Engaging Communities for Better Health for All
Lessons Learned and Good Practices in 2014
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ACRONYMS

3MDG Three Millennium Development Goal Fund
AEI&CS Accountability, Equity, Inclusion and Conflict Sensitivity
AHRN Asian Harm Reduction Network
AMW Auxiliary Midwife
CBO Community Based Organisation
CHW Community Health Worker
CSO Civil Society Organisation
DRC Danish Red Cross
EPI Expanded Programme for Immunization
FMO Fund Management Office (3MDG)
HAP Humanitarian Accountability Partnership
HIV Human Immunodeficiency Virus
IRC International Rescue Committee
IEC Information, Education and Communication
INGO International Non-Governmental Organisation
LNGO Local Non-Governmental Organisation
MANA Myanmar Anti-Narcotics Association
MNCH Maternal, Newborn and Child Health
MoH Ministry of Health
MRCS Myanmar Red Cross Society
NSP Needle and Syringe Program
PSI Population Services International
RI Relief International
SDH Social Determinants of Health
SRHC Sub Rural Health Centre
TB Tuberculosis
THD Township Health Department
TMO Township Medical Officer
TSG Technical Strategic Group
UHC Universal Health Coverage
UNOPS United Nations Office for Project Services
VHC Village Health Committee
1. OVERVIEW

Background

The 3MDG Fund accelerates progress towards the health Millennium Development Goals and Universal Health Coverage (UHC) in Myanmar. In partnership with the Ministry of Health (MoH), development and implementing partners, and community-based organizations, 3MDG will strengthen health systems at all levels and improve access to quality health services for poor and vulnerable populations. In particular, our work focuses on improving maternal and newborn child health, combating HIV and AIDS, tuberculosis and malaria, and strengthening the health system using a rights-based approach. Through strategic investments, the Fund supports the country in achieving UHC by 2030 and ensures that every citizen shall have the right to essential health care.1

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). Towards this goal, the Ministry is developing strategies, policies, and programs to strengthen responsibility, fairness and inclusion in the health sector to increase access to quality health services.2

The 3MDG Fund recognises 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.

We know that to achieve UHC and better health for all, there are several critical and interrelated elements that must come together to create a robust, coordinated and effective health system. This includes human resources for health, governance and stewardship, infrastructure, supply chain, evidence based strategy and policy, and community engagement (see Figure 2). While the 3MDG Fund has been working to support the Ministry of Health in each of these areas, this report focuses on the last of these elements, community engagement.

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1 2008 Constitution of the Republic of the Union of Myanmar – Article 367
2 For example, the Demographic Health Survey (DHS) will have disaggregated data (by gender and wealth quintiles) that will inform the development of UHC policy.

Figure 1: Community engagement for enhanced health services quality and responsiveness
Figure 2: 3MDG Support to Myanmar Universal Health Coverage - Health for All – Vision 2030
When considering Myanmar’s social, cultural and economic context, along with 3MDG’s target population for interventions, it is easy to see why responsible, fair and inclusive approaches are a priority in improving health for all, and these are accordingly the guiding principles that underpin the work of the Fund, including its approach to engaging communities (see Figure 3). In Myanmar:

- Over two-thirds of the population lives in remote and hard-to-reach areas, making it difficult for people to get to hospitals and health centres.
- There are over 130 distinct ethnic groups and over 100 languages and dialects spoken. Evidence shows that people’s cultural traditions have a strong influence on health-seeking behaviours. In addition, people may not understand health information that is not in their language, and have difficulty interacting with health service providers who do not speak the local dialect.
- Around 37% of the population lives in poverty. Despite significant increases in investment in health by the government, out of pocket expenditure remains high (estimated 60-80% of total health expenditure). For the poor and near poor, this may lead to delays in seeking care, and/or impoverishment due to high medical and travel expenses. They may also experience discrimination of the poor.3

Decision-making power differs between men and women. This affects the choices women make about health care for themselves and their children.

**Purpose of this report**

This report considers the challenges encountered and the lessons learned in 2014 at all levels of the system in engaging communities to achieve better health for all. It highlights the good practices that have already been demonstrated, including by our 3MDG implementing partners, many of whom are working closely and collaboratively with the Township Health Department and Community Based Organisations at the local level to improve health outcomes for all people in Myanmar.

It also reveals a variety of methods and levels of engagement, including information sharing, two-way consultation and communities, and service providers jointly working together to foster collaboration and empowerment to contribute to better health for all.

**Important steps taken so far**

At the sectoral level and through policies, plans and programmes, the MoH has taken important steps to deepen engagement with communities. For example, through its Essential Health Services Access Project, which aims to increase coverage of essential health services of adequate quality, the Ministry is developing mechanisms to enable community to engage in the planning process. As part of the project, communities will be informed of government’s efforts to improve service delivery and specifically about the additional resources being sent to health facilities, and engaged to participate in planning processes.

These efforts will include basic health staff, networks of grassroots volunteers, women’s groups, and use existing mechanisms, such as health committees at village and township levels. Additionally, health committees will be revitalized and strengthened to provide feedback to the townships.

At the technical level, community members are invited to participate as representatives on the MoH Technical Strategic Groups (TSGs) for HIV and TB. Through this, community members have the opportunity to be involved in relevant technical discussions and contribute to decision-making, and can provide inputs on engagement with civil society and communities. The National TB Program invited members of the TB Self-Help Group to join the recent national consultation meeting to develop the 2016-2020 National Strategic Plan. Similarly, people living with HIV/AIDS are represented on the HIV TSG.

Moreover, at the level of research and evidence collection, the Department of Medical Research (DMR) Lower Myanmar recently organised a symposium dedicated to Community Based Organizations (CBOs) entitled ‘Community Based Health Care: the Bedrock of Health Systems’ with financial support from the 3MDG Fund. At this event, in early 2015, the MoH highlighted the importance of community involvement in the health systems and recognized the dedication and hard work of CBOs, CSOs and volunteers.

It demonstrated the importance of generating better information and dialogue for all stakeholders around community health needs and identifying ways to address barriers limiting access health services.

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3 For example, the UNDP Local Governance Mapping report (2014) referenced service user concerns regarding discrimination of the poor at the community level (The State of Local Governance Trends in Chin, p.6).
2. A FRAMEWORK TO SUPPORT COMMUNITY PARTICIPATION

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, partnerships with civil society) into one strategy, calling it an Accountability, Equity and Inclusion Framework.

Shortly thereafter, funding was allocated to each of the Fund’s implementing partners - 18 in total at that time - to hire an ‘AEI Focal Point’ to lead and facilitate this work within their organisations and in project communities. Additional funding was allocated to partners to operationalise and mainstream AEI&CS activities into their health programmes (e.g. community meetings, notice boards, community feedback mechanisms), and in early 2014 the Fund engaged a technical assistance provider to support the Fund and its partners in implementing the key strategies identified in the AEI&CS framework in a tangible and meaningful way.

At the same time, it was decided to include ‘conflict sensitivity’ principles into this cross-cutting bundle, given that conflict sensitivity is underpinned by many similar tenets as ‘AEI’ – e.g. transparency and information sharing, social inclusion, meaningful participation of all stakeholders including civil society organisations, acting responsibly and sensitively as development actors in fragile contexts, seeking out and addressing community concerns through ‘feedback mechanisms’ and so on.

The AEI&CS concept was integrated by 3MDG across its internal project cycle. All applicants submitting a proposal for funding to the 3MDG Fund are required to address accountability, gender, inclusion and conflict sensitivity issues; resources have been provided to partners to build the capacity of their staff and partners on AEI&CS; all new partners supporting MNCH services in townships are required to complete a detailed situation and stakeholder analysis in the planning phase; all funded partners are required to provide six-monthly reporting to 3MDG on their progress in implementing AEI&CS practices; and the 3MDG logframe includes indicators to monitor ‘enhanced health services accountability and responsiveness through capacity development of target communities, civil society organizations and the public sector’.

Thus in 2014, the scope of 3MDG’s work to support UHC through community engagement slowly took shape. The body of this AEI&CS work accelerated and became clearer as the year progressed. The introduction of this work has presented many challenges, as well as opportunities, for learning and reflection. The majority of 3MDG implement-
ing partners have implemented the key steps requested of them – namely, an AEI&CS Focal Point is recruited in most organisations, internal awareness-raising on the key principles has been initiated, they have undertaken a self-assessment to identify gaps and have developed a capacity building plan.

Encouragingly, most partners indicated that there was an overall increase in staff awareness of fundamental concepts and practices, and increased levels of confidence in understanding and applying basic concepts of accountability, equity and inclusion. In some cases exposure to key concepts and principles has already spread beyond our 3MDG implementing partners, to their partner CBOs/CSOs, to non-3MDG project staff within an organisation (e.g. Global Fund), and to basic health staff in the community.

Many partners noted the importance of having a dedicated human resource (AEI&CS Focal Point) funded to facilitate this work within their organisation, however some also indicated that to enhance the sustainability and effectiveness of this work, the scope needed to be expanded to include and engage other programme and project staff within organisations.

The 3MDG Fund recognises that the institutional, behavioural, cultural, attitudinal and social change required for effective implementation of the principles of responsibility, fairness, inclusion and do-no-harm in the health sector of Myanmar takes time and will be incremental and progressive in nature.

This report considers the challenges encountered and the lessons learned in the early stages of ‘building capacity and raising awareness’, and the good practices demonstrated along the way.

### Figure 5: AEI Focal Points recruited at Dec. 2014

<table>
<thead>
<tr>
<th>Number of AEI Focal Point Staff recruited</th>
<th>Component 1 (8 partners)</th>
<th>Component 2 (10 partners)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>% achieved</td>
<td>87%</td>
<td>80%</td>
</tr>
</tbody>
</table>
FIGURE 6: 3MDG ASSESSMENT TOOL ON RESPONSIBILITY, FAIRNESS, INCLUSION AND CONFLICT SENSITIVITY

STANDARD 1
Leadership on Responsibility, Fairness and Inclusion
Organisations demonstrate their commitments to program quality, which includes accountability, equity and inclusion.

STANDARD 2
Staff Capacity and Support
Organisations support their staff to improve programme quality.

STANDARD 3
Information Sharing and Transparency
Organisations publicly communicate their mandates, projects and what stakeholders can expect from them.

STANDARD 4
Participation
Organisations involve beneficiaries and communities in all phases of their projects.

STANDARD 5
Feedback and Response Mechanisms
Organisations put formal feedback and response mechanisms in place to gather and act on feedback.

STANDARD 6
Monitoring, Evaluation and Learning
Organisations learn from experience to continually improve their performance.

STANDARD 7
Conflict Sensitivity
Organisations ensure that their activities do not make conflicts worse and where possible that they improve possibilities for peace.

STANDARD 8
Working with Partners and Other Stakeholders
Organisations collaborate with partners and other stakeholders to ensure coordinated and efficient interventions.
3. WHAT WE LEARNED IN 2014

**Context-appropriate communication is crucial**

An overarching lesson of 2014 coming from multiple sources, including our implementing partners, was that the 3MDG language of ‘accountability, equity, inclusion and conflict sensitivity’ was too technical, complex, and unfamiliar to many people in Myanmar (particularly those in the field and in communities). We have learned that the terminology used to articulate cross-cutting issues is crucial to securing recognition, ‘buy-in’ and participation.

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&CS 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 our rights-based work.

> Read more about the achievements of our partner, Asian Harm Reduction Network, in using context-appropriate communication methods to engage communities on page 13 of this report.

**Measuring progress on cross-cutting issues is challenging**

A key analytical challenge in the first year has been determining how we will know when the principles of responsibility, fairness, inclusion and do-no-harm are being applied effectively, and how we will measure progress.

In an effort to answer this question the 3MDG Fund established eight ‘standards’ to guide its implementing partners, accompanied by an annual self-assessment tool with a series of indicators centered on the standards. Implementing partners were supported through a set of eight training sessions throughout the year, and provided with resources, tools, and training on the standards and assessment tool.

The self-assessment process was conducted for the first time by 3MDG partners in late 2014 and required them to hold formal consultations on AEI and CS related matters with four main groups: their senior management team, field staff, partners and community beneficiaries (aggregate results for 2014 are provided at Annex I). The idea behind the annual self-assessment for all partners was to provide 3MDG with a baseline and a sense of where the gaps and strengths are, thus enabling the Fund to direct its resources and capacity development efforts into common areas of need, and ensuring that our partners are engaging their project communities formally on a set range of issues, such as the extent to which they consult with and include women in all stages of their project.

We learned in 2014 that this process has both strengths and weaknesses. On the positive side it emphasised the importance of connecting with communities and provided partners with a defined process and tool (focus group discussions) for listening to community views. At the end of 2014, partners had consulted with a total of 921 community beneficiaries (458 women and 463 men).

Overall, feedback from partners about the self-assessment tool and process was positive, however it was perceived by some as time-consuming, a burden rather than a benefit, and was sometimes seen as an institutional compliance tool.

It seemed a logical and realistic first step for the AEI&CS project in 2014 to start with 3MDG partners, especially to provide a baseline and mechanism for 3MDG to gauge progress and performance. However in 2015 we will revisit the assessment tool to further adapt it to the needs and capacities of partners, and also consider what accompanying interventions might be used to promote social accountability and address the social determinants of health to achieve better health for all in Myanmar.

**Gender must be kept on the agenda**

From its inception, 3MDG committed to ensuring that all aspects of programming are informed by gender analysis and use every opportunity to promote gender equality and address gender discrimination and gender norms that undermine the rights of women (Description of Action, 2011). These principles are clearly reiterated in the 3MDG AEI&CS Framework.

However we learned in 2014 about the need to keep gender visibly on the agenda; that if gender issues (in particular women’s empowerment and equality), are not explicitly promoted they potentially become sidelined or invisible.

The term ‘gender’ is not explicitly referenced in the AEI&CS acronym, and this meant that additional work needed to be done to ensure that gender, and in particular women’s equality and empowerment, remained a prominent issue as implementing partners were trained and coached on implementing AEI&CS.
As a first and important step in 2014, 3MDG ensured that gender was mainstreamed into all tools, indicators and training for implementing partners under the AEI&CS rubric. Additionally, the community focus group discussions conducted by partners required a mandatory separation between women’s and men’s groups to ensure that their different voices and needs were heard. To bolster these efforts, the 3MDG Fund offered additional and dedicated gender awareness training in 2014 by a local organization, Thingaha Gender Organization.

3MDG has made further efforts to broaden and strengthen these initiatives by monitoring women’s participation on health planning and decision-making bodies, including Comprehensive Township Health Planning and annual reviews, in peer/self-help groups and community volunteer groups in project areas, and National Annual Review Meetings of the National Disease Programmes.

Despite these efforts, 3MDG learned that there is more work to do in 2015 and 2016 to keep gender on the agenda. The results of the 2014 assessments revealed that while partners made a significant commitment to address the wider factors that perpetuate women’s inequality, translating policy into practice remains challenging.

Community feedback mechanisms: finding the right fit takes time

In 2014, 3MDG implementing partners reflected upon the strengths and weaknesses of community feedback mechanisms established previously under the Three Diseases Fund, along with other mechanisms used in Myanmar and internationally to obtain and respond to community feedback about health services. They considered what approach would be the right fit for Myanmar at this time.

Based on the 2014 self-assessments, we learned that community members know to some extent that they can raise issues, and generally 3MDG partners are open to receiving and discussing feedback. Additionally, although most partners noted that they do not have formal feedback and response mechanisms in place, they nevertheless receive opinions, experiences and feedback through a number of other channels (predominantly committee and coordination meetings and health workers).

We learned that in most cases, communities have not been consulted on how they prefer to provide feedback and that NGOs were further advanced than INGOs in gathering and responding to feedback.

Some organisations had learned from their own endeavours in establishing feedback mechanisms that the concept of ‘feedback’ itself was very new in communities and that needed to build understanding about the concept and build trust amongst community members to feel confident in using it.

The establishment of formal feedback and response mechanisms were identified as a common priority action by implementing partners in 2015, and the Fund will also continue working on complementary approaches to increase community engagement such as enhanced information sharing and increased participation.

Awareness has grown, capacity on conflict sensitivity needs strengthening

After just one year of work there are already signs that momentum and awareness has grown. Notwithstanding these advancements, we learned that many of our partners are still in the early stages of building awareness and capacity on conflict sensitivity and do-no-harm, and this was generally perceived as a relatively new, complex and challenging concept to apply. The self-assessment results confirmed this, showing that many implementing partners lack conflict sensitivity policies and have not conducted conflict analyses in the areas where they work. Many partners do however make extensive efforts to ensure that the recruitment of staff, volunteers and partners in conflict-affected areas is done in ways that do not exacerbate conflict or cause harm to communities.

We also recognized that our partners operating in conflict affected areas are learning rapidly about the on-ground complexities and operational sensitivities, and are thus in a prime position to share their experiences and learn from one another to improve their approaches to health programming. A key objective of the 3MDG Fund in 2015 will be to establish ‘learning groups’ to facilitate cross-learning, and peer information exchanges between partners in conflict affected areas.

Read more about the good practices of our partner, Population Services International, on page 15 of this report.

> Read more about the efforts of our partners, Relief International and Myanmar Anti-Narcotics Association to ‘do no harm’ and practice conflict sensitive approaches on pages 21-23 of this report.

> Read more about the experiences of our partner, Danish Red Cross, in setting up a community feedback mechanism on page 16 of this report.

The establishment of formal feedback and response mechanisms were identified as a common priority action by implementing partners in 2015, and the Fund will also continue working on complementary approaches to increase community engagement such as enhanced information sharing and increased participation.
Information-sharing challenges

In 2014 the 3MDG Fund learned that partners are utilising many different methods to share information with stakeholders and communities, such as health education sessions, Rural Health Centre and Sub Rural Health Centre coordination meetings and immunization sessions, Village Health Committee and Village Tract Health Committee meetings, community consultation meetings, information display boards, Information Education and Communication (IEC) materials, advocacy meetings, regular monthly meetings with volunteers, and that local languages are often used to ensure that information is understood by communities.

The types of information being shared includes information about project activities, emergency referral mechanisms (including per diem, transport), budget availability for new activities, achievements and challenges, the organisation’s background, rights to access an organisation’s support by beneficiaries, specific AEI&CS information, donor project coverage, and target beneficiaries.

Despite these good practices, through their focus group discussions with communities, several partners realised that communities were unaware of who they are, the services they are offering, and how they work.

Implementing partners learned that sharing accurate, timely and accessible information strengthens trust, increases understanding, deepens levels of participation, and improves the impact of programmes.

> Read more about how IRC is sharing information and fostering connections between health stakeholders in Chin State, on page 18 of this report.

AEI & Conflict Sensitivity is integral not additional

A challenge in 2014 was in increasing understanding amongst all stakeholders that responsible, fair and inclusive practices are integral to providing effective health programmes and high quality services, rather than an additional or separate stream of work. In providing distinct ‘AEI&CS’ resourcing for partners, the 3MDG Fund intended to promote and prioritize these principles in the mindset of all health sector organisations, but also potentially enabled these issues to be perceived as additional to (rather than integrated within) everyday health service delivery.

The intention has always been that AEI&CS should be mainstreamed within organisations rather than conducted as a separate activity or ‘add on’, however there is still more work to be done on this in 2015 and 2016.
4. GOOD PRACTICES FROM THE FIELD

3MDG provides funding to implementing partners to reach people who are vulnerable or have limited access to health care – including pregnant women, young children, people living with HIV, people in hard-to-reach, rural and urban slum areas, mobile migrant populations, and those most at risk including people who inject drugs, sex workers, men who have sex with men, people in conflict-affected areas, and prison populations.

In the following section of the report, examples are provided of the ways in which 3MDG implementing partners are already practicing the principles of AEI&CS by engaging communities, developing capacity, creating spaces to connect and learn, and strengthening responsibility in the health sector by working collaboratively with township authorities and civil society organisations.

“Hotlines are the easiest way to get information because they save time and money, are easy to use, maintain confidentiality, and increase accessibility. The challenge lies in the quality of the telephone line which is sometimes problematic”.

Dr. Tun Linn Thaw, Accountability, Equity and Inclusion Manager
Using hotlines for increased access

National coordination bodies and 3MDG implementing partners have all been actively working to create an enabling environment – addressing policy, legal and social barriers in order to expand and improve HIV prevention for people who inject drugs.

As part of 3MDG’s support to the National Strategic Plan for HIV and AIDS, in 2014 3MDG provided US$2.3 million in financing for Harm Reduction activities implemented by the Asian Harm Reduction Network (AHRN).

AHRN provides services through drop-in-centres, community outreach and mobile activities for people who inject drugs – a population with diverse ethnic, religious and social backgrounds in project areas characterized by conflict and high physical vulnerability.

In an effort to remove barriers and increase access for its target beneficiaries in Kachin and Northern Shan, in 2014 AHRN set up ‘hotlines’ as a community feedback mechanism on its needle and syringe programme (NSP). The primary objective is to ‘create a link between AHRN and the community by allowing them to voice their concerns. Moreover, there are many benefits such as improved community knowledge on the program, reduced risk for unwanted needle injury, increased numbers of needles and syringes returned, AHRN becoming practiced at directly responding to community concerns, and reducing conflict within the community’.

Reducing stigma to increase access

In addition to the hotlines, AHRN is currently developing advocacy guidelines and user-friendly communication materials about the organisation and its services. They know that harm reduction is not a concept easily accepted by the general population, and they often face resistance from stakeholders about their needle and syringe exchange programme. Communication with the community promotes the positive impacts of AHRN’s activities in an effort to reduce stigma and address some of the social barriers experienced by people who inject drugs.

Lessons learned

• The value in creative and context-appropriate ways for beneficiaries and the wider community to reach the service provider and to receive a response and follow-up actions.

• Importance of engaging with the local community and increasing their awareness of the implementing partners’ interventions (in this case, on drug use and public health).

• Disseminating the correct information in a timely manner.

• Encouraging an enabling environment for the rights of service users.

Informing and responding to communities

The hotlines are available during office hours (9:00am-5:00pm Monday to Friday). To increase awareness, outreach workers distribute pamphlets about the hotline service to the community, including information about the importance of the needle and syringe programme, how to apply first aid and who to call if a needle injury ‘prick’ occurs in the community, and the phone number to call if used needs and syringes are discovered. The hotline is answered by a focal point, supported by a project manager and medical unit in case further interventions, such as counselling or post-exposure prophylaxis (PEP) treatment, are required.

Most requests are related to discarded needles and syringes, and enquiries about drug detoxification and methadone maintenance therapy. Sometimes the hotline service results in a person coming into a drop-in-centre where they know they can receive further information and services. Most of the community members give feedback about the discarded used needles and syringes in their area through AHRN outreach workers. The calls to the hotline (or) the feedback by community through outreach worker can also result in the Project Manager sending out the needle patrol team to collect discarded needles, thus reducing concerns amongst the general community.
“We usually reach women of low socio-economic status through community health workers that visit their villages, gather small groups and conduct health talks. The health talk messaging is designed around their lifestyles, acknowledging that they are busy mothers whose main priority is to provide the best care possible to their families. PSI designs creative visual aids to make the messaging compelling and easy to understand.”

Sara Gallo, Programme Coordinator, PSI
In Myanmar, many people currently access health care services through the private sector. The 3MDG Fund supports interventions that both improve the quality and availability of private sector services and are complementary to public health services.

In 2014, the 3MDG Fund supported Population Services International (PSI) with US$2.1 million to provide complementary private sector support for maternal and child health.

PSI develops marketing plans tailored for the target population of new programs or projects. Prior to preparing the marketing plan, PSI gathers consumer insights from the target population to better understand their behaviours, beliefs and practices. Often members of the target population join the marketing planning meetings to provide immediate or real-time feedback about the activities and messages suggested by PSI, for example in the design of new multivitamins, ‘maymay VitaPlus’ that PSI developed with 3MDG funding.

Activities targeting women and related to reproductive health, and maternal and child health, are implemented by PSI’s channel of private medical providers (Sun Quality Health) and a network of community health workers (Sun Primary Health). Additionally, PSI conducts community events, mass media campaigns and interpersonal communication (IPC) activities.

For reproductive health and MNCH, PSI has developed a Facebook page for their ‘OK Contraception’ brand and a new mobile app for maternal and child health. On the Facebook page, users ask questions about contraception such as “which contraceptive has the fewest hormones” and they receive a response from the reproductive health counsellor within 24 hours.

PSI’s mobile app, the first maternal health app in Myanmar, is called maymay (mama in Myanmar) and targets expecting mothers. The app provides reproductive health and maternal and child health messaging directly to users (e.g. pregnancy warning signs, breastfeeding and birth-spacing information), and it also enables users to find the nearest PSI provider, clinic hours and services.

**Lessons learned**

- Using different strategies for vulnerable groups is essential in order to attend to their particular needs and address the factors contributing to their vulnerability.
- The success of programs should be measured by their ability to offer actionable solutions to the target population and the uptake of the desired behaviour change.
- The primary goal in reaching any target population, including women, is to understand the population and determine what factors influence their behaviour and decision-making.
- The more project activities and campaigns reflect the realities of the target populations, the easier it is for them to create the desired behaviour change.

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Creative approaches to reach women
Across Regions and States in Myanmar, ‘supply and demand side interventions’ are being used to address the challenges people face in accessing essential services. On the supply side, the 3MDG Fund is providing financial and capacity building support to the public sector to strengthen service delivery. An essential part of the approach to improve service provision for hard to reach areas is through enhancing the planning capacity of the township health departments. On the demand side and through the public sector as well as the implementing partners, the 3MDG Fund is strengthening community-based health services, the referral of emergency cases, and private sector health care services.

The Danish Red Cross (DRC) partners with the Myanmar Red Cross Society (MRCS) to support maternal newborn and child health services in Mindat and Matupi townships of Chin State, and received a total of US$1.1 million from the 3MDG in 2014.

In Myanmar, about 70 per cent of the population resides in rural areas. Myanmar has one of the highest maternal and infant mortality rates in south-east Asia. The key challenge facing many mothers and their children, especially in rural areas, is limited access to healthcare.

DRC/MRCS began focusing on developing awareness and capacity to ensure that beneficiaries can raise complaints and give feedback about the programme and organisation to improve programme quality and effectiveness, and that feedback is acted upon. The main challenges currently faced are:

- Complementing and not undermining existing strong social structures in targeted villages.
- Addressing complaints and feedback in a context where it is not always culturally appropriate to raise concerns by both project staff and volunteers and communities.
- Addressing the feedback and response needs of geographically and culturally diverse and extremely remote communities with low literacy rates.

To help reverse this situation the DRC has been supporting MRCS to improve the health of rural communities, focusing on pregnant women and children under five, by working through government health services and strengthening the health system at the grass roots through village health committees (VHCs) and volunteer health workers.
The culture of feedback

The concept of complaints and feedback mechanisms in Myanmar is not something immediately understood or obvious when consulting communities. People are generally reluctant to raise concerns or make complaints and have little awareness of their right to do so. This reflects a culture where it can be seen as inappropriate to complain when people are trying to help.

Yet programme staff and volunteers receive many questions from the community, so it is clear that the broader definition of feedback should be clarified with both community members and volunteers to encourage all types of feedback that can encompass questions and not only complaints. The language used to translate “complaint” and “feedback” is also important. The Myanmar word for “suggestion” is often a more positive way to translate these terms that can both be perceived as negative.

Community feedback preferences

Community focus group discussions and interviews with staff and volunteers revealed the following:

• There is a low awareness of rights to complain and provide feedback.

• Feedback is often considered negative rather than constructive.

• The overwhelming preference is for verbal feedback either via phone or via village health committees.

• Mobile phone coverage is still very low in most villages, despite a fast increase in coverage in larger towns of Chin State.

• Community members do not mind the cost of a phone call to provide feedback directly to the project office.

• Providing feedback via a focal person (e.g. a VHC representative) is considered preferable to community meetings because it is more confidential.

• Men voiced a preference to be able to provide written feedback (more men than women are literate) because they can be more detailed in their requests than they can by phone, although verbal was still the overriding preference.

• Although more people can communicate in their local dialect, communities voiced a preference for written communications materials about the feedback system or other programme communications and IEC materials to be in Myanmar language.

• Suggestion boxes are not widely used because many people are illiterate and/or not sure how to use them and they are also seen to be slow.

Current feedback practice

During 2014, DRC and MRCS began implementing a feedback system through a variety of channels. There is an informal feedback system where community members can speak to field supervisors, Red Cross volunteers or community leaders on an ad hoc basis and this is usually passed on to the AEI Officer based in Mindat. In addition, six-monthly focus group discussions, facilitated by the AEI Officer, were started in late 2014. There were also 37 suggestion boxes in 37 villages installed in 2014, although they are rarely used.

Until March 2015 the focus groups discussions had successfully gathered feedback but there was a need to further formalize the system to more rigorously document feedback in one place to allow for analysis in trends and programme changes and to ensure that community members receive a response.

This process of formalization began in March and continues to develop as per the strategy outlined below.

Field Supervisors will be required to systematically gather feedback from the VHC every time they are in each village and document this in a feedback form template and provide to the AEI officer. The VHC will also help to promote the various channels for feedback within the community through suggestion boxes. These are already in place in some villages (9 in Mindat and 28 in Matupi).

To encourage their use, Field Supervisors will advocate to AMWs and CHWs and VHCs to remind the community to use them as well as providing written guidance on the accompanying noticeboard or community gathering spaces. Field Supervisors will check them regularly with a VHC representative.

Lessons learned

• Advocacy, awareness-raising and training are an important and necessary first step. All MRCS staff are trained in feedback and complaints mechanisms theory and practice.

• Consistency is important. The MRCS AEI Officer developed a question and answer (Q&A) document, in consultation with field supervisors and staff, to ensure that all staff are aligned in their responses to questions regularly asked by the community. Speaking with ‘one voice’ avoids confusion and misinformation.

• Tracking feedback and using this for programme improvements is essential. A summary of feedback will be included in all monthly reports to management in order to advocate for programme changes.

• A feedback system is important but is only one element of a comprehensive AEI system that increases the quality of service provision to communities.
Across Regions and States in Myanmar, ‘supply and demand side interventions’ are being used to address the challenges people face in accessing essential services. On the supply side, the 3MDG Fund is providing financial and capacity building support to the public sector to strengthen service delivery. An essential part of the approach to improve service provision for hard to reach areas is through enhancing the planning capacity of the township health departments. On the demand side and through the public sector as well as the implementing partners, the 3MDG Fund is strengthening community-based health services, the referral of emergency cases, and private sector health care services.

The International Rescue Committee (IRC) is a 3MDG partner provided with a total of US$1.1 million in 2014 to support to maternal, newborn and child health services in remote and conflict affected areas in Chin and Kayah States.

In 2014, we learned about ways in which 3MDG implementing partners are creating spaces to connect and learn by working collaboratively with their partners and other stakeholders, bringing different groups together to foster better understanding, and strengthening their partner’s capacities.

In Chin State, IRC started to build awareness and confidence amongst its own organisation and other stakeholders (THD, Village Health Committee, basic health staff and partner CBOs) to apply the concepts of responsibility, fairness, and inclusion in the health sector. In particular, IRC trialled the application of these principles to increase access to immunization in Ngo-laung village.

In particular, IRC trialled the application of these principles to increase access to immunization in Ngo-laung village.

The target community was selected on the agreement of the THD, IRC and the CBO project team (Karuna Myanmar Social Services), and was based on the interest of the village to trial this activity.

Bringing the community, basic health staff and the THD together

Using a bottom-up process and starting at the village level, IRC (working with partner CBOs) facilitated discussions with the community, (VHC) and basic health staff. VHC members, including the auxiliary midwife (AMW), pregnant mothers, and mothers of children under five years old were invited to participate.

After sharing project information and information about the approach to responsibility, fairness and inclusion, community members were encouraged to share their experiences of the basic health staff in the village.

Community members identified concerns about the sufficiency of medical supplies and equipment, provision of information for expectant mothers on delivery and antenatal care, and the lack of vaccinations for many children because mothers or caregivers were not aware of immunization dates in advance; with the result being that those requiring immunization were often absent when vaccinations were available in their communities.

The IRC team met with the basic health staff at the Sub Rural Health Centre (SRHC), including the midwife and Public Health Supervisor, explaining the challenges of implementing the expanded programme for immunization (EPI) at the village level.

This was followed up with a further session at the quarterly SRHC meeting to ensure that everyone was informed of the identified EPI issue. The basic health staff agreed that it was difficult to share an agreed vaccination date with the village in advance. This was due to challenges such as availability of equipment to keep vaccines at an appropriate temperature to transport the vaccine from the township supply point to rural villages.

The relevant issues were then discussed with the Township Medical Officer (TMO) and the Health Assistant at the THD. The TMO explained the difficulties and potential solutions, including lack of regular transportation facilities and refrigeration at Kanpetlet Township for vaccines.

Despite these challenges, the THD made a commitment to set a fixed date on EPI for March 2015.
Providing feedback to the village

The outcomes from the meeting with the THD were shared with the VHC and the community.

The basic health staff acknowledged that the lack of a clear date for EPI activities had limited access to immunization for health users and explained that March 2015 had been agreed as the next period for EPI.

It was agreed that the THD would communicate a specific date with the communities in advance to ensure caregivers were prepared and that children would be ready for immunization.

Lessons learned

• Improving accountability, equity and inclusion is a step-by-step process which requires a flexible timeframe.

• The first step is often building a relationship and trust between health service users and providers; processes that promote dialogue and mutual understanding enable meaningful, responsive and accountable relationships between health officials, frontline staff and service users to develop.

• Efforts by implementing partners should support VHC members and basic health staff to develop their capacity, to take ownership, enabling them to take responsibility for facilitating community meetings and receiving feedback on priority health needs from community members.

• As a result of the responsiveness of the basic health staff and THD to the community and VHC, the local community has dramatically changed their attitude towards, and engagement with, health related activities. They have 'developed a sense of ownership on health seeking behaviour'.

“In Chin, inclusiveness is very important because local populations are very diverse and because the geographic terrain isolates these groups. There are many different ethnicities with different dialects, different beliefs, norms, traditions customs and practices. Also, these communities and service providers often have long-standing, independent and often divergent ideas concerning individual rights”

IRC Six-Monthly Report to 3MDG, June-December 2014
“This support to VHCs on transparency and information sharing helps community members understand that support for referral services does not depend on any political or religious affiliations, or any other bias. To strengthen these approaches, RI provides regular information sharing sessions in the community relating to factors that could create conflict such as discrimination related to different community groups, and the potential implications if VHC members invite their relatives or friends to committee meetings (e.g. reducing cooperation, cohesiveness and trust).”

Wint Wah Aung, Accountability and Responsiveness Coordinator
The 3MDG Fund is financing health care in conflict-affected areas to address the health needs of underserved populations. These are areas where the MoH has identified challenges to serve the population through the public health system.

In agreement with the MoH and other stakeholders, an implementing partner works with the township health departments, ethnic health organizations and civil society groups that may have access to areas not accessible to basic health staff.

A primary aim for the 3MDF Fund is to maximize the positive outcomes of health programming in communities in conflict affected areas and minimize any negative impact, to achieve better health for all peoples of Myanmar. In support of these efforts, the 3MDG Fund developed essential principles to guide partners operating in conflict affected areas:

1. Understand the conflict
2. Prior consultation with all stakeholders
3. Meaningful participation of civil society organisations
4. Work with existing health structures and providers
5. Balance beneficiary groups.

Relief International (RI) adheres to a 'Do No Harm' policy across its organisation, even in non-conflicted areas such as the Ayeyarwady Region. In 2014, the 3MDG provided RI with US$1.4 million of financing for planning and implementing public and community based health services in the Ayeyarwady Region and Shan State.

RI aims to best serve their beneficiaries ‘with dignity, efficiency, and professionalism’. The organisation’s approach to doing no harm is not limited to the staff of the organisation – RI also encourages all project stakeholders to consider community participation in each project, and stakeholders are supported to have an understanding of the RI code of conduct.

The staff code of conduct includes respecting local laws and regulations, culture and customs. This guides RI to do no harm in implementing each activity. Further, as soon as a new staff member is hired by RI, they receive an induction that includes an overview of accountability, equity and inclusion principles.

As part of its work to support MNCH services, RI has supported VHCs to follow do-no-harm principles through the creation of a code of conduct, helping to facilitate dialogue between VHC members, and supporting VHC members to develop clear guidelines such as selection criteria to ensure they are accountable and transparent in their work with local communities.

Lessons learned

- Trust is the most important ingredient for cooperation between stakeholders, partners and communities.
- Transparency and regular information sharing about who an organisation is, what it is doing (together with the THD) in community, and any challenges or achievements is an essential component to building trust.
- If communities can trust their VHC representatives, they will participate in the committee’s development process. VHC’s should be supported to give clear information to the community and basic health staff such as plans, activities, financial status, and selection criteria.

PHOTO: A feedback session at the house of a service user, a staff from RI interviewing two women (Credit: Relief International, 3MDG)
“Community acceptance is very important for our project. We would like to raise awareness, determine the ‘connectors’ in the community, and include ethnic groups. It is important to understand all of the key players and the relationships between them – local authorities and law enforcement, family and client, community and client, community and Ethnic Armed Groups, and CSOs”.

Dr Mi Mi Khine Zin, Accountability, Equity and Inclusion Officer
3MDG has been working to strengthen and expand existing services seeking more effective and sustainable outcomes for people who inject drugs. This included the expansion of Harm Reduction services into additional townships where drug use is prevalent.

As part of 3MDG’s support to the National Strategic Plan for HIV and AIDS, in 2014 3MDG provided US$1.1 million of financing for Harm Reduction activities implemented by Myanmar Anti-Narcotics Association (MANA).

MANA’s service delivery is based on a comprehensive package including needle and syringe programmes, opioid substitution therapy, HIV testing and counselling, antiretroviral therapy, prevention and treatment of sexually transmitted infections, condom distribution for IDUs and their partners, targeted information, education and communication (IEC).

MANA also develops capacity by training peer educator drug users to participate in harm reduction interventions and increase access to underserved and vulnerable populations. The organization has ten project areas funded by 3MDG, and around half of these are in conflict affected areas of northern Shan State.

As a result of the capacity development and awareness raising efforts of the 3MDG Fund in 2014, MANA developed stronger knowledge of the significance of conflict sensitive approaches in health programming.

Accordingly, MANA plans to conduct two conflict sensitivity case studies (one in 2015 and 2016) to produce information about the impact of the project in the community, aiming to maximise the positive outcomes of MANA’s work.

The case studies will provide context analysis and impact analysis to inform programme adjustments as required. In addition to the case studies, MANA plans to train project staff to use a “do no harm” approach in all project areas, including those in conflict and non-conflicted affected areas.

Lessons learned

- Understanding the context and consulting with all stakeholders is essential for informing effective health programmes and to maximise positive outcomes in conflict affected areas.
- Raising awareness, increasing community acceptance and promoting social inclusion are crucial for harm reduction interventions to ensure that they do no harm.
- Building trust between project staff, communities, and vulnerable drug users helps to reduce discrimination.
- Conflict sensitivity means that an organisation must have flexibility and be prepared to adapt their health interventions based on an in-depth understanding of the dynamic and changing context.
- Conflict sensitive approaches can increase beneficiaries’ access to services, particularly by promoting social inclusion.
5. MOVING FORWARD

Our priority will be to continue supporting the Ministry of Health in its vision to reach Universal Health Coverage by 2030 across all strategic areas, including deepening and widening the meaningful participation of community members in the planning, delivery and evaluation of health services. Our work will focus on how we can best utilise community engagement, including the participation of civil society organisations, to contribute to a stronger health system and improve health outcomes for all people in Myanmar now and in the future.

Our work will be shaped by an approach that is kept simple and context-appropriate, with user-friendly language and a continued emphasis on applied skills, aiming to equip our partners and other interested stakeholders with practical tools, training and resources to answer the question of ‘how to’ practice and integrate the principles of responsibility, fairness, inclusion and do-no-harm in their actual day-to-day work on health projects and programmes.

We will continue to motivate and train our implementing partners to engage communities (particularly the most vulnerable and at-risk members) in a wide variety of ways, including through regular focus group discussions and the establishment of well-functioning community feedback mechanisms. We will continue to monitor progress and provide capacity development support and technical assistance where common gaps are identified.

Greater focus will be given to awareness-raising and capacity development on gender and health, disability awareness and social inclusion, and on understanding the importance of the social determinants of health in influencing health outcomes.

In 2015, the 3MDG Fund will expand its initiatives on community engagement to include local Civil Society Organisations (CSOs) and small community based organisations to achieve better health for all in Myanmar. In June 2014 the 3MDG Fund issued a call for proposals for local CSOs and six organizations were selected for the ‘Collective Voices: Understanding Community Health Experiences’ funding stream, with contracts commencing in March 2015.

All of the organisations are focusing on issues that are gender specific or related to sexual and reproductive health, including improving access to quality health services for disadvantaged women; developing greater understanding of the relationship between gender and health-related knowledge, behaviours and attitudes; and contributing to community awareness and accurate utilization of family planning services.

Each lead organization is required to partner with a minimum of three additional CBOs to develop the capacity of smaller organizations. This means that in total 3MDG will reach 25 CBOs through this funding stream, strengthening the capacity of local organizations to support the health sector now and in the future. Findings and experiences from the projects will be shared nationally.

Lastly, our emphasis in 2015 and onwards will shift towards greater cross-learning and peer information sharing between 3MDG implementing partners operating within Myanmar’s health sector, with less reliance on external or top-down expertise.

Many of our implementing partners are reaching a stage of operational maturity and have been practicing ‘accountable, equitable, inclusive and conflict sensitive approaches’ for some time now, so they are best positioned to share experiences, challenges and lessons with each other for greatest impact and contextual relevance.

In this regard, the 3MDG Fund will establish regular partner Learning Groups (also known as Communities of Practice) to facilitate this dialogue and exchange. We will also consider ways to respond to our partners’ requests to expand training and awareness to their field staff that are at the forefront of health service support and delivery within Myanmar’s communities.

These continued efforts will be a part of 3MDG’s broader efforts to contribute to better health for all in Myanmar through a responsible, fair and inclusive health sector.
ANNEXES
### Annex I: Aggregate Results - 2014 Assessments on AEI & CS

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
<th>Average Score Overall*</th>
<th>Average Score C1 Partners</th>
<th>Average Score C2 Partners</th>
<th>Average Score INGOs</th>
<th>Average Score LNGOs</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Leadership on Accountability, Equity and Inclusion</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>38%</td>
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<tr>
<td>2</td>
<td>Staff Capacity and Support</td>
<td>57%</td>
<td>71%</td>
<td>49%</td>
<td>64%</td>
<td>34%</td>
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<tr>
<td>3</td>
<td>Information Sharing and Transparency</td>
<td>50%</td>
<td>54%</td>
<td>46%</td>
<td>51%</td>
<td>46%</td>
</tr>
<tr>
<td>4</td>
<td>Participation</td>
<td>49%</td>
<td>56%</td>
<td>45%</td>
<td>52%</td>
<td>39%</td>
</tr>
<tr>
<td>5</td>
<td>Feedback and Response Mechanisms</td>
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<td>32%</td>
<td>22%</td>
<td>22%</td>
<td>40%</td>
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<tr>
<td>6</td>
<td>Monitoring, Evaluation and Learning</td>
<td>55%</td>
<td>58%</td>
<td>54%</td>
<td>57%</td>
<td>49%</td>
</tr>
<tr>
<td>7</td>
<td>Conflict Sensitivity</td>
<td>30%</td>
<td>58%</td>
<td>26%</td>
<td>32%</td>
<td>28%</td>
</tr>
<tr>
<td>8</td>
<td>Working with Partners and Other Stakeholders</td>
<td>68%</td>
<td>65%</td>
<td>69%</td>
<td>70%</td>
<td>64%</td>
</tr>
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*Scores are based on the finalised assessment results of 16 out of 18 implementing partners. Two partners had not finalised their results at the time of publication.