with the 3MDG project before they could train others (Figure 12.3).
Overall, the workshop and training were successful in achieving the goal of increasing technical knowledge and skill set, and developing a greater understanding of the Collective Voices initiative. Participants felt high levels of satisfaction in relation to the workshop content and training methods, and as a result majority of the participants were able to devise M&E strategy and logical framework modelling for their own organisation and contribute to developing one for Collective Voices.

4.3 Experiences with the Collective Voices Partnership: Best Practices and Lessons Learned

At the last session of the workshop, there was a plenary discussion on best practices and lessons learned during Stage 1 of the Collective Voices Initiative.

Best Practices

There were many recommendations on best practices discussed during the session. Importantly, it was established that the conduct of orientation workshops combined with field visits by 3MDG staff established confidence in the partnership.

All six partner Lead CSOs learned and applied PLA approach, which helped to draw the participation of the community, and the Collective Voices Initiative did help to promote a higher role for the partners in their respective State and Regions. The training sessions helped to solidify the importance of partnership between Lead CSOs and CBOs.

Community members were provided an opportunity to give voice to their needs and explore possibilities to change their situation, and CBOs received a chance to hear/listen to the advice of the community. This also led to advocacy to authorities, which led to gained recognition and support from different levels, notably at the township level.

3MDG also organized learning and sharing session prior to Stage 2 preparation of project proposals. The six partner CSOs shared their findings from Stage 1 and initial Stage 2 project design.
Lessons Learned

There were a number of lessons learned throughout this process. Importantly, it was determined that there were a few misunderstandings at the outset. The community misunderstood the questions that were discussed in the meetings, and they therefore gave irrelevant answers. This meant that some organizations had to revise the terms, retrain the staff and redo the information collection twice.

The different nature of some target populations (e.g. lesbian) led to unexpected issues occurring. It was suggested that any project targeting potentially sensitive areas such as sexual, rights, etc., must incorporate a risk analysis and risk mitigation strategy. Developing a skilled communication framework/strategy in advocacy is also required.

A weakness in public speaking skills of facilitators was also observed, and that there was weak coordination between lead organisations and partner CBOs.

Lastly, the delayed commencement of the project, beginning at the onset of the monsoon season, affected the efficiency of the project.
5 PART V: CONCLUSIONS AND RECOMMENDATIONS

There are significant inequalities in the health status of the population of Myanmar especially access to affordable, quality health care and more so in rural areas, the hard to reach remote states and the vulnerable. The 3MDG Fund was set up in 2012 to have a catalytic role in facilitating a health development process where people in communities will be provided with information to help them access health services, and public health system will be supported in listening to the voice of the people and responding accordingly.

When the 3MDG Fund was first designed in 2012, the Fund and MoH were two separate entities. The previous 3 Diseases Fund focused on humanitarian assistance and epidemiology. Now it is MNCH services (component 1), prevention, treatment and care of the three diseases (component 2) and HSS including community engagement as cross-cutting elements (component 3).

In late 2013 the 3MDG Fund consolidated the main crosscutting issues relevant to the Fund (e.g. gender, beneficiary accountability, social inclusion, community engagement and partnerships with civil society) into one strategy, calling it an Accountability, Equity and Inclusion (AEI) Strategic Framework, later called ‘Health for All’ (to make it more user-friendly and less technical).

In support of this Framework, in June 2014 3MDG launched a new initiative, ‘Collective Voices: Understanding Community Health Experiences’. Through this unique two-stage initiative, 3MDG is partnering with six CSOs to generate better information for all stakeholders on the social factors limiting access to health care (stage 1 -completed) and empower local organizations to implement effective solutions at the community level (stage 2 -continuing). The Fund’s “Health for All” strategy continues to complement’s the efforts of the Myanmar MoH by focusing on community engagement, skills enhancement, capacity development and improved performance of its programme.

The Initiative is closely supported by the 3MDG Accountability Programme Officer (APO) and a three member-technical and grant management team (the Health for All Team). A decision was made to develop from the bottom–up an M&E Strategy and Logical Social Framework for Collective Voices. A Consultant was hired for the purpose of improving the knowledge and understanding of Lead CSOs and CBOs in M&E and to enable them to provide direct inputs from their project into building such a strategy and framework in a phased and sustained manner.

1. General Conclusion and Recommendations:

Conclusion 1: Given that the CSO-CBOs proposed activities and results although containing similar elements, include substantial differences in approach, it is important to ensure their project data collection and reporting system is aligned with the suggested overall Collective Voices Logical Social Framework.

Recommendation 1: A meeting should be called between the 3MDG Health for All Team and the implementing six CSO-CBOs to seek further harmonisation of the Collective Voices Logical Social Framework output and outcome indicators with those of the six projects being implemented to ensure alignment, consistency and feasibility of data collection across the Initiative. Ensure that M&E component of projects are adequately resourced both at the level of Lead CSOs and Health for All.

Conclusion 2: 3MDG reports to a set of indicators. In turn the process for developing M&E Strategy and Logical Social Framework has recognized this from the outset and this Report emphasizes that the signal
of success of Collective Voices will not only be at their level but how they have contributed to the overall success “how their (Initiative) outcome contributes to our (3MDG) outcome”.

**Recommendation 2a:** Once recommendation 1 has been achieved the 3MDG Health for All team and M&E team should meet to establish how the Collective Voices Logical Social Framework is contributing to the overall 3 MDG log frame. It is suggested that Output 5 is kept intact as there will be INGOs reporting towards it and that the Collective Voices goal is added, ensuring there is no duplication in reporting.

**Recommendation 2b:** There should be integration and mutual buy-in with 3MDG mid-term review and the final summative evaluation using the planning and scheduling matrix (Annex 14) as a guideline. There will be some budget and resources implication on both sides but would help increase joint activities and co-ordination between two critically important parts of 3MDG.

**Recommendation 2c:** In order to make the M&E Strategy for Collective Voices functional, an M&E Assistance Framework should be mutually agreed so that the 3MDG M&E unit can play the role of routine in-house support for Health for All Team and Lead CSO partners. Joint activity could be around analysing Stage 1 consolidated results and establishing “baseline”, the mechanism for data feedback from Lead CSOs, support for the development of selection criteria of a company and budgets for midterm/end of term evaluations as well as ToR for the evaluator(s) and help in formulating the table of content of the Collective Voices Annual Report.

**Conclusion 3:** Given that the CV M&E Strategy will soon be in place, it is expected that relationship among relevant CV partners and those 3MDG partners working in Component 1 (MNCH) will be further reinforced especially those present in the same state/region/township.

**Recommendation 3:** In order to ensure that there is no dual reporting to 3MDG and data inflation, there is an imperative that the three Lead CSOs (AYO, COM and CAD) meet with C1 partners and have a discussion on the CV M&E strategy outputs and outcomes in order to bring greater clarity to the ‘joint’ intervention process, role and responsibility and contribution/attribution of each partner.

**Recommendation 3b:** It is highly encouraged that CV organisations work with and learn from each other on how to join forces with other implementing partners and stakeholders in their project areas.

**Conclusion 4:** In recognition that Output 5 of 3MDG encourages community participation as part of health responsiveness, the whole M&E Strategy and the Logical Social Framework and quantitative indicator- qualitative analysis of change (Annex 11) focus on responsiveness in favour of health seeking behaviour.

**Recommendation 4:** Collective Voices Communication Framework that has been developed for the purpose of joint brand recognition (Lead CSO, 3MDG and Collective Voices) will need to be aligned and harmonized into the 3MDG communication framework/strategy. As Stage 2 project implementation begins this month, accelerated communication will be crucial to encourage large-scale uptake of services by the community in the coming year. This activity will have budget implications for Collective Voices and must be duly considered.

**Conclusion 5:** The M&E Strategy for Collective Voices including the formulation of the Logical Social Framework are following closely in the footstep of trainings on organisational strengthening of the six Lead CSOs and project cycle management but only one of the CSOs had formally integrated M&E functions into staff responsibility, sole or otherwise. There were two M&E officers who attended the M&E training course but their role and responsibility was not clear vis-à-vis the Collective Voices project.
**Recommendation 5:** The Health for All Team should ask the Lead CSO to formally designate a senior staff as focal point in support of implementing the M&E Strategy especially the monitoring of data collection, reporting and analysis. A ToR to this effect should be prepared and joint team meetings should be planned on a six monthly basis to discuss the findings especially quality of project data and reliability.

**Conclusion 6:** Trainings on a variety of relevant subjects such as PLA tools, gender and conflict sensitivity and disability, have been ongoing for the partners including CBOs and there is the same exposure to all 6 partners. Stage 1 projects have identified the need not just for MNCH but also for sexual and reproductive health and behaviour change communication. It is critical that both MNCH and SRH trainings are underpinned by gender, social inclusion and rights as many of the projects are targeting adolescent and youth, girls and women, sexual minorities and prevention of HIV.

**Recommendation 6:** Preferably as soon as possible, otherwise when space opens up, the Health for All Work Plan should introduce a socially inclusive, gender and rights based SRH training that also includes components such as sexuality education and behaviour change communication. In fact it would be interesting to do the training utilizing social accountability tools. If properly rationalized and justified, Collective Voices should be able to pass the budget eligibility criteria without any overlap with Component 1 (MNCH).

**Conclusion 7:** In order to measure effectively change from the implementation of the projects, a KAP (Knowledge, Attitude and Practice) survey will be necessary especially in relation to outcomes related to Objective 1 - women’s empowerment and Objective 2 - health seeking behaviour (to be incorporated into the Planning and Scheduling Matrix). The survey will specifically provide data in relation to the following outcomes:

**Objective 1 - Outcome indicator 1** - Percentage increase in community knowledge and awareness of women’s healthcare needs

**Objective 2 - Outcome indicator 1** - Percentage increase in knowledge and awareness of 3 MDG health issues and local health services

**Objective 2 - Outcome indicator 4** - Percentage increase target community satisfaction with delivery of local services, baseline and follow-up satisfaction surveys are necessary to provide data in relation to this indicator.

**Objective 2 - Outcome indicator 2** - Percentage increase in timely referrals from target communities who receive health service, the issue of countering the issue of subjectivity in relation to measuring timeliness might be addressed to some extent by defining requirements within referral mechanisms for EmOC or ECC.

**Recommendation 7a:** The KAP survey should be designed and implemented to be undertaken within the CSO-CBO work plans early in the Stage 2 implementation phase, with a review incorporated as part of the Mid-term review in October 2016.

**Recommendation 7b:** A separate baseline survey would be necessary if the community assessment (Stage 1) did not provide sufficient qualitative and quantitative information necessary to indicate current community views regarding local health services, to be followed up during the Mid-term review.

**Recommendation 7c:** It may difficult to define a baseline in relation to timeliness of emergency referral of cases and hence it may be appropriate to measure whether referral mechanisms operate to the access standards as defined within the referral mechanism protocol.
2. Developing the M&E Strategy: Lessons Learnt

- A key difficulty in developing the Collective Voices 3 Os table (Annex 11) is the fact that the Lead CSOs are still developing their M&E plans for their projects. Therefore, it was difficult to identify measurable indicators without knowing what might be feasible and manageable from their perspective.

- Equally, some Lead CSOs did not provide clarity around what they would undertake themselves or facilitate through the CBO partnership working for example with local health services. It was difficult in some instances to know what they would and would not take responsibility for delivering e.g. increasing outreach health services or delivering training to health service staff. This should be clearer once they develop in more detail their work plans which must be reviewed by the 3MDG Health for All Team to ensure consistency.

- Lead CSOs-CBOs are planning a wide variety of interventions, some are covered by all projects e.g. IEC with communities, however, there are significant outliers where plans exist within the projects to improve health staff training, increase basic health service outreach provision and provide youth centres. It was difficult to capture all this variety and potential innovation within the overall Logical Social Framework of the Collective Voice.

- There was some difficulty harmonising Collective Voices LSF with the 3MDG log frame, given that the latter log frame although mentioning capacity building (though not to the same extent of capacity building and technical assistance being undertaken by Collective Voices) and community feedback mechanism strengthening, is not explicit regarding improving community health seeking behaviour. This could be due to the fact that 3MDG log frame predates Collective Voices LSF and the 3MDG itself which has evolved with a greater focus on communities but this aspect remains weak within the 3MDG log frame. Greater dialogue on how to align CV LSF with the 3MDG log frame is necessary working through the M&E Sub-committee of the Fund Board.

3. M&E Strategy: Added Value of the Templates for Project Implementation

1) Theory of Change Template

Conclusions

- Collective Voice Theory of Change (ToC) is rooted in Social Framework analysis and can be used with Lead CSO-CBOs to ensure they understand how their own projects ToC are inter-connected with Collective Voices wider ToC and the relationship between partners.

- It provides consistency in Collective Voices communication with Lead CSOs regarding the expected changes they are collectively aiming to achieve given significant variations in the projects they are proposing to implement.

- It shows how their interventions are connected with the wider 3MDG programme objectives – enhancing health services responsiveness and accountability to poor communities – emphasising their important role in contributing to achieving Health for All.

- It is apparent when reviewing the Lead CSO proposals the significant challenges they may face in developing partnerships both with township health services and with 3MDG partners especially in component 1 and 2. The ToC also provides an explanation to different stakeholders regarding their collective role in advancing Health for All.

Recommendations

- Given that the network of relationships within 3MDG Collective Voices is complex, yet engagement and partnership development is so crucial to the Lead CSO-CBOs projects success, it
should not be presumed that all have the capacity, knowledge and tools necessary to undertake this successfully.

- Specific capacity building in partnership development focusing upon leveraging shared values and objectives, and mutual self-interest with other partners especially those in component 1 and 2 is critical so Health for All Team together with Lead CSOs must have a proactive plan to address this gap for it is likely to be highly beneficial. This in turn could be linked with the Lead CSO-Collective Voices Communication Framework.

2) 3Os Template

Conclusions

- The 3Os template includes proposed Collective Voices output and outcome indicators that can be used as a tool to ensure that those within Lead CSO-CBOs projects are aligned with Collective Voices as a whole.
- It is important to ensure that a minimum set of indicators are agreed which are feasible and manageable to collect ideally as part of Lead CSO reporting process within their individual projects, rather than adding the additional burden of a new layer of reporting requirements. This is something for Collective Voices to consider as Lead CSOs finalise their project proposals following the recent M&E capacity building workshop.
- The analysis of Lead CSO-CBO planned health seeking behaviour highlights potential gaps in delivering a comprehensive approach (covering demand/supply side), which may be clearer once these are aligned with other interventions being delivered by 3MDG partners.

Recommendations

- The analysis of Lead CSO-CBOs proposed health seeking behaviour interventions (figure 3) highlights that some will set-up both improved emergency referral mechanisms, together with some form of community health fund/income generation to support health service access. However, others are only proposing to improve referral mechanisms without a community health fund to mitigate family outcome of pocket health expenditures. This is something that Health for All Team needs to clarify with Lead CSOs to ensure that this is not a limiting factor on health service access in their proposals.
- The health seeking behaviour analysis also identifies some interventions more on the supply side e.g. Bright Future increase in BHS outreach. It is important if these are in scope for the Col that they are coordinated with local MoH health service strengthening interventions and INGO MNCH interventions in particular states/regions. The Lead CSO-CBOs demand side interventions are more likely to be effective when implemented concurrently with MoH/INGO supply-side interventions illustrated in figure 4.

3) Logical Social Framework

Conclusions

- The Logical Social Framework (LSF) provides an overarching summary of how Collective Voices is able to assess its contribution to achieving its goal which contributes to 3MDGs output 5
- The LSF provides a means by which Collective Voices can harmonise data collection and reporting with Lead CSOs in order to measure their contribution to achieving the overall outputs, outcomes and goals of the unified Collective Voices initiative.
- The LSF is important because it highlights how CSOs-CBOs capacity development and implementation efforts (positive or negative) are crucial to the success of the overall Collective Voices programme.
It highlights the importance of Lead CSOs reporting changes in relationships with key stakeholders (positive or negative) in their project monitoring as this provides information for shared learning between different Collective Voices partners.

**Recommendations**

- Information regarding changes in relationships that support or hinder project implementation between CSO-CBOs, State/Region/Township Health officials, INGOs or other stakeholders should be shared with 3MDG through regular reporting (by adding this to the quarterly reporting template and/or adding this as a CV rolling forum agenda item). It might indicate opportunities for opening up dialogue and making progress on key project objectives, or problems integrating CSO-CBO interventions with the wider 3MDG programme. For example, information shared regarding successful tactics to develop partnerships with INGOs might be of assistance to other CSO-CBOs operating in the same region/state.

- The LSF highlights the importance of collaborative relationships between Lead CSOs-CBOs, state and private sector providers, INGOs and other stakeholders to arrive at the planned outputs and outcomes in a measurable way. Therefore it is important that Lead CSO-CBOs working at state/region level are involved in local coordination mechanisms and are able to share their work plans with key stakeholders to maximise their combined efforts and reduce duplication.

### 4) Communication Framework

**Conclusions**

- The brand values emerging from the Collective Voices Communication Framework provide the basis for ensuring that Lead CSO-CBOs deliver a coherent message regarding the programme at national, state/region, township and community level with all partners and stakeholders.

- The Framework is an important tool that can be used during the delivery of the Collective Voices to guide the development of work plans detailing proactive communication initiatives.

- Opportunities can be sought related to key milestones in the implementation of Lead CSO-CBO projects and the wider 3MDG programme to highlight Collective Voices contributions to improving universal health care.

- A forward looking work plan would scan the horizon for opportunities to implement the Communications Strategy and raise the profile of the Collective Voices Initiative at different levels (national, state/region, township, and community) in terms of how it contributes to Health for All.

**Recommendations**

- In implementing the Communications Strategy it is important to clarify responsibilities at different levels (national, state/region, township and community) between the 3MDG Health for All APO and CSO-CBOs.

- Shared communication work plans will ensure appropriate dialogue and agreement, and a coherent and coordinated approach over an agreed timeline.

- Lead CSOs propose to produce a range of resources and materials as part of their projects and ideally the style and messages should be guided by 3MDG and Collective Voices branding guidelines.

**Closing Remarks**

The Consultant can confidently say based on experience of the strategy development process (desk research, training course, workshop and interviews) and analysis that 3MDG has in general been the catalyst for:
Challenging Business as Usual: There are many best practices on aid effectiveness to emulate, challenges that were overcome and lessons learned by Collective Voices. On the other hand, the M&E strategy implementation provides an opportunity to increase efficiency and effectiveness to the benefit of target communities. When LSF is implemented in the selected townships, Collective Voices can add value by “getting the biggest bang for the buck” and CSO-CBOs will have the chance to increase their practical analysis and learning from the M&E training course and workshop.

A developing Paradigm Shift. There is full awareness at the highest echelons of 3MDG that Collective Voices continues to show increasing potential not just for community engagement but also to build a relationship with the public health system. The 3MDG and Collective Voices seem to have re-energized the enthusiasm of the MoH in meeting its access goals. For example the MoH has asked Collective Voices partners to provide training to state/region and township level staff on community engagement and listening to community voices, as part of its township micro planning process. Furthermore, Lead CSO-CBO project is about to have SMARTer objectives, measurable output and outcome indicators and “best of all we have budgeted for M&E activities for the first time.”

Developing a movement away from a Charity Perspective to One of Entitlement: 3MDG’s programme is rooted in the rights based approach – the right to have your rights realized. Having Collective Voices partners on the ground provides leverage especially in politically difficult times and places. When training is conducted according to international standards, it stands to reason that rights based approach is built in. This has allowed issues of gender equality and equity in terms of services and care and GBV/SV and HIV to be brought to the table and the language of upcoming MoH documents is beginning to change.

Greater accountability by INGOs towards Health for All Team and vice versa: 3MDG is responsible for the entire programme namely the three components. INGOs working for component one (MNCH) are a natural ally as is state governance and health departments. The APO represents the Initiative’s engagement with MoH and the three components of 3MDG Fund. This kind of three way partnerships is rare and there is potential for strengthening it as the Initiative progresses.

Innovation and sustainability and potential opportunities to communicate: Lead CSO’s have developed strong strategic partnership as Collective Voices and secured funding for the moment from 3MDG. The M&E Strategy is slowly but surely being integrated into Collective Voices. Projects implementation has just started and now is a good time to get the joint 3MDG Collective Voices Communication Framework rolling.

Knowledge generation, documenting, sharing and management: The M&E Strategy is a directional and guidance tool that has a long history and has now found a new home in Myanmar. Due to the bottom-up approach and the use of Collective Voices proposals in arriving at outputs and outcomes, the strategy will have great flexibility and adaptability during discussions with Lead CSOs. With a bit of creativity Collective Voices M&E Strategy should find resonance within the 3MDG M&E log frame. There is still significant overlap and synergy to tap into on quality and participation. Cross cutting issues make for commonality in purpose but further buy in is necessary from higher levels in MoH.

Creating Windows not Mirrors in Community Health Development: The intention of 3MDG and Collective Voices is to help people in the community especially the poor and vulnerable. This will happen when Stage 2 implementation begins very soon. The learning curve as with all new initiatives has been difficult to start with, familiarity and ease with the situation has set in with Stage 1 and as advocacy and new trainings get fulfilled, further recognition at national level will be followed by potential opportunities on the ground. Collective Voices will have a momentum of its own as it increases in confidence and gains more support for 3MDG. This has the potential to take the Fund and the Initiative to new heights in the coming years.
6 ANNEXES

Annex 1: CV: Coverage by Lead CSOs-CBOs
See separate document.

Annex 2: Terms of Reference (Annex B)
See separate document.

Annex 3: Scope and Methodology
See separate document.

Annex 4a: CV: Agenda for Training Course
See separate document.

Annex 4b: CV: Agenda for Workshop
See separate document.

Annex 5: Training Output: Theory of Change
See separate document.

See separate document.

Annex 7: Training Output: Project Objectives, Outputs and Outcomes
See separate document.

Annex 8: Training Output: Logical Social Framework
See separate document.

Annex 9: CV: Dual pathway to Developing and Implementing a Participatory M&E Strategy
See separate document.
Annex 10: CV: Theory of Change

See separate document.

Annex 11: CV: Objectives to Outputs to Outcomes to Change

See separate document.

Annex 12: CV: Logical Social Framework

See separate document.

Annex 13: CV: Pro-active Communication Framework

See separate document.

Annex 14: CV: M&E Planning and Scheduling Matrix

See separate document.

Annex 15: CV: Suggested DAC Evaluation Criteria and Questions

See separate document.