REPORT of the TRAINING

on

SOCIAL DETERMINANTS OF HEALTH

and

UNIVERSAL HEALTH COVERAGE

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REPORT of the TRAINING on
SOCIAL DETERMINANTS OF HEALTH
and
UNIVERSAL HEALTH COVERAGE
Myanmar

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The Consultant would like to express his gratitude to Julia Messner, Accountability Program Officer, 3MDG Fund Management Office, UNOPS, Myanmar, for her suggestions and comments given in developing this Training Manual.

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Professor Than Tun Sein
Yangon, December 2015
# List of Abbreviations and Acronyms

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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>ARH</td>
<td>Adolescent Reproductive Health</td>
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<td>BHS</td>
<td>Basic Health Staff</td>
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<tr>
<td>CBO</td>
<td>Community Based Organization</td>
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<td>CE</td>
<td>Community Engagement</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
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<tr>
<td>DOT</td>
<td>Direct Observe Treatment</td>
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<tr>
<td>EHO</td>
<td>Ethnic Health Organization</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>HRH</td>
<td>Human Resources for Health</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>NGO</td>
<td>Non-governmental Organization</td>
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<td>PET</td>
<td>Participatory Education Theatre</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>SDH</td>
<td>Social Determinants of Health</td>
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<td>TOR</td>
<td>Terms of Reference</td>
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<tr>
<td>UHC</td>
<td>Universal Health Coverage</td>
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<tr>
<td>VHW</td>
<td>Volunteer Health Workers</td>
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<td>VRS</td>
<td>Volunteer Record System</td>
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<td>WHO</td>
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SUMMARY

UHC is an approach to ensure equity in health and health care. As health inequities originate from social determinants of health (SDH) and as these SDH lie outside the health sector, attempting to address health inequities through UHC will not gain success without collaboration with other related sectors. In this endeavour, Non-governmental Organizations (NGOs)/Civil Society Organizations (CSOs) in Myanmar possess a great role to play in addressing SDH. Thus these staffs are to be equipped with capacities on addressing SDH with an aim of achieving UHC. With these conceptual thinking that the training program on Social Determinants of Health and Universal Health Coverage was implemented among the staffs of International NGOs and CSOs who are fund recipients of 3MDG.

There are 8 Training Sessions, for which a Training Manual was developed in accordance with Educational Science principles and pre-tested. These Sessions are:

- Session 1: The Meaning of Health and Key Factors Contributing to Health Outcomes
- Session 2: Social Determinants of Health (SDH)
- Session 3: Sharing Experiences on Improving Health Equity
- Session 4: Strategic Directions for Universal Health Coverage (UHC)
- Session 5: The Roles of CSOs in Addressing SDH: Assessing SDH, Consciousness Raising and Locality Development
- Session 6: The Roles of CSOs in Addressing SDH: Health Promotion Approach
- Session 7: The Roles of CSOs in Addressing SDH: Social Action
- Session 8: The Roles of CSOs in Addressing SDH: Media Advocacy

The learning approaches applied included: Two way discussions during presentations by the Facilitators; Case studies and plenary discussions; Group work and plenary discussions; Role Plays; and Application of Energizers whenever needed. The training process also emphasized on sharing of work experiences of the Participants.

There were two trainings at Yangon (from 14-15 January, 2016 and 21-22 January, 2016), one at Lashio (Northern Shan State) (from 25-26 April, 2016) and one at Mandalay (from 28-20 April, 2016). The number of participants who attended the four training workshops was: 20 in Yangon Workshop 1; 32 in Yangon Workshop 2; 34 in Lashio Workshop; and 41 in Mandalay Workshop.

Evaluation Findings showed a marked improvement in the knowledge of the Participants after receiving training, with an average score of 55.4% (range 13.3%-93.3%) in pre-test results and achieving an average score of 78.3% (range 26.7%-100%) in post-test results. The Participants also gave positive constructive views, qualitatively, on how to improve the training process in future.

Creating and implementing a learning process where knowledge and practices were imparted focusing on the roles of INGO/CSOs in addressing SDH so as to improve health inequities and achieve UHC was considered successfully completed. Recommendations were made basing on the critical views expressed by the Participants.
1 BACKGROUND

Universal Health Coverage (UHC) is defined as: *Securing access for all to appropriate promotive, preventive, curative, rehabilitative and palliative services with financial risk protection.* Myanmar government (previous 2010-2015 military backed government as well as the new civilian government that came into power beginning 1st April, 2016) has commitments for putting into practice the UHC concepts. UHC is an approach to ensure equity in health and health care.

It is to be noted that health inequities emanate from social determinants of health (SDH). SDH is defined as: *The societal conditions in which people are born, grow, live, work and age and that have an impact on our health are called Social Determinants of Health.* See Figure 1 for the Framework of SDH as proposed by World Health Organization (WHO).

As these SDH lie outside the health sector, attempting to address health inequities through UHC will not gain success without collaboration with other related sectors. In this endeavour, Non-governmental Organizations (NGOs)/Civil Society Organizations (CSOs) in Myanmar possess a great role to play in addressing SDH and are to be considered as key players for the success of UHC. Thus these staffs are to be equipped with capacities on addressing SDH with an aim of achieving UHC.

With these conceptual thinking described above that the training program on Social Determinants of Health and Universal Health Coverage was implemented among the staffs of International NGOs and CSOs who are fund recipients of 3MDG. Training Manual and related training materials (power-points) were developed first. These were pre-tested with staffs at 3MDG and necessary modifications made basing on the suggestions given by the participants.

Terms of Reference (TOR) given to the Consultant is attached as Annex 1.
2 TRAINING OBJECTIVES

The overall objective of the training is to expand knowledge, understanding, and capacities among 3MDG implementing partners in Myanmar on the critical issues and policies relating to the social determinants of health (SDH) and Universal Health Coverage (UHC). The emphasis of the training workshops will be on "applied skills", equipping the 3MDG implementing partners with practical tools and resources to apply key learning within their health programmes and projects following the training sessions.

In order to achieve the overall objective, eight training sessions had been developed. The objectives for each Training Session are described below.

Objectives of session 1: The Meaning of Health and Key Factors Contributing to Health Outcomes
At the end of the Session, the participants will be able to:
(1) Define what “health” is; and
(2) Identify what the key factors contributing to health outcomes are.

Objectives of session 2: Social Determinants of Health (SDH)
At the end of the Session, the participants will be able to describe what the social determinants of health are.

Objectives of session 3: Sharing Experiences on Improving Health Equity
At the end of the Session, the participants will have shared the experiences of their organizations in ensuring health equity in communities through health service projects.

Objectives of session 4: Strategic Directions for Universal Health Coverage (UHC)
At the end of the Session, the participants will be able to generate limitations that exist in each of the Strategic Directions for UHC, for Myanmar NGOs/CSOs to complement the Ministry of Health.

Objectives of session 5: The Roles of CSOs in Addressing SDH: Assessing SDH, Consciousness Raising and Locality Development
At the end of the Session,
(1) The participants will become aware of:
   ➢ What the roles of CSOs are;
   ➢ What the approaches are that could be applied to create change in SDH;
   ➢ What “Consciousness Raising” is;
   ➢ What “Locality Development” is;
(2) The participants and will have:
   ➢ Shared their organizations’ experiences relating to “Consciousness Raising” and “Locality Development”; and
   ➢ Identified gaps in incorporating SDH into these two approaches.

Objectives of session 6: The Roles of CSOs in Addressing SDH: Health Promotion Approach
At the end of the Session,
(1) The participants will become aware of:
   ➢ What “Health Promotion” is and its difference from the term “Health Education”;
   ➢ How to incorporate SDH in “Health Promotion”;
(2) The participants and will have:
   ➢ Shared their organizations’ experiences relating to “Health Promotion”; and
   ➢ Identified gaps in incorporating SDH into this approach.
Objectives of session 7: The Roles of CSOs in Addressing SDH: Social Action

At the end of the Session, (1) The participants will become aware of:

- What “Social Action” is;
- How to incorporate SDH in “Social Action”;

(2) The participants and will have:

- Shared their organizations’ experiences relating to “Social Action”; and
- Identified gaps in incorporating SDH into this approach.

Objectives of session 8: The Roles of CSOs in Addressing SDH: Media Advocacy

At the end of the Session, the participants will:

(1) Become aware of what “Advocacy” is;

(2) Be able to identify the differences and similarities between IEC/BCC, Community Mobilization and Advocacy; and

(3) Be able to describe what “Media Advocacy” is and why it is important to creating a critical mass for social change (in support of SDH).
3 TRAINING PROCESS

3.1 An Overview

Details of the learning activities to achieve the training objectives are described in the Training Manual submitted separately to hera. Along the training process, the following learning approaches were applied:

- Two way discussions during presentations by the Facilitators;
- Case studies and plenary discussions;
- Group work and plenary discussions;
- Role Plays; and
- Application of Energizers whenever needed.

The training process also emphasized on sharing of the work experiences of the Participants in each of the group work sessions.

There were two trainings at Yangon (from 14-15 January, 2016 and 21-22 January, 2016), one at Lashio (Northern Shan State) (from 25-26 April, 2016) and one at Mandalay (from 28-20 April, 2016). Time Table of the workshop is attached as Annex 2.

The number of participants who attended the four training workshops was:

- 20 in Yangon Workshop 1;
- 32 in Yangon Workshop 2;
- 34 in Lashio Workshop; and
- 41 in Mandalay Workshop.

These make a total of 127 participants for all the four Workshops. Age and sex characteristics of the participants are shown in Table 1 in Chapter 4, Evaluation Results.

Before each of the training took place, participants were requested to answer Pre-test (quantitative) questions without identifying their names or other particular characteristics except age and sex. At the end of the training, they were asked to answer Post-test (quantitative) questions as well as to provide feedback on the training process, confidentially as in the Pre-test. These Pre-test and Post test questions are attached as Annexes 3 and 4 respectively.

3.2 Key Group Work Outputs

3.2.1 Outputs of Session 1, the Meaning of Health and Key Factors Contributing to Health Outcomes

During Session 1, the Facilitator asked the participants to express their views on the following questions:

- “What a healthy person is like?”
- “What are some of the factors that contribute to good health?”
- “What are some of the factors that contribute to ill health?”
- “Of the factors listed in questions 2 and 3, which are social and which are biological?”
- “Are there differences in health status across different social groups? If yes, what are they, and what are some of the reasons for these differences?”
The participants at all the four workshops came up with similar answers. As for the meaning of health, answers included:

- Can move around, can eat and can work without any one’s assistance;
- Feels happy; smiling;
- Sleeps well and eats well;
- “Having a feeling of hitting the sky with one’s knees”\(^1\);
- No fever;
- No disability;
- Can eat well;
- Has a harmonious relationship with other people;
- Good body shape;
- Etc.

As regards factors that contribute to good/ill health, answers included:

- Education/health education;
- Income;
- Stressful conditions
- Environmental sanitation;
- Nutrition;
- Physical exercises;
- Discrimination;
- Health policy, meaning whether policies pay attention to the health of the poor majority or not;
- Cultural beliefs and taboos;
- Genetics;
- Lifestyles;
- Conflicts;
- Etc.

They were also able to identify diseases emanating from genetics are biological and that social stratifies of differences in health status encompass place, gender, religion, etc. They recall back the previous answers on factors contributing to good/ill health as the reasons for these differences.

During the same Session, the Facilitator asked the Participants (in the plenary) to estimate the percentage contribution of the factors to health outcomes like “individual behaviour”, “clinical care”, “socio-economic factors” and “physical environment”. Their consensus was that “clinical care contributes less than 20% (answers ranging from 15%-20% in different training groups)”.

Thus at the end of the Session, the participants were already instilled with the key concepts of SDH.

### 3.2.2 Outputs of session 2, Social Determinants of Health

During this Session, after the Facilitator presenting on the conceptual framework of SDH, a Case Study on “A Modern Parable” was given and the participants were asked to read through it and answer the questions given in three randomly formed groups. The questions included: What, in their opinion, is the message the story is trying to convey? What parallels can they draw between this modern parable and present day society’s approach to the health problems of the population? What do they think is the “machinery” that causes ill health in present-day society?

\(^1\) It is a direct translation from a Myanmar saying to describe the feeling of a healthy person expressing that he or she is so healthy that he or she can hit the sky with his or her knees.
Through the participatory learning process, all the groups at all the workshops in Yangon, Lashio and Mandalay were able to come up with conceptually correct answers saying, for example,

- Providing treatment will not solve a health problem if the root causes of the problem could not be identified;
- Not paying attention on prevention and primary health care approach; and
- Giving more attention on getting profits than on people’s health.

Priority being paid for development and/or profit to the detriment of people’s social lives, including health, was compared with such situations in Myanmar like, construction of a hydro-electrical dam over Irrawaddy river, construction of Yangon-Mandalay expressway without proper attention being paid for the safety of traffics and people using it, copper mines at Let-padaung-taung, jade mines in Kachin State, and so on.

This Session is logically linked to Session 1 and further enhances understanding of SDH by the participants.

### 3.2.3 Outputs of session 3, Sharing Experiences on Improving Health Equity

During Session 3, the Participants, who were (or someone from their organization was) assumed to have already received 3MDG’s training on Health Equity, were given a quick review on the concepts of health equity. As a matter of fact, about 80% of the Participants had never attended training on Health Equity (see Table 2 in Section 4.1).

Then a group work was assigned after dividing into three groups where the participants had to share their organizations’ experiences on how equity issues were being addressed. For example, how were social groups defined and how were target beneficiaries defined? What were the indicators used to monitor and evaluate improvements in health equity? They were also requested to share the facilitating factors in providing services to improve health equity and related success stories if any (only one for each group).

Thus this Session is solely on experience sharing and exploring to what extent their organizations are putting health equity concepts into practice.

All the groups described the ways their organizations were targeting vulnerable groups like mothers and children, those residing in hard-to-reach areas and minority ethnic groups. Few groups even indicated that they performed social mapping to identify those from lower social group in each village. There were also groups who said their organizations targeted those who are socially marginalized in a community, for example, drug users and female sex workers.

As almost all the participants’ organizations were engaged in community based maternal and child health services, the indicators identified for monitoring and evaluation of health equity were focused on the number of mothers from lower social group or from a hard-to-reach area referred for emergency obstetric care. Health volunteers trained by their organizations were identified as main facilitators for the success of their interventions at grass-roots level. Some also identified village health committees formed by their organizations or local Ethnic Health Organizations (EHOs) as key players for the success in ensuring health equity.

At the same time, discussions were made as regards cultural influences prohibiting timely access to health services (for example, gender issues in remote rural areas of Chin State making delays in timely arrival of pregnant mothers for emergency obstetric care) and difficulties in increasing
coverage with immunization services for children in areas under EHOs (due to language barriers as well as lack of proper collaboration between the government MOH and EHOs).

One experience shared by one representative from International Red Cross (IRC) worthy noting. The person’s narration is as follows: “In Kayah State, there is a Network called Civil Health and Development Network (CHDN), formed by EHOs from 6 armed groups. In promoting child rights, this Network is gaining successes. If the government could collaborate with this Network, there would be more successes in protecting child’s rights. However, there is no collaboration as yet.”

3.2.4 Outputs of Session 4, Strategic Directions for UHC

During Session 4, presentation was made on what the nine strategic directions for UHC were. This was followed by a group work where each of the three groups was assigned with randomly chosen three Strategic Directions for UHC. The Participants had to identify limitations that exist in each of the three Strategic Directions, for Myanmar NGOs/CSOs to complement the Ministry of Health (MOH), and also ways to overcome these limitations.

Majority of the Participants (about 86%, see Table 3 in Section 4) were unaware of the Nine Strategic Directions for UHC, though theoretically all the staffs of NGOs/CSOs collaborating with MOH should be aware of these. In spite of this limitation all the Participants agreed that their organizations would be able to make contributions to MOH in all the nine strategic directions for achieving UHC. However, Participants were unable to share their experiences of collaboration with MOH in the activities relating to some of these strategies.

The followings are some of the key outputs that emerged in group works:

**Essential Health Package**

Participants in some groups were unable to generate ideas relevant to Essential Health Package (EHP). This probably was due to the fact that they were not involved in designing EHP by the MOH. This fact was revealed during plenary discussion. Some of the group discussions framed only around supply chain management of essential drugs, pointing out the need to improve it.

There were few groups who said that they were the staffs who were working at the grassroots levels and knew the people’s situations very well. They could share their experiences. Thus they should be involved in developing EHP, they said. They also said that through monitoring and evaluation systems, they could find out whether the EHP is reaching the intended target beneficiaries or not, and provide feedback for better improvement in the delivery of the EHP.

Some groups identified community based emergency referral system as an area which constituted one key element of EHP for achieving UHC, but having many constraints due to:

- Trained Volunteer Health Workers (VHWs) were being neglected by Basic Health Staffs (BHS);
- What was agreed (between INGO/CSO and MOH) was not known at township levels making difficult to collaborate.

**Human Resources for Health**

Participants said they could contribute to the MOH in Human Resources for Health (HRH) area through involvement on providing training to health volunteers and BHS. INGO and CSO staffs themselves being components of HRH, they could contribute their services for the success of UHC. TB
Volunteers like DOT (Direct Observe Treatment) providers, Malaria Volunteers like those trained early diagnosis and prompt treatment, etc., are also HRH of great importance for Primary Health Care (PHC) services. As regards constraints, the following issues were highlighted:

- Needing more linkages between BHS and VHWs;
- Centralized decision-making under MOH making effective collaboration at township levels weak;
- Lack of support to VHWs making more attrition;
- Needs continuous capacity strengthening of Community Based Organizations (CBOs) in various aspects;
- Vacant posts existing at local level health facilities.

**Essential Medicine**

This is one area where the Participants were unable to make active discussions. Discussions by the Participants took place around the following issues:

- To review and revise national essential drug list and should be made to be widely known among health staffs;
- After dividing the Department of Health (DOH) into Department of Medical Care (DOMC) and Department of Public Health (DOPH), internal conflicts emerged between clinical side and public health side (within the same hospital) making difficulties in drug supply management.

**Public-Private Partnership**

This is also one area where the Participants were unable to make effective discussions. INGOs/CSOs fall into the category of Private no-for-profit organizations; thus the importance of partnership between these organizations and the government is quite salient said the Participants. They discussed the need for:

- Collaborating with EHOs enhances effective delivery of PHC services;
- Collaboration with General Practitioners in delivering PCH services.

**Community Engagement**

Being participants from International NGOs/CSOs, Participants were well versed with Community Engagement approaches and experiences. Only about 48% of the Participants said they had never attended any training on Community Engagement/Community Mobilization training (See Table 2 in Section 4). The Participants repeated the same answers given during Session 3 as regards how they mobilized the communities.

Lack of decentralization was pointed as one constraining issue for proper application of Community Engagement (CE) and practical realization of the voices heard. High turn-over of trained staff and new recruits taking their positions, at INGOs, is considered one constraining factor for putting CE into practice.

According to the Participants, government staffs were said to consider CE as an extra burden for them and are not interested in it. This made collaboration and co-ordination between BHS and INGO/CSO staffs weak.
Interesting information given was that all the community based projects being donor-driven, CE and listening for priority needs did not take place. The participants pointed out that even selection of project areas was donor-driven.

**Evidence-based Information and Health Management Information System**

The Participants said they were involved in strengthening health management information system (HMIS) at the township levels through capacity building of BHS in quality data collection, data analysis and data reporting. Other discussion points included:

- To establish community based Volunteer Record System (VRS);
- To develop on-line reporting system and for this to happen, to make internet access to various geographical areas;
- The need of local authorities’ participation in collecting data to monitor seasonal migratory population as well as internally displaced people data in conflict affected areas at the local level;
- Information sharing between BHS and INGOs/CSOs;
- The need for capacity building of NGO/CSO staffs in research methods;
- The need to pass Ethical Review Committee of MOH takes time and makes delays.

**Policies for Health**

This is another area where the Participants were constrained to make productive discussions. However, this area is considered by the Participants that INGOs and CSOs could play important roles and deliberations were made on:

- Promoting evidence-based policy making;
- NGOs/CSOs to take part more in evidence-based advocacy.

**Governance and Stewardship**

The Participants were again unable to make productive discussions in this area. The Participants were aware that since health governance involves three sets of actors --- State actors, including politicians, policy-makers, and other government officials; health service providers; and beneficiaries, health service users, and the general public --- the INGO/CSO staffs fall into the category of health service providers. Thus they considered themselves of having a key role to play as the linkages among these three categories of actors constitute the effective core of health governance. Other expressions made included:

- Myanmar health sector is in need of major reforms to promote health equity;
- Evidence-based advocacy could enhance good governance and proper stewardship;
- MOH data should be transparent and shared with NGOs/CSOs.

Participants pointed out that unless MOH could steer other Ministries, collaboration at township levels would be weak.

**Health Financing**

The Participants discussed the financial support their organizations were providing to the poor people to make them access to essential health services. Other issues discussed involved:
3.2.5 Outputs of session 5, The Roles of CSOs in Addressing SDH: Assessing SDH, Consciousness Raising and Locality Development

One of the group works in Session 5 was to share their organizations’ experiences relating to “Consciousness Raising” activities; and “Locality/Community Development” activities and whether they were able to address SDHs through these approaches.

Participants discussed how Participatory Learning and Action (PLA) approaches (community mobilization approaches) had been applied for Consciousness Raising among local community members. These approaches included Ten Seed Technique, Participatory Education Theatre, and Problem Tree Analysis.

Experiences were also shared on how Self Help Groups, Mother Support Groups and Village Health Committees were formed and how these community-based organizations were able to address health inequity issues. Participants said that because their organizations were able to identify the root causes at local levels and searched for solutions through participatory approaches with local people, they were able to address health inequity issues.

One example was given by a Wa medical doctor on how he attempted to form a “Funeral Services Organization” for helping the poor people at Tang-Yang in Wa Region in northern Shan State. He invited three elders from three different religions, Buddhism, Christianity and Islam, and discussed with them the poor people’s sufferings from being unable to afford to observe funeral services. Then, with the agreement of these elders, and later bringing in other well-wishers, the Organization for helping poor people in funeral services irrespective of race and religion was formed. This is considered a good example of locality development through consciousness raising and addressing equity as well.

One example given by a Participant was the Area Development approach used by World Vision Myanmar, in different phases. These are said to be 20-year projects which involved not only health but also other development projects, for example child development, all linked to each other. He Participant said that CBO formation and strengthening (locality development) came in only in the second phase after gaining trust of the local people through delivering services.

3.2.6 Outputs of session 6, The Roles of CSOs in Addressing SDH: Health Promotion Approach

During Session 6, Participants were provided a Case Study: Project Brotherhood, the story about a black men’s clinic at Woodlawn Health Center, Chicago, Illinois, which is an example of Health Promotion approach that incorporates social determinants. Then, each group works together to provide answers for the following questions:

- What SDH did the Project Brotherhood plan to be address?
- What data collection method was applied to assess SDH?

---

2 Wa is one of the 135 ethnic groups of Myanmar.
What innovative health education approach was applied by the project? Share experiences of any innovative approaches of providing health education, if any, applied by your organizations.

What approaches were applied to address SDH?

As for innovative approaches of providing health education, Participants identified Participatory Education Theater, Creating Youth Friendly Corners, Hot-line services for reproductive health, cooking contests for nutrition promotion, puppet shows, etc., which, as a matter of fact, are approaches commonly used by many NGOs/CSOs and could not be considered innovative.

Participants said that since all the approaches applied target towards vulnerable groups like Intravenous Drug Users (IDUs), pregnant mothers and children and people with disability, their organizations were addressing SDH. Innovative approaches that were said to have been applied by their organizations included:

- Forming Mother Support Groups for disseminating maternal and child health (MCH) related messages;
- Youth Corners for disseminating adolescent reproductive health (ARH) messages to youths;
- Integrated health education and active case finding mobile clinics for TB;
- Attitude games (for example, debating on traditional beliefs in causes of malaria other than mosquito-bite; whether someone keeping a condom is socially acceptable or not);
- Participatory education theater (PET).

### Outputs of session 7, The Roles of CSOs in Addressing SDH: Social Action

Presentations and two-way discussions in the plenary took place for clear understanding of what is meant by “Social Action”.

During the Session, explanation was made by the Facilitator that Social Action is the practice of taking action – usually as part of an organized group or community – to create positive change. Emphasis was made that the “Social Action” is meant to be practiced by those who have little power in society like the poor, minorities, or people with disabilities.

An example given on how a CSO, in order to address diabetes problem among poor people, organized a march where people carried body bags, each representing a person in their community who died from diabetes; a group of community members suffering from diabetes followed behind; and this again was followed by another group followed, carrying posters highlighting the social determinants associated with diabetes, including statistics.

Then, ask the participants on their experiences that had taken place recently in Myanmar where certain social action approaches had been applied. They were able to identify “Let-pa-daung-taung” demonstrations where role plays by community members were included in making demonstrations against the copper mines project in central Myanmar. When asked specifically for the health sector, the participants identified “Black Ribbon Movement” organized by medical doctors against giving high level civilian posts to military medical doctors and non-medical military officers from the Ministry of Defence.

Participants were informed that health practitioners can take part in social action in a variety of ways, for example, providing current, relevant information and data to help develop the messages conveyed through social action activities, identifying appropriate audiences for a particular message (e.g., an elected official, the public at large), and so on.
This Session was brief and there was no group work involved, and thus unable to describe specific group work outputs.

3.2.7 Outputs of session 8, The Roles of CSOs in Addressing SDH: Media Advocacy

During this Session, a presentation with two-way discussions took place for understanding the differences between Information, Education, Communication/ Behavior Change Communication (IEC/BCC), Community Mobilization and Advocacy, and the importance of media advocacy. Before the Session ends, a role play was performed after dividing the Participants into three groups and assigned with three different scenarios.

The role play seemed to be the most enjoyable part of the workshop as all the participants performed their best bringing forward the key messages intended.

3.3 Observations Made

As an overall, all the training workshops took place with active participation of majority of the Participants. They appeared eager to learn and also most of the possessed field experiences to share with others.

What noticed from the two workshops at Lashio and Mandalay was the reluctance to associate with others and attempts to dominate discussions in group works by the Participants from the government sector. This probably was due to these participants holding positions like Township Medical Officers or Assistant Directors from State/Region Public Health Departments.

However, this situation was improved to a great extent at Lashio after the morning sessions in the first day of the workshop. Most of them also took part in making presentations of group work products. When role play was performed all except two (i.e., 4 out of 6) from the government sector actively participated in the performances. These two left the workshop earlier in the second day afternoon.

On the other hand, there seemed no visible improvement at Mandalay workshop till the last moment. In spite of request made by the Facilitators for taking turns in making presentations of the group work out-puts, none except one did it. Only this government staff also participated actively in the role play. The remaining persons (i.e., 5), though they were present till the closing of the workshop, shunned from participating in the role play.
4 TRAINING EVALUATION RESULTS

4.1 Quantitative results

As for quantitative assessment, the Participants had to respond, without identifying their names and also confidentially, the Pre-test as well as Post-test questions that involved the following statements (see Annexes 3 and 4):

- Two background variables (age and sex);
- Five statements on past training received (SDH; Health Equity; UHC; Advocacy; and Community Mobilization);
- One statement (Yes or No) on awareness of the Nine Strategic Directions for UHC in Myanmar; and
- Fifteen knowledge statements (correct answers).

Score 1 is given for every correct knowledge statement ticked, total scores were then divided by 15 and multiplied by 100 giving a percentage score for each participant. In Post-test, the back ground variables and the fifteen knowledge statements of the Pre-test were again included. In addition, 21 attitude statements (7 each about the training, the participants and the facilitators) were added.

For each attitude statement, a Participant had to respond either “Strongly Disagree” (Score 1), “Somewhat Disagree” (Score 2), “Somewhat Agree” (Score 3) or “Strongly Agree” (Score 4). Average attitude scores were then calculated. Quantitative findings are shown in the following sub-paragraphs.

4.1.1 Age and Sex Characteristics

Table 1 Age and Sex Characteristics of the Participants

<table>
<thead>
<tr>
<th>Participant Characteristic</th>
<th>The two Yangon Workshops (n=52)</th>
<th>Lashio and Mandalay Workshops (n=75)</th>
<th>All the four Workshops (n=127)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Mean, in years</td>
<td>33.6</td>
<td>29.7</td>
</tr>
<tr>
<td></td>
<td>(Range, in years)</td>
<td>(24-64)</td>
<td>(22-65)</td>
</tr>
<tr>
<td>Age groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Under 25 years, in No (%)</td>
<td>5 (9.6)</td>
<td>6 (8.0)</td>
</tr>
<tr>
<td></td>
<td>Between 25 and 45 years, in No (%)</td>
<td>40 (76.9)</td>
<td>65 (86.7)</td>
</tr>
<tr>
<td></td>
<td>Above 45 years, in No (%)</td>
<td>7 (13.5)</td>
<td>4 (5.3)</td>
</tr>
<tr>
<td>Sex</td>
<td>Male, in No (%)</td>
<td>29 (55.8)</td>
<td>45 (60)</td>
</tr>
<tr>
<td></td>
<td>Female, in No (%)</td>
<td>23 (44.2)</td>
<td>30 (40)</td>
</tr>
</tbody>
</table>

From the above Table, mean age of the Participants is around 31 years with a wide range from 22-65 years. Majority of them fall into the age range 25-45 years. There were more male participants.
4.1.2 Past Training received on Specific Topics

Table 2 shows the responses given by the Participants whether they had received training or not in SDH, Health Equity, UHC, Advocacy and Community Mobilization.

Table 2 Percentages of Participants who did not receive past training in SDH, Health Equity, UHC, Advocacy and Community Mobilization

<table>
<thead>
<tr>
<th>Topic of Past Training Received</th>
<th>No. (%) of Participants answering “NO”</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The two Yangon Workshops (n=52)</td>
</tr>
<tr>
<td></td>
<td>Lashio and Mandalay Workshops (n=75)</td>
</tr>
<tr>
<td></td>
<td>All the four Workshops (n=127)</td>
</tr>
<tr>
<td>SDH</td>
<td>90.4</td>
</tr>
<tr>
<td>Health Equity</td>
<td>93.2</td>
</tr>
<tr>
<td>UHC</td>
<td>90.6</td>
</tr>
<tr>
<td>Advocacy</td>
<td>93.2</td>
</tr>
<tr>
<td>Community Mobilization</td>
<td>90.6</td>
</tr>
<tr>
<td></td>
<td>84.9</td>
</tr>
<tr>
<td></td>
<td>79.5</td>
</tr>
<tr>
<td></td>
<td>94.5</td>
</tr>
<tr>
<td></td>
<td>80.3</td>
</tr>
<tr>
<td></td>
<td>72.6</td>
</tr>
<tr>
<td></td>
<td>66.9</td>
</tr>
<tr>
<td></td>
<td>56.2</td>
</tr>
<tr>
<td></td>
<td>48.0</td>
</tr>
</tbody>
</table>

It is a good finding that only 48% of the Participants said they had not been trained in Community Mobilization. Though an assumption was made that the Participants had had been trained in Health Equity by 3MDG, the finding showing that about 80% of them saying they had never been trained in this topic indicates possible turn-over of staffs at these organizations.

4.1.3 Participant Awareness of the Nine Strategic Directions for UHC

Table 3 shows the responses given by the Participants whether they were aware or not of the Nine Strategic Directions for UHC in Myanmar.

Table 3 Percentage of Participants who were not aware of the Nine Strategic Directions for UHC

<table>
<thead>
<tr>
<th>Training Site</th>
<th>No. (%) of Participants answering “NO”</th>
</tr>
</thead>
<tbody>
<tr>
<td>The two Yangon Workshops (n=52)</td>
<td>82.7</td>
</tr>
<tr>
<td>Lashio and Mandalay Workshops (n=75)</td>
<td>90.4</td>
</tr>
<tr>
<td>All the four Workshops (n=127)</td>
<td>85.8</td>
</tr>
</tbody>
</table>

The above data shows that majority of the Participants (about 86%) were unaware of the nine strategic directions for UHC, developed by the Ministry of Health.

4.1.4 Pre-test/Post-test Knowledge Scores

Table 4 shows average knowledge scores achieved at the two Yangon workshops, the Lashio-Mandalay workshops and all the four workshops in separate columns. Table 5 shows the number (and percentage) of Participants according to different ranges of scores.
### Table 4 Average Knowledge Scores achieved

<table>
<thead>
<tr>
<th>Training Site</th>
<th>Average Score and (Range of Scores) Achieved</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>The two Yangon Workshops</td>
<td>Pre-test: 60.7% (33.3%-86.7%) Post-test: 80.3% (46.2-100.0%)</td>
<td>There was a total of 52 Participants at Yangon Workshops who answered Pre-test. In Post-test, two did not provide answers and two did not give complete answers for most of the questions and thus their answer sheets (4 in total) were discarded. This leaves only 48 Participants for calculating the Post-test scores. In Pre-test, there was one Participant who got 33.3% and one Participant who got 86.7%. In Post-test, there were two Participants who got 46.2% and three Participants who got 100%.</td>
</tr>
<tr>
<td>Lashio and Mandalay Workshops</td>
<td>Pre-test: 51.5% (13.3%-93.3%) Post-test: 76.9% (26.7%-100%)</td>
<td>There were 41 Participants at Mandalay Workshop and all the Participants responded the Pre-test and Post-test questions perfectly. There were 34 Participants at Lashio workshop. Two had to be discarded in pre-test and four (including the previous two) had to be discarded in post-test because of either improperly or incompletely filling the answers or not answering at all. In the Pre-test, there was only one person who got 13.3% and also only one person who got 93.3%. In the post-test, there was only one Participant who got 26.7% and there were two Participants who got 100%.</td>
</tr>
<tr>
<td>All the four workshops</td>
<td>Pre-test: 55.4% (13.3%-93.3%) Post-test: 78.3% (26.7%-100%)</td>
<td>A marked improvement as an overall.</td>
</tr>
</tbody>
</table>

From **Table 4** one could observe a marked improvement in knowledge among the participants at all the workshops. It could be noted that the improvement was achieved more with Yangon Participants.

**Table 5** further confirms the findings in Table 4. Here, it could be noted that those achieving more than score 70% had been increased at all the workshops, and more in this increase could be observed with Yangon Participants.

These findings from the two Tables signify the effectiveness of the workshops.
### Table 5 Number (and %) of Participants according to different Range of Scores

<table>
<thead>
<tr>
<th>Range of Scores</th>
<th>No. (and %) of Participants</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(n=52)</td>
<td>(n=48)</td>
</tr>
<tr>
<td><strong>The two Yangon Workshops</strong></td>
<td></td>
<td>10 (19.3)</td>
<td>2 (4.1)</td>
</tr>
<tr>
<td>Less than 50%</td>
<td></td>
<td>28 (53.8)</td>
<td>7 (14.6)</td>
</tr>
<tr>
<td>50-70%</td>
<td></td>
<td>14 (26.9)</td>
<td>39 (81.3)</td>
</tr>
<tr>
<td>Above 70%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

|                       |                             | (n=73)   | (n=71)    |
| **Lashio and Mandalay Workshops** |                             | 36 (49.3)| 3 (4.2)   |
| Less than 50%         |                             | 31 (42.5)| 13 (18.3) |
| 50-70%                |                             | 6 (8.2)  | 55 (77.5) |
| Above 70%             |                             |          |           |

|                       |                             | (n=125)  | (n=119)   |
| **All the four Workshops** |                             | 46 (36.8)| 5 (4.2)   |
| Less than 50%         |                             | 59 (47.2)| 20 (16.8) |
| 50-70%                |                             | 20 (16.0)| 94 (79.0) |

#### 4.1.4 Attitude Scores

Calculation of attitude statements had already been explained in the beginning of this Section. Attitude Scores of 1-2 indicate negative perceptions, 3 indicates somewhere between negative and positive perceptions, and 4 indicates positive perception. Thus, those average scores 3.5 and above are categorized as “Positive Perceptions”, and those below 3.5 “Negative Perceptions”.

Table 6 shows the attitude scores achieved by the Participants. All the Scores considered “Positive Perceptions” are italicized.

From the attitude scores, the following Statements (bolded in the Table) received “Negative Perceptions” (less than 3.5) at all the workshops and they deserve proper attention for future workshop designs:

- The methods of training used during the workshop were appropriate;
- Training materials were consistent with the training objectives;
- Training materials were adequate;
- The training flowed in such a way that learning was enhanced;
- Most participants enhanced my learning process;
- My expectations were met;
- Enough content presentation; and
- There was a good time management.

As no further exploration was made by asking “Why?” on each of the response made for each attitude statement, the reasons for dis-agreeing with the statement (in other words, making a negative expression) were not clear. However, possibilities could be extracted out from some of the qualitative answers given (see Table 7). These possibilities include (but not limited to):

- Not using Myanmar language in the power-points;
- Not explaining every sentence given in the power-points;
- There are more words than pictures in the power-points;
- Not providing stationaries (note books, ball-pens, etc.) to the participants;
Too many topics squeezed in into the 2-day training workshop;
Training duration is too short and should be extended for another one day;
Less time received for group discussions;
Expected more to learn about UHC and the workshop emphasized more on SDH.

Table 6 Average Attitude Scores achieved for each Attitude Statement

<table>
<thead>
<tr>
<th>Attitude Statement</th>
<th>Average Attitude Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yangon Workshops</td>
</tr>
<tr>
<td><strong>About the Training</strong></td>
<td></td>
</tr>
<tr>
<td>1. The training objectives set were made clear at the beginning of the Training</td>
<td>3.5</td>
</tr>
<tr>
<td>2. The training objectives had been achieved</td>
<td>3.2</td>
</tr>
<tr>
<td>3. The presentations were helpful for the participants’ learning</td>
<td>3.4</td>
</tr>
<tr>
<td>4. The methods of training used during the workshop were appropriate</td>
<td>3.3</td>
</tr>
<tr>
<td>5. Training materials were consistent with the training objectives</td>
<td>3.3</td>
</tr>
<tr>
<td>6. Training materials were adequate</td>
<td>3.0</td>
</tr>
<tr>
<td>7. The training flowed in such a way that learning was enhanced</td>
<td>3.4</td>
</tr>
<tr>
<td><strong>About the Participants</strong></td>
<td></td>
</tr>
<tr>
<td>8. Most participants were active in the discussion</td>
<td>3.2</td>
</tr>
<tr>
<td>9. Most participants enhanced my learning process</td>
<td>3.3</td>
</tr>
<tr>
<td>10. There was a good collaboration in my group</td>
<td>3.4</td>
</tr>
<tr>
<td>11. Most of the participants were open to new ideas</td>
<td>3.3</td>
</tr>
<tr>
<td>12. I have had the opportunity to ask questions</td>
<td>3.5</td>
</tr>
<tr>
<td>13. I learned new things in the workshop</td>
<td>3.5</td>
</tr>
<tr>
<td>14. My expectations were met</td>
<td>3.3</td>
</tr>
<tr>
<td><strong>About the Facilitators</strong></td>
<td></td>
</tr>
<tr>
<td>15. Good knowledge of the topic</td>
<td>3.7</td>
</tr>
<tr>
<td>16. Enough content presentation</td>
<td>3.4</td>
</tr>
<tr>
<td>17. Appropriate teaching methodologies</td>
<td>3.3</td>
</tr>
<tr>
<td>18. Effective in motivating participants</td>
<td>3.5</td>
</tr>
<tr>
<td>19. Skilled in relating with the participants</td>
<td>3.6</td>
</tr>
<tr>
<td>20. Good listener</td>
<td>3.6</td>
</tr>
<tr>
<td>21. There was a good time management</td>
<td>3.4</td>
</tr>
</tbody>
</table>

4.2 Qualitative results

Qualitative evaluation on the training process was made by asking the participants to give their comments and suggestions by writing them confidentially on a sheet of paper. They were asked not to mention their names and their organization identities.

There were 34 participants (out of 127, i.e., only 26.7%) who provided their qualitative evaluation remarks. Table 7 shows the findings.
Table 7 Opinions expressed by the Participants

<table>
<thead>
<tr>
<th>Remarks given</th>
<th>No. of persons who gave the remark</th>
</tr>
</thead>
<tbody>
<tr>
<td>The training should be given separately for local NGOs/CSOs and more preferably in <strong>Myanmar language</strong></td>
<td>1</td>
</tr>
<tr>
<td>Myanmar translation of the <strong>power-point slides</strong> is preferred</td>
<td>2</td>
</tr>
<tr>
<td>There are more words than pictures in <strong>power-point slides</strong>; this should be corrected.</td>
<td>1</td>
</tr>
<tr>
<td>Should explain every sentence given in the <strong>power-points</strong> in details</td>
<td>1</td>
</tr>
<tr>
<td>Use more visualization techniques in <strong>power-point</strong> presentations, for example, video clips, animations</td>
<td>1</td>
</tr>
<tr>
<td>Please share <strong>power-points</strong> in advance</td>
<td>1</td>
</tr>
<tr>
<td>Too much <strong>group works</strong>; two-way discussions in the plenary can be OK for some Sessions</td>
<td>3</td>
</tr>
<tr>
<td>Some of the <strong>group work</strong> instructions are not clear</td>
<td>3</td>
</tr>
<tr>
<td>For Case studies, please give local ones rather than international ones</td>
<td>1</td>
</tr>
<tr>
<td>Some Myanmar translations (for <strong>group work</strong> instructions) are not perfect</td>
<td>2</td>
</tr>
<tr>
<td>When summarizing the Sessions (after each <strong>group work</strong>), please give more examples from Myanmar’s context</td>
<td>1</td>
</tr>
<tr>
<td>Show references for the data presented</td>
<td>1</td>
</tr>
<tr>
<td>There are too many <strong>Session topics</strong> and too many <strong>group works</strong> requiring too many questions to be answered, making time management poor</td>
<td>1</td>
</tr>
<tr>
<td>There are too many <strong>Session topics</strong> squeezed into the two-day training. Should focus more on fewer topics and also giving more time for them.</td>
<td>1</td>
</tr>
<tr>
<td><strong>Workshop duration</strong> is too short; should give more time for group discussions as well as for the whole workshop; may need to extend to another one day.</td>
<td>11</td>
</tr>
<tr>
<td>Training Time Table is too tight</td>
<td>2</td>
</tr>
<tr>
<td>The first day program did not fit into the time frame set in the Time Table</td>
<td>3</td>
</tr>
<tr>
<td>Different backgrounds of <strong>Participants</strong> made some <strong>Participants</strong> unable to participate in group works</td>
<td>1</td>
</tr>
<tr>
<td>The number of <strong>Participants</strong> should be limited to 25</td>
<td>1</td>
</tr>
<tr>
<td>The <strong>training room</strong> is too small to accommodate the <strong>Participants</strong> (expression made at Lashio and Mandalay)</td>
<td>4</td>
</tr>
<tr>
<td>Lighting of the <strong>training room</strong> is too poor making the <strong>Participants</strong> sleepy (comment given at Mandalay workshop)</td>
<td>2</td>
</tr>
<tr>
<td><strong>Tea break</strong> snacks should be different</td>
<td>1</td>
</tr>
<tr>
<td>Should distribute <strong>stationaries</strong> to the <strong>Participants</strong>, like note books, clear bags, etc.</td>
<td>2</td>
</tr>
</tbody>
</table>
Need to include more **energizers** | 1  
---|---  
Understood more on how UHC, Equity and SDH are linked | 2  
The training focused more on SDH than on UHC. I want to learn more about UHC. | 6  
The most liked Session is the Session on Media Advocacy | 1  
A reward should be given to the Role Play Team (in the Session on Media Advocacy) that best performed the play | 1  
The training helps a lot for our organization. Learned a lot about SDH. | 2  
I want to train staffs of my organization (lower level staffs) on what I learned from the workshop, but with a simplified and modified version. I would like to get support for this. | 2  
Wants Training on:  
- Advocacy | 29  
- Community Mobilization | 5  
- Participatory Learning and Action (PLA) | 2  
- Communication | 4  
- Accountability, Equity and Inclusiveness | 4

It could be noted from the Table that “short workshop duration with a tight training program involving many topics” was one of the key complaints. Suggestions were also given on how to improve the ways power-points were prepared and presented. Expressions were made that they wanted to learn more about UHC and indicated training topics they wanted as: Advocacy; Community Mobilization; PLA; Communication; and Accountability, Equity and Inclusiveness.

The suggestion given by the two Participants for providing technical support to make the Training Manual into a simplified version for training of lower level staffs is noteworthy. This shows the enthusiasm of the Participants to disseminate the concepts and practices of UHC and SDH further.
5 CONCLUSION AND RECOMMENDATIONS

Creating and implementing a learning process where knowledge and practices were imparted focusing on the roles of INGO/CSOs in addressing SDH so as to improve health inequities and achieve UHC was successfully completed. During the learning process, all the participants participated actively and post-test evaluation results confirmed the effectiveness of the process. At the same time, gaps in the learning process were identified through the Participants’ positive critical comments and these need to be taken into consideration in similar training in future.

The details of the comments and suggestions made by the Participants should be taken into consideration to the possible extent in future training. This will necessitate modifications of the Training Manual and power-points to some extent.

From a broad perspective, and at the same time basing on the Training Evaluation results, and valuable suggestions and comments made by the Participants, the following recommendations are made:

- Participant composition should be made as homogenous as possible, as regards their background qualifications and ranks at their respective organizations, in conducting this kind of workshop which involve to a great extent of expressing critical views on the work performances by INGOs/CSOs and BHS at township levels;

- The optimum number of participants should be set at 30 the maximum for an effective participation and learning to take place. This also is in consonance with the Educational Science principles;

- Either the training duration should be extended to 3 days, or some Session Topics or some group work guidelines should be trimmed and kept at 2 days in future training workshops on UHC/SDH;

- The suggestion given by the two Participants for providing technical support to make the Training Manual into a simplified version for training of lower level staffs is noteworthy for providing necessary technical support.
Position Title: Senior Training Consultant - Social Determinants of Health and Universal Health Coverage  
Position: Consultant  
Level: Senior-level  
Type of Consultant: National  
Focus of consultancy: Myanmar  
Project: Program budget (88556) Component 3  
UNOPS Organization Unit: Myanmar Operations Centre (MMOC)  
Duty Station: In-country short term assignment  
Duration: Up to 29 days in-country assignment

A. Background
UNOPS is the Fund Manager for the Three Millennium Development Goal (3MDG) Fund, a multi donor fund supported by Australia, the United Kingdom, the European Union, Sweden, Denmark, Switzerland and the USA. The Fund was established in 2012 to provide support for health needs in Myanmar.

The three components of the 3MDGF are:
1. Maternal, Newborn and Child Health (MNCH) care. Increasing the availability and accessibility of essential services;
2. HIV, TB and Malaria. Support for specific interventions for populations and areas not supported by the Global Fund;
3. Health systems strengthening.

The detailed programme description is outlined in the 3MDG Fund Description of Action. UNOPS has been selected as the Fund Manager for the 3MDG Fund. The Fund Manager Office (FMO) is accountable to the Fund Board for a number of performance indicators, amongst which IP engagement through grants issuance, grants management and effective and efficient review of IP progress reporting on the implementation of the 3MDG, is a major responsibility of the FMO.

The 3MDG Fund follows an overarching goal to contribute to national progress towards the three health MDGs and universal health coverage through a rights-based approach. This means ensuring equitable access to health services, empowering women, engaging communities in decision making and implementation, ensuring the voices of minorities and other vulnerable groups are heard.

To strengthen this rights-based approach to health, the 3MDG Fund has been providing capacity building support for all of its partners (international NGOs and local Civil Society Organizations, including those who deliver programmes in some parts of the country where conflict has existed until recently, or is ongoing). Training and learning sessions will play a key role in strengthening the capacity of partners to contribute to a responsible, fair and inclusive health sector in Myanmar.

In this regard the 3MDG Fund is seeking a Senior Training Consultant to lead three workshops with 3MDG implementing partners on the social determinants of health (SDH) and Universal Health
Coverage, to expand knowledge, understanding, and capacities on these critical issues and policies in Myanmar. The emphasis of the training workshops will be on "applied skills', equipping 3MDG implementing partners with practical tools and resources to apply key learning within their health programmes and projects following the training sessions. The sessions must be informed by international examples and best practices of other countries that have addressed the SDH and have introduced UHC, along with the challenges and successes that have resulted from these approaches. It is expected that these training sessions will contribute to the 3MDG Funds' approach to Health for All and enhance 3MDG partners' understanding and practice of the principles of Responsibility, Fairness, and Inclusion and how these relate to UHC and SDH, to maximize the positive outcomes of 3MDG health programming in communities to achieve better health for all people in Myanmar.

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

i) Designing, planning and developing relevant, context-appropriate training course materials on SDH and UHC, using a Participatory Learning Approach with an emphasis on 'applied skills'.
ii) Discussion meetings with 3MDG staff on designing and facilitating the workshop and field based sessions.
iii) Conduct a two-day session with 3MDG programme staff as a 'pre-testing' session for the training modules, and adjust materials and training delivery as required based on the feedback of 3MDG programme staff.
iv) Conduct two, two-day training workshops in Yangon for 3MDG implementing partners (in November or December 2015).
v) Conduct two further workshops in Mandalay and Lashio customized for 3MDG implementing partner field staff (in early 2016).
vi) Utilise pre and post-testing methods to evaluate the effectiveness of each training session in enhancing 3MDG implementing partners' knowledge on SDH and UHC.

vii) Submission of Final Report with Findings and Recommendations.

It is expected that preparation of training materials will take up to 12 days; training sessions (including the two-day pre-testing session at 3MDG) will take a total of 10 days, travel time to the field will take up to 4 days, and final report preparation up to 3 days.

C. Deliverables
1. Develop appropriate training course materials on SDH and UHC
2. Deliver pre-testing session with 3MDG programme staff
3. Complete two, two-day training workshops in Yangon for 3MDG implementing partners.
4. Complete two further workshops in Mandalay and Lashio focusing on 3MDG implementing partner field staff.
5. Final Report with Findings and Recommendations

D. Academic and Professional Qualifications
1. Professional Qualifications

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

E. Functional / Behavioural Competencies:
1. Respect for Diversity: Shows respect for and understanding of diverse points of view and demonstrates this understanding in daily work and decision-making; works effectively with people from all backgrounds.
2. Planning and Organizing: Identifies priority activities and assignments, adjusts priorities as required; foresees risks and allows for contingencies when planning.
3. Client Orientation: Establishes and maintains productive partnerships with clients by gaining their trust and respect; identifies clients' needs and matches them to appropriate solutions.
4. Vision: Identifies strategic issues, opportunities and risks; clearly communicates links between the Organization's strategy and the work unit's goals; generates and communicates broad and compelling organizational direction, inspiring others to pursue that same direction.
Annex 2 Time Table

Registration: 8:30-9:00 am
Participants answer pre-test questions soon after registration

<table>
<thead>
<tr>
<th>Day and Time</th>
<th>Session Number and Title</th>
<th>Remarks/Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day 1</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 9:00-9:15 am | Opening Remarks  
Self-Introduction by Participants and Facilitators | |
| 9:30-10:00 am | Session 1: The meaning of health and key factors contributing to health outcomes | 2-way discussion in the Plenary |
| 10:00-11:00 am | Session 2: Social Determinants of Health (SDH) | Presentation and Group Work |
| 11:00-11:15 am | TEA BREAK | |
| 11:15-11:45 am | Session 2: Social Determinants of Health (SDH)  
Plenary Session | |
| 11:45-12:30 pm | Session 3: Sharing Experiences in Improving Health Equity | 2-way discussion in the Plenary and Group Work |
| 12:45-1:45 pm | LUNCH BREAK | |
| 1:30-2:00 pm | Session 3: Sharing Experiences in Improving Health Equity  
Plenary Session | |
| 2:00-2:30 pm | Session 4: Strategic Directions for Universal Health Coverage (UHC)  
Presentation by Facilitator | Presentation and Group Work |
| 2:30-3:15 pm | Session 4: Strategic Directions for Universal Health Coverage (UHC)  
Group Work | |
| 3:15-3:30 pm | TEA BREAK | |
| 3:30-4:30 pm | Session 4: Strategic Directions for Universal Health Coverage (UHC)  
Plenary Session | |
<p>| <strong>Day 2</strong> | | |
| 9:00-9:05 am | Recap | |
| 9:05- | Session 5: The Roles of NGOs/CSOs in Addressing SDH: Assessing | Presentations and |</p>
<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:00 am</td>
<td>SDH, Consciousness Raising and Locality Development</td>
<td>Group Work</td>
</tr>
<tr>
<td>11:00-11:15 am</td>
<td>TEA BREAK</td>
<td></td>
</tr>
<tr>
<td>11:15-12:30 pm</td>
<td>Session 6: The Roles of NGOs/CSOs in Addressing SDH: Health Promotion</td>
<td>Presentation and Group Work</td>
</tr>
<tr>
<td>12:30-1:30 pm</td>
<td>LUNCH</td>
<td></td>
</tr>
<tr>
<td>1:30-2:30 pm</td>
<td>Session 7: The Roles of NGOs/CSOs in Addressing SDH: Social Action</td>
<td>Presentation and 2-way Discussion in the Plenary</td>
</tr>
<tr>
<td>2:30-3:30 pm</td>
<td>Session 8: The Roles of NGOs/CSOs in Addressing SDH: Media Advocacy</td>
<td>2-way Discussions</td>
</tr>
<tr>
<td>3:30-3:45 pm</td>
<td>TEA BREAK</td>
<td></td>
</tr>
<tr>
<td>3:45-4:45 pm</td>
<td>Session 8: The Roles of NGOs/CSOs in Addressing SDH: Media Advocacy (Continued)</td>
<td>2-way Discussions and Role Play</td>
</tr>
<tr>
<td>4:45-5:00 pm</td>
<td>Closing</td>
<td>Answering Post-test Questions</td>
</tr>
</tbody>
</table>
Annex 3 Pre-test Questionnaire

You do not need to write your name. Just indicate your age (as of last birthday) and sex.

Age (as of last birthday)

---------  Years

Sex
Your sex: [ ] Female  [ ] Male

Past training received
Have you attended the following trainings before (please tick one response for each statement)?

(i)  Social Determinants of Health  [ ] 1 YES  [ ] 2 NO
(ii) Health Equity  [ ] 1 YES  [ ] 2 NO
(iii) Universal Health Coverage  [ ] 1 YES  [ ] 2 NO
(iv) Advocacy  [ ] 1 YES  [ ] 2 NO
(v) Community Mobilization  [ ] 1 YES  [ ] 2 NO

Awareness
Have you ever heard of the Nine Strategic Directions for Universal Health Coverage?
[ ] 1 YES  
[ ] 2 NO

Knowledge
(1) Is the following true or false?
Individual behavior is the factor that contributes most to health outcomes (Indicate ONLY ONE)
[ ] 1 True
[ ] 2 False
[ ] 3 Don’t Know/ No Response

(2) Which of the following factors are Social Determinants of Health? (Can indicate more than one statement)
[ ] 1 Income
[ ] 2 Education
[ ] 3 Physical Environment
[ ] 4 Social Support Networks
[ ] 5 Genetics
[ ] 6 Gender
[ ] 7 Don’t Know/ No Response

(3) Which of the following statements is TRUE? (Indicate ONLY ONE)
[ ] 1 Health inequity and health inequality is the same
[ ] 2 Health inequity results from biological factors
[ ] 3 Unfair social group differences in health outcomes are considered inequity in health
[ ] 4 Health inequities are the results of individual choices
[ ] 5 Don’t Know/ No Response
(4) The characteristics of a Civil Society Organization:
(Can indicate more than one statement)
[ ] 1 Social arena that exists between the State and the individual or household
[ ] 2 Possesses the coercive or regulatory power
[ ] 3 Lacks the economic power
[ ] 4 Provides the social power or influence of ordinary people
[ ] 5 “Third Sector” of society, distinct from government and business
[ ] 6 Don’t Know/ No Response

(5) An approach or approaches to address Social Determinants of Health:
(Can indicate more than one statement)
[ ] 1 Implementing health education program
[ ] 2 Forming Self Help Groups for the poor people
[ ] 3 Holding a press conference
[ ] 4 Demonstration in front of the Ministry of Health
[ ] 5 Don’t Know/ No Response
Annex 4 Post-test Questionnaire

(Section 1)

You do not need to write your name. Just indicate your age and sex.
Age (as of last birthday)

-------- Years

Sex
Your sex: [ ] Female [ ] Male

Knowledge
(1) Is the following true or false?
Individual behavior is the factor that contributes most to health outcomes (Indicate ONLY ONE)
[ ] 1 True
[ ] 2 False
[ ] 3 Don’t Know/ No Response

(2) Which of the following factors are Social Determinants of Health? (Can indicate more than one statement)
[ ] 1 Income
[ ] 2 Education
[ ] 3 Physical Environment
[ ] 4 Social Support Networks
[ ] 5 Genetics
[ ] 6 Gender
[ ] 7 Don’t Know/ No Response

(3) Which of the following statements is TRUE? (Indicate ONLY ONE)
Health inequity and health inequality is the same
[ ] 1 Health inequity results from biological factors
[ ] 2 Unfair social group differences in health outcomes are considered inequity in health
[ ] 3 Health inequities are the results of individual choices
[ ] 4 Don’t Know/ No Response

(4) The characteristics of a Civil Society Organization:
(Can indicate more than one statement)
[ ] 1 Social arena that exists between the State and the individual or household
[ ] 2 Possesses the coercive or regulatory power
[ ] 3 Lacks the economic power
[ ] 4 Provides the social power or influence of ordinary people
[ ] 5 “Third Sector” of society, distinct from government and business
[ ] 6 Don’t Know/ No Response

(5) An approach or approaches to address Social Determinants of Health:
(Can indicate more than one statement)
[ ] 1 Implementing health education program
[ ] 2 Forming Self Help Groups for the poor people
[ ] 3 Holding a press conference
[ ] 4 Demonstration in front of the Ministry of Health
[ ] 5 Don’t Know/ No Response

(Section 2)

Please indicate your agreement/disagreement with the statement below using the scale:
1 = Strongly Disagree  
3 = Somewhat Agree  
2 = Somewhat Disagree  
4 = Strongly Agree

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>YOUR SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABOUT THE TRAINING</td>
<td></td>
</tr>
<tr>
<td>1. The training objectives set were made clear at the beginning of the Training</td>
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<tr>
<td>2. The training objectives had been achieved</td>
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<td>3. The presentations were helpful for the participants’ learning</td>
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<tr>
<td>4. The methods of training used during the workshop were appropriate</td>
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<tr>
<td>5. Training materials were consistent with the training objectives</td>
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<tr>
<td>6. Training materials were adequate</td>
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<tr>
<td>7. The training flowed in such a way that learning was enhanced</td>
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<tr>
<td>ABOUT THE PARTICIPANTS</td>
<td></td>
</tr>
<tr>
<td>8. Most participants were active in the discussion</td>
<td></td>
</tr>
<tr>
<td>9. Most participants enhanced my learning process</td>
<td></td>
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<tr>
<td>10. There was a good collaboration in my group</td>
<td></td>
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<tr>
<td>11. Most of the participants were open to new ideas</td>
<td></td>
</tr>
<tr>
<td>12. I have had the opportunity to ask questions</td>
<td></td>
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<tr>
<td>13. I learned new things in the workshop</td>
<td></td>
</tr>
<tr>
<td>ABOUT THE FACILITATORS</td>
<td></td>
</tr>
<tr>
<td>14. Good knowledge of the topic</td>
<td></td>
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<tr>
<td>15. Enough content presentation</td>
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<tr>
<td>16. Appropriate teaching methodologies</td>
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<tr>
<td>17. Effective in motivating participants</td>
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<tr>
<td>18. Skilled in relating with the participants</td>
<td></td>
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<tr>
<td>19. Good listener</td>
<td></td>
</tr>
<tr>
<td>20. There was a good time management</td>
<td></td>
</tr>
</tbody>
</table>

**COMMENTS, INSIGHTS, LESSONS LEARNED ON THE WHOLE TRAINING INCLUDING HOW TO IMPROVE FUTURE TRAINING** (in English or Myanmar or both combined). Please also mention any of the Sessions (of this training) that you would like to receive training in more depths, or any other training topics that you would like to receive (in connection with SDH).