Report of the Qualitative Analysis and Learning Consultant

Myanmar

June 2015
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Myanmar

Dr Than Tun Sein
June 2015
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ACKNOWLEDGEMENT

The Consultant would like to express his gratitude to Ms Julia Messner, U Hre Bik, Daw Yadanar Khin Kyaw, Daw Aye Thiri and U Thiha Nyi Nyi of 3MDG Office, and all the staffs of the CSOs and CBOs engaged in the exploration of “Collective Voices”, for their collaboration in my assignment.
**LIST OF ABBREVIATIONS AND ACRONYMS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AEI</td>
<td>Accountability, Equity and Inclusiveness</td>
</tr>
<tr>
<td>ARH</td>
<td>Adolescent Reproductive Health</td>
</tr>
<tr>
<td>AYO</td>
<td>Ar Yone Oo</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organization</td>
</tr>
<tr>
<td>CDDCET</td>
<td>Community Driven Development and Capacity Building Enhancement Team</td>
</tr>
<tr>
<td>CM</td>
<td>Community Meeting</td>
</tr>
<tr>
<td>COM</td>
<td>Community Oriented Myanmar</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>IDI</td>
<td>Individual Depth Interview</td>
</tr>
<tr>
<td>KII</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>LNGO</td>
<td>Local Non-Governmental Organisation</td>
</tr>
<tr>
<td>LSB</td>
<td>Light Star Bridge</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSC</td>
<td>Most Significant Change</td>
</tr>
<tr>
<td>NSM</td>
<td>Non-State Actor</td>
</tr>
<tr>
<td>PET</td>
<td>Participatory Education Theatre</td>
</tr>
<tr>
<td>PLA</td>
<td>Participatory Learning and Action</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>SDH</td>
<td>Social Determinants of Health</td>
</tr>
<tr>
<td>TMO</td>
<td>Township Medical Officer</td>
</tr>
<tr>
<td>TOR</td>
<td>Terms of Reference</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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Conceptual Framework of Social Determinants of Health was the key reference made in the Consultant’s work. Within this broader frame, a specific conceptual framework depicting demand side and supply side factors, with demand side factors emphasizing on social group differences, culture and gender elements, was depicted by the Consultant as a reference for assessing the information generated by the grant recipient organizations.

As Community Action Cycle approach and application of Participatory Learning and Action (PLA) tools at each step of the cycle is considered the basis of community based programs, these were given key considerations in designing the one-day training. As all the Civil Society Organisations (CSOs) have their own Consultants recruited with sub-contracts, one-day training appeared acceptable for some of the CSOs. However, this did not seem to happen to two CSOs as their Consultants were unable to provide necessary technical support following the ideas shared during the training.

The overall impression on the CSOs was that they were all with full enthusiasm to make qualitative information collection a full success. Based on the preliminary findings, the Consultant attempted to generate possible interventions that the CSOs might be able to implement in the next cycle. However, alternatives may be brought up after understanding the whole picture when final reports are made by the CSOs.

Recommendations are made to: consider Community Action Cycle approach and application of PLA tools if 3MDG funding support aims for interventions to be followed by preliminary exploration of community voices; clearly inform the grant applicants at early stage about this approach and tools to be identified in their proposals; and in case research proposals are to be submitted, the proposals are to be made based on specific standards of a research proposal, and also to get approval from an ethical review committee.
1. **BACKGROUND**

The most powerful of the causes that need to be addressed to improve health among the poorest and most vulnerable communities are the social conditions in which people live and work. These are referred to as the Social determinants of Health (SDH). These SDHs are deeply enmeshed in people’s hierarchy of social group differences, power and resources available to them. Such situations are then in turn under the influence of the political and socio-economic context of their societies. Figure 1 below depicts the Conceptual Framework of SDH\(^1\). The interdependence between health and social conditions is well-recognized in the Millennium Development Goals (MDGs), and its framework has explicitly demonstrated that substantial gains in poverty reduction, food security, education, women’s empowerment and improved living conditions in slum areas, are highly essential in many countries for achieving health targets\(^2\), \(^3\). Other MDG objectives would only be achieved with improvements being made in health.

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**Note:** The figure is adapted from the figure provided in the document by Solar O and Irwin A, A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice), Geneva, World Health Organization, 2010.

**Figure 1 Conceptual Framework of Social Determinants of Health**

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As indicated in Figure 1, the context (governance, macro-economic policies, social and public policies, etc.,) and socioeconomic position of individuals (income, education and occupation related social group differences, gender, and ethnicity) are together referred to as “structural determinants” and these are key components of the “social determinants of health inequities”. As could be noted in Figure 1, the social determinants of health inequities included in the structural determinants further operate through a set of intermediary determinants of health to shape health outcomes.

The purpose of the Collective Voices grants are said to be:

- To support local organisations to build upon areas of competency and interest, and empower them to implement innovative, community-led approaches to address Accountability, Equity and Inclusiveness (AEI)-related challenges.
- To produce qualitative information about AEI-related priorities and gaps within specific communities or populations.
- To create spaces for the voices of marginalised people to be heard.
- To better understand and address beneficiary and community needs by supporting CSOs/CBOs/LNGOs to develop innovative AEI approaches based on community inputs and engagement, advocacy, awareness raising and capacity building.
- To develop opportunities for lessons learning from the ground up.
- To increase sustainability of interventions through community ownership.

Taking into consideration of the purpose statements described above, the Consultant considers that Community Action Cycle approach applying PLA tools at each stage of the Cycle suits perfectly for empowering the communities and addressing AEI issues.

The “Collective Voices” qualitative exploration in the first phase intends “to understand the local social contexts in which disease burden is experienced and which affect health seeking behaviours”. The fund recipients (Civil Society Organizations, or CSOs) also expressed in the objectives of their proposals for qualitative explorations to address health seeking behaviours and cultural and gender issues inherent in these behaviours. Thus the Consultant considers that the Conceptual Framework shown in Figure 2 could serve as a general frame to assess the outputs of all the CSOs’ qualitative undertakings.
In Figure 2, both the demand side and supply side are portrayed as access to and utilization of health services are determined by all the factors on both of the sides. It is to be noted that though the focus of information to be generated by the qualitative information collection will be on demand side, supply side issues will be generated at the same time as they constitute the two sides of the same coin.

Within the frame of economic and political systems, socio-demographic factors, cultural beliefs and practices, gender discrimination, the disease patterns, health literacy and poor geographical access to health facilities, are said to be the factors, on the demand side, that influence whether a health care provision is utilized or not 4, 5, 6, 7, 8, 9, 10, 11. Poor are more vulnerable in terms of affordability and choice of health provider in countries where economic disparity is immense and with no government policy for providing social health protection to the poor. Absence of democratization at the grassroots level, especially among the poor, makes poor people be excluded from the benefits of health care system; in addition, it also restricts them from participating in decisions that affect their health, leading to greater health inequalities.

Terms of Reference (TOR) for the consultancy work are attached as Annex 1.

In this consultancy, the term Civil Society Organization (CSO) refers to the social arena that exists between the State and the individual or household. It differs from the State in lacking the coercive or regulatory power; and it differs from the market or private business sector in lacking the economic power. However, Civil Society provides the social power or influence of ordinary people. This is considered the key essence of the theory and practice of CSOs. Because of this inherent principle of CSOs, the CSOs have even been referred to as the “Third Sector” of society, distinct from government and business. Community Based Organization (CBO) refers to local organizations set up by local community members.

Within the context of the 3MDG project, CSOs are the fund recipients and considered to possess necessary technical skills to perform the project work. These CSOs, in collaboration with local partner CBOs in areas where the projects are to take place, will perform information gathering. While doing so, it is expected that the skills of performing qualitative data collection will be imparted to their partner CBOs.

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2. **TRAINING ON QUALITATIVE INFORMATION COLLECTION USING PARTICIPATORY LEARNING AND ACTION (PLA) APPROACHES TO BE APPLIED DURING COMMUNITY MEETINGS**

2.1 Designing Training

Before designing, planning and developing course materials, the Facilitator first made a review of the project proposals submitted by the grant recipients so as to make the one-day training fit in into their needs.

On review of the project proposals, the following observations were made.

- All the project proposals did not fit in well with the requirements of a proper research proposal.
- Information gathering approaches as indicated by the grant recipients in their proposals are as shown in Table 1 below.

<table>
<thead>
<tr>
<th>Grant recipient</th>
<th>Information gathering approaches indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Ar-Yone-Oo</td>
<td>Community Meetings</td>
</tr>
<tr>
<td>(2) Bright Future</td>
<td>Qualitative methods: Focus Group Discussion (FGD); Individual Depth Interview (IDI); Key Informant Interview (KII) PLA: (No specific approach indicated)</td>
</tr>
<tr>
<td>(3) Charity Oriented Myanmar</td>
<td>Homogeneous Group Discussions PLA: Venn Diagram; Historical Time-lines; Seasonal Calendars; Mobility Map; Transect Walk</td>
</tr>
<tr>
<td>(4) Community Driven Development &amp; Capacity Building Enhancement Team</td>
<td>(No indication made)</td>
</tr>
<tr>
<td>(5) Community Agency for Rural Development</td>
<td>Community Meetings</td>
</tr>
<tr>
<td>(6) Phan Tee Ein</td>
<td>Qualitative methods: FGD; IDI; KII Homogeneous group discussions (as a matter of fact the same with FGD) PLA: Body Mapping; Services Web; Problem Wall; Solution Tree</td>
</tr>
</tbody>
</table>

- There were also descriptions made that their organizations would incorporate interventions such as: advocacy; out-reach health education sessions; developing visual aids, vinyl, booklets, video clips, documentary films; edutainment; assessing level of community participation; and empowering community.

Within the frame of the TOR given, new developments that emerged and the observations described above, the training materials were developed and the training given. Because of limited duration, training took place more as sharing opinions between the Facilitator and the grant recipients as regards how they would gather qualitative information from the field during community meetings.

The workshop, conducted on 20 March 2015 was attended by 35 participants from six CSOs, who are grant recipients, and related Community Based Organizations (CBOs). The Time Table of the Training is as shown in Annex 2.
2.2 Training Process

2.2.1 Story Telling

After self-introductions by the participants training began with a Story Telling\(^{12}\) by the Facilitator. The essence of the story is to build self-reliance attitude and practice by outside helpers among the community members that they intend to deliver development. The participants, after discussion, were specifically informed that what the CSOs planned to perform in project areas must leave behind their skills of performance among the CBOs that they are supposed to be working with.

2.2.2 Community Action Cycle

Next, Action Cycle of Community Mobilization\(^{13}\) (Figure 3 shown below) was introduced informing that though this approach was not mentioned in any of the project proposal, this was what they should keep thinking of as they would have to come to the second stage of implementing projects to address priority issues discovered in the first phase. Attention was also drawn to the CSO that mentioned “assessing level of development of community participation” in their project proposal to think of what they really wanted to assess, to which level of participation they were referring to and whether such an assessment should be desirable and would be possible within the project duration they were thinking of.

![Figure 3 Community Action Cycle](image)

Other points discussed, referring back to key technical terms they used in their proposals, included:

- As regards advocacy, they were reminded that this activity needed a proper training and whether their members (CSO as well as CBO) had already received this training.

\(^{12}\)This story as well as Notes used as references (Reference Notes) by the Facilitator and also the Power-points shown will be submitted as separate documents.

\(^{13}\)Description of a Community Action Cycle is given in the Reference Notes.
As for developing educational materials whether they were thinking of developing new materials or use existing ones, and if thinking of developing new ones, how these would differ from the ones already developed by the MOH.

2.2.3 Categorizing Community Meetings

When discussing Community Meetings the participants were explained that these Meetings could broadly be divided into two categories: Community Meetings in Groups; and Community Meetings with Key Informants and Selected Groups. These Community Meetings are to be applied throughout the Community Action Cycle and relevant PLA approaches are to be performed at different stages.

2.2.4 Drawing Maps during Community Meetings

Drawing Maps during Community Meetings included tools like Social Mapping; Mobility Map; Transect Walk; and Observation. No single CSO mentioned Social Mapping approach in their proposals. As this tool is highly valuable in identifying social group differences, its importance in addressing equity issues and using PLA approaches are explained briefly. On discussing with the related CSO representative on the intention behind using Mobility Map, key concept seemed to be missing and seemed that its usage was not really necessary. This was discussed and clarified. The participants were told that whatever PLA tool is used, there must be a sound reason why that particular tool is applied and it is highly important what output or outcome from it is expected by the user for generating priority issues and developing solutions.

2.2.5 Drawing Relationship and Flow Diagrams during Community Meetings

Drawing Relationship and Flow Diagrams during Community Meetings involved PLA tools like Body Mapping; Causal Impact Analysis; Sexuality Lifeline; Problem Tree; and Venn Diagram/ Chappati Diagram. The second, the third and the fourth tools are not mentioned in the proposals but discussed in brief their usefulness in exploring adolescent reproductive health (ARH) issues. The participants were reminded to use the manual on ARH education, developed by MOH, as their reference is their facilitating and discussing with the target groups. This manual was shown to them. They were also reminded the constraints of drawing Problem Tree and Venn Diagram/ Chappati Diagram with the community in Myanmar’s context. These diagrams usually ended up with outside facilitators driving participants on the answers instead of the participants themselves could identify easily.

2.2.6 Scoring and Ranking during Community Meetings

PLA tools for Scoring and Ranking during Community Meetings which included Wealth and Well-Being Ranking (Identifying Social Group Differences); Ten Seed Technique; and Pairwise Ranking were discussed. No single CSO mentioned any of such priority setting tools in their proposals. They were informed that after identifying issues of concern, these must be prioritized and priority solutions also identified together with the community, and not that they (CSOs) prioritised and identified solutions by themselves.

While discussing, participants were informed that Wealth and Well-Being Ranking (Identifying Social Group Differences) and Social Mapping always went together. The tool developed by the Facilitator and that has been found practical and highly informative in Myanmar’s context on Identifying Social Group Differences and linking these to a Social Map was explained to the participants.¹⁴

¹⁴ This is described in Reference Notes.
2.2.7 Drawing Calendars and Time Lines during Community Meetings

Drawing Calendars and Time Lines during Community Meetings included: Seasonal Calendars; Historical Timeline; and Daily Time Use Analysis. Except for Historical Timeline, the other tools are useful in gender analysis.

Though gender is an issue that the CSOs are intending to address at their project sites, key tools like Seasonal Calendars and Daily Time Use Analysis are significantly missing. The participants were reminded that they should be aware of gender concepts related to identifying “roles and responsibilities”, “access and control” and “condition and position” in case they were planning to perform gender analysis. These were not discussed in detail as the experts assisting the CSOs were considered knowledgeable these technical issues.

The “Historical Timeline” that one of the CSOs was thinking differed from the original concept and practice behind it. The CSO was aiming for looking into “Most Significant Change (MSC)” applying the “Historical Timeline”. This innovative idea was welcomed, but supported with caution. Generally, MSC is applied in evaluating the impact of a program and this is why this tool was not included in the Facilitator’s learning materials.

2.2.8 Drawings during Individual Meetings with Selective Community Members

In research terms these “Selective Community Members” refer to community members meeting preset criteria like key informants who know very well of a community’s situation (Key Informant Interviews) or individuals with specific experiences, especially sensitive ones (Individual Depth Interviews).

Drawings during Individual Meetings with Selective Community Members, PLA tools that could be applied include Trend Analysis; Sexuality Lifeline; and Picture Story. These were discussed just to make the CSOs aware of such tools which could be helpful in generating voices of people, especially the Picture Story.

2.2.9 Data recording format

The following was introduced as a field note taking format after performing each Community Meeting session:

- Title: (method and issues discussed)
- Date: Place and Time (length of duration)
- Drawn by:
- Facilitated by:
- Recorded or redrawn by:
- Materials used:
- Process:
- Key Findings:

The participants were reminded that the Consultant would like to make discussions based on this particular format on meeting with the grant recipients.

2.2.10 Overall impression

Majority of the participants participated actively, raising clarifying questions whenever considered necessary. It seems that some CSOs are focusing too much on the tools of PLA rather than
“generating issues, prioritizing them, generating solutions and prioritizing these solutions”, all to be taken place with the community. Whether the CSOs are intending to impart their skills like applying PLA tools to their partner CBOs is also unclear.

These could probably be due to being unclear with the aims of 3MDG in providing grants to CSO, or the concept and practice of Community Action Cycle was not incorporated from the very beginning. If this Cycle was made as the key approach, the project would become more look like developing a Community Based Program and issues of ethical clearance might have been cleared. CSO needs to be clearly informed that this must be in one way capacity building process for their partner CBOs.

2.3 Evaluation Findings

Qualitative evaluation on the training process was made by asking the participants to give their comments and suggestions by writing them confidentially on a sheet of paper. They were asked not to mention their names and their organization identities. There were 24 participants (out of 35) who submitted their evaluation remarks. Table 2 shows the findings.

<table>
<thead>
<tr>
<th>Remarks given</th>
<th>No. of persons who gave the remark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs more days; limited time; limited discussions; seemed to be in a rush; “you should have demanded 3MDG for more days for this training”</td>
<td>14</td>
</tr>
<tr>
<td>Useful for future work</td>
<td>5</td>
</tr>
<tr>
<td>“I want to learn more from you”; “We want to know if the Facilitator could provide similar training at local areas if invited”</td>
<td>4</td>
</tr>
<tr>
<td>Presentations were well prepared making interesting to the participants</td>
<td>2</td>
</tr>
<tr>
<td>Request would like to be made for the Facilitator to involve in later stages of work by the CSOs</td>
<td>2</td>
</tr>
<tr>
<td>Noted possession (by the Facilitator) of experiences of working with different ethnic groups (of Myanmar)</td>
<td>1</td>
</tr>
<tr>
<td>Myanmar translation for the term Transact Walk is considered inappropriate</td>
<td>1</td>
</tr>
<tr>
<td>Do we need to apply all the PLA tools in our 3MDG project?</td>
<td>1</td>
</tr>
<tr>
<td>Leading CSOs (grant recipients) possess technical skills and this workshop is considered more useful for CBOs</td>
<td>1</td>
</tr>
<tr>
<td>A bit boring because only one person was teaching</td>
<td>1</td>
</tr>
<tr>
<td>Tables should be kept in front of each participant</td>
<td>1</td>
</tr>
<tr>
<td>Sessions are too long</td>
<td>1</td>
</tr>
</tbody>
</table>

Those expressing thanks are not indicated in the findings. From the Table above it could be noted that one-day workshop was considered by the majority to be too short. However, at the same time, one remark saying that “CSOs possess technical skills” of performing what was being discussed by the Facilitator, it fit in well with the purpose of conducting the workshop\textsuperscript{15}. Assumption was made that

\textsuperscript{15} The purpose of the workshop was not to provide training in new skills (in performing qualitative interviews and application of PLA approaches) to the CSOs, but to share views and opinions and have agreements between the Facilitator (Consultant) and the experts of the CSOs to have a common understanding on how the data collection tools identified in their proposals would fulfill achievement of objectives set. An assumption was made by the Facilitator that the CSO experts possess skills to apply data collection tools identified in their proposals. Thus the remark given by one CSO staff saying that “CSOs possess technical skills of performing what
all the CSOs possessed technical skills relating to “listening to the voices” of target community members. Thus, they are considered well equipped with PLA approaches (and even other qualitative research methods) to be able to perform the project work. In this case, one-day workshop was meant for exchanging views on the PLA approaches considered related to their work, and one day is considered enough.

On the other hand, to make CBO members skilful in these approaches, one day is not sufficient. There would only be their awareness raised. Then, another assumption is that this capacity building is in the hands of the “Consultants” working for the CSOs. This also is the ultimate outcome expected from the projects. Whether this happened or not should be evaluated if situation allows.
3. **FIELD TRIP FINDINGS**

The purposes of the field visits were to:

- Discuss/observe whether concepts and practices shared during the one-day training on Community Meeting (CM) and PLA tools at 3MDG Office in Yangon (to be referred to as Yangon Training from here onwards) were being applied or not;
- If applied, how these were applied;
- If not applied, why these were not applied; and
- To provide opinion on the implications of preliminary findings, if any, for developing interventions in Phase 2.

Field trips\(^{16}\) were made to Mon State from 12-5-15 till 16-5-15, CSOs in Yangon on 19 and 20 May, 2015, and visited Chin State from 8-5-15 till 12-5-15.

### 3.1 **Community Driven Development and Capacity Building Enhancement Team (CDDCET)**

Visit was made to CDDCET head office located at Bilin, Mon State, to discuss with Project staffs and also with partner CBO members. Visits were also made to Bant Bwe Kone and Nae Char Karen villages. Out of the planned 20 project villages, data collection has been done at Nae Char village, and it was in progress at Bant Bwe Kone village at the time of visit.

#### 3.1.1 **The frame for Community Meetings (CMs)**

The partner CBOs of CDDCET are:

- Lan-pya-kye-sin (Self Reliance Group/Township Leading Group);
- Light Star Bridge (LSB), a cluster organization with two additional CBOs –
  - Paung Kue; and
  - Ah Lin yaung.

As for the **CDDCET**, the following specific objectives and/or outcomes identified in their project proposal constituted the key guiding frame in assessing their Community Meetings (CM) performances and the initial results they have achieved:

- Identifying gaps in access to family planning and reproductive health services.

At the time of field visit, the CBOs in collaboration with CDDCET has completed one CM at Nae Char village and a second CM was performed at Bant Bwe Kone village on the day the Consultant and the 3MDG team arrived (13-5-15).

### 3.1.2 **Performing CMs and applying PLA tools**

After arriving back from the Yangon Training, CDDCET recruited a local Consultant from Yangon for providing PLA training on tools considered relevant to their project. CDDCET does not use the term FGD for community sessions as suggested and uses Community Meetings. The more specific training

\(^{16}\) Three staffs from 3MDG Office accompanying the Consultant in the trip performed interviews with the relevant local stakeholders from the perspectives of monitoring progress of the project activities, and these are not reported here.
they received from their Consultants seemed to have imparted necessary skills to the staffs of CDDCET and CBOs for mobilizing the community and generating their views. Though originally not identified in their project proposal, they were able to apply PLA tools at CMs.

The following PLA tools were applied:

- Social map showing a desirable community
- Problem Tree
- Listing and Pairwise Ranking
- Wealth Ranking
- Causal Impact Analysis
- Trend Analysis
- Venn Diagram
- Social Mapping
- Resource Mapping
- Seasonal Calendar

The following suggestions were given as regards the use of PLA tools based on observations made:

- “Creating shared vision of a desirable community” was what was suggested during the Yangon Training and drawing a “Social map showing a desirable community” was not only totally wrong, it does not carry information of any kind relevant to the project. The Facilitators were suggested to drop this tool down.

- As the objectives behind drawing a “Problem Tree” and performing “Causal Impact Analysis” are the same, the Facilitators were suggested to use only one of the two so as not to waste the valuable time of a CM.

- “Listing and Pairwise Ranking” approach was well applied in prioritizing preferred contraceptive methods and community suggestions to improve health of their villages.

- Performing “Wealth Ranking” seemed quite informative, but the idea was adopted from the previous United Nations Development Programme (UNDP) project’s tool and was too detailed. For UNDP may be it was a necessity because UNDP intended to implement livelihood interventions for those from lower social groups. Whether such details are necessary or not depends on what kind of intervention to be followed in the second phase. For example, in case a scheme of “Health Equity Fund” is to be established at Bilin Hospital, the information would become quite useful. The Facilitators were suggested to drop this tool as this has no relevance to the exploration they are engaged with.

- “Trend Analysis” was pointed out to be an unnecessary tool and suggested that this should be deleted from application. This tool did not generate information relevant to the objectives of their project proposal.

- As for “Drawing Venn Diagram” suggestion was made to identify individuals or organizations in their community who are influencing their opinions related to health seeking behaviour. At the time of field visit, this tool was used to identify influences of organizations outside their community on their local organizations.
“Social Mapping” and “Resource Mapping” (specifically meant for identifying health care resources) could be done together instead of drawing two different maps. However, as this mapping exercise would also not help them to identifying cultural barriers influencing health seeking behaviour, suggestion was given to drop down this tool as well.

The Consultant’s opinion was given on drawing “Seasonal Calendar” that the Calendar had minor value for the next cycle of their project and could be dropped down.

Thus PLA tools of value for use during CMs remained only two: Problem Tree or Causal Impact Analysis, Venn Diagramming and Listing and Pair-wise Ranking.

Recording of findings followed what has been suggested during the Yangon Training but needing further improvements. For example, unnecessary descriptions were made on how the session was conducted and key findings needed to be described more to provide more information. Corrective suggestions were given.

3.1.3 Key findings (Nae Char village) in brief

The followings are the key findings in brief from CMs that have been completed:

- Birth spacing practice is prevalent among mothers of all social groups.
- Hypertension is prevalent among many of the pregnant mothers and considered the top priority health problem for the mothers.
- Though transport has been improved to some extent because of new road constructions taken place between various villages, transport of mothers encountering emergency conditions to Bilin hospital is still not without difficulty especially for mothers from lower social groups.

Priority solutions generated by the community

- To train a new Auxiliary Midwife (AMW) to replace the older AMW who is now 55 years old and is unable to perform as active as before
- To make easy access to contraceptives especially for poor mothers
- To provide health education on priority health problems of pregnant mothers
- To set up a community health fund for emergency referrals of pregnant mothers to Bilin hospital
- To provide a separate place at the village for caring pregnant mothers

The findings described above highlight that there were no serious issues as regards awareness and practice of birth spacing among Karen mothers at the project villages. There might be exceptional few especially among those from poor families.

Possible solutions for the next implementation phase seem to be emerging, but still need to triangulate the findings from other CMs.

3.1.4 Conclusion

Preliminary considerations for possible intervention for the second phase

Preliminary findings indicated that access to family planning is not a serious issue for mothers at project villages, though exceptional few may exist among those from lower social group. Hypertension is found to be prevalent among many of the pregnant mothers, and this might end up...
as obstetrical emergencies. In such situations, mothers from lower social group would be the ones to face difficulties in reaching Bilin hospital in time. In this connection, establishing community health funds could be considered one possible solution to be taken as an intervention. It is to be noted in the previous paragraph that this emerged as one priority solution during CMs.

_Favourable condition for the possible intervention imagined_

An advocacy meeting held at Township Administrative Office where representatives from 17 Departments of different sectors, including the Township Medical Officer (TMO), participated. Township Working Group for implementation of the project was formed with TMO as the Chairperson, CBO representatives as members and the Project Manager of the 3MDG-supported project as Secretary. The township authorities promised their full support to CDDCET for getting collaboration from village level authorities. Likewise a promise of full support was received from the TMO. Village level advocacy meetings were held for representatives from 20 project villages and all these went well. Monthly meetings of the Township Working Group were taking place regularly with TMO participation.

This is a strong indication that Township Administrative and Health Departments would also provide full support on the intervention measures and local authority support and inter-sectorial collaboration has already been ensured from the beginning of the project.

_Strengths of CDDCET project_

The followings are the strengths:

- Karen villages located off-tract of the Bilin - Nat Kyi highway, located somehow in hard-to-reach areas, being chosen as project villages;
- Enthusiastic and skilful Facilitators of CMs; and
- PLA approaches being applied during CMs.

_Weaknesses of CDDCET project_

The following weaknesses were observed:

- Using some of the PLA tools without any rationale;
- The original specific objective of finding out gaps in access to family planning services has no more relevance to the mothers at study villages; and
- No information on cultural barriers to accessing reproductive health services has been generated, but only geographical and financial barriers had been identified.

Thus suggestions were given to re-focus the CMs and data collection tools to generate cultural barriers on accessing reproductive health services.

### 3.2 Bright Future

#### 3.2.1 The frame for CMs

The head office of Bright Future (La Yee Anar Gut) is located at Nyaung Kone Village, Mudon Township, Mon State, and their partner CBOs being –

- Lawee Mon;
- Rain-manya Charity Foundation; and
As for the Bright Future, the key guiding frame in assessing their CM performances and the initial results they have achieved fell into the following specific objectives and/or outcomes indicated in their project proposal:

- Identifying key health issues and health seeking behaviours in communities.

The Bright Future reported that 23 FGDs out of planned 72 FGDs had already been performed at some of the 24 project villages.

### 3.2.2 Performing CMs and applying PLA tools

After arriving back from the Yangon Training, Bright Future recruited a local Consultant from Yangon for providing training on qualitative data collection. Trainers gave training on FGD, KII and IDI. Thus training did not include PLA approaches as suggestions given during the Yangon Training.

Bright Future, as in the case of CDDCET, does not use the term CM as requested and instead used FGD. At the time of field visit, 23 FGD sessions out of planned 72 FGDs at 24 villages had already been completed. On closer examination, all the FGD sessions did not meet the technical criteria required for a FGD session as follows:

- Participant composition for each FGD session was not homogenous; and
- FGD guide included questions that were suitable only for individual interviews.

The FGD guide was said to have been developed by the Local Consultant. The Consultant reshaped the guide (referred to as CM guide) making it much simpler with only four key themes. Suggestions were also given to:

- Change the term FGD to CM; and
- To apply PLA tools as considered relevant (especially the ranking tools for prioritizing either barrier issues or solutions).

Though not described in the original proposal, key health issues and health seeking behaviours of migrant workers in rubber plantations were explored using the same guide developed by the Local Consultant.

No PLA tool, except social mapping, was applied. Even, social mapping was used without any application value for generating information to identify key health issues and health seeking behaviours. Corrective advises were given by the Consultant. As the villages included as project sites are large villages with over 1,000 households, drawing social maps for the whole village would be unnecessarily time consuming. Suggestion was given to hold CMs after dividing the villages into 4-5 sections and to draw social maps for each section with community members coming from respective sections.

PLA tools for prioritizing barriers to health care access and solutions generated by the community were suggested for use in later CMs.

As for migrant workers, suggestion was given not to identify social groups and not to draw social map as these are irrelevant.
As regards **Recording of findings** the same situation was observed as that for CDDCET: though recording of findings followed what has been suggested during the Yangon Training there is a need for describing the key findings to a greater extent.

In the project proposal it is mentioned that a consultant would be recruited for analyzing qualitative data collected. However, on asking the concerned leaders how the qualitative data generated during the so-called “FGD sessions” would be analysed they were unable to give any answer.

### 3.2.3 Key findings in brief

The followings are the key findings of the completed “FGDs” as discussed by the Project Manager:

- Diarrhoea and dengue haemorrhagic fever were the common seasonal illnesses of children;
- Drugs were bought from local drug shops when their children became ill, but those who could afford would go to private clinics at their villages or at Mudon town;
- Non-communicable diseases are also on a rise in their villages, and many people considered that sudden deaths from such illnesses like heart attack were “good for the persons died because they did not need to have long sufferings”;
- When dog bite cases went to public hospitals for taking anti-rabies vaccination, rabies vaccines were out-of-stocks at the hospitals;
- At Mon villages, performing ceremonies to offer spirits almost always go together with taking treatment of an ill person and such ceremonies are quite expensive;
- Snake bite cases are also common and local villagers have traditional practices of cutting the breast of a chicken into and covering this cut part on to the bitten site before taking any treatment; and
- Drug use among young people is in a rise and is becoming a serious social problem.

At one village, villagers requested for an assistant to recover drainage of a canal which has become a breeding site for mosquitoes.

There are said to be about four social groups at the project villages, and the two lower groups fall more or less into poor group. The key difference between the third lower social group and the fourth lower group is that the third group could engage to a small extent in selling things but still they have to struggle for daily survival; and the lowest group possesses nothing but their body to sell their labour. In these villages, the second, or middle, social group constitutes the largest. Generally, people from this middle and upper groups have no serious constraints for accessing to health services.

Suggestions given by the participants during CMs at rubber plantation migrant sites included for:

- Providing appropriate measures for emergency transportation of patients with severe malaria to a hospital;
- Forming mobile health teams to visit migrant workers regularly; and
- Providing appropriate measures for access to birth attendants for pregnant mothers.

### 3.2.4 Conclusion

**Preliminary considerations for possible intervention for the second phase**

In the light of the preliminary findings, interventions to improve health care for migrant workers, focusing more on malaria and maternal and child health, could be one possible intervention to be considered. As the rubber plantations sites are like borders between jurisdictions of Non-State Actors (NSA) and the Governments, support from the NSA could even be received; or such an intervention
might be like practical realization of “Health as a Bridge for Peace (HBP)” concept. See Annex 3 for brief explanation of the HBP concept and practice.

The following is the strength of Bright Future:

- Enthusiastic and skilful Facilitators of CMs.

The following is a weakness observed:

- Being unable to apply proper PLA tools during CMs; and
- Information on cultural barriers to accessing health services has been generated, but this did not come out as a priority solution that the community was expecting.

Being not able to apply PLA approaches could be due to the fact that the Bright Future representatives who participated at Yangon Training did not capture the concepts and practices briefed by the Consultant and thus they were unable to make a proper request to the Local Consultant they have recruited.

3.3 Phan Tee Ein (Creative Home)

Visit was made to the head office of Phan Tee Ein and met the project staffs.

3.3.1 The frame for CMs

The central goal of Phan Tee Ein project, as spelled out in the proposal states: improved access to quality health services for disadvantaged groups (poor women [young and elderly], women infected with and affected by HIV, Lesbians, Transgender).

The emphasis of the exploration through CMs are said to be on gender specific health needs, services gaps, priority areas and possible interventions.

3.3.2 Performing CMs and applying PLA tools

At the time of visit, no CMs have been held yet. Gender and health issues would be explored during CMs and the following PLA tools were said to be considered for application during CMs:

- Body Mapping;
- Ten Seed Technique;
- Daily Time Use Analysis; and
- Social Mapping.

Edutainment would be performed first before conducting CMs, and some games addressing gender equity issues were also planned to be incorporated.

On examining the CM guide (similar to FGD guide), it was found that guide was totally a quantitative data collection questionnaire.

Suggestions were given to:

- Drop Body Mapping; Daily Time Use Analysis; and Social Mapping as these would not generate cultural and social barrier issues;
- Re-develop the CM guide (and a brief explanation was given as regards the characteristics of a FGD guide);
- Consider conducting two CM sessions each at each study site for each of the following participant categories:
  - Poor women;
  - Yong women (aged between 18-24);
  - Transgender; and
  - Lesbians
- To describe precisely how “poor” was categorized and the process involved in selecting poor women, old and young;
- Perform Story Telling sessions with individual women with HIV (after moving the study site to Wakema town where no interventions have been implemented yet addressing women infected with HIV) as CM Sessions are ethically not appropriate;
- Apply Ten Seed Technique (as already planned) for prioritizing gender specific health needs and solutions for meeting these needs; and
- Drop Edutainment program during the exploration phase.

Nominal Group Technique was said to have been incorporated later.

### 3.3.3 Key findings in brief

There were no findings available yet at the time of visit to the office. When a request was made to provide preliminary findings in due course before last week of June, 2015, a brief report was given to the Facilitator.

The preliminary findings showed that the information gathered was unable to display issues on the demand side of health services utilization. One key finding from “Rice Distribution Game” that explored gender issues was that high priority was given to “Father” rather than to a “Pregnant Mother” for providing food.

### 3.3.4 Conclusion

**Preliminary considerations for possible intervention for the second phase**

As no concrete information has been generated yet, it is not possible to imagine any possible intervention. However, on knowing the existence at Phan Tee Ein a person trained in facilitating Participatory Education Theatre (PET), this technique might be considered for empowering the target beneficiaries to overcome social and cultural barriers that would be identified during CMs. The concepts and practice of PET in brief is described in Annex 4.

The strength of Phan Tee Ein is that it is a strong and famous CSO in Myanmar. On the other hand, it seems to be lacking professional skills to perform qualitative explorations as well as application of PLA tools and these are the weaknesses of Phan Tee Ein.

### 3.4 Charity Oriented Myanmar (COM)

COM head office was visited and met the project staffs. One fortunate situation was that the two Free Lance Consultants recruited by COM for qualitative data collection applying PLA tools were also present during the visit. The two Consultants had pre-tested the tools for conducting CMs/PLAs and had given training to the Facilitators who would be performing these.
There will be 30 villages, ten each being chosen from two townships in Delta (Labutta and Mawgyun) and one in Dry Zone (Magway township). CMs had been completed at 6 villages at Magway, 5 villages at Labutta and 5 villages at Mawgyun townships. However, data are still in the field. Request was made to ask from the field and to send 2-3 samples of the results to the Consultant.

3.4.1 The frame for CMs

The project identified its focus as “studying gender sensitive evidence collection by participatory approaches” and the target participants were described as: girls, men and women in each study village.

3.4.2 Performing CMs and applying PLA tools

PLA tools to be applied during CMs involved:

- Village Mapping (with heterogeneous groups);
- Mobility Mapping (with heterogeneous groups);
- Transect Walk;
- Historical Time Line (with homogeneous groups);
- Seasonal Calendar (with homogeneous groups);
- Daily Time Use Analysis (with homogeneous groups); and
- Venn Diagram (with homogeneous groups).

Relevance of the two tools - Historical Time Line and Seasonal Calendar - to generate information for application in the next implementation phase was discussed and suggested that these could be dropped. Another suggestion given was to probe not only into gender roles and responsibilities but also into gender access and control of resources.

3.4.3 Key findings in brief

Data were said to be still in the field at the time of visit to the office. Request was made for providing preliminary findings before the last week of June, 2015, as in the case for Phan Tee Ein, brief preliminary findings were provided to the Facilitator. Key findings in the brief report showed:

- Profiles of common diseases at the study village;
- Health care provider to who the villagers sought care (volunteer workers, basic health staffs, traditional practitioners, quacks, etc.,) were identified but description of answers for the reasons of seeking to each category of health care provider were too minimal;
- As regards gender issues, being male dominant in family decision making, including decisions for health care seeking, was described;
- Gender roles (productive, reproductive and community management roles) were elicited and properly described showing women being overburdened with these different roles; however, how to link these roles with improving health seeking behaviours remains a challenge;
- COM was able to apply identification of social group differences at each study village; here again, COM was unable to link the social groups (especially those at the lower level) with health seeking behaviours.)
3.4.4 Conclusion

Preliminary considerations for possible intervention for the second phase

From the preliminary information generated, it is still hard to reflect the possible health-related intervention, focusing on the demand side, in the next stage.

The following is the strength of COM:

- Consultants recruited for data collection, data analysis and report writing are the same persons and they are involved throughout the project; and
- They are well-versed in the principles of applying PLA tools and they could provide good reasons on why they considered applying each of the PLA tool identified, and are prepared to use them creatively.

No weakness (in the application of qualitative information gathering and PLA approaches) was observed so far.

3.5 Ar Yone Oo (AYO) Social Development Association

Visits were made to partner CBO head offices, “K” Cho Land Development Association (COLDA) at Mindat and Kawnuthang Rural Development Organization (KRDO) at Kanpetlet, to discuss with Project staffs17. Visits were also made to one project village each in each township.

There were 12 villages each covered by the project in the two townships, with proper attention being paid to include different sub-ethnic groups (3 in Mindat township and 5 in Kanpetlet township) and different faith professions (Christian, Buddhist and Nat or Spirit worshipping) in selecting the villages. The farthest village chosen is located 85 miles and 75 miles away respectively in Mindat and Kanpetlet townships; the nearest villages being 20 miles and 2 miles away respectively in Mindat and Kanpetlet townships. Out of the planned 12 villages in each township, 9 CMs been held in Mindat township, and CMs had been held at all the villages in Kanpetlet township. Plans are underway for re-visits.

3.5.1 The frame for CMs

The specific objectives described in the project proposal of AYO are:

- To understand community health experiences through community participation;
- To address gender and health through focusing on reproductive health and health for women;
- To explore barriers and limitations among the culturally distinct Chin ethnic population in remote villages; and
- To promote accountability, equity and transparency in accessing health services for the remote ethnic population in Chin State.

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17 The Consultant was unable to visit only one partner CBO, Matupi Women’s Organization (MWO), located at Matupi.
3.5.2 Performing CMs and applying PLA tools

In addition to CMs, homogeneous group interviews were held with target community members to explore reproductive health issues, for example women married during past 5 years, men married during past 5 years, single females, and single males. The PLA tools applied involved:

- Problem Tree Analysis;
- Venn Diagramming; and
- Transect Walk.

The qualitative interview guides were found to be comprehensive and specific for generating cultural and gender issues.

Identifying social group differences was said to have been dropped as it was considered “sensitive” to local community as no one wanted to be categorized as poor. When the Consultant asked one key informant, while visiting a project village in Mindat township, as regards their perceived social group differences the community at their village could be categorized into three as shown in Table 3.

Table 3 Perceived Social Group Differences at Pu Koen village, Mindat Township

<table>
<thead>
<tr>
<th>Social group hierarchy</th>
<th>Key jobs for earning</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper</td>
<td>Grow “wa-u” and own about 5-6 acres</td>
<td></td>
</tr>
<tr>
<td>Middle</td>
<td>Grow “wa-u” and own about 1-2 acres</td>
<td>Majority group</td>
</tr>
<tr>
<td>Lower</td>
<td>Grow “wa-u” and own less than 1 acre; work as manual labourers</td>
<td></td>
</tr>
</tbody>
</table>

As ignoring social group differences could not affect the information that Ar-Yone-Oo is seeking, no suggestion was given to apply this approach. There seemed not to have significant social group differences at the study villages as households are few and are dispersed over the townships. Suggestions were given on more appropriate approaches of facilitating CM sessions and PLA approaches so that Facilitators would not portray as “Teachers” but as “Learners” and also not as “Superiors in status” but as “Equals” to the participants.

The CBOs had already advocated township level administrative authorities, but health sector had been left out. Suggestion was given to inform the township health department for getting their support and collaboration.

3.5.3 Key findings in brief

The followings were the key preliminary findings:

- When became ill, villagers had to drink boiled locally available herbs (See Box 1 for gender issue);
- Occasionally, when someone from their village was travelling to the town, they might ask to buy drugs from drug shops there;
- Some may consult a shaman and take advice from him;
- At some villages where midwives were stationed, they could not get any services from the midwife for treatment of minor illnesses as the midwives stayed at towns most of the time,

18 Elephant foot yam and Botanical name is: *Amorphophallus campanulata*. Earning from growing these plants is on a rise among local people. These are said to be among export items to China.
and the midwives, most of who were from the same ethnic group, came to the villages only for about 3 days in a month to perform immunizations and nutrition support to children;

- Reproductive Health (RH) knowledge was low among both young men and women;
- Mothers took services from TBAs during deliveries, and though there were trained AMWs, villagers considered TBAs were more qualified for taking delivery care; and
- Majority of mothers were not practicing birth spacing, due to the following reasons:
  - Low awareness of these practices;
  - Among those who knew, preferred not to take injections which were considered either costly or might cause skin allergies, and IUDs might cause cancer; and
  - They want to have large families (See Box 2 for gender issue).

Box 1 Gender issue in seeking health care
Husband is the key decision maker whether his wife becomes ill and in deciding whether she should take treatment or not. His wife may be suffering a serious illness, but her husband is reluctant to sell the nwar-nauk (gayal or domesticated wild ox) for letting his wife take treatment. However, when his wife dies, he has no reluctance to killing his ox to serve villagers attending the funeral.

On the other hand, when a husband dies, his wife is highly willing to let their ox be killed and sold to earn money so that her husband could take treatment at town.

Box 2 Gender issue in birth spacing
Husband is the key decision maker whether his wife should practice birth spacing or not. The general preference is for a son in a family, and in case daughters are being born consecutively, the husband may divorce his wife and make a second marriage.

One situation observed and informed during the visit in Mindat township was that 8 villages among 12 study villages were accessible to internet connections. Information was also given that International Red Cross (IRC) was considering for an e-health system in such villages for health related data collection and service provision.

Another positive situation for both Mindat and Kanpetlet townships were the projects being implemented by IRC and Kayunar Myanmar Social Services (KMSS) on health financial protection for emergency referrals of pregnant mothers and under-5 children. This financial protection covers transport expenses and drug costs.

3.5.4 Conclusion

Preliminary considerations for possible intervention for the second phase

Local CBOs could play in raising gender awareness among communities; promote male involvement in maternal and child health care; and linking to maternal and child health services available in the communities.

The strength is that the local CBO staffs possess facilitation skills for performing CMs and PLA approaches due to their previous experiences working at UNDP and INGOs.

No serious weakness was observed so far.
4. **OVERALL CONCLUSION AND RECOMMENDATIONS**

4.1 **Overall Conclusion**

In spite of changes that had to be made to fit in well with the policy of MOH as well as the intended qualitative explorations to be made by the CSOs/CBOs, and ensuing delays, Consultant was able to complete the Training and Field Visits as follow-ups on the performances of the grant recipient organizations. The Consultant was unable to make field visits for one CSO working in northern Chin State due to time constraints.

It was noted that, though all the CSOs/CBOs were with high enthusiasm for making their information collection that would reflect collective voices of the community a success, there were two CSOs who seemed not to be well versed with the concepts and practices related to the work they have to perform, especially with PLA approaches. This probably was due to the Consultants their organizations recruited (with sub-contracts for developing proposals and data collection tools) were unable to provide necessary technical support for the purpose.

Based on the preliminary findings, the Consultant attempted to generate possible interventions that the CSOs might be able to implement in the next cycle. However, alternatives may be brought up after understanding the whole picture when final reports are made by the CSOs.

Whatever the final findings might show, and though interventions are to be applied for addressing demand side culture and gender issues, they will need to be linked to the supply side factors.

4.2 **Recommendations**

In future, in case community based intervention is to be made after preliminary exploration of priority issues in a community, Community Action Cycle approach, or any other similar approach, should be given as a frame to the grant applicants.

If Community Meetings, with relevant PLA approaches applied at different stages of the Community Action Cycle, are to be performed (instead of qualitative or quantitative research methods) for exploring and prioritizing issues/solutions, request should be made to the grant applicants to describe rationale behind any PLA approach they identified. This will ensure unnecessary attention being paid on the tools rather that the outputs and outcome that would meet as the project intended.

The purpose of making CSOs involve their CBO partners must transparently be informed from the beginning to the CSOs saying that they are responsible for developing their partners’ capacity in issue/solution identification and prioritisation skills using PLA approaches. Whether this happened is to be evaluated at a time appropriate.

If the proposals are to be submitted as research proposals, the proposals should meet specific standards of a research proposal, and also will need approval from an ethical review committee.
ANNEXES

ANNEX 1 TERMS OF REFERENCE

Position Title: Qualitative Analysis and Learning Consultant
Position: Consultant
Level: Senior-level
Type of Consultant: National
Focus of consultancy: Myanmar
Project: Program budget (88556) Component 3
UNOPS Organization Unit: Myanmar Operations Centre (MMOC)
Duty Station: In-country short-term assignment
Duration: 8 days

A. Background

UNOPS has, since 2006, managed donor funds for health for the population of Myanmar. These funds are administered and managed by UNOPS through Multi-Donor Trust Funds (MTDFs). UNOPS has previously managed the Three Diseases Fund (3DF) as well as the Joint Initiative on Maternal, Newborn and Child Health (JI-MNCH). UNOPS currently manages the Three Millennium Development Goals Fund (3MDGF) as well as being contracted under a dual-track Principal Recipient mechanism to manage Global Fund grants in Myanmar. UNOPS also manages a Food Security and Livelihoods Trust Fund in Myanmar (LIFT). This consultancy works within the line management of the programme management team of the 3MDGF.

Over the period 2005 - 2012, UNOPS acted as Fund Manager for the US$138 million Three Diseases Fund (3DF). The 3DF multi-donor Trust Fund was supported by the Governments of Australia, Denmark, the Netherlands, Norway, Sweden, the United Kingdom, and the European Union. The aim of the Fund was to contribute towards a reduction in morbidity and mortality from HIV, Tuberculosis and Malaria in Myanmar through activities targeting high-risk groups as well as interventions covering the general population.

UNOPS further managed the Joint Initiative on Maternal, Newborn and Child Health (JI-MNCH) MDTF. This fund was supported by the Governments of Australia, Norway and the United Kingdom. The JI-MNCH was a collaborative programme between MoH, UN agencies and NGOs which aimed to increase access to maternal and child health services among poor and hard-to-reach populations in areas affected by the 2008 Cyclone Nargis. JI-MNCH built upon the successful post-Nargis coordination between the former Health Cluster and the Myanmar Ministry of Health (MOH). In addition to resources from MOH, UN and NGOs, the programme drew on a US$12 million fund over a three-year period until 2012. Planning and coordination around delivery of health services under the JI-MNCH was based upon the elaboration of Coordinated Township Health Plans which determined priority public health interventions as well as apportioned distinct yet complementary roles to MoH, UN agencies and NGOs.

In 2012, UNOPS was contracted by 3DF and JI-MNCH donors, joined by the US Government in 2013, to act as the Fund Manager for the newly established Three Millennium Development Goals Fund (3MDGF). The 3MDG Fund builds upon the successes of 3DF and JI-MNCH and is intended to provide continued support for health needs in Myanmar over the period 2012 through 2015. Total donor commitments and contributions to the Fund equal approximately US$250-300 million.

The aim of the 3MDGF, whose scope is significantly expanded beyond that previous health donor funding instruments in Myanmar, is to contribute towards the goal of attainment of MDGs 4, 5 and 6 in Myanmar.
The 3MDG Fund will be supported through a pooled donor fund. It will be implemented in line with aid effectiveness principles, including ensuring harmonisation and alignment with the initiatives of other donors such as the Global Fund and GAVI. Funding from European Union donors will respect the provisions of the European Union Council Decision on Myanmar/Burma. The 3MDG Fund will also build on the achievements of 3DF and JI-MNCH in promoting wider sectorial coordination, transparency and accountability.

3MDG recognises that Local NGOs and CSOs often have existing service delivery capacity and experience, greater access to hard to reach areas and underserved communities, and are best placed to understand the local social contexts in which disease burden is experienced and which affect health seeking behaviours. In the first half of 2014, preparatory work, including consultations with internal and external stakeholders, was conducted prior to the launch of 'Collective Voices' grants which will target local CSOs. The purpose of the grants is to encourage six lead local organisations to implement innovative, community-led projects that explore accountability, gender equity and social inclusion issues at the local level.

During the first phase commencing in January 2015, the selected CSOs will be expected to jointly conduct an information gathering evidence collection project (in partnership with CSOs/CBOS/LNGOs) at the community level. It is recommended that a short-term national consultant be recruited to support the organisations to develop their capacity in the collection and analysis of qualitative information. This will be achieved firstly through a "Qualitative Information Collection" training workshop in order to provide technical assistance to Collective Voice grant recipients (including 6 Civil Society Organizations and their local partners), followed by a series of field-based technical assistance to the organisations.

B. TSF Consultant Duties

Under the overall supervision of the 3MDG Fund Director, technical supervision of the Head of the Performance Management Unit, and under the direct supervision of the Accountability Program Officer, the incumbent of the consultancy will carry out the following duties and responsibilities:

   i) Designing, planning and developing relevant course materials (including qualitative methodology, data collection, analysis and interpretation) using a Participatory Learning Approach

   ii) Discussion meetings with 3MDG staff on designing and facilitating the workshop and field based technical support

   iii) Facilitation and evaluation of a "Qualitative Data Collection Training Workshop" for Collective Voices grant recipients (6 Civil Society Organisations and their local partners)

   iv) Provision of qualitative analysis technical assistance to Collective Voices grant recipients during Phase I in the Study/Project areas

   v) Submission of Final Report with Findings and Recommendations

C. Deliverables

   i. Developed appropriate training course materials

   ii. Trained Collective Voices fund recipients (5 Civil Society Organisations and their local partners) on "Qualitative Information Collection and Analysis" through an initial Yangon-based workshop and a series of field-based technical assistance to the organisations.

   iii. Interim Report on provision of field-based technical assistance to 5 CSOs and their local partners on "Qualitative Information Collection and Analysis"

   iv. Final Report, no longer than 10 pages, with Findings and Recommendations

D. Academic and Professional Qualifications

   1. Professional Qualifications:
Masters degree required. PhD in social science or health sciences preferred.

2. Experience
   a) Involvement with UN, Donors, Academia, Government and International Non-Governmental Organizations
   b) Proven track record of at least 10 years in the field of health research and evaluation.
   c) Previous involvement with and knowledge of the UN system, donors, academia, government, international Non-Governmental Organisations and civil society.
   d) Computer and information technology literacy, including demonstrated expertise in Microsoft Word and Excel.
   e) Publications in peer reviewed journals or key reference documents is an asset.

E. Functional / Behavioural Competencies:

1) **Respect for Diversity:** Shows respect for and understanding of diverse points of view and demonstrates this understanding in daily work and decision-making; works effectively with people from all backgrounds.

2) **Planning and Organizing:** Identifies priority activities and assignments, adjusts priorities as required; foresees risks and allows for contingencies when planning.

3) **Client Orientation:** Establishes and maintains productive partnerships with clients by gaining their trust and respect; identifies clients' needs and matches them to appropriate solutions.

4) **Vision:** Identifies strategic issues, opportunities and risks; clearly communicates links between the Organization's strategy and the work unit's goals; generates and communicates broad and compelling organizational direction, inspiring others to pursue that same direction.
## ANNEX 2 TRAINING TIME TABLE

### 20 March 2015 - “Approaches to Community Meetings”

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Presenter</th>
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<tbody>
<tr>
<td>09:00 – 10:30</td>
<td>▪ Story Telling by the Facilitator</td>
<td>Dr. Than Tun Sein</td>
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<tr>
<td></td>
<td>▪ The Action Cycle of Community Mobilization</td>
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<td>▪ Community Meetings</td>
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<td></td>
<td>➢ Community Meetings in Groups</td>
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<td>➢ Community Meetings with Key Informants and Selected Groups</td>
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<td>▪ Drawing Maps during Community Meetings</td>
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<td>➢ Social Mapping</td>
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<td>➢ Mobility Map</td>
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<td>➢ Transect Walk</td>
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<td>➢ Observation</td>
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<td>10:30 – 10:45</td>
<td>Coffee break</td>
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<td>10:45 – 12:30</td>
<td>▪ Drawing Relationship and Flow Diagrams during Community Meetings</td>
<td>Dr. Than Tun Sein</td>
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<td>➢ Body Mapping</td>
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<td>➢ Causal Impact Analysis</td>
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<td>➢ Sexuality Lifeline</td>
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<td>➢ Problem Tree</td>
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<td></td>
<td>➢ Venn Diagram/ Chappati Diagram</td>
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<td>▪ Scoring and Ranking during Community Meetings</td>
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<td>➢ Wealth and Well-Being Ranking (Identifying Social Group Differences)</td>
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<td>➢ Ten Seed Technique</td>
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<td>➢ Pairwise Ranking</td>
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<td>12:30 – 13:30</td>
<td>Lunch break</td>
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<td>13:30 – 15:30</td>
<td>▪ Drawing Calendars and Time Lines during Community Meetings</td>
<td>Dr. Than Tun Sein</td>
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<td>➢ Seasonal Calendars</td>
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<td>➢ Historical Timeline</td>
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<td>➢ Daily Time Use Analysis</td>
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<td>▪ Drawings during Individual Meetings with Selective Community Members</td>
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<td>➢ Trend Analysis</td>
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<td>➢ Sexuality Lifeline</td>
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<td>➢ Picture Story</td>
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<td>15:30 – 15:45</td>
<td>Coffee break</td>
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<td>15:45 – 16:30</td>
<td>▪ A Community Meeting Facilitator’s Role</td>
<td>Dr. Than Tun Sein</td>
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<td>▪ What Next after Community Meetings?</td>
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<td>▪ Evaluation of the Training</td>
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<tr>
<td>16:30 – 17:00</td>
<td>Closing</td>
<td>Julia Messner</td>
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ANNEX 3 WHAT IS HEALTH AS A BRIDGE FOR PEACE (HBP)?

The HBP concept is rooted in values derived from human rights and humanitarian principles as well as medical ethics. Health as a Bridge for Peace was formally accepted by the 51st World Health Assembly in May 1998 as a feature of the ‘Health for All in the 21st Century’ strategy. Armed conflict directly and indirectly affects health. Violence is a major source of disease causing: death and injury, the breakdown of and reduced access to health systems, the increase incidence of communicable diseases, reduced water and sanitation and disease prevention, psychosocial effects, malnutrition, etc. We not only need to deliver health in conflict situations but also health can be a neutral meeting point to bring conflicting parties to discuss mutually beneficial interventions in post-conflict situations.

Conflicts result in widespread violence against people increasing the risk of psychological trauma within entire communities. Frequently, they become the primary targets of ethnic cleansing, murder, sexual violence, torture, and mutilation. In these situations, it is important to quickly obtain sufficient information to develop a community-based emergency mental health response, together with the affected and host communities. Thus community based mental health interventions could arise as an essential need among post-conflict communities that would involve but not limited to:

- Training of community volunteers of basic mental health skills, e.g., active listening, cultural sensitivity, trauma management, community-based activities, community empowerment;
- Involving the concerned community/ies in decision-making processes;
- Organizing creative and recreational activities for children as a means of strengthening the health and positive aspects of their personality as opposed to overemphasizing trauma and clinical activities (e.g., sports, theatre, singing, story-telling, dancing);
- Allowing for reestablishment of cultural and religious events;
- Facilitating creation of self-help groups;
- Etc.
ANNEX 4 CONCEPTS AND PRACTICES OF PARTICIPATORY EDUCATION THEATER IN BRIEF

PET is an educational theatre methodology which uses a participatory approach to allow the audience to probe, reflect on and respond to issues which concern them. This approach poses questions and problems rather than supplying answers and solutions. The aim is to bring about change in the target community's perception of the world and themselves as individuals within it. By changing perception we do not simply mean raising awareness, but allowing the community to examine their attitudes towards the unresolved dilemmas and contradictions presented in the drama which reflects their lives.

A PET projects aims to communicate first to people through their emotions and to then allow the participants to reflect on and to then allow the participants to reflect on and examine these feelings objectively.

The PET forms two main stages:
- The scene is set by the actors/educators through short episodes of scripted theatre; and
- Through the role of the facilitator, the audience is invited to participate to help solve the dilemmas presented in the initial scenes.

A Facilitator acts as a bridge between the actor/teachers and the community to assist with their understanding and eventual participation. The actor/teachers must be able to interact with any new character the community deem as being necessary in their attempts to resolve the particular dilemma.

An example:

Brief description of a PET: Ma Mya Mya, a nurse has the HIV virus. Her husband (Ko Maung Maung) does not. They have not yet had any child. The husband’s dilemma is whether to keep Ma Mya Mya as his wife or insist that she should leave the home.

The scene was then played. After the scene was played, majority of the community felt strongly that Ma Mya Mya should leave the home. A small number of people felt that her husband should keep her. One member of the audience suggested that a friend should talk to Ko Maung Maung.

The Facilitator asked him to come and help by stepping into the shoes of the friend. The friend spoke to the husband for approximately 20 minutes. Gradually the husband began to reconsider and, finally agreed that he may be able to keep his wife and use condoms. There was a spontaneous round of applause from the audience. The Facilitator asked the audience what had changed their minds.

This participatory approach provides opportunities for:
- Community members to interrogate both characters and situations within the drama;
- Empowerment by allowing the participants to intervene and determine the narrative sequence of the drama;
- Involvement of the participants in the contradictions and paradoxes raised by the drama; and
- Improvisational role-playing to allow participants to put themselves in the position of the characters in the drama.