Case study: How effective are community feedback and response mechanisms in improving access to better health for all?

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Executive Summary

The Three Millennium Development Goal Fund (3MDG) aims to improve maternal, newborn and child health (MNCH), and combat HIV and AIDS, tuberculosis, and malaria. It strengthens structures and institutions to deliver sustainable, efficient and responsive health care across Myanmar. 3MDG also addresses the social determinants of challenges to accessing health care through the Collective Voices programme.

Implementing partners (IPs) in all components are involved in setting up Community Feedback and Response Mechanisms (CFRMs). This case study aims to qualitatively assess the effectiveness of CFRMs in improving access to better health outcomes, including for the most vulnerable people, in 3MDG supported areas.

The case study was undertaken over 35 days and involved a desk review, semi-structured interviews, focus group discussions and observations with over 120 people. Two field visits took place, one to MNCH and Collective Voices partners in Magway, and one to HIV/TB/Malaria partners in Kayin. Due to the timescale, observations were limited to two field visits to Magway and Kayin, which meant that the sample of communities and IPs does not reflect the entire 3MDG Programme. The study was not undertaken in conflict-affected areas however efforts were made to include IPs operating in conflict-affected states in interviews and focus group discussions.

The case study is structured in four main sections: literature review; approach; findings; and recommendations. The findings are structured around the key themes: context, capacity, awareness, gender and inclusion, voice, engagement, and responsiveness. Successes and challenges are described, with good practices identified under each theme. The recommendations section is in two parts. The first part provides recommendations for 3MDG and partners to implement in the remaining, relatively short, period of the Fund and explores the implications of the recommendations on the capacity building programme and on monitoring and evaluation. The second part provides recommendations for future programmes, donors and government.

Summary of findings

Context: The effectiveness of CFRMs are affected by the context. Hopes are high for the new government, however, historical structures and incentives in government remain and the scope of reforms are still uncertain. The political aspect of CFRMs means a conflict sensitive approach is essential, particularly in conflict-affected states. Social and cultural norms have different impacts on how men and women are able to participate in CFRMs. The language of CFRMs could benefit from a shift towards the language of listening to people’s voices. New technologies offer opportunities for people to voice their views.

Capacity: Most IPs have CFRMs in place and staff are trained. Communities, however have low awareness of CFRMs. The Myanmar context is impacting on the effectiveness of CFRMs with many IPs feeling that the current approach is risky. Where CFRMs are having an impact
it is where there is high organisational commitment to feedback, and IPs spend time on trust-building and use local coalitions and networks.

**Awareness:** Awareness of CFRMs is low although it is increasing with women’s awareness increasing most during the previous year. This may be due to most CFRMs only recently being established. Awareness is significantly higher for beneficiaries of LNGO IPs. Where CFRMs are effective it appears to be where there is awareness and feedback is explicitly linked to information-sharing and a participatory approach.

**Voice:** Social and cultural norms such as arh nah dei and hpon are having an impact on how women engage with CFRMs. Men and women have different preferences as to how they would like to voice their views which also varies depending on age, location and potentially other factors. The terminology around CFRMs also appears to have an impact on how people feel able to voice their preferences with the language related to Collective Voices more likely to support feedback than the language around feedback mechanisms. The extent to which people feel able to express their views to government is dependent on the openness of the TMO to feedback. This is potentially something to build on.

**Engagement:** IPS from each 3MDG component are currently creating spaces for engagement. IPs that frame feedback around listening to people’s voices rather than a feedback mechanism appear to be more successful in offering a constructive way for communities and service providers to engage on health issues and come up with solutions that support improved access to health services. It is early to say whether this is improving health outcomes. Again, taking time to build trust and relationships is having a positive effect. Networking and coalition building is helping amplify people’s voices. The involvement of government supports constructive dialogue, particularly when discussions are expertly facilitated. Existing spaces such as mobile clinics, township meetings and ethnic administration coordination meetings are being used and support busy health staff and reduce costs compared with establishing new spaces. New technologies are already being used to share health information and create networks. 3MDGs mHealth programme could potentially support CFRMs.

**Gender and inclusion:** While overall awareness is low, slightly more women than men are aware of CFRMs. This is, however, not translating into women providing more feedback. IPs are establishing CFRMs based on women and men’s preferences however social and cultural norms continue to impact on women’s ability to engage. The focus on poverty as a driver of exclusion and vulnerability addresses a core issue and avoids political sensitivities, however it risks ignoring how religion and ethnicity affect how people can voice their views on health services. Other issues could also be addressed more effectively such as age, disability and migration.

**Responsiveness:** There is evidence of changes to health services as a result of feedback although it is early to say whether this will result in changes to health outcomes. Changes are also evident in the way communities and service providers are working together. The language used by the government is increasingly supportive of CFRMs and this would be further supported by guidance from Nay Pyi Taw on how states/regions and township health departments should engage with communities. Given the current approach it is likely
that a listening approach rather than feedback mechanisms will have more success in the medium term in improving access to health services. 3MDG and IPs have integrated a Health for All approach, including CFRMS, to a certain extent however it is still seen by some 3MDG staff and IPs as a separate exercise. Tracking changes is being done at micro level but there are challenges in aggregating results and using this evidence to support policy change at national level.

**Recommendations**

**Recommendation 1**: Shift focus from feedback mechanisms to listening to voices and creating spaces for engagement. Where feedback mechanisms are improving access to health services and health outcomes, continue to support them. Where they are not working promote participatory approach where the focus of capacity building and technical support is on a) empowering people, particularly the poorest and most marginalised, to voice their preferences, and b) facilitating collaborative engagement on how to improve access to health care and the quality of services. IPs should involve government in the early stages where possible, while 3MDG should advocate at national level for guidance from the centre to state/region and township health departments. 3MDG should encourage high level organisational commitment within IPs. Continue to work with local CBOs to create spaces for engagement and use local facilitators/consultants where possible.

**Recommendation 2**: Promote a flexible and adaptive approach to getting feedback to allow IPs to build trust and adapt to changing opportunities and the pace of change in a specific context. Support IPs to plan in a flexible way, investing time and resources in building trust and relationships and allowing for changes to how and when engagement takes place based on changes in the context.

**Recommendation 3**: Continue to support health information sharing including on services available and link explicitly to listening to people’s voices

Sharing information on health services, ways to engage with health service providers, and the constraints to health service delivery should be explicitly linked to the process of listening to people’s voices, for example in future capacity building. Use existing AEI&CS communities of practice and learning sessions to share good practice on how information-sharing is already supporting people voice their preference and influence changes.

**Recommendation 4**: Support IPs to build trust and develop networks and coalitions around specific issues. HIV/TB/Malaria and Collective Voices should continue to build on existing networks and work with local CBOs and national networks and coalitions. MNCH should consider more focus on building networks and coalitions at township level where there are opportunities to do so. This could involve joining existing networks and coalitions or working with other stakeholders to identify problems of common interest and work together to solve them. Government should be involved from the start in new networks and coalitions as they can play a key role in identifying issues and constraints which can also be solved collaboratively with others.

**Recommendation 5**: Build on the work being done to use existing opportunities for engagement, such as township meetings and mobile clinics, to create spaces for sharing information and listening to people’s voices. Use communities of practice and learning sessions to share examples of good practice. Explore ways the Health Systems
Strengthening team could support creating opportunities for an inclusive and participatory approach to township health planning for example through the World Bank’s Essential Health Service Access Project, or public financial management work, for example exploring opportunities for people to voice their views on health issues in the Citizens Budget.

**Recommendation 6:** Consider the potential for mHealth to explore ways to use technology to facilitate feedback on access to, and quality of, health services. This could be piloted in one or two townships where there is a receptive Township Medical Officer and agreement from the State/Region Health Department. There are potential risks and tensions which would need to be carefully managed in the design of any online feedback tool.

**Recommendation 7:** Focus on social and cultural norms in gender capacity building and consider capacity building on other drivers of marginalisation. Work with men and women to address how social norms affect how women can engage. Support partners with capacity building and resources to ensure people with disabilities and the elderly are included in voicing their preferences and accessing health services. Review capacity building plans and any forthcoming analysis to ensure other issues/groups are included such as ethnicity, religion and migration.

**Recommendation 8:** Continue to integrate the Health for All approach into 3MDG, and advocate to the Ministry of Health for guidance for states/regions and township health departments. 3MDG should continue to advocate internally and to IPs’ senior management on integrating the Health for All approach, framing CFRMs as a listening to voices approach rather than a formal process. 3MDG should offer support to the government to develop guidance from MoHS to state/regions and township health departments.

**Recommendation 9:** Review the capacity building programme to support IPs to shift the focus of the feedback from formal mechanisms to listening to voices and creating spaces for constructive engagement. A flexible programme of capacity building should be offered to IPs to support: empowering people, particularly the poorest and most marginalised, to voice their preferences; linking information-sharing explicitly to listening to voices; creating spaces for collaborative engagement on how to improve access to health care and the quality of services; trust-building; networking and coalition building; addressing social norms; and inclusion of people with disabilities. This can build on the existing work planned on participation, gender/inclusion and do no harm given the relevance of the recommendations to the other AEI&CS Standards. Partners also requested further support on data collection, particularly feedback that is received during day-to-day activities and feedback on issues that can be resolved quickly. Simple, practical tools and examples of good practice should be provided, from Myanmar where possible. Training in Myanmar languages by local staff and facilitators should also be prioritised where possible.

**Recommendation 10:** Review reporting formats and the AEI&CS self-assessment tool to reflect any changes made. Provide IPs with further support on data collection of views collected via feedback mechanisms, day-to-day activities and listening/participatory approaches, as well as how to aggregate up the data in order to identify trends and evidence that can be used to influence policy and practice. Share data with communities as this can drive community mobilisation and support discussions on health service delivery. The 6-monthly AEI&CS reporting format has recently been revised to simplify the format and to include quantitative information on feedback received through both feedback...
mechanisms and listening/participatory approaches. The tool also records the main qualitative changes made as a result of feedback. Given the remaining time period of 3MDG could consider piloting a qualitative assessment scorecard with willing IPs, the results of which could inform future programming and practice. The AEI&CS self-assessment tool indicators should be reviewed. One option is to discard Standard 3 as the recommended approach is largely covered by Standards 1, 2 and 4. Potentially an indicator on networking and coalition building could be added. Another Option would be to retain Standard 3 as optional for those IPs who are implementing a feedback mechanism rather than focusing on voice and engagement.

**Acronyms**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>3MDG Fund</td>
<td>3 Millennium Development Goal Fund</td>
</tr>
<tr>
<td>AEI&amp;CS</td>
<td>Accountability, Equity, Inclusion and Conflict Sensitivity</td>
</tr>
<tr>
<td>BHS</td>
<td>Basic Health Staff</td>
</tr>
<tr>
<td>CAD</td>
<td>Community Agency for Rural Development</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organisation</td>
</tr>
<tr>
<td>CDDCET</td>
<td>Community Driven Development and Capacity Enhancement Team</td>
</tr>
<tr>
<td>CFRM</td>
<td>Community Feedback and Response Mechanism</td>
</tr>
<tr>
<td>COM</td>
<td>Charity-Oriented Myanmar</td>
</tr>
<tr>
<td>CPI</td>
<td>Community Partners International</td>
</tr>
<tr>
<td>DDMO</td>
<td>Deputy District Medical Officer</td>
</tr>
<tr>
<td>DRC</td>
<td>Danish Refugee Council</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Programme on Immunisation</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>GAD</td>
<td>General Administration Department</td>
</tr>
<tr>
<td>GoM</td>
<td>Government of Myanmar</td>
</tr>
<tr>
<td>HAP</td>
<td>Humanitarian Accountability Partnership</td>
</tr>
<tr>
<td>HSS</td>
<td>Health Systems Strengthening</td>
</tr>
<tr>
<td>INGO</td>
<td>International non-Governmental Organisation</td>
</tr>
<tr>
<td>IP</td>
<td>Implementing Partner</td>
</tr>
<tr>
<td>IRC</td>
<td>International Rescue Committee</td>
</tr>
<tr>
<td>LNGO</td>
<td>Local non-Governmental Organisation</td>
</tr>
<tr>
<td>LRC</td>
<td>Local Resource Centre</td>
</tr>
<tr>
<td>MANA</td>
<td>Myanmar Anti-Narcotics Association</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal, Newborn and Child Health</td>
</tr>
<tr>
<td>MoHS</td>
<td>Ministry of Health and Sports</td>
</tr>
<tr>
<td>MSI</td>
<td>Marie Stopes International</td>
</tr>
<tr>
<td>NPT</td>
<td>Nay Pyi Taw</td>
</tr>
<tr>
<td>PSI</td>
<td>Population Services International</td>
</tr>
<tr>
<td>PWD</td>
<td>People with Disabilities</td>
</tr>
<tr>
<td>SCI</td>
<td>Save the Children International</td>
</tr>
<tr>
<td>THD</td>
<td>Township Health Department</td>
</tr>
<tr>
<td>TMO</td>
<td>Township Medical Officer</td>
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</tbody>
</table>
VEA  Voice, Empowerment and Accountability
VHC  Village Health Committee
VHVG Village Health Volunteer Group
VTHC Village Tract Health Committee
1. Introduction and background

1.1 The 3 Millennium Development Goal Fund (3MDG)

3MDG aims to improve maternal, newborn and child health (MNCH), and combat HIV and AIDS, tuberculosis, and malaria. It strengthens structures and institutions to deliver sustainable, efficient and responsive health care across Myanmar. 3MDG also addresses the social determinants of challenges to accessing health care through the Collective Voices programme. Implementing partners (IPs) in all components are involved in setting up Community Feedback and Response Mechanisms (CFRMs) which aim to provide communities and individuals with the opportunity to provide feedback on health services so that health service providers in the public and private sector can improve health services. This case study aims to assess the effectiveness of CFRMs.

1.2 The framework guiding CFRMs

CFRMs are designed and implemented within a framework and approach that guides the work of 3MDG, building on the original 3MDG Description of Action. The Description of Action states that “people must be able to hold decision makers to account for meeting their obligations and commitments. This requires mechanisms for review and monitoring of government performance and for reporting on government failure to meet obligations” which include “functional complaints mechanisms” (3MDG Fund, 2012, p24).

The 3MDG Fund Accountability, Equity, Inclusion and Conflict Sensitivity (AEI&CS) Framework sets CFRMs in the context of a theory of change in which inputs such as capacity building, information, and systems and tools will lead to better health services accountability and responsiveness. This in turn will improve access to services and ultimately improve health outcomes (3MDG Fund, 2013a, p7):

- Taking this a step further, the 3MDG Fund approach to “Health for All” (3 MDG Fund, 2015b) locates CFRMs within a rights based approach underpinned by four principles: responsibility, inclusion, fairness and ‘do no harm’. The approach aims to support access to health services for all people in Myanmar, including those who are vulnerable, or in hard to reach or conflict affected areas.

- The first principle, responsibility, promotes good governance and accountability, encourages keeping commitments to the people who use health services, listening (and responding to) the voices of people, and empowering and informing users about health and how to access services.

- To ensure inclusion, 3MDG supports ensuring the voices of all people are considered in health planning and decision-making, understanding diverse experiences and needs,
fostering mutual respect, tolerance and making all people feel valued – including women, ethnic groups, the poor, and people with disabilities and engaging communities to plan and deliver quality health services.

3MDG encourages fairness, which involves being fair and just to all people who use health services regardless of gender, age, ethnicity and location, understanding that people are different and need different support to access health services, being fair to women and men, girls and boys and taking actions to address discrimination.

In order to do no harm, the approach involves understanding the context in which 3MDG partners operate, ensuring health activities do not create or worsen conflict and, where possible, using health activities to improve the opportunities for peace.

To implement the Health for All approach, 3MDG develops capacity, engages communities, strengthens responsibility in the health sector, and creates spaces to connect and learn. Implementation of Health for All involves the application of a set of standards which includes a standard on CFRMs (Standard 3) as well as standards on Participation, Information-sharing and Transparency, and Conflict Sensitivity.

1.3 How CFRMs are implemented

CFRMs are defined as “formal mechanisms to gather and act on feedback concerning a project” (3MDG Fund and Pact, 2016, p32). They promote the Health for All principles, particularly responsibility, by listening and responding to the voices of people using health services.

3MDG encourages IPs to solicit and respond to feedback in a range of ways, with no one format or approach mandated. Close to 90% of IPs indicate they have a formal CFRM in place. Table 1 gives some examples of the range of ways in which IPs are encouraging and responding to feedback:

<table>
<thead>
<tr>
<th>Feedback mechanism</th>
<th>Examples of issues raised</th>
<th>Changes as a result of feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feedback form on referral service (MSI)</td>
<td>Cost of transport to health clinic</td>
<td>No significant changes so far</td>
</tr>
<tr>
<td>Insight Unit – focus group discussion (PSI)</td>
<td>Quality of product</td>
<td>Production paused while customer preferences addressed</td>
</tr>
<tr>
<td>AEI practice model – stakeholder analysis, advocacy, participatory community/THD meetings (IRC)</td>
<td>Basic Health Service (BHS) staff not based in community</td>
<td>Community provided accommodation and BHS staying in communities for part of month</td>
</tr>
<tr>
<td>Facilitated community meetings (Collective Voices, IRC, SARA, MANA)</td>
<td>Quacks not referring serious cases to health facilities</td>
<td>Quacks working with THD to refer cases</td>
</tr>
<tr>
<td>Suggestion box (CPI)</td>
<td>Too early to say as only recently implemented but no use at the time of review</td>
<td>No significant changes so far</td>
</tr>
<tr>
<td>Key informant (staff) and outreach (clients) interviews (Burnett)</td>
<td>Tensions in the community where services are provided to drug users</td>
<td>Programme adapted, relationship with community improved and health service uptake increased</td>
</tr>
</tbody>
</table>

There are broad differences in the way MNCH, HIV/TB/Malaria, Health Systems Strengthening and Collective Voices IPs implement CFRMs. MNCH partners, for example, are more likely to develop CFRMs that solicit feedback on referral support, Village Health
Committee funds, and training that they provide, rather than the health services offered by the Township Health Department (THD). There are successful exceptions to this, for example the work of IRC in Chin State and DRC, also in Chin State.

HIV/TB/Malaria IPs are more involved in the direct delivery of health services. There are fewer challenges (discussed in the Findings section of the report) to soliciting and responding to feedback on health service delivery. These IPs are more likely to develop CFRMs that look for feedback on access to, and quality of, health services.

The Health Systems Strengthening programme currently does not engage with CFRM with perceptions that this is not relevant for them as they are not involved in service delivery.

Collective Voices partners work with local CBOs, focusing on listening to community voices. They use participatory approaches to work with communities and health service providers to identify and collaboratively address challenges in accessing health services.

1.4 How 3MDG supports IPs to implement CFRMs

IPs have a funded AEI&CS focal point who is responsible for promoting a Health for All approach in their organisation, including the development of CFRMs. 3MDG has also provided capacity building and developed communities of practice. This is supported by external technical assistance, currently provided by Pact Myanmar.

Capacity building has involved sessions on Information-sharing and Transparency, Participation and CFRMs. Examples of good practice from around the region were presented to IPs. Ongoing support is provided through the communities of practice and periodic learning sessions.

In response to requests from IPs for concrete steps to follow, a set of 10 steps are recommended: consult the community; identify the preferred way of providing feedback; develop a procedure; develop tools; develop communication materials to promote awareness; communicate to staff; set up and run CFRMs; communicate to beneficiaries; monitor feedback; and provide responses.

1.5 How CFRMs are monitored

There is an outcome indicator and an output indicator in the 3MDG logframe that aimed to measure feedback on health services. Outcome indicator 14 is “Proportion of community members reporting receiving services of good quality or better”. This indicator has proved challenging to measure and no baseline exists. Discussions are ongoing with the Fund Board to decide how to address this issue.

Output indicator 5.2.2 was adjusted in July 2016 from “Number and percentage of community members i) aware of ii) use mechanism(s) to provide feedback in 3MDG supported areas to “number of feedbacks received by IPs and number and percentage responded to”. There were data collection challenges and issues of the relevance of the data in relation to awareness.

Partners report to 3MDG on the implementation of the Health for All approach every 6 months. The reporting format has a section for CFRMs and includes the number of feedback received under 6 categories: suggestion, positive feedback, negative feedback, question,
concern, others. In July 2016 this format was simplified following some confusion over the 6 categories.

IPs are also asked to identify the top three issues raised in feedback and list the changes made as a result. Between January and December 2015, 3MDG partners received a total of 3,947 instances of feedback and provided responses to 2,115 (54%). The percentage responded to by HIV/TB/malaria partners was significantly higher than the average with 1,896 feedbacks received and a 70% response rate.

An Accountability, Equity, Inclusion and Conflict Sensitivity Self-Assessment Tool was designed to help IPs evaluate how well they are translating the Health for All principles into practice in their projects and organizations. The assessments highlight good practices and areas for improvement in the four Standards: 1) Participation, 2) Information Sharing and Transparency, 3) Beneficiary Feedback and Response Mechanisms, and 4) Conflict Sensitivity. The self-assessment of Standard 3 involves scoring against 10 indicators (seen Annex 4). In the most recent self-assessment of the Health for All Standards, Standard 3 on CFRMs is the lowest scoring standard (3MDG Fund and Pact 2016, p4).
2. Purpose and structure of the case study

2.1 Purpose of the case study

The purpose of the case study is to qualify assess the effectiveness of community feedback and response mechanisms (CFRM) in improving access to better health outcomes, including for the most vulnerable people, in 3MDG Fund supported areas.

The case study analyses:

a) the context in which CFRM are being used by 3MDG MNCH, HIV/TB/Malaria, and Collective Voices partners as well as non-3MDG organisations.

b) community awareness of CFRM, use of CFRM, and responsiveness of service providers;

c) IP capacity to implement CFRMs, including recording feedback and making appropriate changes to service delivery, now and in the future;

d) how communities engage with the CFRM;

e) how inclusive the CFRMs are to the different needs of women and men, ethnic minorities, people with disabilities and other vulnerable groups;

f) whether changes are taking place to improve access to health services, in the accountability of health service providers to users, and in relationships between communities and other stakeholders in the health sector.

In addition to the above findings the report:

g) identifies and documents successes and challenges of different models and approaches;

h) identifies and documents good practices, including where CFRMs are linked to other stakeholders including the Township Health Department;

i) provides recommendations on a) how to improve the accessibility and inclusivity of CFRMs and the responsiveness of health service providers, b) the role of formal community feedback and response mechanisms in the broader policy and practice context in Myanmar.

2.2 Structure of the case study

The case study is structured in four main sections: literature review; methodology; findings; and recommendations.

The literature review discusses relevant literature on people-centred health care, voice, empowerment and accountability, as well as the approach of the government. Based on the literature review a conceptual framework was developed which guided the design of the review questions.

The methodology section describes the review questions, the case study setting, how data was collected and analysed as well as the limitations, confidentiality issues and implications of the case study.
The findings section details the results of the review based on the findings from semi-structured interviews and focus group discussions undertaken in Myanmar. The findings are structured around the key themes identified in the conceptual framework: context, capacity, awareness, gender and inclusion, voice, engagement, responsiveness and health outcomes. The findings are also informed by the literature review, including partner reports and documents and other review documents. Successes and challenges are described, with good practices identified under each theme.

The recommendations section is in two parts. The first part provides recommendations for 3MDG and partners to implement in the remaining, relatively short, period of the Fund. The second part provides recommendations for future programmes, donors and government.
3. Literature review

3.1 Description of literature review

There is little academic literature specifically on formal CFRMs so the review focused on literature on people-centred health care, and on voice, empowerment and accountability. Also reviewed were the 3MDG Fund strategy documents and reports, implementing partner reports, review reports and government reports, strategies and speeches.

3.2 People-centred Health Care

People-centred health care is based on the concept that “health systems should ultimately seek to serve people and society” (Sheikh et al 2014, pii1). A people-centred approach focuses on “the need for spaces in which people’s voices have influence in shaping the health system that seeks to serve their interests” (ibid).

People-centred governance of health systems means engaging in power dynamics within health systems and between health providers and communities/individuals. (Sheikh et al 2014, pii2). Engaging people in decision-making about health resources requires trust: relationships matter (Sheikh et al 2014, pii4). The literature on participation and accountability in people-centred healthcare suggests that engaging communities in the provision of PHC “tends to result in services that are better tailored to local needs, with better quality, uptake, accountability and health outcomes (Abimbola et al 2014, pii30).

In addition to improved health outcomes, the inclusion of peoples’ views in health priority setting “is perceived as a means to restore trust, improve quality of healthcare and health outcomes, better accountability, and more efficient use of resources (Kamuzora et al 20113, p1). Key to this is quality external facilitation and support to health professionals and community representatives and acknowledging that these kind of changes take time and will not necessarily involve a linear process (Kamuzora et al 20113, p9-10).

The literature on people-centred health care thus asserts the importance of people being able to influence the health system and that this can result in improved access and quality of health services. Central to this is the need for trust and an understanding of the context and the power dynamics that play out in that context. This is relevant to CFRMs as they are potentially a way of people being able to influence health service provision.

3.3 Voice, Empowerment and Accountability

The literature on voice, empowerment and accountability (VEA) describes voice as the ability of citizens to express their preferences and be heard by the state (Rocha Menocal and Sharma, 2008). Empowerment is a process, usually focused on disadvantaged groups, where individuals or groups increase their ability to achieve or control desired outcomes (Combaz and McLoughlin, 2014). Accountability refers to citizens holding decision-makers to account for their actions and usually requires transparency, responsiveness and enforceability (ibid).

Overall evidence of the impact of VEA interventions is limited, though a review of the literature does show that impact is dependent on context, specifically “on pre-existing
power relations, social norms, levels of equity or exclusion, leadership, and the capacity and will of both state and civil society actors” (Combaz and McLoughlin, 2014, p1).

A systematic review of transparency and accountability initiatives highlights the role of empowerment and capacity development in “enhancing community accountability, promoting inclusive service delivery and giving voice to all people”. Interventions that are “grounded in grassroots communities” and focused on capacity building and access to resources “enabled citizens to take incremental steps along the ladder of power and strengthened the voice of some of the most excluded people” (Lynch et al. 2013, p72).

There is strong evidence that citizen engagement contributes to strengthening participation, enhancing responsiveness and accountability from states, and developing inclusive societies, particularly at local levels (Gaventa and Barrett, 2012). In isolation the formation of community health groups appears to have no effect on health outcomes, however, can be effective when combined with support to health staff and facilities. Information given to communities about health services tends to improve health outcomes (Mansuri and Rao, 2013).

CFRMns are a way of providing people with a voice, empowering them to achieve or control their health outcomes, and for health service providers to be responsive to them for the delivery of quality health services. While the evidence is limited on the overall impact of VEA, there is strong evidence of the importance of local context-specific design, citizen engagement and the provision of information, all relevant to CFRMs.

### 3.4 Government of Myanmar

The GoM has committed to achieving Universal Health Coverage by 2030 and to achieving the Sustainable Development Goals. In the current government, the Ministry of Health and Sports has committed to community engagement as a way of improving access to, and quality of health service provision.

Furthermore, in the inaugural address on 1 April 2016, the Union Minister Dr Myint Htwe committed to “knowing the ground reality” (p5), “enhancing the feedback system” (p6), and stated the need to “inculcate this nature of responsiveness” (p10) and to “listen to the voices of the people” (p22).

This language supports the implementation of CFRMs which are a way to engage individuals and communities, share the ground realities and an opportunity to listen to people’s voices.

### 3.5 Conceptual framework

The conceptual framework for the case study is based on the literature on people-centred health care, on voice, empowerment and accountability, the 3MDG Fund theory of change, and emerging priorities of the GoM.
This study will assess the effectiveness of CFRMs in improving health outcomes based on the extent to which:

**Context:** CFRMS are effective within the political, historical, social and cultural context.

**Capacity:** service providers have the policies, tools, systems and trained staff in place to receive and respond to feedback. Communities have the skills and knowledge to use CFRMs.

**Awareness:** communities have information about health services to which they are entitled, and know how to provide feedback to health service providers.

**Gender and inclusion:** the voices of all people are considered, regardless of sex, gender, age, religion, ethnicity, ability, and geography.

**Voice:** communities have the information, skills and resources to understand what services are available, and to provide feedback to health service providers.

**Engagement:** there are spaces to engage constructively with government. There is trust between government and communities.

**Responsiveness:** service providers are responding to the feedback from communities and improving access to, and quality of, health services.

**Health outcomes:** as people are able to provide feedback on health service provision and service providers are responsive to feedback, the assumption is that access to quality health services improves. As a result, health outcomes improve.
4 Approach

4.1 Definition of community feedback and response mechanisms

CFRMs are defined as “formal mechanisms to gather and act on feedback concerning a project” (3MDG Fund and Pact, 2016, p32).

Table 1 gives a few examples of the range of ways 3MDG IPs solicit feedback. Table 2 provides a typology of social accountability mechanisms and how CFRMs fit into the ways social accountability is addressed in Myanmar.

4.2 Review questions

The case study questions are designed around the conceptual framework.

Question 1: How does the context in Myanmar – legal, political, historical, economic and socio-cultural – affect the effectiveness of CFRM? (Context)

Question 2: What is the capacity of IPs to implement CFRMs now and in the future? Do communities have the skills and knowledge to use CFRM? (Capacity)

Question 3: How aware are communities of health services to which they are entitled? Are they aware of CFRMs and how to use them? How could awareness improve? (Awareness)

Question 4: How have people used CFRMs? Are there any spaces to engage constructively with government. Is there trust between government and communities? (Engagement)

Question 5: How have people expressed their views? How have they been supported to express their views? (Voice)

Question 6: What makes it easy or difficult to use CFRM? Are there any groups – women, people with disabilities, ethnic groups - unable to access them? (Gender and Inclusion)

Question 7: Have there been any changes in how people access health services as a result of the CFRM? Any changes to relationships between communities and health providers? (Responsiveness)

Question 8: How have people’s health outcomes improved? (Change)

4.3 Case study setting and population

This case study involved interviews, focus group discussions and observations with over 120 people. Two field visits took place, one to MNCH and Collective Voices partners in Magway, and one to HIV/TB/Malaria partners in Kayin. There were 31 semi-structured interviews: 17 with 3MDG IPs, six with Ministry of Health and Sports staff at national, state/region and township levels, two with donors, and six with 3MDG teams. Six focus group discussions took place with Collective Voices partners and VHTCs/VHCs in Magway and Kayin. Additional interviews were undertaken with other organisations including ActionAid, Pyoe Pin, Pact and LRC to explore different methodologies and approaches. See Annex 2 for all study participants.
4.4 Information collection
The case study was undertaken over 35 days with the consultant based in Myanmar for 24 days. Data collection involved: 1) a desk review of the relevant theory and grey literature (strategies, reports, reviews) documenting CRFMs in Myanmar; 2) semi-structured interviews to examine the capacity of IPs to implement CRFMs, including responses to feedback; 3) semi-structured interviews and focus group discussions to explore: awareness, use of CRFMs and the responses from IPs; gender and other inclusion issues; and change in relationships, access and health outcomes; and 4) observations on the use of CRFMs, inclusion issues and change.

4.5 Analysis
The desk review formed the basis for the conceptual framework, categories for analysis, and provided data to answer the key questions. Interviews were semi-structured and, consistent with qualitative methods, an open stance was retained allowing for probing into emerging themes and issues and seeking clarification. The data from reports, interviews, focus group discussions and observations were triangulated against the results of the AEI&CS Assessment (3MDG and Pact, 2016) and other partner and 3MDG reports. The data was then synthesised and summarised in this report.

4.6 Limitations
The case study was undertaken over 35 days which is a relatively short time to undertake a desk review, field work, analysis and writing. Due to the timescale, observations were limited to two field visits to Magway and Kayin, which meant that the sample of communities and IPs does not reflect the entire 3MDG Programme. This is particularly relevant in a country as diverse geographically and ethnically as Myanmar.

The study was not undertaken in conflict-affected areas however efforts were made to include IPs operating in conflict-affected states in interviews and focus group discussions. During discussions with communities and other stakeholders, translation was necessary; 3MDG Fund staff provided staff to translate. MoH Liaison Officers, the Township Medical Officers in Magway and Kayin, accompanied us on some visits potentially affecting the responses of some of those interviewed.

4.7 Confidentiality
All individuals participating in this review could choose whether or not to participate. All information provided has been treated in a confidential manner. The privacy of all individuals or groups participating has been respected: no identifying information has been revealed in written or other communication without permission. The data has been interpreted as fairly and accurately as possible, given the caveat that the reviewer necessarily brings their own lens to the case study.

4.8 Implications of the case study
The case study has potential implications on: the implementation of the Health for All approach during the remaining period of 3MDG Fund; the design of future health
programmes by 3MDG Fund, donors, GoM and implementing partners; and learning on CFRM can potentially influence socially accountability efforts in other sectors in Myanmar.
5 Findings

This section details the findings from the case study review. It synthesises data from the semi-structured interviews, focus group discussions, observations and the literature review. The findings are structured, based on the conceptual framework, around seven key themes: context, capacity, awareness, voice, engagement, gender and inclusion, and responsiveness.

5.1 Context

5.1.1 Historical legacy of military rule

The legacy of decades of military rule, conflict, exclusionary economic policies and under-investment in infrastructure and basic services remains and will be challenging to undo. While there has been reform, the structure, staffing and incentives of government administration has not changed. These structures and incentives were designed for staff to implement instructions from above, rather than support feedback mechanisms and engagement with communities.

The General Administration Department, in the Ministry of Home Affairs, still plays a key role in decision-making in all sectoral issues, including health, which makes participatory approaches and accountability complex to implement. Lines of accountability, for example to whom the Township Medical Officers are responsible, remain blurred making institutionalising feedback systems challenging.

Public opinion surveys before the 2015 election show deep distrust between citizens and the state and between different groups in society (The Asia Foundation, 2015). The government rarely engaged citizens, particularly in ethnic states, in decisions that affected their lives. State and region governments had very limited legislative or revenue powers (Hook et al 2015, px) and budget processes gave Parliament and the public minimal information about public finances and little opportunity to influence budget decisions (Hook et al 2015, px). The lack of trust makes constructive engagement and responsiveness to communities’ views challenging.

5.1.2 Political transition

The new ruling party, the National League for Democracy (NLD), and its government have a strong mandate from the majority of Myanmar’s citizens and aim to take a more participatory and consultative approach. People appear to be cautiously optimistic about the future, however there is significant uncertainty about the parameters of reform and expectations of the new government are very high. The peace process, aiming to end decades of conflict in ethnic states, is a priority for the government, which also has to deal with complex and entrenched tensions in Rakhine State.

In terms of the Health Sector, the Minister for Health has undertaken visits throughout the country to “listen to the people”. State and region level “listening campaigns” have taken place with plans being consolidated at national level to influence the forthcoming National Health Plan. 3MDG Collective Voices partners were involved, under the previous government, in building the capacity of Township Health Departments (THDs) to listen to
community voices. According to MoH these kinds of consultations will continue though they will be funded through the health budget and do not require external support.

While the listening approach has been welcomed by government, external partners are pushing the government to institute formal feedback mechanisms, particularly complaints and grievance mechanisms (see page 28 for more details). In the long term this may be possible, however in the short term this is likely to remain challenging with other methods more likely to encourage people to voice their preferences, to improve government accountability, and ultimately improve health outcomes.

5.1.3 Language and social/cultural norms and practices

There are ways in which the language of CFRM could better support the process. The word feedback is a neutral term in Myanmar – tont yyan mu – but in reality it is often used with a negative tone and has negative or blaming associations (see also 3MDG Fund 2015d, p17). While it was chosen to avoid the more obviously negative complaints or grievance mechanism, the word feedback does not hold fully positive connotations. In Kayin State one partner has removed the word feedback from their materials based on the views from community members.

The term for politics in Myanmar, naing ngan yeh, is associated with decades of military rule and political repression and “involvement in and discussion of politics has long been seen as dangerous or requiring expertise beyond the capacity of ordinary people” (The Asia Foundation 2014, p51). Given the political nature of providing feedback on service provision, great care needs to be taken with the language used to describe how peoples’ views are used to influence policy, budgets and service delivery. The language around listening to voices appears to have no negative connotations and may be a more useful way of describing the process and approach.

Myanmar is ethnically very diverse, and there are multiple languages spoken. Indeed, not all people in Myanmar speak Burmese. Given the sensitivities around language, the ideal is to have all documentation available in local languages. With over 100 local languages and further dialects this is challenging and expensive. Where possible, however, translation of materials into local languages is likely to support more effective feedback from communities.

Social and cultural norms and practices also affect how people are able to provide feedback. Arh nah dei, for example, is demonstrated in the way men and women “refrain from asserting themselves, because they feel obliged to maintain the other person’s dignity or ‘face’, or to show respect or politeness” (Gender Equality Network 2015, p34). The concept of politeness, yin kyay hmu, has a particular impact on women who are expected to uphold high standards of politeness.

The concept of hpon gives higher authority and status to men. Inherent in the concept are beliefs about men’s “innate leadership and decision-making authority” (Gender Equality Network 2015, p34) which affects how women can engage in giving feedback. Providing feedback to those who are perceived to be in positions of authority or those who are older, particularly for women to men, is extremely challenging given how concepts like arh nah dei, hpon and yin kyay hmu influence norms and practices.
5.1.4 Conflict sensitivity/do no harm

The layers of complexity - the historical legacy of decades of military rule, the stage of political transition, and prevailing social and cultural norms – that affect how people can engage with health service delivery, are compounded by ongoing conflict in several states in Myanmar.

While public sector reform can build trust in government, and between Bamar and other ethnic groups, it is important to acknowledge that the provision of public services is “fraught with political complications, and attached closely to the competing nation-building agendas that shape subnational armed conflicts” (Joliffe 2014, p1).

The context within which CFRM are implemented is even more complex in conflict affected states, where feedback is potentially directed at both the Burmese government and/or ethnic administrations. With the provision of public services linked to conflict, there is potential for feedback on those services to generate conflict. In these contexts, careful analysis of local power dynamics is required before implementing CFRMs to ensure a do no harm approach. Participatory approaches, access to information and trust-building are essential.

5.1.5 Increasing access to technology

Between 2012 and 2015 mobile phone ownership increased from 10 percent to 70 percent of the population. By 2020 this is expected to be more than 90 percent. In addition to the health promotion possibilities, 3MDG Fund is currently exploring the use of mobile phone technology to “facilitate creative and collaborative problem solving and capacity building” (3MDG 2016).

There is scope for technology to support feedback on access to, and quality of, health services. Some 3MDG partners are already using Facebook, Zapy and WhatsApp to share health information and create networks. One TMO interviewed uses a personal Facebook page to share health information. Viber was used for real-time reporting during floods in Magway.

There are also challenges with technology, for example, the capacity of people in rural areas to use apps. There is also a low level of trust in some parts of government on the veracity of feedback given anonymously online.
5.2 Capacity

Service providers have the policies, tools, systems and trained staff to receive and respond to feedback. Communities have the skills and knowledge to use CFRMs.

5.2.1 Policies, tools, systems and trained staff

Capacity building was undertaken in early 2015 on participation, information sharing and developing CFRMs. Tools have been developed to support the development of CFRMs including a 10 step process to set them up.

The AEI&CS self-assessment revealed that 90% (15 out of 17) of IPs have CFRMS in place. IPs feel that they have been trained and know how to use them and seven out of 17 IPs have also trained their partners on how the CFRMs work (3MDG Fund and Pact 2016, p14).

5.2.2 Communities’ skills and knowledge

While awareness of CFRM was measured in the AEI&CS self-assessment (see Section 5.3), whether communities have the skills and knowledge to use CFRMs is not measured. During focus group discussions with Village Health Committees and Village Tract Health Committees it was clear that the low awareness (see Section 5.3) of the CFRMs was limiting their use. It is not yet clear whether growing awareness will provide communities with the skills and knowledge to use CFRMs.

5.2.3 Challenges related to capacity

While the review questions were about policies, tools and training, the majority of comments on capacity building were related to the challenges in implementing CFRMs in the Myanmar context.

The 2015 training on CFRMs took place alongside training on information sharing and participation, and included sessions on the importance of adapting CFRMs to the local context. However, respondents perceived that implementing CFRMs is still challenging as a result of the historical legacy, the stage of the political transition, and how Myanmar social and cultural norms affect how feedback can be given and

GOOD PRACTICE

In order to implement the Health for All approach, Population Services International (PSI) sought to collect insights and feedback from key audiences, including SQH providers, community health workers and most importantly, consumers. Crucially, PSI senior management made sure the process fit their business model.

In 2015, an “Insight Unit” was set up under the Marketing and Communications department. The goal is to fully understand these audiences’ wants, needs, motivations, and perceptions of PSI products and services in order to better target PSI activities.

During 6 monthly visits, staff gather insight from PSI audiences through focus group discussions (FGDs). They compile and disseminate these insights to the relevant PSI departments.

Through the FGDs they have had feedback on specific products, the capacity building providers would like, and issues affecting product uptake.

Feedback on a new product Orasel, for example, led to production being paused while PSI tested new flavours and packaging.

PSI tracks feedback and actions taken in their Insight and Response Tracker. They have feedback loops between PSI, target audiences and external stakeholders so that people know how their feedback has been actioned.
received. Many respondents welcomed more support on how to implement CFRMs specifically in the Myanmar context.

Soliciting formal feedback, without the resources or responsibility to address people’s concerns, holds risks and limits the scope of feedback. Many IPs receive feedback about out-of-pocket expenses which they cannot address, and many issues directed at Township Health Departments (THDs) cannot be addressed at township level. One IP shared that staff feel CFRMs “have no purpose as nothing happens”.

Whether or not the government is involved in CFRMs affects IPs capacity to request feedback on issues outside of their control. The government’s current focus on listening is still to lead to an openness to external feedback in all THDs. There are constructive relationships to build on at township level and guidance from Nay Pyi Taw would support increased engagement at Township level.

This is particularly challenging for some, though not all, MNCH IPs who do not have a service delivery role. Some of these MNCH partners have set up CFRMs to get feedback on services they provide - referral support, VHC funds, and training - rather than the health services offered by the Township. MSI, for example, has a feedback form limited to referral mechanisms as this is something they can address. While this is a practical solution, it limits the scope for feedback to improve access to, and quality of, health services.

Data management is an issue with requests for capacity building on how to record and track feedback, particularly informal feedback and feedback that is addressed quickly and without referral to another team or more senior member of staff. There were requests for a systematic way of providing feedback from the grassroots to the national level.

### 5.2.4 Successes related to capacity

During the review it became clear that the organisational commitment to soliciting feedback and acting on it, as well as the approach to getting feedback were as likely to be important as just having formal policies, tools, and systems and capacity building.

High level organisational commitment and the integration of feedback into an IP’s organisational approach seems to be supporting the implementation of effective CFRMs. For example, MANA has integrated CFRMs into their Standard Operating Procedures so that all staff are familiar and understand their role in implementing them. See also the Good Practice from PSI, (page 18) which demonstrates the role organisational commitment can have in how CFRMs are implemented.

Time spent on trust-building between communities and health staff also supports constructive engagement. Collective Voices IPs, for example, are all local NGOs with informal and formal networks and connections. They have used these connections and networks, supported by quality local facilitators, to build trust and relationships with and between communities and health providers, before engaging them in discussions on health services.
5.3 Awareness

Communities have information about health services to which they are entitled, and know how to provide feedback to health service providers.

5.3.1 Awareness of CFRMs

Awareness of CFRMs by intended project beneficiaries is low with Pact focus group discussions revealing that only 25% of interviewees were aware of CFRMs (3MDG Fund and Pact 2016, p14).

The awareness of women and girls increased most over the last year, from 11% to 26% among those interviewed in focus group discussions. Women now show slightly more awareness than men of CFRMs (26% vs 24%) (3MDG Fund and Pact 2016, p16).

There was a noticeable difference between local and international NGO IPs, with LNGO beneficiaries being more than twice as likely to have awareness and understanding of how to use CFRM (Pact and 3MDG Fund 2016, p16).

The scope of the case study did not allow for data collection from communities on awareness. Discussions with IPs and VHCs and VTHCs suggested however that: the low score may reflect the fact that many INGO CFRMs have only recently been developed and that IPs are still to create awareness of their CFRMs; and that existing awareness raising may not be having the impact is should. One VHC had been participating in a CFRM but was not aware of that terminology.

5.3.2 Information on health services

Awareness of the CFRM, combined with information sharing on available health services, and how the service provider operates, supports constructive feedback. Burnet Institute, for example, recognised the importance of sharing information about their harm reduction work with the local community. Communities were concerned about the number of drug users and dealers in their communities so Burnet Institute organised a face to face meeting where they shared information about the programme and heard views from the community. They adapted their programme, accepting only drug users who were coming to the centre to use health services. Health service uptake increased as a result. See also the box on Good Practice from IRC.

GOOD PRACTICE

IRC, a Component 1 partner, has developed an AEI&CS Practice Model which is integrated into the organisation’s governance approach.

IRC spend time creating awareness in communities on health service availability. This manages expectations and conflict risk. They work with Township Health Departments, Rural Health Centres, Basic Health Staff, and General Administration Department staff to raise awareness of the importance of listening to feedback.

When communities and health service providers are ready to engage constructively then IRC will organise a joint meeting. If not, they continue advocacy and awareness raising with each separately. This approach takes time and acknowledges the politics and potential tensions in soliciting feedback on health services.

In Chin State discussions are already changing health services provision. Communities had high expectations of services provided by BHS staff. BHS staff felt they could not provide these level of services as there was no accommodation for them in the Village Tract. IRC worked with the village to see how they could support BHS staff. Now there is accommodation for BSH staff and it is anticipated more services will be available in the community.
5.4 Voice

How have people expressed their views? How have they been supported to express their views?

*Voice* is understood as the ability of people to “express their preferences and to be heard by the state, either through formal or informal channels, in written or oral form” (Combaz and Mcloughlin 2014, p4)

5.4.1 Social/cultural norms

During the case study review, the historical legacy of decades of military rule repeatedly came up as a barrier to people expressing their views and preferences. There is no tradition of providing feedback to government and many people, including IP staff and community members, do not feel it is safe or appropriate to do so.

There is evidence of social norms such as *hpon* and *arh nah dei* affecting peoples’ ability to speak freely. When asked directly about *hpon*, people in focus group discussions said this did not affect women’s ability to express their views. However, in focus group discussions with village tract health committees in Magway and Kayin States, a different picture emerged with *hpon* and *arh nah dei* in evidence (see page 20).

5.4.2 Terminology

Both IPs’ and community members’ concerns about feedback mechanisms, were often based on the terminology. Facilitated conversations on the other hand, aimed at coming up with collective solutions, appear to lead to people being able to voice their preferences, more changes in relationships and increased access to health services. There are no such concerns around the terminology of the approach of Collective Voices partners.

5.4.3 Preferred ways of expressing voices

People are more likely to talk to people from their own community who understand the local context and its social and political sensitivities. High quality facilitation by local consultants, as well as the use of personal and informal networks, has supported the Collective Voices approach.

Men and women have different ways in which they prefer to express their preferences. MANA, for example, undertook focus group discussions which revealed different ways men and women prefer to give feedback. This varied not only by sex, but by age and location, indicating again that local context analysis is crucial.

The extent to which people feel able to express their views to government on health issues depends on the extent to which TMOs and other government staff are open to feedback. In
In Chin State the Community Agency for Rural Development (CAD), a Collective Voices partner, is engaging community members, government health providers and “quacks”. Concerns had been raised that “quacks”, unqualified people offering medical services, were not referring people to health facilities in time for emergency treatment. CAD built relationships with communities, “quacks” and health service providers. Then they engaged them together in a workshop to discuss and resolve this issue. Using formal and informal networks and local context analysis, CAD aimed to create a dialogue between the key players. According to CAD, quacks are now referring people to government health services when they need them. They attend regular network meetings and share information with the government service providers to ensure people access health care they need.

5.5 Engagement

There are spaces to engage constructively. There is trust between government and communities.

5.5.1 The focus of engagement: listening approach or feedback mechanism?

Participatory approaches that frame the approach around listening to people’s voices appear to be more successful than an approach focusing on feedback mechanisms, offering constructive ways for health service providers and users to engage on health issues. Collective Voices, MNCH, and HIV/TB/Malaria IPs all engage communities in discussions about access to, and quality of, services whether they are being delivered by the government or the IP. The 3MDG IPs self-assessment of AEI&CS implementation reveals that IPs score themselves highly on participation, particularly on women and girls having equitable access to project activities, and that project partnerships are built through a highly collaborative process (3MDG Fund and Pact 2016, p7).

However, IPs do not always associate the feedback they receive through regular community meetings or focus group discussions as coming through a “feedback mechanism” as listening is an approach, rather than a tool. Despite this, IPs that have adopted a participatory approach, bringing communities and government together to discuss health services, appear to be having more success effecting change as a result of the feedback received.

Notably, local NGOs are more likely to consult communities, including women and girls and other traditionally disadvantaged groups, than INGOs (3MDG Fund and Pact 2016, p14). The reasons for this require further study, however this may be due to their legitimacy as local organisations and their understanding of the local context or that they have integrated participation or feedback into their approach from the beginning of their programmes.

Concerns about formal feedback mechanisms are mostly related to how the process has been framed. There are perceptions that formal feedback mechanisms, often seen as a complaint or a grievance, are challenging to implement. Some MNCH IPs talked explicitly about being afraid to give
direct feedback to the Ministry of Health, as this might negatively affect their relationship with them – “we have to be cautious of these things, our work depends on our relationship with the TMO”. These IPs are designing CFMRs focused on soliciting feedback on IP activities rather than on health services. HIV/TB/Malaria IPs work with extremely vulnerable populations for whom there is the perceived risk of loss of services or experiencing further discrimination should they provide unwelcome feedback. There is also a perception that government fears feedback, partly as there is no culture of responding to feedback, and partly as many issues likely to be raised cannot be resolved at RHC or Township level. Framing feedback as listening to people’s voices rather than as formal mechanisms may reduce the perceived risks for all stakeholders and provide opportunities for constructive engagement on improving health services.

5.5.2 Trust-building and relationships

Taking the time to build trust and constructive relationships prevents conflict and seems to be improving access to health services. IRC, for example, emphasises the need for local stakeholder analysis, relationship building, and advocacy before engaging health service providers and communities together. Relationships also need to be built with the General Administration Department (GAD) as GAD leads township planning and budgeting processes. Burnet Institute, SARA and MANA have used community meetings to build trust in local communities where there are concerns about the services being provided. These have supported changes to health service delivery that will also likely improve health outcomes.

Networking and coalition building is helping amplify people’s voices. Collective Voices partners use formal and informal networks to build trust between communities and service providers in support of constructive engagement. Collective Voices IP, CAD, talks of the importance of the “collective voice” including government, and the importance of building a relationship with Township Health Departments. Similarly, in Magway, Collective Voices IP, SCVG, is working with Pu Htoe Village Health Volunteer Group to network and share health information, working with midwives to provide them with information on community needs. HIV/TB/Malaria IPs work with existing networks and coalitions, such as the Drug Users Network, to share the views of marginalised client groups with National Disease Programmes on AIDS, Malaria and TB.

Expert facilitation, preferably by a local consultant or staff, is important when discussing sensitive issues, particularly in areas still affected by conflict. Conflict is also related to service provision, and relationships need to be built and managed, potentially with both government and ethnic administrations in order to reduce rather than create conflict. Feedback on health services can be extremely sensitive and ongoing conflict sensitivity
analysis supports decisions on whether a CFRM is appropriate. IRC, for example, is taking a cautious approach in Kayah State, while Relief International may not implement a formal CFRM in Shan State. They are continually assessing the situation/getting on-ground feedback to inform their programming.

5.5.3 The government’s focus on listening to voices

The government is providing opportunities for people to voice their preferences. Magway THD, for example, undertook an assessment where they listened people’s views on health services. To maximise the numbers attending, they linked the assessment to mobile clinic visits. People appeared to be comfortable providing feedback directly to government on health issues experienced in communities, but not on the quality of health services. SCVG complemented the THD meetings with additional focus group discussions as people were able to say more to a third party. This information was then shared with government to complement the direct feedback. The extent to which the “listening campaign” is inclusive in all states and regions is unclear.

At the same time there are calls for the government to implement formal feedback or grievance mechanisms. Community feedback is to be integrated as part of township health planning within the governance and stewardship of the latest World Bank loan. The Asia Foundation suggest introducing “a public complaints mechanism that citizens can access at the level of the township administration” (Hook et al 2015, pxiii) to demonstrate that reforms translate into better public services. The National Health Network advocates the role of patients in monitoring the quality of care, for example through the use of Community Score Cards. (National Health Network 2015, p24).

These may well materialise however they will likely take time to be implemented effectively and change the culture of how feedback is received and acted upon. In the short to medium term it is more likely that a focus on a listening approach, rather than complaints or grievance processes, will be more successful in improving the quality of health services.

5.5.4 Spaces for constructive engagement

Using existing spaces for engagement supports busy health staff and reduces transportation costs as additional meetings are not required. Mobile health clinics, for example, have been used to share health information and get community views. Township data sharing meetings, ethnic administration coordination meetings, and regular Township quarterly meetings and planning processes are all opportunities for constructive.

Collective Voices partners provided training at the state/region level to Ministry of Health and Sports staff on the principles of community engagement, how to build trust between providers and communities including utilizing CSOs as partners in this process, and how to conduct participatory community engagement using PLA tools (3MDG Fund 2015f, p14-15). TMOs spoken to during the case study welcomed this though emphasised the need for expert facilitation as health is a very technical issue.

New technologies are already being used to share health information, create networks and monitor health service provision. In Magway Viber has been used for real-time reporting on the flood response. Some TMOs use their personal Facebook pages to share health information and events. JSI/UNICEF are training midwives on the Commcare Mobile App.
Non-3MDG NGOs, with EU funding, are using Facebook to report on human rights abuses, share information and support each other. Some TMOs did voice concerns about the use of technology such as the use of hate speech and the anonymity of those providing comments. Mobile phone coverage is increasing swiftly and, with training and careful administration, could be harnessed to support constructive engagement between communities and health service providers.

5.6 Gender and Inclusion

The voices of all people are considered, regardless of sex, gender, age, religion, ethnicity, ability and geography.

5.6.1 Gender

While overall awareness of CFRMs is low, slightly more women (26%) than men (24%) were aware of them (3MDG Fund and Pact, p20). Women, however, appear not to provide much feedback via the CFRM (3MDG Fund and Pact, p21). IPs have made efforts to involve beneficiaries in the design of CFRMs with attempts made to reflect men and women’s different preferences for how they would like to provide feedback.

MANA found that the ways women wanted to provide feedback varied from one location to another. SCI found in Magway that women prefer face to face meetings, while men prefer to discuss in health education meetings and are more likely to speak up in quarterly township meetings. Relief International learned that women are easier to engage in some ways as they are available at more times and as their services were mostly provided for women. However, village health committees mostly involve men, suggesting an imbalance in decision-making power and that women’s voices are not equally valued.

Social and cultural norms continue to affect how women exercise their voice and engage in discussions about health. During data collection for this case study VTHC members repeatedly said that “we work shoulder to shoulder” and that hpon has no effect on women’s voice or ability to access CFRMs. Observations however showed that men were always the first to talk and women rarely talked unless asked a specific question. The exception was women in positions of power, for example midwives and auxiliary midwives. During the field visits for this case study, one VTHC had not invited the women members of the committee as the IP had not specifically requested them to do so.

Community meetings and focus group discussions are not always designed around women’s preferences for how they would like to engage or with awareness of power dynamics and social and cultural norms. While VTCs, VTHCs and regular Township meetings provide an obvious entry point to deliver feedback, they may not be the most supportive to women’s voices being heard in feedback processes. Feedback from IPs during the AEI&CS self-assessment showed that women prefer to provide feedback by phone unless women make up a high percentage of facilitators in which case they are comfortable providing feedback in person. Discussions facilitated by women are more likely to be successful in helping women voice their preferences and give feedback on health services.

5.6.2 Addressing politically sensitive drivers of vulnerability and exclusion
In the health sector vulnerability and exclusion are repeatedly described in relation to poverty – “regardless of religion or ethnicity, poverty is the equity issue” (3MDG HIV/TB/Malaria team). Out of pocket payments remains the main way people, especially the poorest, pay for health care, and this puts people at risk of catastrophic expenditure. While this focus on poverty as the way of defining vulnerability addresses a core issue and may avoid political sensitivities, it risks ignoring how religion and ethnicity affect how people are able to provide feedback on how they access health services. This is particularly relevant in conflict affected states.

5.6.3 Age, disability and migration

Age, disability and economic migration are less political than ethnicity and religion and yet they are also not sufficiently addressed. Age is generally not considered though a few IPs said that when there are community meetings they do outreach to include the elderly, for example Bright Future in Mon State.

Ensuring economic migrants access health services has been challenging as they tend not to visit health facilities or engage in discussions about health services. Outreach work, with meetings timed for when they are not working, has worked for example in Seikphyu.

People with disabilities are not specifically targeted to participate in CFRM with some partners saying “we forgot to include them” and others saying it is costly to include relatively small numbers of people and donors do not fund the extra cost.
5.7 Responsiveness

Service providers are responding to feedback from communities and improving access to, and quality of, health services.

5.7.1 Changes in access to health services

Changes in access to health services are being seen although changes to the quality of services are, so far, less evident. In Pu Htoe Village in Magway the midwife works with the Village Health Volunteer Group to share information on TB prevention and drug compliance (Collective Voices). With the support of the VHVG the midwife was able to reach more people. It is, however, too early to know if this results in better health outcomes.

MSI in Seikphyu (MNCH) have been getting feedback through their regular activities, rather than a formal CFRM. As a result, they identified an area that was underserved and have now set up new programme in this area.

In Chin State there were previously no fixed dates for EPI vaccinations. Midwives would turn up in a village and people would not be available, missing out on a crucial health service. IRC (MNCH) worked with communities and the township health department to identify the problem and a solution. There are now a fixed range of dates scheduled so that community members know to be available. Again, it is early to say, however it is likely that this will increase the uptake of EPI.

5.7.2 Changes in ways of working

Changes are evident in different ways of working, particularly where time has been invested in relationship and trust building. As a result of stakeholder analysis and trust-building, IPs are able to share sensitive feedback in a constructive way. In Chin State, for example, “they are gradually absorbing feedback at the township health department because our message is we are here to help you” (Joseph Win Hlaing Oo, Director, CAD).

Charity-Oriented Myanmar (COM) recognise the importance of engaging politically: COM has a development department and a political department. The latter engages with national government and township health departments holding meetings, hosting dinners, sharing sessions, community meetings, and public talk shows.

While IPs can effect change at State/Region and Township level, there is still perceived to be a need for advocacy to Nay Pyi Taw for top-down instruction to support feedback and participatory approaches. This is potentially a role 3MDG could play.

5.7.3 Changes in the government’s approach

The government is beginning to listen to communities’ voices. The government’s “listening campaign” has resulted in State/Region level reports to MoH which will be used to develop...
In Hpa An, the Deputy District Medical Officer (DDMO) has been working with 3MDG Component 2 partners to deliver HIV, TB and malaria programmes. Using the regular mobile clinic, the team asked for people’s suggestions on how to improve health services.

People wanted a broader range of services provided through the mobile clinic, for example for diarrhoea and respiratory problems. Even though the team’s priority is TB and malaria, they began to provide additional services during the regular mobile clinic visits. As a result, more people are also being tested at the clinics for TB and are receiving treatment.

“Suggestions from the community are very important. Before they had to pass through many steps. But now the mobile team can hear people’s views, we are motivated by our seniors and NPT, and the area is more secure. We can provide more diagnosis and treatment”

Dr Nay Winn Lynn, DDMO, Hpa An, Kayin State

5.7.4 Changes in how 3MDG works

Changes are also evident in the way 3MDG works. The AEI&CS approach, including CFRMs, was designed after the rest of the programme. This initially led to challenges in implementation with it being seen as additional, rather than integral to how 3MDG operates. This has changed with 3MDG teams better integrating the approach into how they work.

Challenges remain, however, with some team members saying “we don’t talk about the AEI feedback in the team, that is for the AEI team”, “health is very technical so there is not much need to involve CSOs” and “I don’t think we have incorporated AEI because we don’t do service delivery”. Future programmes should ensure that they integrate a Health for All/AEI&CS approach from the beginning.

3MDG has adapted its own approach to AEI&CS based on feedback from IPs through “communication pathways” (interestingly not called feedback mechanisms). The initial strategy was seen to be overly technical and has since been simplified in the Health for All approach. Initial technical assistance providers also took a complex, process oriented approach to AEI&CS, and CFRMs in particular. Pact have simplified this over the last year based on feedback from IPs. A further shift towards a listening approach, rather than a formal feedback process, may support more effective CFRMS and further changes in relationships, access to health services and improved health outcomes.

a national health plan. It is unlikely that these reports will be shared publicly and remains to be seen how the feedback from the campaigns improves access to, and quality of, health services.

While MoH currently has not requested external funding or support for the national planning process and the listening campaign, Collective Voices partners did provide training for State and Region staff, including some township-level staff such as TMOs, THNs and Health Assistants, in participatory approaches to support township health planning as part of the World Bank loan.

While the extent to which the process is inclusive is unclear, this marks a different way of working and relating to citizens. Most likely to be successful in improving health services in the short to medium term are participatory, inclusive health planning and budgeting processes such as the listening campaign.
5.7.5 Tracking and monitoring changes in health services and health outcomes

Less than half of IPs have clear records of feedback received and how it is responded to (3MDG Fund and Pact 2016, p15) which makes it challenging to track how all IPs are responding to feedback and making changes as a result. Additionally, there are challenges in recording feedback that arises through day-to-day activities or feedback that is addressed quickly without being referred elsewhere. IPs would welcome further support with recording feedback received in a range of ways.

Changes in ways of working, access to health services and health outcomes can be tracked at micro level but there are also challenges in tracking and aggregating change at national level. Six-monthly reporting by IPs records the top three issues identified through CFRMs and the main changes that have been made as a result. This information is aggregated in 3MDG regular reporting and backed up by learning papers and qualitative analysis such as this case study.

This could be supported further by the use of a tool such as Pyoe Pin’s Qualitative Assessment Scorecard which complements quantitative indicators and systematically tracks and analyses harder to measure changes. For example, Pyoe Pin has an indicator on the quality of cooperation in civil society activity which is measure by three sub-indicators: organisations and individuals act cooperatively, organisations and individuals communicate effectively, and cooperative action is inclusive of marginalised social groups. Each indicator is scored strongly agree, agree, disagree or strongly disagree and backed up with a narrative explanation. This narrative is compiled in six-monthly reports which provide evidence of the qualitative changes taking place. The evidence generated is used to influence national and local policy and practice.
6 Conclusions and Recommendations

The Conclusions and Recommendations section synthesises and summarises learning from the Findings Section and makes recommendations for a) the remaining period of the 3MDG Fund and b) for future health sector programmes.

The first part on conclusions and recommendations for 3MDG clusters recommendations in 6 key areas and discusses potential implications on capacity building and monitoring and evaluation:

- Overall approach: shift the focus from mechanisms to listening to people’s voices
- Creating awareness: link health information sharing explicitly to listening to people’s voices
- Amplifying people’s voices: support networks and coalitions
- Creating spaces for engagement: use existing spaces for listening to people’s voices and build a listening approach into new spaces
- Gender and inclusion: address social norms and tackle other drivers of marginalisation
- Fostering responsiveness: continue to integrate approach and advocate to MoHS

The second part focuses on recommendations for future programmes and includes: focus on voice and engagement; using an adaptive programming approach; the importance of context analysis; linking health information to listening; addressing social norms; including the most vulnerable and marginalised; working with local CBOs and NGOs; working with government; using new technologies; measuring qualitative as well as quantitative changes in access to health services and health outcomes.

6.1 Conclusions and recommendations for 3MDG

6.1.1 Summary of findings

Context: The effectiveness of CFRMs are affected by the context. Hopes are high for the new government, however, historical structures and incentives in government remain and the scope of reforms are still uncertain. The political aspect of CFRMs means a conflict sensitive approach is essential, particularly in conflict-affected states. Social and cultural norms have different impacts on how men and women are able to participate in CFRMs. The language of CFRMs could benefit from a shift towards the language of listening to people’s voices. New technologies offer opportunities for CFRMs.

Capacity: Most IPs have CFRMs in place and staff are trained. Communities, however have low awareness of CFRMs. The Myanmar context is impacting on the effectiveness of CFRMs with many IPs feeling that the current approach is risky. Where CFRMs are having an impact it is where there is high organisational commitment to feedback, and IPs spend time on trust-building and use local coalitions and networks.

Awareness: Awareness of CFRMs is low although it is increasing with women’s awareness increasing most during the previous year. This may be due to most CFRMs only recently being established. Awareness is significantly higher for beneficiaries of NGO IPs. Where
CFRMs are effective it appears to be where there is awareness and feedback is explicitly linked to information-sharing and a participatory approach.

**Voice:** Social and cultural norms such as arh nah dei and hpon are having an impact on how women engage with CFRMs. Men and women have different preferences as to how they would like to voice their views which also varies depending on age, location and potentially other factors. The terminology around CFRMs also appears to have an impact on how people feel able to voice their preferences with the language related to Collective Voices more likely to support feedback than the language around feedback mechanisms. The extent to which people feel able to express their views to government is dependent on the openness of the TMO to feedback. This is potentially something to build on.

**Engagement:** IPS from each 3MDG component are currently creating spaces for engagement. IPs that frame feedback around listening to people’s voices rather than a feedback mechanism appear to be more successful in offering a constructive way for communities and service providers to engage on health issues and come up with solutions that support improved access to health services. It is early to say whether this is improving health outcomes. Again, taking time to build trust and relationships is having a positive effect. Networking and coalition building is helping amplify people’s voices. The involvement of government supports constructive dialogue, particularly when discussions are expertly facilitated. Existing spaces such as mobile clinics, township meetings and ethnic administration coordination meetings are being used and support busy health staff and reduce costs compared with establishing new spaces. New technologies are already being used to share health information and create networks. 3MDGs mHealth programme could potentially support CFRMs.

**Gender and inclusion:** While overall awareness is low, slightly more women than men are aware of CFRMs. This is, however, not translating into women providing more feedback. IPs are establishing CFRMs based on women and men’s preferences however social and cultural norms continue to impact on women’s ability to engage. The focus on poverty as a driver of exclusion and vulnerability addresses a core issue and avoids political sensitivities, however it risks ignoring how religion and ethnicity affect how people can voice their views on health services. Other issues could also be addressed more effectively such as age, disability and migration.

**Responsiveness:** There is evidence of changes to health services as a result of feedback although it is early to say whether this will result in changes to health outcomes. Changes are also evident in the way communities and service providers are working together. The language of the government is increasingly supportive of CFRMs and this would be further supported by instruction from Nay Pyi Taw on how states/regions and township health departments should engage with communities. Given the current approach it is likely that a listening approach rather than feedback mechanisms will have more success in the medium term in improving access to health services. 3MDG and IPs have integrated a Health for All approach, including CFRMS, to a certain extent however it is still seen by some 3MDG staff and IPs as a separate exercise. Tracking changes is being done at micro level but there are challenges in aggregating results and using this evidence to support policy change at national level.
6.1.2 Conclusions and recommendations

Overall approach: shift the focus from mechanisms to listening to people’s voices

**Conclusion 1:** Feedback mechanisms are proving challenging to implement in some cases given the political context, historical legacy and prevailing social and cultural norms and practices. Local NGOs appear to have more legitimacy and success in creating spaces and generating feedback than INGOs, and a listening approach fits with the government’s approach to community engagement. Approaches appear to be more successful where there is high level organisational commitment to feedback. Given the aim of feedback ultimately being to improve health outcomes, rather than a governance aim of increased accountability, a shift in focus might support more effective giving and receiving of feedback that influences how health services are delivered.

**Recommendation 1:** Shift focus from feedback mechanisms to listening to voices and creating spaces for engagement. Where feedback mechanisms are improving access to health services and health outcomes, continue to support them. Where they are not working promote participatory approach where the focus of capacity building and technical support is on a) empowering people, particularly the poorest and most marginalised, to voice their preferences, and b) facilitating collaborative engagement on how to improve access to health care and the quality of services. IPs should involve government in the early stages where possible, while 3MDG should advocate at national level for guidance from the centre to state/region and township health departments. 3MDG should encourage high level organisational commitment within IPs. Work with local CBOs to create spaces for engagement and use local facilitators/consultants where possible.

**Conclusion 2:** Responsiveness to feedback has been greater where time and resources have been spent building trust within communities and between communities and health service providers. Informal relationships have been as important as formal relationships and processes in ensuring that people’s voices are heard and changes are made to how people access health services. Responsiveness appears to be the most effective where there has been flexibility in the approach of IPs.

For example, the flexible and iterative approach taken by IRC in their AEI Practice Model fosters relationships that support constructive dialogue. Collective Voices IPs work with local CBOs and with government health providers to tackle locally relevant issues based on feedback from local communities, and using and building, local capacity to find solutions. The funding to Collective Voices partners is flexible and phased, allowing for learning and changes in the context to influence future implementation.

**Recommendation 2:** Promote a flexible and adaptive approach to getting feedback to allow IPs to build trust and adapt to changing opportunities and the pace of change in a specific context. Support IPs to plan in a flexible way, investing time and resources in building trust and relationships and allowing for changes to how and when engagement takes place based on changes in the context.
Creating awareness: link health information sharing to listening to people’s voices

**Conclusion 3:** Access to information on a) health services, b) ways to engage with health service providers in planning and budgeting processes and c) the constraints and limitations of health service providers seems to support improved access to health and constructive dialogue with health service providers. Activities aimed at sharing information are not always explicitly linked to feedback.

**Recommendation 3:** Continue to support health information sharing including on services available and link explicitly to listening to people’s voices. Sharing information on health services, ways to engage with health service providers, and the constraints to health service delivery should be explicitly linked to the process of listening to people’s voices, for example in future capacity building. Use existing AEI&CS communities of practice and learning sessions to share good practice on how information-sharing is already supporting people voice their preference and influence changes to health services.

Amplifying people’s voices: support networks and coalitions

**Conclusion 4:** Networks and coalitions amplify people’s voices. Including government in networks and coalitions from the start helps find common interests and creates dialogue rather than tension and opposition. Networks and coalitions also offer potential support to health information sharing and to including peoples’ preferences in planning and budgeting processes. Taking the time to build trust and constructive relationships prevents conflict, supports constructive engagement, and seems to be improving access to health services.

**Recommendation 4:** Support IPs to build trust and develop networks and coalitions around specific issues. HIV/TB/Malaria and Collective Voices should continue to build on existing networks and work with local CBOs and national networks and coalitions. MNCH should consider more focus on building networks and coalitions at township level where there are opportunities to do so. This could involve joining existing networks and coalitions or working with other stakeholders to identify problems of common interest and work together to solve them. Government should be involved from the start in new networks and coalitions as they can play a key role in identifying issues and constraints which can also be solved collaboratively with others.

Creating spaces for engagement: use existing spaces for listening to people’s voices and build a listening approach into new spaces

**Conclusion 5:** A range of ways to engage communities and health service providers are already being used such as mobile health clinics, township data sharing meetings, ethnic administration coordination meetings, and regular township quarterly meetings and planning processes.

Continuing to work with the World Bank on public financial management and township health planning and budgeting potentially offers new opportunities to create spaces for constructive engagement. The training of government staff, by Collective Voices partners, in participatory approaches offers potential opportunities to work with government in future.

**Recommendation 5:** Build on the work being done to use existing opportunities for engagement, such as township meetings and mobile clinics, to create spaces for sharing information and listening to people’s voices. Use communities of practice and learning...
sessions to share examples of good practice. Explore ways the Health Systems Strengthening team could support creating opportunities for an inclusive and participatory approach to township health planning for example through the World Bank’s Essential Health Service Access Project, or their public financial management work, for example exploring opportunities for people to voice their views on health issues in the Citizens Budget.

**Conclusion 6:** While there are capacity issues, mobile phone ownership is increasing swiftly and people are already using technology to share information and to network and support each other. 3MDG’s planned mHealth may use mobile phone technology to build capacity, share health information and facilitate networking. Currently though, this does not include plans to create online spaces or fora for people to voice their issues, suggestions and concerns about health services.

**Recommendation 6:** Consider the potential for mHealth to explore ways to use technology to facilitate feedback on access to, and quality of, health services. This could be piloted in one or two townships where there is a receptive Township Medical Officer and agreement from the State/Region Health Department. There are potential risks and tensions which would need to be carefully managed in the design of any online feedback tool.

**Gender and inclusion: address social norms and tackle other drivers of marginalisation**

**Conclusion 7:** Social and cultural norms continue to affect how women and girls are able to voice their preferences. While poverty is a key factor affecting access to health services, it may be helpful to sensitively address more political inclusion issues around ethnicity and religion as they are key drivers of marginalisation. Disability is not affected by political sensitivities and people with disabilities are generally not included in listening to people’s voices or engaging with health service providers on health issues.

**Recommendation 7:** Focus on social and cultural norms in gender capacity building and consider capacity building on other drivers of marginalisation. Work with men and women to address how social norms affect how women can engage. Support partners with capacity building and resources to ensure people with disabilities and the elderly are included in voicing their preferences and accessing health services. Review capacity building plans and any forthcoming analysis to ensure other issues/groups are included such as ethnicity, religion and migration.

**Fostering responsiveness: continue to integrate approach and advocate to NPT**

**Conclusion 8:** Within 3MDG there has been tremendous progress in integrating the AEI&CS approach across the programme. However, there are still challenges in fully integrating feedback/listening to people’s voices across all components as staff do not fully understand the relevance and advantages of the approach. Not all IPs have high level organisational support for feedback mechanisms; a listening, participatory approach may be more in line with their existing organisational priorities/practices.

Changes are already evident in ways of working and access to health services although it is early to say whether these changes will result in changes in health outcomes. While some IPs are supporting change at State/Region and Township level (for example IRC in Chin State, Charity Oriented Myanmar in Magway, and Medical Association of Myanmar in
Kayin), there is still perceived to be a need for advocacy to Nay Pyi Taw for top-down instruction.

**Recommendation 8:** Continue to integrate the Health for All approach into 3MDG, and advocate to the Ministry of Health for guidance for states/regions and township health departments. 3MDG should continue to advocate internally and to IPs’ senior management on integrating the Health for All approach, framing CFRMs as a listening to voices approach rather than a formal process. 3MDG should advocate to government for guidance from MoHS to state/regions and township health departments and offer further support in building capacity.

**Implications for capacity building programme**

**Conclusion 9:** The above recommendations may have implications on the planned programme of capacity building and the format of the AEI&CS self-assessment tool. IPs have appreciated the capacity building, particularly when facilitators are Myanmar speaking, as well as case studies, learning sessions and best practice examples which make AEI&CS as concrete and practical as possible.

**Recommendation 9:** Review the capacity building programme to support IPs to shift the focus of the feedback from formal mechanisms to listening to voices and creating spaces for constructive engagement. A flexible programme of capacity building should be offered to IPs to support: empowering people, particularly the poorest and most marginalised, to voice their preferences; linking information-sharing explicitly to listening to voices; creating spaces for collaborative engagement on how to improve access to health care and the quality of services; trust-building; networking and coalition building; addressing social norms; and inclusion of people with disabilities. This can build on the existing work planned on participation, gender/inclusion and do no harm given the relevance of the recommendations to the other AEI&CS Standards. Partners also requested further support on data collection, particularly feedback that is received during day-to-day activities and feedback on issues that can be resolved quickly.

Simple, practical tools and examples of good practice should be provided, from Myanmar where possible. Training in Myanmar languages by local staff and facilitators should also be prioritised where possible.

**6.1.6 Implications for M&E**

**Conclusion 10:** Should the above recommendations be accepted, there will be implications for monitoring and evaluation and opportunities for learning. There are data collection challenges with IPs requesting support on how to record feedback both through feedback mechanisms, day-to-day activities and listening/participatory approaches, as well as challenges aggregating up the data in order to use it at national level.

The AEI&CS self-assessment tool indicators for Standards on Information-sharing, Participation and Do No Harm already reflect many of the recommendations made here. Having a separate standard for CFRMs implies to IPs that CFRMs are different from a participation and information-sharing and require additional tools and activities.
The existing 3MDG logframe indicators related to feedback do not measure qualitative changes as a result of feedback. There is potential learning on hard to measure qualitative change in the Pyoe Pin qualitative assessment scorecard (QAS).

**Recommendation 10: Review reporting formats and the AEI&CS self-assessment tool to reflect any changes made.** Provide IPs with further support on data collection of views collected via feedback mechanisms, day-to-day activities and listening/participatory approaches, as well as how to aggregate up the data in order to identify trends and evidence that can be used to influence policy and practice. Share data with communities as this can drive community mobilisation and support discussions on health service delivery.

The 6-monthly AEI&CS reporting format has recently been revised to simplify the format and to include quantitative information on feedback received through both feedback mechanisms and listening/participatory approaches. The tool also records the main qualitative changes made as a result of feedback. Given the remaining time period of 3MDG could consider piloting a qualitative assessment scorecard with willing IPs, the results of which could inform future programming and practice.

The AEI&CS self-assessment tool indicators should be reviewed. One option is to discard Standard 3 as the recommended approach is largely covered by Standards 1, 2 and 4. Potentially an indicator on networking and coalition building could be added. Another Option would be to retain Standard 3 as optional for those IPs who are implementing a feedback mechanism rather than focusing on voice and engagement.
6.2 Recommendations for future programmes

Integrate a Health for All approach in the design phase of any new programme. This will avoid Health for All being seen as a separate activity requiring additional resources.

Focus on voice and engagement, rather than formal feedback or complaints mechanisms. In the medium term this is more likely to be successful, particularly if the aim is to improve relationships between health service providers and communities, access to health services and health outcomes, rather than just the accountability of the health sector.

Context matters. Build in on-going and local political economy analysis¹ and conflict sensitivity analysis to the design of a new programme, particularly in conflict-affected areas.

Use an adaptive programming approach to support flexible funding so IPs can respond to opportunities and constraints.

Support the provision of information about health services, constraints faced by health service providers, and health planning and budgeting processes and explicitly link this to helping people voice their preferences about health services and work with health service providers to identify solutions.

Address social norms which affect how men and women can engage in discussions about health service delivery.

Ensure the most vulnerable and marginalised are included. Include religion and ethnicity in any analysis that informs programme design. Ensure people with disabilities can engage in discussions on health service. Identify and include other groups e.g. economic migrants.

Work with local community based organisations and NGOs to encourage voice and engagement. Build networks and coalitions to amplify people’s voices.

Work with the government, where possible, to create spaces for engagement. At national level promote participatory approaches to health planning, policy formation, health service delivery and evaluation, and public financial management. At state, region and township level work with government to involve communities, including those most marginalised, in local planning processes.

Use new technologies to create online fora for voicing preferences bearing in mind the risks and capacity issues.

Measure qualitative as well as quantitative changes in how voice and engagement support government and communities work together to improve access to health services, the quality of health services, and health outcomes.

Undertake review. Evidence is limited on how people-centred health care and voice, empowerment and accountability interventions impact on health outcomes. Rigorous review, for example on whether the Collective Voices approach improves health outcomes, could contribute to the global evidence base.

¹ Political economy analysis aims to understand the incentives, relationships, distribution and contestation of power between different groups and individuals and which impact on development outcomes. This helps design politically feasible and more achievable interventions, over realistic timescales, while addressing the risks involved.
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## Annex 1: Questionnaire

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<tr>
<th>Key Questions</th>
<th>Instrument</th>
<th>Who</th>
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<tr>
<td><strong>Context:</strong> How does the political, legal, social and cultural context in Myanmar affect the effectiveness of CFRM?</td>
<td>Semi-structured interview Focus Group Discussion</td>
<td>All</td>
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<tr>
<td><strong>Capacity:</strong> What is the capacity of IPs to implement CFRMs? Do communities have the skills and knowledge to use CFRM?</td>
<td>Semi-structured interview Observation</td>
<td>IPs Donors Community committees Beneficiaries</td>
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<td><strong>Awareness:</strong> How aware are communities of what health service they are entitled to? Awareness of CFRMs and how to use them? How could awareness improve?</td>
<td>Observation Focus Group Discussion Semi-structured interviews</td>
<td>IPs Community committees Beneficiaries Collective Voices partners</td>
</tr>
<tr>
<td><strong>Engagement:</strong> Are there spaces to engage constructively with government? Is there trust between government and communities?</td>
<td>Semi-structured interview Focus Group Discussion Observations</td>
<td>IPs Community committees Beneficiaries</td>
</tr>
<tr>
<td><strong>Voice:</strong> How have people expressed their views? How have they been supported to express their views?</td>
<td>Semi-structured interview Focus Group Discussion Observations</td>
<td>IPs Community committees Beneficiaries</td>
</tr>
<tr>
<td><strong>Inclusion:</strong> What makes it easy or difficult to use the CFRM? Are there any groups of people – women, people with disabilities, ethnic groups - who are unable to access them?</td>
<td>Focus Group Discussion Semi-structured interview Observations</td>
<td>IPs Community committees Beneficiaries Collective Voices partners</td>
</tr>
<tr>
<td><strong>Responsiveness:</strong> Have there been any changes in how people access health services as a result of the CFRM? Any changes to relationships between communities and health providers?</td>
<td>Semi-structured interview Focus Group Discussion Observations</td>
<td>Beneficiaries Community committees IPs Donors</td>
</tr>
<tr>
<td><strong>Change:</strong> How have people’s health outcomes improved?</td>
<td>Semi-structured interview Focus Group Discussion Observations</td>
<td>Beneficiaries Community committees IPs Donors</td>
</tr>
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</table>
## Annex 2: Case study participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Implementing partners</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Gyaw Htet Doe</td>
<td>Technical Director</td>
<td>Substance Abuse Review Association (SARA)</td>
</tr>
<tr>
<td>Dr Aung Ko Ko</td>
<td>Programme Manager</td>
<td>Burnet Institute</td>
</tr>
<tr>
<td>Dr Phone Myint Win</td>
<td>Country Representative</td>
<td>Burnet Institute</td>
</tr>
<tr>
<td>Mimi Khang Zin</td>
<td>Programme Associate/ AEI Focal Point</td>
<td>MANA</td>
</tr>
<tr>
<td>B Htoo</td>
<td>Programme Officer</td>
<td>Charity-Oriented Myanmar</td>
</tr>
<tr>
<td>Melanie Kempster</td>
<td>Head of Health Programmes</td>
<td>Relief International</td>
</tr>
<tr>
<td>Wint Wah Aung</td>
<td>AEI Focal Point</td>
<td>Relief International</td>
</tr>
<tr>
<td>Joseph Win Hlaing Oo</td>
<td>Founding Director</td>
<td>Community Agency for Rural Development</td>
</tr>
<tr>
<td>U Win Htin</td>
<td>Chairperson</td>
<td>CDDCET</td>
</tr>
<tr>
<td>Kang Khan Mang</td>
<td>Project Manager</td>
<td>Ar Yone Oo</td>
</tr>
<tr>
<td>Mi Laayi Htaw</td>
<td>Project Manager</td>
<td>Bright Future</td>
</tr>
<tr>
<td>Min Nwe Tun</td>
<td>Consultant</td>
<td>Bright Future</td>
</tr>
<tr>
<td>Dr Swe Win</td>
<td>AEI Focal Point</td>
<td>Myanmar Medical Association</td>
</tr>
<tr>
<td>Thein Tun Aung</td>
<td>AEI Coordinator</td>
<td>Save the Children International</td>
</tr>
<tr>
<td>Khin Youn Hlwar Htun</td>
<td>Programme Support Officer</td>
<td>Save the Children International</td>
</tr>
<tr>
<td>Dr Khin Wint Yee Hla</td>
<td>Senior Programme Quality Adviser</td>
<td>Save the Children International</td>
</tr>
<tr>
<td>Dr Khin Chaw Ko</td>
<td>Senior Roving Support Manager</td>
<td>Save the Children International</td>
</tr>
<tr>
<td>Dr Swe Win</td>
<td>AEI Focal Point</td>
<td>Myanmar Medical Association</td>
</tr>
<tr>
<td>Aung Lin Kyi</td>
<td>Director</td>
<td>SCVG</td>
</tr>
<tr>
<td>Wunna Htun</td>
<td>Community Facilitator</td>
<td>SCVG</td>
</tr>
<tr>
<td>Si Thu</td>
<td>Community Facilitator</td>
<td>SCVG</td>
</tr>
<tr>
<td>U Gyaw Ni</td>
<td>Committee member</td>
<td>Pu Thoe Village Health Volunteer Group (VHVG)</td>
</tr>
<tr>
<td>Daw Khin Cho Than</td>
<td>Committee member</td>
<td>&quot;</td>
</tr>
<tr>
<td>Daw Yu Mon Aung</td>
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<td>&quot;</td>
</tr>
<tr>
<td>Daw Mar Mar Aye</td>
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<td>&quot;</td>
</tr>
<tr>
<td>U Aung Myo Naing</td>
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</tr>
<tr>
<td>U Than Soe</td>
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<td>&quot;</td>
</tr>
<tr>
<td>Ma Hay New Zaw</td>
<td>Midwife</td>
<td>Pu Thoe Village</td>
</tr>
<tr>
<td>Aung Min Soe</td>
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<td>Save the Children International</td>
</tr>
<tr>
<td>Dr Hein Htet Soe</td>
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<tr>
<td>Khin Maung Chin</td>
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<tr>
<td>U Htun Shwe</td>
<td>Village Administrator</td>
<td>Chaung Phyu Village Tract Health Committee</td>
</tr>
<tr>
<td>U Aung Kyi Hlaing</td>
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<td>&quot;</td>
</tr>
<tr>
<td>U Win Naing</td>
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</tr>
<tr>
<td>Daw Sein Kyi Than</td>
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</tr>
<tr>
<td>Daw Sein</td>
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<tr>
<td>Daw Sandar Win</td>
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<td>&quot;</td>
</tr>
<tr>
<td>Dr Zayar Hpone Maw</td>
<td>Regional Coordinator</td>
<td>MSI Magway</td>
</tr>
<tr>
<td>Dr Zar Ni Min Hein</td>
<td>Assistant Township Manager</td>
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</tr>
<tr>
<td>Dr Htet Htet Htun</td>
<td>Senior Project Officer</td>
<td>&quot;</td>
</tr>
<tr>
<td>Si Thu Aung</td>
<td>Project Manager</td>
<td>&quot;</td>
</tr>
<tr>
<td>Dr Wai Mon Oo</td>
<td>AEI Officer</td>
<td>&quot;</td>
</tr>
<tr>
<td>Dr Hla Hla Myint</td>
<td>Field Coordinator MNCH</td>
<td>&quot;</td>
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</table>

*" indicates role unspecified.
<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Dr Nyein Chaw Ny</td>
<td>Township Coordinator</td>
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<tr>
<td>U Win Myint</td>
<td>Village Health Committee Chair</td>
<td>Auk Seik Village Health Committee</td>
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<td>U Aung Htay Win</td>
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<td>U Aung Naing Win</td>
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<tr>
<td>U Than Tan</td>
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<td>U Than</td>
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<tr>
<td>Sara Gallo</td>
<td>Programme Manager</td>
<td>PSI Myanmar</td>
</tr>
<tr>
<td>Aung Zaw Lin</td>
<td>Consumer Insight Officer</td>
<td>PSI Myanmar</td>
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<tr>
<td>Kaung Htet Soe</td>
<td>AEI Focal Point</td>
<td>CPI</td>
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<tr>
<td>Naw Paw Sharo</td>
<td>Area Coordinator</td>
<td>Kayin Baptist Convention</td>
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<tr>
<td>Nant Christalyn</td>
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<tr>
<td>Saw Htar Nat Moo</td>
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<td>CPI</td>
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<tr>
<td>Dr Aung Thant Tin</td>
<td>Project Coordinator</td>
<td>Medical Action Myanmar</td>
</tr>
<tr>
<td>Pyone Mjinzu</td>
<td>Operations Officer</td>
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<tr>
<td>Dr Zayar Htike</td>
<td>Project Medical Coordinator</td>
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<tr>
<td>Dr Kyaw Lynn Aung</td>
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<tr>
<td>Mariette Van Der Beek</td>
<td>Operations Coordinator</td>
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<tr>
<td>Dr Tint Maw</td>
<td>Senior Health Coordinator (MNCH)</td>
<td>IRC</td>
</tr>
<tr>
<td>Dr Thet Naung Soe</td>
<td>Senior Programme Manager (MNCH Chin)</td>
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</tr>
<tr>
<td>Dr Khin Zaw</td>
<td>Senior M&amp;E Manager</td>
<td>IRC</td>
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<tr>
<td>Pansy Tun Thein</td>
<td>Director</td>
<td>LRC</td>
</tr>
<tr>
<td>Orlen Ocleasa</td>
<td>Programme Quality, Impact and Learning Adviser</td>
<td>ActionAid</td>
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<tr>
<td>Yi Yi Win</td>
<td>Programme Quality, Accountability and Village Book Coordinator</td>
<td>ActionAid</td>
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<tr>
<td>Khin Khin Mra</td>
<td>Learning and Knowledge Management Coordinator</td>
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<tr>
<td>Han May</td>
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<tr>
<td>Meg McDermott</td>
<td>Programme Officer, Asia, Eurasia</td>
<td>Pact</td>
</tr>
<tr>
<td>Aaron Leonard</td>
<td>Senior Programme Manager</td>
<td>Pact</td>
</tr>
<tr>
<td>Dr Ohnmar Aye</td>
<td>Township Medical Officer</td>
<td>Magway Township, Magway</td>
</tr>
<tr>
<td>Dr Mon Mon Myint</td>
<td>Acting Regional Director for Health</td>
<td>Magway Regional Health Department</td>
</tr>
<tr>
<td>Dr Zaw Aung</td>
<td>Township Medical Officer</td>
<td>Ngaphe Township, Magway</td>
</tr>
<tr>
<td>Daw Khin Than Aye</td>
<td>Township Nurse</td>
<td>Ngaphe Township, Magway</td>
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<tr>
<td>Dr Kyaw Kyaw</td>
<td>Township Medical Officer</td>
<td>Seikphyu Township, Magway</td>
</tr>
<tr>
<td>Prof. Dr. Soe Lwin Nyein</td>
<td>Director General</td>
<td>Department of Public Health, Ministry of Health and Sports</td>
</tr>
<tr>
<td>Dr Nay Winn Lynn</td>
<td>Deputy District Medical Officer</td>
<td>Hpa An, Kayin State</td>
</tr>
<tr>
<td>Daw Nan Chaw Lay</td>
<td>Trained Nurse</td>
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<tr>
<td>Tomas Lundstrom</td>
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<tr>
<td>Ben Powis</td>
<td>Social Development Adviser</td>
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<tr>
<td>Mya Maw</td>
<td>Programme Officer</td>
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<tr>
<td>Peter McDermott</td>
<td>Deputy Head</td>
<td>DFID</td>
</tr>
<tr>
<td>Paul Sender</td>
<td>Fund Director</td>
<td></td>
</tr>
<tr>
<td>Julia Messner</td>
<td>AEI&amp;CS Programme Officer</td>
<td></td>
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</tbody>
</table>

**Other INGOs, NGOs, and CBOs**

- Pansy Tun Thein, Director, LRC
- Orlen Ocleasa, Programme Quality, Impact and Learning Adviser, ActionAid
- Yi Yi Win, Programme Quality, Accountability and Village Book Coordinator, ActionAid
- Khin Khin Mra, Learning and Knowledge Management Coordinator, ActionAid
- Han May, Learning and Knowledge Management Coordinator, ActionAid
- Meg McDermott, Programme Officer, Asia, Eurasia, Pact
- Aaron Leonard, Senior Programme Manager, Pact

**Government**

- Dr Ohnmar Aye, Township Medical Officer, Magway Township, Magway
- Dr Mon Mon Myint, Acting Regional Director for Health, Magway Regional Health Department
- Dr Zaw Aung, Township Medical Officer, Ngaphe Township, Magway
- Daw Khin Than Aye, Township Nurse, Ngaphe Township, Magway
- Dr Kyaw Kyaw, Township Medical Officer, Seikphyu Township, Magway
- Prof. Dr. Soe Lwin Nyein, Director General, Department of Public Health, Ministry of Health and Sports
- Dr Nay Winn Lynn, Deputy District Medical Officer, Hpa An, Kayin State
- Daw Nan Chaw Lay, Trained Nurse

**Donors**

- Tomas Lundstrom, SIDA
- Ben Powis, Social Development Adviser, DFID
- Mya Maw, Programme Officer, DFID
- Peter McDermott, Deputy Head, DFID

**3MDG Fund**

- Paul Sender, Fund Director
- Julia Messner, AEI&CS Programme Officer
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Swe Sin Mya</td>
<td>CSO Capacity Building Officer</td>
</tr>
<tr>
<td>Gulshod Allabergenova</td>
<td>M&amp;E Officer</td>
</tr>
<tr>
<td>Kyaw Htin Soe</td>
<td>Public Health Analyst (C2)</td>
</tr>
<tr>
<td>Pyae Phyo Aung</td>
<td>Public Health Analyst (C2)</td>
</tr>
<tr>
<td>Robert Bennoun</td>
<td>Head of C2 Programme</td>
</tr>
<tr>
<td>Panna Erasmus</td>
<td>Head of C1 Programme</td>
</tr>
<tr>
<td>Yin Yin Htun Ngwe</td>
<td>Senior Public Health Officer</td>
</tr>
<tr>
<td>Wai Yee (Krystal) Khine</td>
<td>HSS Project Analyst</td>
</tr>
<tr>
<td>Meng Hsuan Ann Lin</td>
<td>HSS Specialist</td>
</tr>
<tr>
<td>Mya Yee Mon</td>
<td>Equity and Social Inclusion Specialist</td>
</tr>
<tr>
<td>Hre Bik</td>
<td>Capacity Development Analyst</td>
</tr>
<tr>
<td>Jan Philip Klever</td>
<td>Programme Support Officer</td>
</tr>
<tr>
<td>Yoshinori Ikeda</td>
<td>Performance Management Officer</td>
</tr>
</tbody>
</table>
### Annex 3

**Table 2: Typology of Social Accountability Tools and Mechanisms\(^2\)**

<table>
<thead>
<tr>
<th>Function</th>
<th>Potential Mechanisms and Tools</th>
<th>3MDG Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies and plans</td>
<td>Consensus conferences Public hearings National conversations Participatory planning</td>
<td>Participatory planning: 8 States and regions health departments have been trained in community engagement by Collective Voices partners.</td>
</tr>
<tr>
<td>Budgets and expenditures</td>
<td>Participatory budgeting Independent budget analysis Public expenditure tracking surveys Social audits Citizens budgets Sharing budget information</td>
<td>Other examples: Citizens’ Budget published by Ministry of Finance for 2015-2016</td>
</tr>
<tr>
<td>Delivery of services and goods</td>
<td>Citizens’ report card Community scorecards Community feedback and response mechanisms (CFRM) Public hearings</td>
<td>Formal CFRM: MNCH and 2 IPs are implementing suggestion boxes and using community meetings and focus group discussions to generate feedback. Dialogue/participation: Collective Voices partners hold face-face dialogue with government health providers – influencing policy and practice. Community scorecards: IPs trained in June 2016 Other examples: Public hearing on quality of health services in Mon State (LRC and CSO partners); LRC Human Rights Defenders use Facebook to share information and collaborate.</td>
</tr>
<tr>
<td>Public Oversight</td>
<td>Ombudsman Public oversight committees Community oversight committees</td>
<td></td>
</tr>
</tbody>
</table>

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\(^2\) Adapted from World Bank Context Mapping for Social Accountability
Annex 4

AEI&CS Self-Assessment Indicators for Standard 3

3.1 The organization has a policy or equivalent guidance on the establishment and operation of CFRMs which includes receipt, processing, and response to beneficiary feedback.

3.2 A formal feedback and response mechanism is in place for intended project beneficiaries.

3.3 Project staff and partners are trained on the beneficiary feedback and response mechanism and know how it works.

3.4 Intended project beneficiaries are aware of the feedback and response mechanism, understand how it works and are able to use it independent of others.

3.5 The feedback and response mechanism ensures confidentiality and is easily accessible to intended project beneficiaries and communities (including in local languages / dialects).

3.6 Women and girls are regularly consulted on their preferred means for providing feedback (Ex. in person, telephone/ text, written letter/ email).

3.7 Feedback received is always shared when appropriate with all other stakeholders (including partners, donors and governing authorities) who are affected by or need to take action on the information provided.

3.8 Feedback received is acted on in a timely manner by the appropriate groups/individuals.

3.9 There are clear records of feedback received and how it has been responded to.

3.10 Information received through the feedback response mechanism is used to improve current and future activities.
Annex 5

Pyoe Pin Qualitative Assessment Scorecard Example Indicator

<table>
<thead>
<tr>
<th>OUTCOME STATEMENT: Local organisations and individuals acting cooperatively to address the needs and aspirations of Burmese people</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUTCOME INDICATOR 1 INDEX: Quality of cooperative civil society activity (composite of 3 indicators)</td>
</tr>
<tr>
<td>Outcome Quality Indicator Statement 1. COOPERATION: Organisations and individuals act cooperatively</td>
</tr>
<tr>
<td>Strongly agree</td>
</tr>
<tr>
<td>Score</td>
</tr>
<tr>
<td>Checklist: Have there been changes in the quality of cooperation within Burmese society and to what extent are these changes attributable to the project intervention?</td>
</tr>
<tr>
<td>• Evidence that civil society can marshal and analyse evidence as the basis for collective action</td>
</tr>
<tr>
<td>• Evidence of trust and reciprocity (social capital) built around shared social goals within networks of organisations and individuals</td>
</tr>
<tr>
<td>• Evidence of collective action above the level of the individuals IBPs, including where appropriate advocacy with decision makers. For example, policy platforms are developed as the means of using review and analysis to present policy cases</td>
</tr>
<tr>
<td>Discussion/Explanation of score</td>
</tr>
</tbody>
</table>

| Outcome Quality Indicator Statement 2. COMMUNICATION: Organisations and individuals communicate effectively |
| Strongly agree | Agree | Disagree | Strongly disagree |
| Score |
| Checklist: Have there been changes in the quality of communication and to what extent are these changes attributable to the MNCH IBP intervention? |
| • Policy think tanks, independent reviewers, and relevant Myanmar business associations work collaboratively to produce policy discussion papers |
| • Relevant Ministry officials demonstrate involvement by contributing to or vetting and taking up proposals in discussion documents prepared by think tank and local reviewers and relevant Myanmar business associations. |
| • Media demonstrates interest in stories and new items from IBPs |
| • Decision-makers (regional, national) are better informed about effects of changes (positive and negative) to policy at national and regional level on Burmese people |
| • Donor community and other stakeholders are better informed about possible changes and interventions that can increase economic and social opportunities for Burmese people |
| Discussion/Explanation of score |

| Outcome Quality Indicator Statement 3. INCLUSION: Cooperative action is inclusive of marginalised social groups |
| Strongly agree | Agree | Disagree | Strongly disagree |
| Score |
| Checklist: Have there been changes in the inclusiveness of cooperative action and to what extent are these changes attributable to the project intervention? |
| • Evidence of inter-ethnic and inter-faith collective action in which diverse views are surfaced and addressed |
| • Cultural understanding and acceptance can be shown to have grown between selected ethnic groups and the Burmese centre, for example via an acceptance of the need for ethnic language education in early years schooling. |
| • Gender monitoring demonstrates that gender mainstreaming strategies developed by partners have been implemented, and have been effective across IBPs, with evidence of women’s representation and the naming of gender equality challenges through collective action |
| • Economic interdependencies between different ethnic areas, expressed through commercial market chains where formalisation is ensuring broad economic access (not just for the elites in each place) can be shown to have grown. |
| Discussion/Explanation of score |