The Three Millennium Development Goal Fund
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Collective Voices

"Understanding Community Health Experiences of the Communities, Migrants and Vulnerable Peoples of Mudon Township, Mon State"

Bright Future – Stage 1 Completion Report

November 2015

3MDG IS MANAGED BY UNOPS

Acknowledgements and Disclaimers

We would like to thank the donors contributing to the Three Millennium Development Goal Fund (3MDG) for their kind contributions to improving the health of the poorest and most vulnerable people in Myanmar, particularly women and children.

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Abstract

This project is part of a community-based health system/ service delivery review to identify the real problems of health seeking behaviors among local communities, migrant populations, returnees and other internally displaced persons in different areas of Mon State. The project learned about the key social determinants of health by using participatory learning action (PLA) tools and conducting a series of community and health service provider consultations. The findings highlighted the social norms, cultural practices and superstitious beliefs that affect health-seeking patterns of community members in Mon State, and the gaps in understanding between health service providers and community groups that impact on effective health service delivery. The project team will now design Stage 2 activities in an effort to address these issues.

Contents

Acronyms

3MDG	Three Millennium Development Goal Fund
LNGO	Local Non-Governmental Organizations
CSO	Civil Society Organization
CBO	Community Based Organization
BHS	Basic Health Staff
CBO	Community Based Organization
IDP	Internally Displaced person
PLA	Participatory Learning and Action
GoM	Government of Myanmar
NSA	Non State Actors
THD	Township Health Department
TMO	Township Medical Officer
AMW	Auxiliary Midwife
CHW	Community Health Worker
VHC	Village Health Committee

About the project

Background

The Government of Myanmar is now working to achieve the targets for Millennium Development Goals (MDGs) 3, 4 and 5 which are related to HIV, TB and Malaria, Maternal Newborn and Child health. The Three Millennium Development Goal Fund (3MDG) supports the provision of health services in Myanmar and contributes towards the country's efforts to achieve the three health-related Millennium Development Goals. In partnership with the Ministry of Health (MoH), implementing partners, and community-based organizations, 3MDG strengthens health systems at all levels and improves access to quality health services for poor and vulnerable populations. In particular, 3MDG focuses on three key areas: 1) improving maternal and newborn child health, 2) combating HIV and AIDS, tuberculosis and malaria, and 3) strengthening the health system using a rights-based approach.

From the outset, the 3MDG Fund has committed to supporting Civil Society Organizations (CSOs) and communities as part of its rights-based approach and health systems strengthening measures. Collective Voices is an innovative initiative that reflects the notion that, in order for the objectives of 3MDG to be achieved, fundamental changes need to occur in the relationships between health care providers and the communities they serve, especially the poor and marginalized, to achieve improvements in service quality, access and utilization.

In March 2014, the 3MDG Fund announced the launch of a US$1.5 million initiative in partnership with six local organizations to improve the understanding of the social factors limiting access to health care, and to support a meaningful participation of community members for better services and consumer satisfaction. Collective Voices grants were awarded to six lead CSOs working in partnership with a total of 19 smaller community based organizations in March 2015.

Bright Future is one of the six organizations selected to receive funding to increase understanding of the cultural dimensions of health seeking behavior, and the conflict and health situation in Mudon Township of Mon State. Bright Future is partnering with three Community Based Organizations (CBOs): La Wee Mon, Rainmanya Charity Foundation and Hnee Padaw Education Support Group. The Stage I project duration is six months starting in March 2015 to August 2015 and this report is based on findings from Stage I.

Bright Future

Bright Future is a local Non-Government Organization (LNGO) situated in Nyaung Gone village, Mudon Township. Bright Future was founded on 1 July 2007 and the Executive Committee (EC) is composed of seven women. The total membership by June 2014 was 50. It was founded by the Mon Charity Development Group (Reinmanya Foundation) which was the social wing of the New Mon State Party, a key Non-State Actor in Mon, Karen and Taningthayi States. The LNGO was first recognized and licensed by the State Government in 2013 and an accreditation license was issued under the endorsement of the

Chief Minister to work in health and development areas without limitation in Mon State. The organization is solely not-for-profit and focuses on health and social related development.

Bright Future is currently working on care and support for people living with HIV/AIDS with its own community raised funds, and TB referral services for migrant workers after providing health information for better health seeking behaviour. Moreover, the organisation helps the migrant population to adhere to TB services by overcoming cultural dimensions and encouraging good health seeking behaviour in the area of Artemisinin Resistance Malaria.

In addition, Bright Future works on health information related activities including health education, selection of healthy food, psychosocial support and counselling for endemic communicable diseases in the community.

Partner CBO organizations

Bright Future took responsibility as the lead organization and the participating three Community Based Organizations are as follows:

1) La Wee Mon Community based organization (population coverage 18,000 in 9 villages)
2) Rainmanya Charity Foundation (coverage population 16,000 in 8 villages)
3) Hnee Pa Daw Community based Organization (Population Coverage 16,000 in 7 villages)

In each CBO, there is two team leaders and five to seven project staff participating in this project.

Executive summary of Stage I project

Bright Future received a 3MDG/Collective Voices grant disbursement of USD 50,000 to start operating, with the aim of collecting voices about health from the general community and marginalized populations. The project was implemented on the ground by Bright Future as the main lead organization, in partnership with three CBOs. The project intended to cover around 50,000 people from 24 villages of Mudon Township, mainly comprised of rural communities including hard-to-reach villages, migrant clusters, pregnant mothers, women and children, differently abled persons, elders and vulnerable ethnic communities under Non State Actors (NSA). The project Stage I duration was from March to September 2015.

The project was for both demand sides (the community) and supply sides (health providers). The project team did not only focus on engaging communities to understand their health behaviors, but also reached out to health authorities at the local community, township and higher levels. The ultimate goal of the project is to sustain the health services which are requested by communities and incorporate their collective voices into the planning of Township micro-plans, supporting the activities and future operations of demand side providers.

In Mudon Township, where the Collective Voices project was implemented, the total population is 190,247; out of which the male population is 89,872 and the female population is 100,375. The project coverage areas include Nyaung Gone, Kalaw Thaut and Kamarwat village tracts (covering 24 villages), situated on the outskirts of Mudon Township. The area has a slightly higher female population, and has a mix of ethnicities; predominantly Mon, but also Shan, Kayin, PaO, Kalar and Bamar. The main economy comes from farming, rubber plantations and seasonal crops. The main income of the family solely depends from the income of young people who emigrate to work in Thailand. The migrant population is gradually increasing due to the growing economy of rubber plantations.

The project target groups include:

1. General Communities
2. Reproductive Age Women
3. Adolescent and young people
4. Elderly persons
5. School age children
6. Pregnant Mothers
7. Mobile migrant workers
8. Mothers having children
9. Disabled people

At the beginning of Stage I, community meetings and provider meetings were conducted by preparing social and community mapping and health facilities mapping to understand social barriers which limit access to health services in the community and to increase the direct provision of health services (diagnosis, treatment and care) through community-level facilities such as rural and urban health facilities, station and township hospitals.

The project discovered a range of barriers such as the unmatched timing of health services to the available time of communities, lack of information on the schedule of health visits, lack of emergency referral systems, no youth friendly centres, weak communication with traditional healers who are the first health care provider most community members seek help from, and other local norms and concepts that delayed health seeking behaviors. The findings were shared at face-to-face workshops between the community and service providers. Stage II of the Collective Voices project will be based on the issues identified in Stage I.

Project rationale

It is essential to have safe, respectful communities where a range of health and social issues can be shared with respective health stakeholders. The project found that the general community, migrants and clusters of communities under the NSA find it hard to get the health services they need from the conventional health system. During Stage I, a series of community meetings and health service provider meetings were held, along with social consultations. They provided strong evidence of social and cultural barriers hindering access to health services by the communities.

Goal

The goal of the Collective Voices Stage I project was to understand the situation of health services in communities, including for migrants, and whether there is equitable access to health services regardless of socio-economic status (gender, education, age, ethnicity and religion etc.).

The specific goal of the Bright Future project was to have a two pronged approaches to communities and health services providers, to:

1) Mainly focus on understanding the health seeking behaviours, culture and language barriers of the communities in 6 villages of Mudon Township.

2) Advocate to Basic Health Staff, medics from Non-State actors and other health services providers to understand the local norms, cultures and dialect (essential usage of terminology) through face-to face meetings to provide more effective health services.

At the end of Stage I, the findings were presented to respective key health stakeholders, highlighting common health seeking behaviors among local communities and vulnerable populations.

Project purpose

The main purpose of the project in Stage I was to produce qualitative information identifying gaps and challenges, which can then be used to lobby respective health providers on behalf of vulnerable communities. This involved identifying the social determinants of health and getting detailed information by conducting community meetings with vulnerable groups and supply side service providers. Moreover, the project aimed to record the mobility of populations based on seasonal variety, noting the distribution of the health service delivery points for potential referrals to be established in Stage II.

The project also aimed to strengthen the capacity of local organizations to build upon areas of competency and interest, including representing communities and marginalized populations, and empowering the communities to explore innovative ideas and suggestions that come from practical evidence-based information about health care especially in relation to accountability, equity and inclusion.

In addition, the project expected to build the capacity of community stakeholders, including migrants, to continue supporting health services to access hard to reach communities. This included creation of a platform so that all information provided from the communities could be shared directly with health services providers to incorporate into township microplanning.

The detailed objectives of the project were as follows:

1) To observe the ground situation relating to equitable access to health services for all people regardless of their socioeconomic background (gender, education, age, ethnicity, religion etc.)
2) To understand the social and societal barriers that hinder access to health services, and identify the key social determinants of health in communities
3) To develop rights based mechanisms to be understood by community groups
4) To improve health seeking behaviours by upgrading health knowledge
5) To advocate to Basic Health Staff, medics from Non-State actors and other health services providers in the project areas to understand the local norms, cultures and dialect through counselling, and arranging face-to face meetings to efficiently provide health services

Long term objectives are:

1) To contribute to a reduction in unnecessary, unexpected mortality and morbidity due to delayed health seeking based on poor knowledge of health issues and health services

2) To reduce the stigma and social determinants of health within communities so that people can get healthcare on time
3) To increase knowledge on basic healthcare, and increase the reach of health services by better understanding the voices of the communities

Project strategy

The main strategy was advocating to the demand side (community users) and supply side (health care providers) to conduct community and provider meetings using Participatory Learning and Action Tools (PLA), and participatory mapping of community residences, migrant and mobile clusters, health facilities, private health providers, and traditional healers to identify social barriers which limit access to health services, and to inform health service providers of those issues to enable increased access to quality health services.

At the same time, the project made partnerships with local CBOs to strengthen their capacity. The voices of the communities and health providers, their common health experiences, and the key issues and challenges were discussed to inform new policy and planning that includes participation of stakeholders through a community engagement approach.

Bright Future explored the experiences and issues of the communities and health providers by conducting community meetings, provider meetings, and face-to face workshops as well as migrant and seasonal mapping to understand the prioritized community challenges in getting health services, and health provider's difficulties in delivery of health services. Minor issues on information gaps were solved during face-to-face workshops.

Thematic areas

Proposals for Collectives Voices funding were required to fit within at least one of five thematic areas identified below.

- Theme 1 – Gender and Health
- Theme 2 – Cultural Dimensions of Health Seeking Behavior
- Theme 3 – Conflict and Health
- Theme 4 – Age, disability and health challenges
- Theme 5 – Health information

Bright Future Stage I Collective Voices activities addressed mainly the following thematic areas but also promoted other areas: Theme 2 - Cultural Dimensions of Health Seeking Behavior, and Theme 5 - Conflict and Health.

Cultural dimensions of health seeking behavior

For the cultural dimensions of health seeking behavior, the project planned to explore the behaviors that hinder access to health services in the area of prevention, investigation and case management. This included the health knowledge of household mothers about safe motherhood, prevention of seasonal endemic diseases, and how to get a referral for severe cases to appropriate health service providers on time.

Another activity was to advocate to health care providers to strengthen their understanding of local customs, norms and issues of conflict and health so that health services can more effectively reach the most vulnerable populations. The health service providers were also informed about the key local dialects through the main LNGO and its three allied CBOs. At the end, the two groups (health service providers and community) were mobilized to create a platform together to address demand for services by working together in a regular face-to-face workshop.

Conflict and health

The project is based in the former brown zones of Mon State where there were clusters of conflict between the Myanmar Army and ethnic militia groups. Because of this, there were many displaced persons leaving their homes (often fleeing to Thailand) to avoid the conflict. The project planned to reach these former IDPs and returned refugees who have missed out on formal health services. They returned from refugee camps in Thailand because of Myanmar's political reforms and the partial success of peace talks. Moreover, the project indirectly reached out to communities under the administration of Non-State actors (NSA) through medics from the NSA. We have started (and will continue) to explore the psychological and social impacts of armed conflict on communities and how to strengthen transparency and accountability to get ideal health services to them. The project is also strengthening monitoring and evaluation of health services in armed conflict zones by using local volunteers.

The project explored any condition of disability due to mine injury or other armed conflict accidents, and assessed the demand for health rights and services from disabled and marginalized populations. To add further value, the project also explored the health demands and needs of vulnerable ageing people, since most villages have a remaining ageing population while young people have gone across the border to Thailand to find work. Moreover, at the end of stage I, health information was shared to such communities through volunteers by localized education, health talks during outreach sessions, and by setting up central speakers in the village to share health messages to overcome cultural barriers, improve health seeking behaviors, and understanding of the implications of conflict on health.

Design and tools

Stage I project design and PLA tools

We reached out to health authorities at the local, community, township and higher levels, asking questions, holding mutual interactive discussions, sharing experiences and providing feedback on the issues raised by communities during community meetings.

The project design helped to identify health problems related to cultural and social practices during community meetings. During these meetings, information on health services distribution, migrants and marginalized populations were identified. PLA tools were used to assess the ground situation and health needs of communities in project villages.

Maps and diagrams were used to see the areas of coverage and to get a consolidated understanding. There was a range of information put onto the map: social issues (places of poorest households, of local spiritual persons, traditional healers, and health posts, migrant's habitats, and the seasonal mobility of people, movement of returnees, emigrants who crossed the borders, and mobile populations in Mudon). Moreover, the **Transect method** was tested by volunteers to discuss the health challenges with interested persons and key informants on his/her way throughout the village.

Seasonal Calendars and **Time trends** were also put on the map to understand people's movement related to rubber and other plantations. **Timelines** of routine life for risk groups were also discussed and how best to approach health services to reach such communities.

During Stage I, the community meetings collected health seeking behaviors in the community, social determinants of health, and services from different types of providers (1) Private practitioners, (2) BHS, (3) traditional healers, (4) pharmacy attendants and (5) village health volunteers by using PLA tools. The project also used a multi-disciplinary team who were involved in orientation training, designing the Stage I project, designing PLA tools and facilitating community meetings with selected PLA tools. Then, the findings were compiled, recorded and analyzed.

Community meetings

A total of 72 community meetings were conducted, led by Bright Future and its three CBO partners. Community meetings targeted different groups: Group (1) for the general population and young people, Group (2) for village elders, other risk groups and Group (3) for pregnant mothers, lactating mothers, women of child bearing age and married women. There were separate sessions with migrant groups and other ethnic minorities.

The community meetings were warm, informal, frank and transparent. The community meeting facilitators were trained by Bright Future's consultant team. Before these meetings, the local health authorities were informed and participated in brainstorming on the design of the meetings.

During community meetings, the questions asked to community members were about their social behavior, culture, gender, conflict issues (stigma and discrimination), marginalization and isolation etcetera (the questions used are presented in the Annexes). The main issues discussed were reproductive, maternal and newborn health, elderly care, communicable and non-communicable diseases.

The community meetings found challenges in every step of the sequence of health seeking behaviors. The meetings also covered the referral mechanisms for emergency cases, perceived steps of healthcare management by communities; treatment linked to informal sources (pharmacy, grocery stores), traditional healers, non-formal health providers; health seeking behaviors from vulnerable people (old age persons, people with disabilities, child bearing mothers etc.) for common priority diseases (non-communicable diseases, communicable diseases, localized priority health issues, RMNCH).

The meetings also identified gender imbalance issues, lack of health information and other localized challenges due to instability of the region by armed groups. Due to its sometimes sensitive nature, some information was difficult to ask about or probe at during the community meetings. Frequent trainings and rehearsing practices made the team more skillful in probing and creating more interactive discussions.

In some community meetings, community members suggested possible solutions for not getting timely health services (e.g. it is difficult for rubber plantation workers to attend to the outreach sessions of Basic Health Staff who normally come during the daytime office hours when the workers are busy with their job). The mapping also found that in most coverage areas (out of 24 villages), most have either a non-active health committee or no health committee at all. Especially in migrant clusters, there is no such committee or group.

Provider meetings

A total of 48 provider meetings were conducted, meant for cross-sectional supply side health personnel such as basic health staff (BHS), doctors from township and station hospitals, medics from non-state actors, privately running retired health providers, community health volunteers (CHW), traditional healers in communities and migrant clusters and village health committee (VHC) members. The main points discussed during meetings were their perspectives on health seeking behaviors by communities and health challenges.

The key issues identified were customs and cultural issues related to accessibility of getting health information and services. The providers shared their experiences linked to curative care and retrospective experiences of patients who came to health facilities as a last resort. When the meeting explored the reasons for poor access to health services, most issues were linked to cultural and superstitious norms, myths, language barriers relating to health promotion (as health information messages in pamphlets and posters are mostly written in Myanmar).

Service providers felt that another barrier was that they did not get the full commitment and support from the communities for their service delivery. There were other issues shared by health providers like gender discrimination, and lack of cooperation and coordination among health service providers. Provider meetings also brainstormed about reducing these challenges. All the suggestions were noted down and provided in feedback to communities during a face-to-face workshop which was held at the end of Stage I.

The project continued to hold meetings to review the level of understanding of local dialects and customs by health care staff; and to convince the health staff to learn about cultural barriers. Moreover, the project team helped them learn minimum local language terms, and the consequences of conflict related to health matters. Activities were created for new basic health staff to learn about health seeking behaviors, cultural barriers, and conflict consequences for Mon and ethnic minorities. In future, new health personnel will be assisted by the local CBOs to learn Mon and other ethnic dialects.

The project organized both community meetings as well as individual supply side discussions with BHS from rural health centres and sub-rural health centres, medics from NSA, health staff from Myanmar Military to review the health communication strategy, improvement of posters, pamphlets, bulletins, and journals related to health, and then reconsider how to translate these into local languages. The project made them culturally appropriate and customized to get local understanding by different target groups.

Face-to-face workshop

At the end of Stage I, one face-to-face workshop was organized by Bright Future. The main aim of the workshop was to get mutual understanding between communities and health providers and ensure they are on the same page. It had the following objectives:

1. To inform health authorities about the health and social challenges of communities and find ways to work together for better health services
2. To share health seeking experiences and health services information and up to date health messages to communities through its leaders and stakeholders' organization
3. To get general advice from communities for health planning, operation of services, and efficiency of health services

Health service providers, community representatives, local NGOs, CBOs, township health and administration personnel attended the workshop. During the workshop, project findings on the social and traditional practices related to health behaviors among communities, health seeking behaviors of migrants, cultural and local norms related to health seeking practices, the language related health barriers, gender related norms among local communities, migrant and vulnerable population were shared and discussed.

Some issues such as information gaps (communities don't know particular health provider's plans and schedule to visit particular villages for routine outreach sessions) were also discussed. Some issues were easy and solved on the spot, right away at the workshop by reorganizing the schedule of health services delivery, presenting and providing education about the consequences of delayed arrival to the health centres and its adverse outcomes to the communities during outreach and HE sessions. Some suggestions and recommendations from both sides were shared, including the importance of new BHS being aware of the culture of the community, developing community engagement as part of micro-planning, and participation and representation of community people and NSA in formal health committee meetings.

IEC materials (pamphlets, posters) and vinyl paper with health information are now being produced to inform communities about the schedule of health services, and to provide updated information on issues for which they have weak health knowledge, as discovered in community meetings. These IEC materials were produced after consultation and guidance from health providers based on the facts from standardized guidelines and protocols.

Stage II of the project will be designed to implement further relevant activities, including holding community meetings, health education campaigns, festive booths, providers' meetings; face to face workshops and outreach facilitation. Ultimately, the project aims to support the community to have healthy and prosperous lives by improving their access to timely, comprehensive health services.

Outcomes and Outputs

Project outcomes

The main outcome of Stage I was gradually increasing awareness of health challenges in accessing primary health care by the implementing organizations (lead NGO and three allied CBOs), equipping them to implement health-related activities in Stage II. The project team practiced sharing the findings about the social determinants of health and other key thematic areas during face-to-face meetings and at a booth display at the Myanmar Health Forum in 2015, which included both a local and international audience.

During meetings with key populations, the community discussed different ways to present these issues to the authorities and setting up a relevant reporting mechanism. The level of understanding and trust was improved between the communities and service providers as a result of Stage I activities.

Project outputs

Stage I mainly focused on assessing the health needs of communities. From the findings of community meetings, provider meetings and migrant mapping conducted in stage I, prioritized and feasible interventions were selected for implementation in Stage II. The findings were assessed together by Bright Future, its three allied CBOs, and the consultant team. The group considered whether the information provided was reliable, credible and accurate. All the collected information from community meetings was compiled.

Bright Future is built as a multi-disciplinary team composed of project staff, CBO leaders, NGO project management committees, a team of consultants and volunteers. All members were involved in the design of the community meetings, data collection, review and analysis of the information. Women were at least half of overall multi-disciplinary team. In total, community meetings were conducted 72 times in 24 villages and provider (public and private) meetings were conducted 48 times.

Title of Activities	Target	Achievement	Remark
Community Meeting	72	72	2 community and 1 migrant session for each village
Participatory Mapping for population distribution pattern; health facilities and natural	48	48	1 for village community and 1 for migrant for each village

barriers			
Timeline Calendar for providers, village communities and migrants	48	48	1 for village community and 1 for migrants for each village
Provider Meeting	48	48	1 for public government health providers; and 1 for private providers/ traditional healers

Findings

Overall common findings from community and provider meetings

1. Low levels of community trust in Health Service Providers.
2. Low levels of health knowledge in communities.
3. Few health service providers reaching communities including migrants.
4. Weak community access to health information.
5. No involvement of communities in health planning processes and weak coordination of health services among health providers (government health staff, NGO staff, private practitioners, military health staff, and medics from Non-State Actors).
6. Delayed health services due to social norms and cultural practices.
7. Unmet needs in RMNCH, Communicable Diseases, Non-Communicable Diseases and locally borne diseases.
8. Training needed for health staff (e.g. interpersonal communication skills, strategic micro-planning at health facilities level, community mobilization, stakeholders mobilization; advanced technical training on Basic Emergency Obstetric Referral, integrated management of childhood illness, setting up referral mechanisms, and some advanced training on locally borne priority diseases.
9. Need for logistics and supplies for certain health commodities.
10. Gaps in sanctioned staff. The health facilities have a structure of sanctioned positions/organogram (e.g. 1 HA, 1 LHV, 2 MW, 2 PHS II etc.), but in some remote facilities, due to the transportation and terrain challenges, not all of the sanctioned positions are filled. The existing staff at that facility bears the burden of covering tasks that would be conducted by the missing sanctioned staff and often become over-burdened. It would be great if the health facilities provided basic health education training to volunteers, stakeholders and to our CBOs to delegate some HE activities in remote hard to reach areas inaccessible by BHS.
11. The unmatched timing of health services provision to the available time of community members, and lack of information on the schedule of health visits to communities.
12. Lack of emergency referral systems.
13. No youth friendly centres.

"We have cases of rabies and due to lack of health knowledge, no one knows what it is and the patient was brought to the monastery. The monk gave him religious prescription and reciting prayers. But finally the patient died. There are similar cases like this, with people finally dying without getting any anti-rabies treatment"

14. Poor communication with traditional healers, who communities seek help from in the first instance when requiring health care.

"As *health information is written in Bamar language in posters, pamphlets or notice boards, for us, we find it difficult to understand and follow some messages. We wish to get health staff who could communicate in Mon language fluently*".
Community meeting participant from the village elder group

"W*e normally go to the grocery store to take anti-pyretic and anti-inflammatory medicine. The composition of drugs was prepared by the shopkeepers. It costs less than seeing doctors and health staff. We only go to the clinic if we are not relieved by the composite drugs from the grocery store*". **Community meeting participant**

"*For me, I tried to cure by myself taking traditional medicines at home. Here, at home, I'm the practitioner for my family. We only go to the traditional healer if the fever has not subsided or ailment is not relieved*". **Community meeting participant**

"*Here, in our community, we, women decide about seeking healthcare by family members. As our husbands are busy with their own businesses (even sometimes they travel and stay in plantation sites for long periods), we are the ones who decide the treatment of ailment for family members*". **Community meeting participant**

Findings from community meetings

The key findings from the community meetings were strongly linked to the social determinants of health. Most were linked to traditional superstitious, spiritual practices and religious prescriptions for ailments. Normally, the traditional healing practices are performed when there is mass cumulative illness. Moreover, some families rely on the roadside pharmacy and traditional herbal medicines as the first resort of treatment. They use boiled betel leaves and medicinal salt for curing minor ailments. In one case, a spiritual leader removed the evil spirit from a 14-year old by violently hitting her back until the girl fainted.

"*I always put a few drops of urine into the eyes of my son, whenever he has red eyes*".
Mother of a five-year old boy

Preventive knowledge was quite low among the interviewed communities and they tended to get treatment when the ailment becomes worse. There were cases of drug addicts among young returnees from Thailand.

The community identified cases where people with snake bites were given local traditional treatment, e.g. the wound of the snake bite was healed with ground rice and the patient was fist fed chili pieces and chili powder before being sent to the nearest health facilities. The communities do not have basic

first aid knowledge and they are in dire need for preventive health knowledge. The local treatment for epilepsy is a spoonful of salt. Some returnee youngsters had contracted HIV and there was nobody who could properly direct them to get the correct drugs.

> "*Community needs health knowledge as well as drugs and treatment by skillful personnel*".
> **Village elder, community meeting participant**

Other health seeking behaviours are linked to language barriers. Many community members in Mudon Township only understand some common words of Bamar and when they are in urban tertiary hospitals, they cannot explain thoroughly to the doctors or nurses about their history of illness.

> "*I don't speak Burmese language very well and sometimes I don't understand some words and phrases. So I said one thing wrong at that time and I was shouted at and scolded*".
> **Mother who joined a community meeting session**

Due to difficulties in proper communication with health staff at tertiary hospitals, the communities typically have to hire a broker to communicate with health staff on their behalf. The worst scenario is when there is an emergency; they do not have knowledge on what to do but have to follow the decision of the brokers which is costly and disempowering.

For chronic cases and elderly persons, the target group suggested that "*it would be good if there is a volunteer group who can visit to the house of people with disabilities and elders so that they are not neglected*". An elder explained, "*we need social and spiritual motivation and we want somebody to whom we can ask updated health news*".

Regarding the lack of a funded referral system, communities explained that they often borrow money from employers or take small shop loans with huge interest rates, using their belongings as collateral.

"*I did borrow money from the village rich people with interest of 20 kyats per 100 for treating the ailment of my child. After he recovered, we couldn't return all we borrowed and our small house kept as collateral was lost***"**.
Mother whose child was treated for Acute Respiratory Infection

There are many similar scenarios found in community meetings, where patients have been discharged from hospital and they could not afford to pay back the collateral, finally giving up their belongings. Furthermore, for the transfer of patients to tertiary centres, they often have to hire private cars nearby at high expense. Some big villages have received donated ambulances but there were no drivers. The communities during these meetings realized that they need to have a proper, financed referral mechanism to save extra charges and ensure they reach health care when needed.

On the issue of gender, there appear to be many hidden issues in communities, including violence against women. Some community members described instances in which, during the critical illness of his

wife, the husband had neglected her and ran away after selling common family belongings as well as abandoning the children. One woman during the meeting explained about the experiences of her neighbor who committed suicide during the first two months of pregnancy due to because she could not withstand the ill-treatment by her husband. "*She committed suicide because she couldn't withstand any more the cruelty of her husband who used to hit her after he was drunk every day*". There were also stories the other way round, with wives said to be neglecting their husbands when ill due to severe disease.

Findings from provider meetings

Providers also shared their experiences as part of this project. For example, they observed that RMNCH services are a key need for communities, especially the hard to reach migrant population. In relation to the consequences of conflict, it was found that due to the prolonged conflict between Ethnic Mon Militants and the Government Army, local communities still do not easily trust the government health system (including BHS), preferring to use ethnic traditional healers especially in far remote ethnic minority areas.

Similar to the findings of the community meetings, the providers mentioned the varieties of cultural practices and customs followed by communities to get remedies and be cured.

> "*For the remedy of red eye, they often add dangerous unknown powders given by traditional healers into the eyes. The drug doesn't have any registration. As a result, the patient was about to lose part of their vision and was sent to an eye specialist*".
> **BHS participant in provider meetings**

> "*The ancestral practices are still being used by communities like sitting on a hot brick after applying turmeric during the puerperium*".
> **BHS participant in provider meetings**

The providers explained that the communities often don't know there are many free of charge services in Township Hospitals and other health facilities, especially for maternal newborn and child health and they really wish that Collective Voices organizations could play a role in passing this message along to communities. The meeting also explored the need for more coordination among various health services providers for greater efficiency, economic value and effectiveness of health services.

The providers argued that they are quite enthusiastic and willing to develop health care knowledge and practices in their respective communities, for example they would like to provide advanced health education for potential threats and outbreaks.

At the provider meetings, some of the ad hoc and solvable issues raised by the communities were shared with individual providers for immediate action. Policy level issues were compiled and forwarded to Township health personnel, some of which were acted upon at the Township level and others that were passed on to the State/Region and Central levels. For example, local issues like reorganization of outreach plans of BHS to cover more migrant clusters were raised during the meeting. The issue was brought to the TMO and finally, after discussion, it was agreed by the TMO for the BHS to work together with the CBOs to facilitate increased health coverage through Health Education. Some policy issues like routine screening of NCDs (diabetes, and hypertension) to over 50 year olds were also discussed to prevent adverse outcomes of NCDs. Though there is no policy yet for covering 50+ adults for NCD screening, it was brought to the central level, based on the communities' voices.

Based on key findings relating to social issues and health seeking behaviors, the final face-to-face meeting provided an opportunity to solve key problems that could be managed by the health care providers.

Challenges and lessons learned

1. One key challenge is that sometimes community members do not show up to receive scheduled health services in their village due to other priority commitments, such as working in rubber plantations throughout the day.
2. Another challenge was the huge traveling distance required to reach migrant clusters for the Collective Voices community meetings (especially during the rainy season).
3. It was also necessary to get permission from the owner of the plantation. There was also a delay in organizing community meetings for migrants, because sometimes the employers of migrant workers didn't allow the employee workers to meet our teams and we had to wait until their completion of their routine jobs.
4. There were some difficulties encountered in dealing with health personnel from the non-state actor government. Permission was also needed to meet medics from Non-State Actors (NSA) but finally we did well for our community and provider meeting sessions by intensive coordination with NSA senior personnel.
5. There were some project implementation challenges – for example, we originally assigned only two note-takers for to record the voices of community during meetings, but this was actually not enough and we needed more than anticipated.
6. It was sometimes difficult to organize community meetings for migrants due to their mobility. They were on the move around the region, making difficult to catch up and follow up.

Recommendations for the way forward in Stage II

1. The project should set up a partnership between health providers (government health department, Non-State Actor health authorities, private health providers) and communities and other stakeholders (local CBOs, charity organizations, administrative authorities, volunteer groups and other interested bodies).
2. Based on the relevant findings of Stage I, the project should develop and produce standards for culturally appropriate materials and compliance mechanisms in line with Myanmar's Universal Health Coverage approach.
3. The project should form a project leading committee to review any disparities in health among ethnic people in Mon State.
4. The project should facilitate the participation of communities in health planning (developing a plan of action), execute actions to improve the operation of health services (e.g. training, community-based efforts in outreach, education and orientation) and conduct participatory review and monitoring for assessing health inequities and cultural competency.
5. The project should continue to develop awareness of health rights and entitlements of communities across a wide range of health issues, including a comprehensive health package at each level of healthcare.
6. The project should work with young people and encourage greater men's involvement to actively promote gender equality and violence prevention. This will include activities such as advocacy, development of policy, facilitating learning opportunities, networking with global entities, and facilitating women's empowerment in project planning and household level decision-making.
7. The project should share health information reciprocally between communities and health care providers through awareness raising campaigns on priority health issues.

For the supply side (health care providers)

a) Cross-learning from one BHS cluster to another cluster, to understand locally innovative approaches in the delivery of health care.

b) Effective outreach services with support from village committees, Collective Voices Partners and community representatives.

c) Periodic meetings with stakeholders to provide feedback on issues raised by communities.

d) Festive activities promoting key health messages to attract vulnerable groups (e.g. young people, migrants, returnees, communities under Non-State Actors).

For the demand side (health service users)

a) Planning, re-activation, and revitalization of Village Health Committees; on-site coaching for leadership.

b) Efficient Health Education and Outreach Sessions of BHS supported by Village Health Committees, volunteers, and project health staff.

c) Participation in a community mobilization campaign led by BHS.

d) Establish a referral mechanism managed by Village Health Committees, community leaders, project staff and volunteers so that emergency cases reach health facilities on time.

e) Providing training for counseling to be used for telephone counseling and giving advice. We will set up a telephone counseling service for sexual and reproductive health problems among young people with the support of the Central Health Education Bureau (CHEB) from Nay Pyi Taw together with locally recruited volunteers. The staff from our partner CBOs will have a schedule to work with BHS and volunteers from Youth Corners which are going to be set up in Kawtparan and Kalaw Thaut. The attendants will be trained on SRH counseling by advanced trainers from CHEB. The ultimate goal of revitalizing Youth Corners is to mobilize young people (either migrants or returnees from Thailand) to be equipped with SRH knowledge to prevent unwanted pregnancy, abortion and prevention of STI and HIV infection. The CBO staff and interested volunteers (including VHW and AMW) will get the training on SRH.

f) Cultural Orientation by project staff to newly appointed health staff, in particular to strengthen their understanding of the ethnic people in the Township and to work effectively and sensitively with them.

Detailed planning will include setting up youth related activities (festive booths, youth centres (with ICT facilities), a mobile library, using the Village Common Loud Speaker System for health messages, a project hotline for collection of suggestions and complaints, digital technology and interview style performing to understand and enhance the knowledge related to health issues. We will also organize a festive booth at community health fairs to develop knowledge on priority health issues (including but not limited to RMNCH) among local communities and vulnerable communities.

From Stage 1 consultations, we realized that some hard to reach migrant communities cannot access health information due to lack of electricity. For these areas, the project team will either physically show up or communicate through mass media and/or locally based FM channels.

Future suggested activities by both providers and communities

1. Provide health education to the communities with the support of community stakeholders
2. Organize health education and community mobilization campaigns at festive events
3. Overcome the issues of low levels of trust towards health service staff - through communities and migrants, community organizations and village committees working together with health staff for efficient health service delivery based on suggestions of communities

4. Collective Voices organisations work together with pregnant mothers and communities to improve heath knowledge by working together with health staff.
5. Create health education and prevention messages in advance of potential outbreaks or seasonal occurrence of diseases.

Conclusion

The project findings were quite comprehensive and useful for planning and designing our project for Stage II. Moreover, the project shared the voices of the communities to wider audiences beyond the project townships, including government health authorities, I/NGO senior personnel, National Health Committee members, UN and development partners, professional societies, and health and social activists during the Myanmar Health Forum in July 2015. As a result of Stage I, community members have increased their capacity and understanding of how to communicate with decision-makers.

Bright Future's project implementation created a strong relationship with local communities, minorities and marginalized populations in the Township area. The project explored gender equity among vulnerable communities, rubber plantation workers, migrants, returnees, and young people. It also considered the social inclusion of all stakeholders including ethnic organizations, along with community engagement and participation through coordination with civil society, local ethnic based organizations and community based organizations. In this way, the project raised the social increased their readiness to support health services either by government or non-state actors.

In conclusion, the Collective Voice Stages I project collected many of the cultural norms, myths and practices of the communities and their health seeking behaviors, particularly in project villages and nearby migrant clusters. For Stage II, the project will keep its momentum and widen its scope to support community participation in health micro-planning undertaken by the Township Health Department, and support health staff from government, Non-State Actors and private health providers ultimately to achieve better health outcomes for the people of Mudon Township.

Annexes

Annex 1: Structure of Collective Voices organizations

Bright Future (Local Non-Governmental Organization) is the main lead organization.

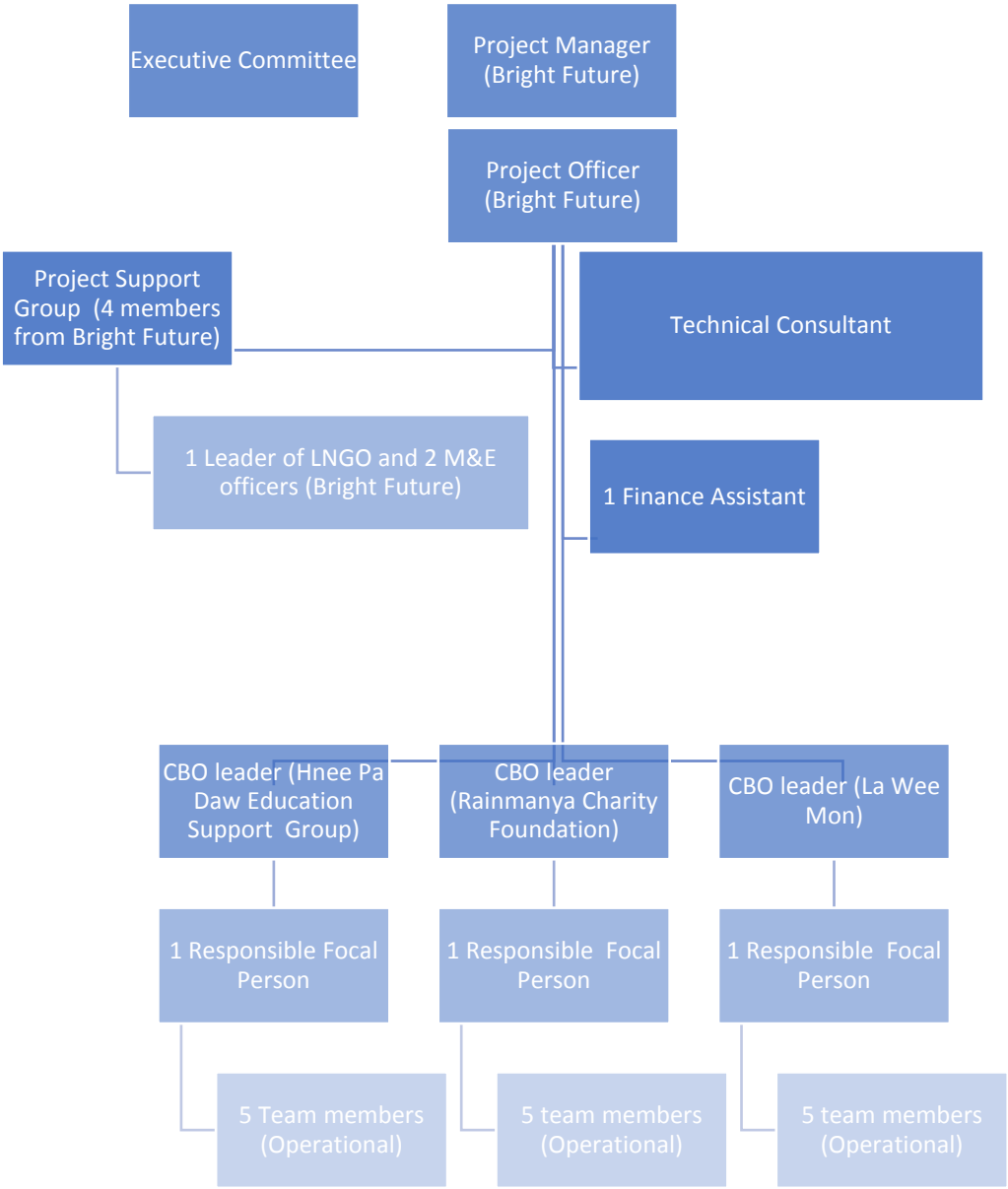
Three Allied CBOs are:

1. La Wee Mon (Community Based Organization)
2. Rainmanya Charity Foundation (Community Based Organization)
3. Hnee Padaw Education Support Group (Community Based Organization)

All three sub-organization CBOs are composed mostly of Mon ethnic people. They understand the cultures, norms and social impact for Mon people more than any outside person or organization, and they are in a good position to sustain such services as locally based organizations.

By combining LNGO and CBOs working together, the project will be quite successful in all proposed areas especially overcoming the cultural dimensions for health rights, overcoming conflict, and better health seeking behaviors.

Annex 2: Project organogram



Annex 3: Matrix of findings - communities' first health services delivery points

General Ailment	Traditional Healers/Home-based Medicine	Social, Cultural, Spiritual Leader	Roadside Pharmacy; Grocery Stores	Trained Private Practitioners, Public Practitioners from Ministry of Health
Elderly	4	2	3	1
Disabled	3	1	2	4
Reproductive age Childbearing Mother	2	1	3	4
Young people	2	1	3	4
Migrants	3	2	4	1
Total	**14**	**7**	**15**	**14**

This information comes from the consultation with random target groups during community meetings. Such questions were not asked routinely every meeting. These are the results from questions on how the risk groups seek their health care, from whom/ from where etc. From this, we can assume that communities mostly rely on roadside pharmacies over other practices. The highest number of respondents said that the elderly normally get treatment most from traditional healers; disabled from trained private practitioners, reproductive age mothers seek health from practitioners, young people as well seek health from practitioners, and migrants rely on roadside pharmacy and grocery stores.

Annex 4: Questionnaires used in provider meetings

Questionnaires for Health Providers

1) What are the major difficulties in providing health services to 1) communities and 2) Migrants?
2) What are the most common diseases or health events you found among 1) communities and 2) migrants?
3) What are the major barriers in communication to local ethnic communities?
4) Who else is providing health service in your project areas?
5) What should we do to reach health services to needy communities and vulnerable populations?

Demography and Epidemiology

- What are the common diseases in this area? What diseases have you ever heard of frequently?
- What are the common seasonal diseases?
- What are the common diseases in pregnant mothers?
- What are the chronic diseases in this area?

For general ailments

- Do all the patients come and get treatment from you?
- How long did they take to see the health staff after onset of fever?
- What are the reasons not coming to see the health staff?
- When the patients come, what are the package of treatment services?
- What do you think are the treatment options for those who don't come to formal health services at your hospital or health centers?
- Are there any traditional treatments taken by communities before coming to your clinic?
- What kind of traditional and spiritual treatment they had taken?
- How do they manage to take local healing remedies?
- How is the communication between you and the clients?
- What are the further treatment if they are not relieved by your limited treatment?

For Emergency cases

- Do they usually come to you for emergency treatment?
- Do you always see the patient at any time they want?
- Do you go particularly to client's house?
- Is there any other places relied by the communities for getting emergency treatment?
- Why don't the communities come directly to you?
- Are there any difficulties for them to come directly to formal health services?
- Is there any mix of getting formal treatment together with traditional spiritual remedy?
- Is there any problem do you think when they come to your clinic?
- What do you think how they overcome such problems before reaching to your centers?
- How do you judge their health knowledge?
- Do you also provide health education?
- How often do you provide health education?

Health Education and Preventive Practices

- What are the reasons when you couldn't provide HE?
- Are there any support from communities for your health education? How? Why not?
- How is the cooperation and coordination between you and communities?

- Is there any problems in communication? What are the problems?
- What kind of support you need for this?

For Chronic Diseases

- Are there any chronic ill cases in your clinic?
- What kind of patients come and see you?
- Who are not coming and see at the clinic out of chronic cases?
- Are there any traditional practice treatment you have heard from here?
- Which kind of traditional remedy?
- What are the problems for them?
- Are there any health education for chronic cases?
- How do you want to suggest for chronic cases?
- What are the main challenges for you when you treat chronic cases? How do you usually solve?
- For related to Traditional cultural practice and Gender discrimination
- What are the risk behaviors in healthcare seeking and how do you do to be better?
- Who decide for ill child at home for seeing at Pediatric Clinic or Pediatric Doctor?
- Who decide for AN care and to see health staff?
- Regarding health knowledge
- How do we do to increase the health knowledge of this communities?
- What kind of help you would request from these people for better health knowledge by communities?
- What do you help to increase the health knowledge of communities?

Annex 5: Agenda for sharing findings of Collective Voices health project (face-to-face meeting)

Place: Yae Pyar Kan Multi-Function Hall, Mudon Township
Time: 08.45 am to 12.00 pm
Date: 28th August 2015 (Friday)
Language: Mon/Bamar

	Time	Description	Speakers
1	08.45-09.15	Registration and Welcome Tea and Snack, Movie Display	
2	09.15-09.20	Opening Ceremony and reading Agenda	MC
3	09.20- 09.30	Opening Remark by Speaker of Parliament of Mon State Pyi Thu Hluttaw	H.E. U Kyin Phe
4	09.30-09.40	Opening Remark by Township Administrator, Mudon Township	Township Administrator
5	09.40-09.50	Opening Remark by Township Medical Officer, Mudon Township	TMO
6	09.50-10.10	Sharing Project related Information and Milestones of Collective Voice Project	Daw Cho Cho Nyunt
7	10.10-10.20	Questions and Discussions	
8	10.20-10.40	Sharing Findings of the project	Dr. Phone Wae Oo
9	10.40-11.00	Sharing Overall Findings of the project	Dr. Min New Tun
10	11.00-11.10	Feedback from Community Representative	
11	11.10-11.20	Feedback from Representatives of health care providers	
12	11.20-11.30	Feedback from migrant representative	
13	11.30-11.40	Way Forwards of Collective Voice Project Phase 2	Daw Cho Cho Nyunt
14	11.40-11.50	Questions and Discussions	
15	11.50-11.55	Words of Thanks to Participants, Field Volunteers, Migrants, Communities and Project staff	Presenters
16	11.55- 12.00	Closing Ceremony	Presenters

Annex 6: Key Informant Interview guidelines used during KII providers meeting (Bright Future Project, Mudon)

1) **What are key Informant Interviews?**
   - In depth Interviews with an individual or group of people
   - Interview is focused on a topic with which the interviewee has firsthand knowledge
   - Primary goal is to obtain qualitative description of perceptions or experiences.

2) **What can key Informant Interview provide?**
   - Qualitative, descriptive data for decision-making
   - Understanding of motivation, behavior and perspectives of participants
   - Examples of successes or shortcomings of the study
   - Preliminary information for designing a quantitative study
   - Know in depth information or challenges in particular area

Advantages Disadvantages of KII/Providers' Meeting

- Provide information from knowledgeable people
- Opportunity to explore unanticipated ideas
- Easy and inexpensive
- Doesn't work for quantitative data
- Vulnerable to informant or interviewer bias
- Difficult to prove validity of findings

I. **Keys to Conducting Interviews**
   - Use interview template to standardize administration
   - Questions/prompts should be presented in the same way to all respondents
   - You want to maintain an engaging tone, remain neutral and avoid giving the impression of having a strong view on the topic to avoid bias
   - Tone of voice, body language, or interview style may cause respondents to answer questions in ways that reflect attitudes toward the interviewer rather than answers to the questions

I. **Keys to Conducting Interviews (continued)**
   - Actively listen
   - Allow sufficient time for interviewee to respond to each question and elaborate on answers
   - Listen for perceptions, ideas and themes
   - Balance note-taking with focused listening
   - Show interest by nodding or saying "Yes" or "I see"
   - Be sensitive to the interviewee by respecting cultural differences and/or background

II. **Keys to Conducting Interviews (continued)**
   - Clarify meanings of response and request detail
   - Repeat part of the question
   - Paraphrase answer back to respondent to confirm interpretation
   - Ask neutral questions:
   - "Could you please tell me more about that?"
   - "Anything else?"
   - "Could you please give me an example?"

III. **Keys to Conducting Interviews**
   - Prepare for questions from respondents

- Prior to the interviews, take time to review info provided to the interviewees
- FAQ – if applicable
- Note-taking - Record notes in as much detail as possible and review right after interview to fill in any missing details
- After the interview, ensure that all handwriting is legible or type notes in electronic template

Annex 7: Questionnaires used for community meetings

1. Please tell us priorities of health problems and its Health seeking behaviors for future purpose? (hint: you can tell from any Non-communicable diseases (DM, Hypertension, Heart Disease; other community diseases (psychological etc..); transmitted diseases; maternal and child health services and Primary Health Care (Prevention, Hygiene Promotion)
2. How do you identify the priority diseases or issues (any issue that would hamper getting health services)?
3. What do you do after knowing ailment? How do you get the health services? From which sources? What is the condition of getting health services (any cash payments??) (For supply site how do you think to reduce CF rate?)
4. For emergency, how do you contact to health staff (either BHS from Government or other providers) When did you earliest seek health services? Response? Please tell us culture.
5. What were the most deathful diseases (disease with high mortality) in this year? How do you advise for betterment?? From any providers legal or illegal?
6. How did they get treatment or (preventive and curative) health services in last year? Any type of services
7. Can you please tell me how do you prevent one of the priority diseases? Or how do you manage if you suffer?
8. Is there any treatment services given outside of government health system? If so, who are they? How do you believe upon them?
9. Is there health talk, training and health promotion campaign that you had seen within last 6 months? What are they?
10. How do you treat fever? (Please write down any methods either local or traditional)

Annex 8: Bibliography

1) *Schilavo-Campo*, Salvaroe et *Sudarm*, Pachampet; " SERVE and To PRESERVE: Improving Public Administration in a Competitive World"
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5) *National Census 2014*- Myanmar