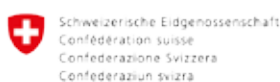




Health for All - Responsibility, Fairness, Inclusion and Do-No-Harm

LESSONS LEARNED AND GOOD PRACTICES IN 2015



3MDG IS MANAGED BY  UNOPS

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acronyms

3MDG	Three Millennium Development Goal Fund
AEI&CS	Accountability, Equity, Inclusion and Conflict Sensitivity
AMW	Auxiliary Midwife
CBO	Community Based Organization
CHW	Community Health Worker
CPI	Community Partners International
CSO	Civil Society Organization
FMO	Fund Management Office (3MDG)
FRM	Feedback and Response Mechanism
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
INGO	International Non-Governmental Organization
IOM	International Organization for Migration
LNGO	Local Non-Governmental Organization
MNCH	Maternal, Newborn and Child Health
MoHS	Ministry of Health and Sports
MSI	Marie Stopes International
NGO	Non Government Organization
SARA	Substance Abuse Research Association
SDH	Social Determinants of Health
TB	Tuberculosis
THC	Township Health Committee
THD	Township Health Department
TMO	Township Medical Officer
TSG	Technical Strategic Group
UHC	Universal Health Coverage
UNOPS	United Nations Office for Project Services
VHC	Village Health Committee

The 3MDG Fund recognizes that, in order to achieve and sustain health for all, efforts must be directed towards the health concerns of the whole population, with particular attention to reaching those who are most vulnerable to healthcare exclusion.

This Lessons Learned report details the substantial work undertaken by 3MDG in 2015 to progress a 'rights-based approach' to health, specifically through a focus on engaging communities and addressing the barriers to equitable health access, particularly for vulnerable groups. This report explains why and how the Fund's approach shifted in 2015 based on issues arising and lessons emerging in 2014. The challenges encountered, the lessons learned, and the good practices demonstrated in 3MDG's approach to achieving better health for all in 2015 are documented here.

The report is supported by international literature and learning, particularly in relation to rights-based approaches to development and gender-mainstreaming endeavours. It provides insight and learning about how rights-based visions interact with the often complex and challenging realities of implementation on the ground, and the various tensions that come with it.

This report can be read in conjunction with significant pieces of work referenced in this report as planned for 2016 but at the time of publication have already been completed – namely, a case study on “How effective community feedback and response mechanisms are in improving access to better health for all¹,” and a report exploring the social barriers to healthcare access in Myanmar.²

When considered together, three main areas of learning with accompanying recommendations emerge. They translate into actions which the new Government of Myanmar can consider during its first year in office. This learning should also be carefully considered by 3MDG donors to the health sector as they begin to develop their strategy for sector support post-2017.

1. Rights foreseen and enshrined in law are best communicated through language generally understood and which can serve to convey a vision of what a responsible, fair and inclusive health sector looks like. The right of each citizen to better health forms an important element of Myanmar's Constitution. The Ministry of Health and Sports could develop a set of guiding principles which would be widely communicated throughout the health sector, for example to policy-makers, to managers, healthcare providers and

1. 3MDG Fund, 'Case study: How effective are community feedback and response mechanisms in improving access to better health for all?', June 2016.

2. 3MDG Fund, 'Collective Voices: Exploring the barriers to healthcare access in Myanmar', 2016

patients alike. This would reinforce to all actors that optimum healthcare is based on key values such as equality, accountability, inclusion, fairness and dignity. This should then guide the way in which health providers and communities can frame their interactions with one another and in the delivery of healthcare.

2. Better health for all cannot be achieved without identifying, understanding and better addressing social determinants of health. Socioeconomic status, education, culture, language, gender and social norms are amongst the major social determinants of health and well-being. They are immensely powerful influences upon people's understanding of health. Beyond being major determinants of health status, they significantly impact upon health through affecting the ways in which people seek healthcare. It is important both to increase investment in levels of health service provision on the supply-side at the same time as making investments which will address the underlying social determinants of health. A better understanding of what influences choice and demand is critical to shaping provision of quality health which people will access in a timely manner. An agenda for research and evidence relevant to social determinants of health should be developed and the results should inform all aspects of health policy and planning.

3. The importance of mutual understanding and trust-building cannot be underestimated in the pursuit of better health for all. Using participatory learning action tools and/or community-based organizations to support and facilitate this process can be an effective means of breaking down barriers and bringing healthcare providers and communities together. Evidence from 3MDG's Health for All work to date demonstrates that trust can be rebuilt, in part based on clear and widely disseminated principles and through investment in understanding social determinants and people's health-seeking behaviours, and also through building awareness and capacity to address these issues.

Dr. Paul Sender
Fund Director

Julia Messner
Accountability Programme Officer



A participant reads the Collective Voices report, "Exploring barriers to healthcare access in Myanmar" at the launch event in Nay Pyi Taw in September 2016.
Photo: 3MDG

Overview

1.1 BACKGROUND

In partnership with the Government of Myanmar and others, the 3MDG Fund aims to have a significant, timely and nationwide impact, improving maternal, newborn and child health, and combating HIV and AIDS, tuberculosis and malaria. It will also strengthen the structures and institutions that deliver sustainable, efficient and responsive healthcare across Myanmar, extending access for poor and vulnerable populations to quality health services.

By pooling the contributions of seven bilateral donors - Australia, Denmark, the European Union, Sweden, Switzerland, the United Kingdom and the United States of America - 3MDG promotes the efficient and effective use of development funds. It is managed by the United Nations Office for Project Services (UNOPS).

3MDG is committed to reducing inequalities in health and improving access to affordable, quality healthcare, especially

in rural and hard-to-reach areas and among poor and vulnerable groups in Myanmar through a rights-based approach. The country has a largely rural population with a high degree of ethnic and linguistic diversity, alongside historical and ongoing insecurity and inter-ethnic conflict. There are significant levels of poverty, and women often experience limited decision-making power within families; a fact mirrored by lower levels of leadership and representation in public forums and institutions. Against this background, equitable access and people-centered health systems and services are crucial.

1.2 THE RIGHT TO HEALTH FOR ALL

To encourage equitable and non-discriminatory access to healthcare, the 3MDG Description of Action³ details that the Fund will implement a 'rights-based approach' to health. This aligns directly with the Myanmar Constitution, which states that 'every citizen, in accord with the health policy laid down by the State, shall have the right to health care'.⁴ The right to health means that people can participate freely, actively and meaningfully in the health-related decisions that affect them, access transparent information, and have the ability to hold decision-makers to account.

The 3MDG Fund recognizes that, in order to achieve and sustain health for all, efforts must be directed towards the health concerns of the whole population, with particular attention to reaching those who are most vulnerable to healthcare exclusion. To put these ideas into action, the 3MDG Fund developed an integrated strategy, the Accountability, Equity and Inclusion Strategic Framework⁵, in 2013. The framework did two important things:

- 1) Outlined a set of core values or principles that help to envision what an equitable, just and responsive health sector in Myanmar could look like.
- 2) Articulated a two-way process of strengthening institutions (including government, international and local non-government organizations (NGOs)) to become more accountable to the people they serve, and building the capacity and confidence of civil society to seek quality, affordable and available health services.

In 2015, 3MDG simplified this work under the banner, Health for All, creating a simple, non-technical approach to communicating the Fund's rights-based work and its principles to a range of audiences, including the Ministry of Health and Sports, NGOs, civil society organizations and communities.

1.3 PURPOSE OF THIS REPORT

This report details the substantial work undertaken by 3MDG in 2015 to progress a 'rights-based approach' to health, including a focus on engaging communities and addressing the barriers to equitable health access, particularly for vulnerable groups. It considers the challenges encountered, the lessons learned, and the good practices demonstrated in 3MDG's approach to achieving better health for all. It also explains why and how the Fund's approach shifted this year based on issues arising and lessons emerging in 2014.

The purpose of this report is to articulate and reflect on the 3MDG approach in the health sector of Myanmar, and to consider the achievements and limitations of putting principles into action in this context.

3. 3MDG 'Description of Action: 2012-2016', Final Draft, 7 February 2012

4. Myanmar Constitution, Article 367

5. 3MDG Fund, 'Fostering Accountability, Equity and Inclusion in 3MDG, Strategic Framework', September 2013



Young girls in Magway Region said that their fathers were the heads of their households, and were usually responsible for deciding when to see a doctor.
Photo: Charity-Oriented Myanmar

The observations, experiences and lessons are based on collated information and analysis from a wide range of sources, including:

- a) Observations and feedback from Ministry of Health community engagement training sessions
- b) Implementing partner reports submitted to 3MDG
- c) Feedback and inputs provided during implementing partner learning and sharing sessions
- d) A Health for All Annual Review and Reflections workshop held with implementing partners
- e) Results of the 3MDG Accountability, Equity, Inclusion and Conflict Sensitivity assessment
- f) 3MDG Health for All training and workshop reports and participant evaluation forms
- g) 3MDG monitoring visits and trip reports
- h) Feedback from independent consultants providing technical support to the Fund

The report is also supported by international literature and learning, particularly in relation to rights-based approaches to development and gender-mainstreaming endeavours. It may be used to inform similar approaches in Myanmar, and in other countries, that aim to improve equitable access to services. It provides insight and learning about how rights-based visions interact with the often complex and challenging realities of implementation on the ground, and the various tensions that come with it.

Finally, the lessons from this report may provide insight into the types of practical measures that can facilitate positive change in the health sector in Myanmar, and to elaborate and deepen the understanding of what a people-focused, rights-based approach to change might look like in the institutional policies and diverse operational practices of a range of actors (government, non-government and private sector) in the health system.

1.4 OUTLINE

Firstly, this report will revisit the key lessons learned in 2014 and briefly discuss the ways in which this resulted in adaptations to the approach taken in 2015. This will be followed by a more detailed discussion of the following three elements:

1. Principles: The normative framework that sets a vision for the health sector;
2. Tools: The instruments used to guide health sector stakeholders in putting the principles into practice and to measure their performance; and
3. Practices: Examples of the activities undertaken by implementing partners to improve participation, information-sharing, feedback and conflict sensitivity in their health programmes and projects to achieve better health for all, and in particular the most vulnerable.

Each of these elements has strengths and limitations, and therefore focusing on just one is unlikely to bring about meaningful change in terms of equitable health access. They are designed to work in concert towards achieving Health for All and contributing to the Sustainable Development Goals agenda. Key lessons will be highlighted in each section, pointing to larger programmatic and policy implications in the concluding chapter and how the Fund will move forward with Health for All work in the year ahead.

Lessons that Informed Changes in 2015

Implementation of the Health for All approach commenced in 2014, with its introduction presenting many challenges, as well as opportunities, for learning and reflection. The key lessons learned and examples of good practices were highlighted in an earlier annual report, and this informed the direction of work undertaken in 2015.⁶

In summary, in 2014 the Fund learned that:

1. Context-appropriate communication is crucial
2. Measuring progress on cross-cutting issues is challenging
3. Gender must be kept on the agenda
4. Awareness has grown, capacity on conflict sensitivity needs strengthening
5. There are challenges in community feedback and information-sharing practices
6. Health for All is integral not additional

Based on these lessons and feedback from Myanmar partners and colleagues, in 2015 the Fund simplified its terminology. Originally known as ‘accountability, equity, inclusion and conflict sensitivity,’ the language and principles (discussed in the next section) were simplified in early 2015 based on reserved reactions from a range of stakeholders, including the Ministry of Health, and subsequent consultations with Myanmar people on what terminology would be contextually appropriate and locally owned. As noted in some of the rights-based literature, “imported, blueprint analyses... with little knowledge of local realities cannot be expected to yield useful analysis. Nor will they be embraced readily by women or men working at the local level.”⁷

Measuring and articulating progress on this body of work also presented challenges in 2014 that informed subsequent changes in 2015. In early 2014, the Fund engaged an international technical assistance (TA) provider to support 3MDG and its partners in implementing Health for All approaches. Although demonstrating some successes, overall feedback from 3MDG implementing partners suggested that this approach was not meeting their needs to the fullest extent possible.

Therefore, in 2015, 3MDG moved away from international technical assistance, placing greater emphasis on engaging local specialists for capacity building, and also simplified the framework and tools guiding implementation (discussed in section 4.0 of this report). The Fund also reconfigured its reporting tools for implementing partners in an effort to capture more qualitative, ‘significant change’ stories about the lives of beneficiaries in Myanmar.

Moreover, in relation to technical assistance and capacity development, the Fund needed to determine the best way to support local organizations and took action to define this in late 2014, which was then carried over and accelerated in 2015. This was based on the 3MDG Description of Action commitment to “prioritise capacity building that strengthens service delivery and civil society, including local NGOs and CBOs,” and “giving high priority to strengthening voice and accountability, including through building the capacity of civil society and community structures.” Accordingly, through a competitive process, 3MDG engaged Pact Myanmar to provide organizational capacity development to national NGO partners. This work is discussed further in Section 4.0 of this report.

6. 3MDG Fund, ‘Engaging Communities for Better Health for All: Lessons Learned and Good Practices in 2014’

7. Porter and Sweetman, 2005 (p.4)

Another early lesson learned, and one that is common to the development sector, was the need to keep gender on the agenda. One of the ongoing challenges of working with an integrated strategy, as opposed to individual strategies on accountability, gender equality or social inclusion, has been the balancing act needed to ensure that adequate attention and effort is invested in each of these interrelated issues. While measures to strengthen accountability received significant attention in 2014, it became clear that gender mainstreaming and social inclusion required more emphasis in 2015. Accordingly, the Fund strengthened its focus on these areas in 2015, including stronger promotion and awareness-raising among stakeholders, greater visibility of gender and inclusion in capacity-building sessions and assessment tools, and more attention to addressing the different health needs of women and men in 3MDG programmes. These efforts are discussed in more detail in section 4.0 of this report.

After the first year of implementation, there were signs that momentum and awareness about the importance of Health for All had grown, but that capacity in some areas, such as conflict sensitivity, needed strengthening. To address this gap, and in line with the move away from international technical assistance as the main source of capacity development, 3MDG established a number of communities of practice between implementing partners (known simply as 'learning groups') to foster participatory cross-learning between health sector organizations. This included one group focused specifically on conflict sensitivity and the experiences of partners delivering health programmes in conflict affected areas. The types of learning groups and early results are discussed further in section 4.0 of this report, and the good practices of 3MDG partner, Community Partners International, are highlighted in section 5.0, explaining how they have partnered with Ethnic Health Organizations to increase access to services for conflict affected populations. 3MDG will also produce a separate learning report that focuses specifically on its conflict sensitive programming.

Finding the best way to ascertain community views and perspectives on



health services in Myanmar was raised as a challenge in 2014, and although implementing partners received capacity building on feedback and response mechanisms in 2015, there are still a range of challenges experienced on the ground in establishing effective feedback channels.

Some of these issues are highlighted in section 4.0 of this report, in addition to a discussion of the 3MDG Collective Voices initiative that was launched in 2015 to better understand how, in communities across Myanmar, healthcare is sought, how health and well-being are understood, and what needs to change within communities and the health sector if the right to health for all is to become a reality.



A Sexual and Reproductive Health Promoter conducts an awareness raising session about family planning, safe motherhood, cervical cancer and sexually transmitted infections at Tlang Kai village in Falam township. Photo: MSI

Importantly, this supports the commitment of the Ministry for Health and Sports, towards:

**“knowing the ground reality,”
“enhancing the feedback system,”
“inculcating a nature of responsiveness”
“listening to the voices of the people.”⁸**

Lastly, a key issue for Health for All was in increasing understanding among all stakeholders that this approach is integral to providing effective health programmes and improving health outcomes in Myanmar, and cannot be treated as a separate or additional stream of work.

Nevertheless, one of the key challenges faced by 3MDG, and an ongoing area of learning, has been around what Cornwall et al explains as:

“the obvious danger of seeing rights as a component to be incorporated into programmes [whereby] they become an add-on, with no intrinsic or organic influence on how things are done.”⁹

This idea is explored further in this report in a discussion on 3MDG-funded focal points recruited by implementing partners to mainstream Health for All work across their organizations. There have been a range of difficulties encountered in this approach, and both partners and independent consultants to 3MDG have suggested alternatives for consideration in future.

8. Government of the Union of Myanmar, Minister for Health, Dr Myint Htwe , inaugural address on 1 April 2016

9. Cornwall and Nyambu-Musemi, 2004 (p.1432)

3 Principles

Rights-based approaches are value-driven; they operate partly by creating a vision of 'what ought to be,'¹⁰ and can promote a set of positive changes needed to address the substantial inequities in access to healthcare and health outcomes for people in Myanmar.

3MDG has articulated its rights-based approach to health through four key principles: responsibility, fairness, inclusion and do-no-harm. These principles have been selected giving due consideration to the priorities in the 3MDG Description of Action, which is based on international best practice concerning the principles of participation and accountability, do-no-harm, transparency, gender equality, and aid effectiveness. As mentioned previously, these principles also reflect language that is contextually appropriate and locally owned.



Kids play outside during a community meeting, where their parents discuss the barriers to health in southern Chin State
Photo: Ar Yone Oo Social Development Association

The first principle, **responsibility**, promotes good governance and accountability, encouraging commitments to be kept, listening (and responding to) the voices of people, and empowering and informing users about health and how to access services.

3MDG encourages **fairness**, which means being fair and just to all people who use health services, and especially recognizing that women and men need different support to access health services.

To ensure **inclusion**, 3MDG recognizes the high degree of diversity that exists in Myanmar and encourages health policies, plans and services that address the needs of different groups.

In order to **do no harm**, the approach involves understanding the context in which 3MDG

partners operate, ensuring health activities do not create or worsen conflict and, where possible, use health activities to improve the opportunities for peace.

These principles have established a common language and an overall vision of a responsible, fair and inclusive health sector, to guide the way in which implementing partners and other health providers can frame their interactions with one another and in the delivery of healthcare.

3MDG's Health for All work has been directed towards ensuring that the principles do not stand alone merely as good intentions but are supported by a strong focus on implementation.

10. Cornwall and Nyambu-Musemi, 2004 (p.1416)

4 Tools

The Fund aims to improve the competencies of health organizations to design health policies and programmes that are relevant, inclusive and responsive to the needs of the people they are intended to serve. 3MDG's Health for All work is accordingly supported by a range of tools to guide and support health sector stakeholders in putting the principles into practice, both institutionally and operationally, and to measure their performance:

1. **A framework** - with four minimum standards to guide implementation.
2. **Capacity-building** - activities based on the four Health for All principles and four standards.
3. **Monitoring** – via an assessment tool, performed annually by 3MDG implementing partners.
4. **Specialists**- Accountability, Equity and Inclusion Officers (focal points).

5. **Budgets** – to support responsible, fair and inclusive practices in health programmes.
6. **Participatory Learning Action (PLA) tools** – to identify priority community needs.
7. **Gender mainstreaming** – to promote gender equality.

The tools focus on strengthening both the institutional elements (policies, structures, systems and procedures) of health organizations and their operational activities (programmes and projects), with an emphasis on increasing community participation and engagement.

4.1 FRAMEWORK

In 2014, 3MDG developed a framework with eight benchmarks or minimum standards, later reduced to four in 2015. The tool was deemed overly complex and insufficient in its attention to women, girls and other traditionally disadvantaged groups. As such, 3MDG contracted Pact Myanmar to adjust and improve the tool based on feedback from 3MDG staff and implementing partners. Version II of the tool focused primarily on project implementation practices and interactions with beneficiaries. These changes resulted in a reduction to four standards:

1. Participation
2. Information sharing and transparency
3. Beneficiary feedback and response mechanisms
4. Conflict sensitivity

The framework has provided a useful and consistent conceptual structure for guiding key activities, and implementing partners reacted positively to the streamlined standards. Nevertheless, 3MDG continued to learn about the politics, compromises and strategic difficulties involved with implementation.

For example, feedback and response mechanisms remain challenging to implement in Myanmar. While the 3MDG Description of Action encouraged establishment of ‘complaints mechanisms to which people can report cases of discrimination in health service delivery’, this has been difficult to achieve. This is due to cultural and social norms, and historical legacy. Decades of military rule have shaped a culture where there is little receptiveness to feedback from below or from within. Despite reforms, there is still reluctance within the public sector, and from the public, to begin to provide feedback.

In 2015, many 3MDG partners had feedback and response mechanisms in place, but had found these difficult to design because of high rates of illiteracy, language differences between communities and officials who were supposed to receive the feedback, and cultural norms that discouraged complaints.¹¹

In 2016, 3MDG will engage a consultant to qualitatively assess the effectiveness of community feedback and response mechanisms in improving the quality of services and access to better health outcomes, including for the most vulnerable people. This will include identifying and documenting successes of different

11. 3MDG Annual Report, 2015 (pp.90-91)

models and approaches, and providing recommendations on how to improve the accessibility and inclusivity of the mechanisms, and the responsiveness of health service providers.

3MDG will also explore options for an implementation review to assess the effectiveness of the Health for All framework and the four standards. Although it appears to have provided a useful conceptual structure for guiding key activities, there is little evidence to indicate how well this has worked in strengthening responsible, fair and inclusive practices.



A 3MDG field monitoring trip to Collective Voices community in Mon State.
Photo: Community Driven Development and Capacity Enhancement Team

Learning:

- **There are challenges in facilitating participatory feedback mechanisms in the Myanmar health sector, stemming from both the health provider and user sides. An in-depth investigation is needed to better understand different feedback approaches and how to improve their accessibility and inclusivity in Myanmar.**

- **An implementation review of the Health for All portfolio is needed, including an assessment of how well the framework and the four standards have worked to date in strengthening the practices of 3MDG implementing partners to contribute towards a more responsible, fair and inclusive health sector.**

4.2 CAPACITY BUILDING

“Proven rights strategies involve building of awareness and self-confidence...often well before any direct attempts at legal or political action.”¹²

The 3MDG Description of Action gave high priority to strengthening voice, accountability and responsiveness through building the capacity of target communities, civil society organizations and the public sector. It committed to capacity building to increase transparency and accountability, in addition to gender analysis and mainstreaming in planning and programming. Moreover, the Description of Action identified a need to enhance support for building government capacity and to explore options for increased use of government systems.

Capacity building has been a key element in the 3MDG Health for All approach, with activities based on the four principles and the four standards. In 2015, this included workshops, communities of practice (known as implementing partner learning groups), and partner exchange visits. At an average of one workshop or learning session occurring every month with up to 26 different implementing partners in 2015, partner staff were provided with practical tools in areas such as gender and project cycle management, community engagement, feedback and response mechanisms, and participatory learning action, among many other topics (a summary of major capacity building and sharing and learning activities are outlined at Annex I).

In the second half of 2015, 3MDG started providing the majority of training and workshops through local experts, delivered in Myanmar language. The aim was to ensure that rights-

12. Miller et al in Pettit and Wheeler, 2005 (p.5)

13. Escobar in Pettit and Wheeler, 2005 (p.7)

based approaches are understood, articulated and aligned with local culture and values rather than “imposing singular Western notions of what rights and development mean.”¹³ This approach has received a highly positive reaction from implementing partners, while cross-learning groups between implementing partners also appear largely successful, enabling learning based on concrete yet diverse realities in Myanmar.

Participant evaluations were completed after each session, alongside pre and post-tests to indicate whether attendees felt that their knowledge and skills were improving. Moreover, feedback has been sought from partners about the structure, content and effectiveness of the learning groups. Based on testing at the end of the training sessions, the majority of participants reported an increase in their confidence and capacity to integrate accountability, gender equality, inclusion and conflict sensitivity into their work. Although this anecdotal evidence indicates that the shift in the 2015 approach has been effective, there is a lack of independent material to support this observation, and it is recommended that this is further explored through a Health for All implementation review.

4.2.1 Capacity Building for Local Organizations

The 3MDG Description of Action committed to “prioritise capacity building that strengthens service delivery and civil society, including local non-governmental organizations (NGOs) and community-based organizations.” It also noted that

“where NGOs work in remote areas with limited organizational capacity and support, there need to be robust systems in place for project monitoring and accountability. National and local NGOs will also benefit from capacity development, as appropriate, for service delivery, accountability and independent monitoring.”

Accordingly, through a competitive process, 3MDG engaged Pact Myanmar in late 2014 to provide organizational capacity development to six national NGO partners, which expanded in 2015 to include a further seven organizations. This was implemented throughout 2015 with a combination of training, workshops and mentoring, based on the partners’ identification of their own capacity gaps. The



Pact holds an organizational capacity development (OCD) workshop with SARA, in order to strengthen their advocacy skills. Photo: Pact

focus was broad, including administration, logistics and procurement, strategic planning, human resources, advocacy and programme management, and will continue through 2016 and 2017.

The Fund is considering options to expand its partnership with Pact to include capacity support for Ethnic Health Organizations in Myanmar in 2016. 3MDG has grants supporting Ethnic Health Organizations under its malaria programme portfolio which support service delivery reaching very vulnerable and conflict affected populations. Ethnic Health Organizations are often the only organizations providing health services and referrals for conflict-affected populations, and strengthening their capacity will contribute significantly to extending the reach of health services to underserved populations.

Furthermore, in 2016 3MDG plans to take stock of its capacity support to local organizations to date. This could include reviewing the strengths and limitations of the approach, including consideration of the potential for scaling-up or continued use in future, given the importance of local organizations in Myanmar in building community health systems and influencing health policy dialogue from the perspective of local constituencies.

4.2.2 Strengthening the Capacity of the Ministry of Health

The 3MDG Fund aimed to provide capacity strengthening measures to the Ministry of Health from as early as 2013, identified in the Accountability, Equity and Inclusion (AEI) Strategic Framework – “to build through policy an enabling environment to support the implementation of AEI principles within health systems.” Despite these intentions and various approaches to the Ministry throughout 2014 to discuss Accountability, Equity and Inclusion support, a suitable entry point was not forthcoming. Arguably, the political context at the time was not favourable for accelerating accountability, equity and inclusion interventions, but the Fund also received feedback from Ministry staff that the Accountability, Equity and Inclusion framework and accompanying language was too technical,

not locally-owned, and confusing.

Meanwhile, in early 2015, 3MDG launched a new initiative, “Collective Voices: Understanding Community Health Experiences,” directly funding local civil society organizations with an initial US\$50,000 each to explore and identify the social barriers that hinder access to healthcare in Myanmar from the perspective of communities themselves. This was all done with support from the Ministry of Health at the central level, and the cooperation and involvement of staff at the State/Region and township level. At the time it was established, Collective Voices was a small and relatively experimental initiative intended to build the capacity of local organizations to explore the social barriers hindering healthcare access and find solutions to overcome them.

It was therefore an unexpected, but warmly welcomed, development when this initiative provided an entry point for strengthening relationships between the Ministry and 3MDG’s partners, and for strengthening the capacity of the Ministry on Health for All issues. In October 2015 the Ministry requested support from 3MDG Collective Voices partners to train its staff to listen to community needs, using participatory methods, and to incorporate their views in township health plans.

Together, 3MDG, Collective Voices partners and Ministry of Health staff developed a training manual and curriculum on participatory community engagement. This was accompanied by a practical training session, delivered by 3MDG Collective Voices partners, focusing on the use of participatory learning action (PLA) tools, and the principles of responsibility, gender equality, social inclusion, and do no harm. The aim was to better equip public sector health staff to prioritize community needs when planning health services, and become more inclusive and responsive to the needs of the people they intended to benefit.

Training was conducted in seven states and regions for Ministry of Health staff through the final quarter of 2015, using a Training of Trainers approach. Feedback received from participants was overwhelmingly positive:



Charity-Oriented Myanmar lead a training session on participatory community engagement with Ministry of Health and Sports staff in Mandalay. Photo: COM

"I can see a lot of younger people here in this training working enthusiastically for the country. In the past we were more successful in engaging communities, but we lost their trust for a certain period of time for various reasons and now is a good time to receive this training to encourage us to rejuvenate our community engagement."

**Dr. Ohnmar Aye, Township Medical Officer
Magway, Community Engagement Training
Participant, 2015**

"We cannot provide effective health services without community participation. The tools we have learned here will be very useful when we go to the community".

**Daw Than Than Win,
Health Assistant, Tamwe**

Learning:

- **Capacity building and training must be adapted to local realities, and provide participants with ideas and methods to adapt and apply in their own operating environments. This is relevant at all levels, but in particular when working with government. Entry points are most likely to arise when there is alignment with government priorities, and when initiatives are culturally and contextually relevant.**
- **An overall implementation review of the Health for All portfolio is needed, including an assessment of how well the interventions delivered by local specialists have worked in strengthening the practices of 3MDG implementing partners to contribute towards a more responsible, fair and inclusive health sector.**
- **In 2016 it will be timely to review the 3MDG approach to capacity development specifically targeted to local organizations, as delivered through Pact, to identify the strengths and limitations of the approach, including consideration of the potential for scaling-up or continued use in future.**
- **Among Ministry staff and implementing partner staff there appears to be an overall understanding and commitment to the principles of responsibility, fairness, inclusion, and do-no-harm but there is a continuing need for technical support and practical tools to facilitate implementation. People know about the ‘what,’ but they need more support on the ‘how.’**

4.3 MONITORING

Development actors and researchers have consistently observed that, despite the best intentions, policy commitments that aim to mainstream equality and inclusion principles are often not translated into action. This can stem from lack of staff capacity, organizational culture and attitudes, the treatment of equality as a separate process which marginalizes rather than mainstreams it, staff simplification of the issues, or not feeling ownership of the policy.¹⁴ Therefore, there is a need to identify and support target actions to translate principles and policies into practice.

3MDG established an ‘Accountability, Equity, Inclusion and Conflict Sensitivity Assessment Tool’ in 2014 in close consultation with local Myanmar focal points from partner organizations, which was refined and simplified in 2015. The assessment is performed annually by implementing partners to monitor how well they are practicing the Health for All principles. It provides a learning and development process whereby an organization uses a set of consistent, external criteria (the set of four 3MDG standards) to reflect on and discuss what could be done differently to improve the quality of health policies, processes, systems and practices. The assessment tool and accompanying resources are aimed at 3MDG partners, but can also be useful for any organization working in the health sector who wishes to strengthen their practices on responsibility, fairness, inclusion and do no harm.

This practical tool guides and assesses rights-based programming among 3MDG implementing partners, and supports the notion of shared accountability; that is, it is not only the State that is accountable to citizens, but so too are other stakeholders such as international and local NGOs.

The assessment process provides a numerical score, but this is not where its real value is found. Rather its benefits are in raising awareness of the organization’s commitments to responsibility, fairness, inclusion, and doing no harm. It encourages a conversation with senior management, beneficiaries and other stakeholders to promote learning and sharing of ideas, and provides a basis for targeted actions to improve practices to achieve the changes that are needed. It also emphasizes the participation of women and other traditionally disadvantaged groups, and moves away from an “over-reliance on policy formation and training to transform organizational practices, procedures and structures.”¹⁵

Importantly, based on feedback from the partners in 2014, the assessment tool was strengthened in 2015 to include a graduated scoring system focused strongly on operational aspects, with in-built examples to highlight what a sub-optimal level of implementation looks like, through to an advanced level. This helped to avoid an ‘all-or-nothing’ approach in a complex and diverse country like Myanmar, instead



14. Moser and Moser, 2005 (p.15)

15. Porter and Sweetman, 2005 (p.7)

demonstrating the various stages that an organization may progress through to gradually improve its practices to the optimum level. Based on weaknesses identified, the partners then developed an improvement plan to target their energies towards addressing identified gaps.

Although the tool plays an important role as the starting point of an overall improvement cycle, it also has limitations. Rights-based approaches and principles remain difficult to measure. The annual assessment provided one way of judging the extent to which rights-based values are being mainstreamed into health programmes and projects, but as a self-assessment the results were limited as they were based solely on the perceptions of the organizations themselves and were not independently verified. Other complementary, qualitative and robust measures, in addition to the assessment tool, are needed to demonstrate the outcomes and impact of Health for All. Further, a review could provide further analysis of the value of the tool and assessment process in moving towards a responsible, fair and inclusive health sector.

Learning:

- **Rights-based approaches, principles and ‘invisible elements’ remain difficult to measure. Assessment tools are valuable when they 1) are accompanied by other qualitative indicators of outcomes and impact, and 2) when they provide a vision or target to aim for, accompanied by clear steps to reach the goal. This approach recognizes the diverse**

organizational and operational contexts faced by health actors in Myanmar, without forcing everyone to reach the goal in the same way, and at the same time.

- **An implementation review of the Health for All portfolio is required, including an assessment of how well the assessment tool and process as worked in strengthening the practices of 3MDG implementing partners to contribute towards a more responsible, fair and inclusive health sector.**

4.4 SPECIALISTS AND BUDGETS

To create change at the operational and institutional level, people are needed to bring this change about. 3MDG has provided funding to each implementing partner since 2014 to recruit an Accountability, Equity and Inclusion Officer to act as a ‘specialist’ or focal point, to drive and mainstream Health for All principles within their organizations, alongside dedicated activity-based budgets to enact relevant policies. With this funding, partners undertook a variety of actions, including capacity building with their own staff and other stakeholders on the principles; development and distribution of information, education and communication materials in relevant languages; and posting notice boards with project and health information in communities.

In 2015, lessons emerged about the challenges in the ability of the Accountability, Equity and Inclusion Officer to effect systemic change in their organization. Their relatively junior and often marginalized position in their organization’s management structures impacted the extent to which the Health for All principles could be mainstreamed. The exception to this was when there was strong support and buy-in from the senior management team. Overall, however, the individuals were not always closely integrated into project implementation activities and meetings, limiting their understanding of the detail of the project, and isolating them as outsiders to the project, who needed to push to convince program staff to adopt these principles.

Conversations with implementing partners suggest that there is also a lack of understanding that Health for All principles and processes provide guidance to address issues



A roadside stop in Chin State.

Photo: Ar Yone Oo Social Development Association

arising in the field, but they are not specific prescriptions for implementing programs. Accountability, Equity and Inclusion Officers, in particular, are often seeking ‘answers’ on how to address difficulties in the field, rather than approaching this as a context-dependent, problem-solving process. It highlights another challenge - the need for information sharing, support and learning within IPs, specifically between field-based staff and higher-level positions in headquarters. Lessons learned efforts to date have focused on sharing challenges and successes across IPs, but efforts to formally share success stories within organizations could also help to navigate these barriers.

As the Accountability, Equity and Inclusion focal point model has not been consistently successful, what has been learned? Ultimately, AEI Officers need to be in close contact with field staff, and ideally need to have a more senior position in the organization or strong senior management support, so that they are able to influence policy. An alternative approach may have been to keep all Health for All mainstreaming activities at the field level, and train field staff directly in Health for All approaches. This could emphasize the practical positive impact of Health for All at the operational level, and could be adopted as field implementation standards.

Interestingly, implementing partners also suggested that one way forward might be to have the Ministry of Health and Sports mandate its own ‘principles’ for all projects in the country, and that this might help to increase implementing partner buy-in across all projects. There is yet to be a coordinated set of principles or strategy along the lines of Health for All at the national level, although the current government has promulgated a similar set of values for positive social change nationwide.

Learning:

- **Mainstreaming principles across an organization is essentially ineffective without senior management support.**
- **The Ministry of Health and Sports could consider mandating its own ‘principles’ to be mainstreamed within all health projects in the country.**

4.5 PARTICIPATORY LEARNING ACTION (PLA) TOOLS

Participatory Learning Action (PLA) tools have been used by 3MDG Collective Voices partners to better understand community health experiences and the social barriers to accessing healthcare. 3MDG has encouraged the use of PLA methods and tools largely due to its emphasis on active participation of communities in the issues that shape their lives; using tools that enable all community members to participate; enabling local people to prioritize issues based on knowledge of local conditions, utilizing collective analysis and learning; and developing realistic solutions.¹⁶



16. Thomas, 2008.

4.5.1 In Practice: Using PLA to Uncover the Social Barriers to Healthcare Access

By facilitating people's involvement and encouraging participation, Participatory Learning Action (PLA) tools are an effective way of giving voice to individuals and communities. Established in partnership with six lead local organizations¹⁷ working with a further nineteen Community Based Organizations in a consortium arrangement, 3MDG Collective Voices organizations undertook community consultations in six states and regions to generate information and improve understanding of the social factors limiting access to healthcare.



Collective Voices partner Bright Future representatives engage with community members at festive events. Photo: Bright Future

The first step of this two-stage project focused on community voices, with more than 500 community meetings undertaken across project areas in Myanmar, mostly at the village level. The organizations facilitated community meetings using Participatory Learning Action PLA tools, including the Ten Seeds Tool, Venn Diagrams, Social Mapping, Health Service Mapping, and Problem Trees. Some of the organizations also held individual interviews with community participants to understand their personal health concerns and barriers they had experienced.

Based on this first stage of consultations, the Collective Voices implementing partners produced a summary report, outlining their key findings, and used this to inform the design of their second stage project activities until the end of 2017. The reports highlight feedback provided directly by community members about the key social barriers, including the voices of women, ethnic minorities, LGBT communities, and other vulnerable groups. On top of decision-making power of women on family planning and health, social stigma and language barriers, the results also identified poor health knowledge and education; limited functioning of and participation in village health committees; weak coordination among healthcare providers; and community reliance on traditional and informal practitioners.

Importantly, through this initiative, 3MDG has not taken an approach that has directly promoted collective voice for 'holding government to account' and potentially alienated the government from participating. Instead the focus has been on strengthening relationships between communities and health service providers, fostering collaborative approaches, and improving understanding and trust. In fact, 'recognizing that relationships matter directs attention to the importance of trust and trustworthiness as a basis for building those relationships and support coordination among health systems agents'.¹⁸

The successful results to date suggest that this approach may provide an alternative, more subtle and constructive avenue towards social accountability, building on greater connectedness between health service providers and citizens.

17. Ar Yone Oo, Bright Future, Community Agency for Rural Development, Community Driven Development and Capacity Enhancement Team, Charity Oriented Myanmar, and Phan Tee Eain.

18. Gibson (2003) in Sheikh, Ransom and Gibson, 2014

Learning:

- **Participatory Learning Action tools can be utilized to facilitate an 'enabling environment' that leads towards greater connectedness and trusting relationships between communities and providers, offering a subtle and effective approach to strengthening social accountability.**

4.6 GENDER MAINSTREAMING

Gender inequality significantly affects a person's ability to realise his or her right to health. Around the world women are in a position of socio-economic disadvantage compared to men and are less likely to have the resources to protect their health. The principle of fairness towards women and men is a key focus for the 3MDG Fund. In 2014, 3MDG learned that gender must be kept on the agenda, and subsequently in 2015 strengthened efforts to promote gender equality and women's empowerment, through the following activities:

Services:

- Targeted delivery of essential health services that primarily benefit women and girls of reproductive age (nutrition, antenatal and postnatal care, and financial support to access emergency services for pregnant women with complications).

Capacity building and monitoring:

- Provided Gender and Project Cycle Management training, including training on gender analysis and mainstreaming, adapted to local realities.
- Provided training on Gender and Conflict Sensitivity, adapted to local realities.
- Provided training on integration of disability inclusion into health programs provided by the Association of Myanmar Disabled Women Affairs.
- Conducted an annual assessment with implementing partners on women's participation in health projects and programmes.



Community members gather to discuss the of accessing healthcare in Mon State. Photo: Driven Development and Capacity Enhance



Collective Voices interviews with southern Chin State uncovered marital expectation to have ma Photo: Ar Yone Oo Social D



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- Collected Most Significant Change stories from implementing partners relating to the lives of women.
- Established a direct funding opportunity for civil society organizations to explore the gendered dimensions of health-seeking behavior through the Collective Voices project.

Promotion and awareness:

- Publication of a gender pamphlet entitled 'Healthy Women, Healthy Men', articulating concrete gender sensitive steps that reflect 3MDG's gender equality commitments.
- Participation in the 16 Days of Activism Against Gender Based Violence Campaign in Myanmar, including hosting a special event about Gender Based Violence.

Despite these efforts, there are ongoing challenges and lessons in relation to facilitating equitable access to health services for women and men. Gradual improvements emerged, particularly at the institutional level of implementing partners. Most have integrated gender issues into their organizational policies, core values and human resource policies and procedures, and are indicating that 'awareness' has improved within their organizations and with some partners. Yet, at an operational level, many implementing partners face continuing difficulties in securing women's participation in programme activities. For example, partners report that women in some communities do not usually go to meetings and health education sessions, and men lead in decision-making.

3MDG has made a start in examining and building awareness on how gender interests intersects with other interests such as accountability, disability, age, and ethnicity. However, going forward in the life of the 3MDG Fund, and beyond, there are further gap areas that warrant attention, as outlined to the right.

Learning:

- **The need for a detailed gender analysis underpinning health programmes and projects from the outset that is reviewed and updated at regular intervals.**
- **There is a need to move towards more sophisticated and nuanced approaches to gender equality, for example strategies and tools that give greater attention to the differences in power relationships and health outcomes between women and women, not just between women and men, and indicators that measure more than women's equal participation, which may not be enough in itself to effect meaningful change.**
- **There is a need to strengthen awareness and practices that properly recognize the gendered dimensions of conflict, and the specific needs and rights of women in conflict affected areas, including within 3MDG's own conflict sensitivity tools and approaches.**
- **There is a lack of robust measures to capture the outcomes and impact of gender equality initiatives.**
- **There is a need for greater attention to, and mechanisms to encourage, the important role that men play in achieving gender equality and facilitating women's and girl's access to healthcare.**

Good Practices

This report has so far outlined the four Health for All principles and four standards that serve to guide and structure the portfolio of work. In the following section, examples are provided of the ways in which 3MDG partners reflect these values and approaches in diverse operating contexts across Myanmar. It explores the complexities of their work, showing that “policies seeking to promote rights in development are consistently confronted by the complexities of political [and social] realities.”¹⁹ At the same time, these partner case studies demonstrate what is possible when health programmes and projects are underpinned by Health for All principles and adapted for greater relevance and impact.

19. Pettit & Wheeler, 2005 (p.6)

5.1 PARTICIPATION

5.1.1 Inclusion of migrant women - IOM

In Myanmar, many people migrate between or within states and regions due to various push and pull factors including the search for better economic opportunities. These migrants are often poor and highly mobile. As they are not registered within the township administration or health systems, they are unaware of where to seek care and have poor access to health services, often turning to informal practitioners or traditional birth attendants with harmful results.

The 3MDG Fund supports the International Organization for Migration (IOM) to reach migrant populations in Ayeyarwady Region. IOM's effort to reach migrant women and children serves as an example of enhancing the participation and inclusion of poor and vulnerable populations to improve health access and outcomes.

IOM selected the Kadoni Kani area in Bogale Township, Ayeyarwady Region, to pilot a 'Migrant friendly Voucher Scheme' in 2015. Kadon Kani has a total population of 25,223 people covering 30 villages that are densely populated with migrants. Most of the migrants have not been able to access healthcare due to a high degree of mobility (they are not permanently located in one area), fear of visiting a health facility, lack of health information and knowledge, and the out-of-pocket financial costs of consultations with health providers. This has

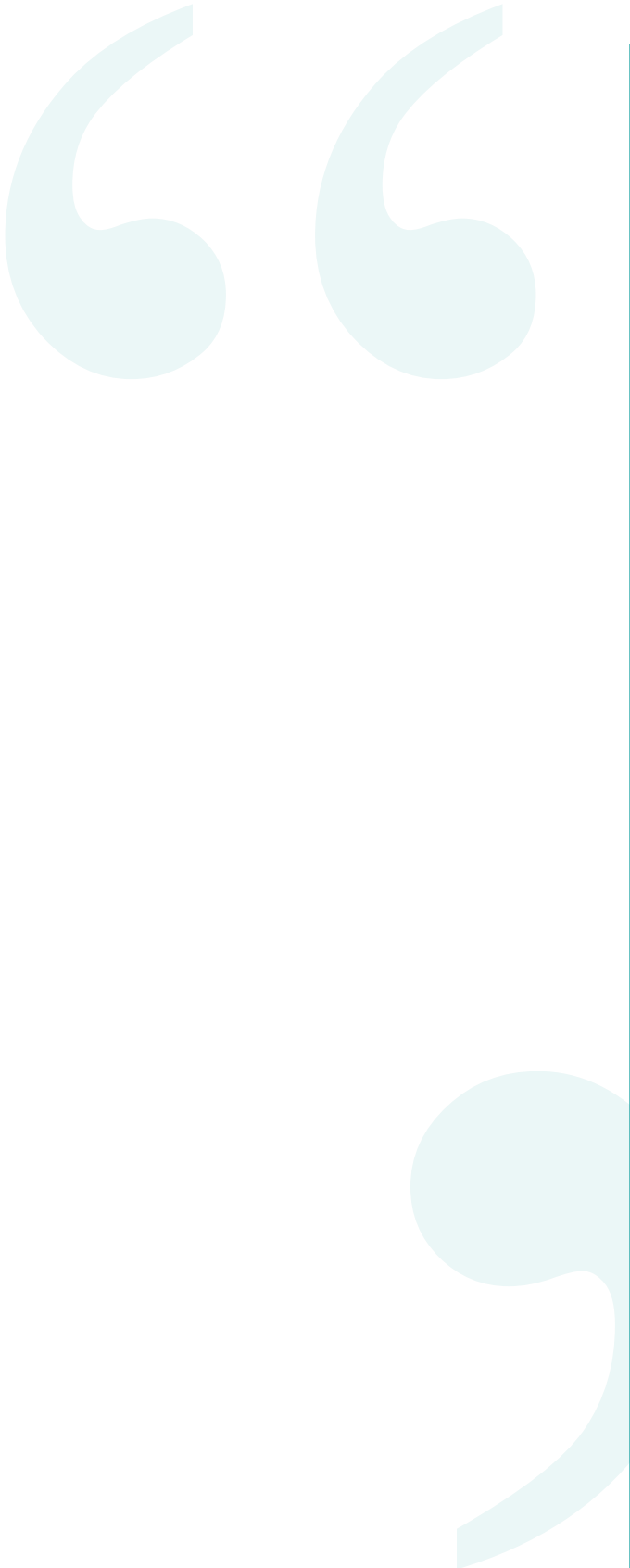
resulted in low utilization rates of primary healthcare services and limited recognition and recording of migrant women for antenatal, delivery, post-natal and routine immunization services.

The main objective of IOM's migrant friendly voucher scheme (MVS) is to enable access to proper antenatal care, institutional delivery, skilled birth delivery and postnatal care for migrant mothers, and increase the accessibility of primary healthcare services for under-five migrant children. The voucher scheme started in July, targeting 6,200 people. Vouchers were distributed to 167 pregnant women (2.7% of the population) and 775 under-five children (12.5% of the population) over a one-year period. A management body was organized, including one member assigned as 'voucher holder' to provide vouchers to 'voucher distributors'. A total of 34 voucher distributors were deployed at 34 migrant clusters in the Kadon Kani area, and vouchers were given to eligible migrants (pregnant women and children under five).

This enabled women to access midwives for maternal care, including ante-natal care from basic health staff, assisted delivery, and post-natal care. Additionally, children were able to access midwives for child health services. The Village Tract Health Committee (VTHC) has since expressed a willingness to continue the scheme and contributed additional funding. Importantly, this has established an ongoing link between basic health staff and migrants.



A midwife vaccinating children of migrant mothers in Hnar Gyi village, Bogale Township. Photo: IOM



According to one woman in the Kadon Kani area:

"I am 34 years old. I have three children and I am pregnant. My husband is a fisherman who is usually away for around four months at a time. During his absence, I am the only one caring for our children. My family is poor and depends on my husband's income, so I did not have ante-natal care during my previous pregnancies. All my pregnancies were delivered by a Traditional Birth Attendant (TBA).

In 2015, an auxiliary midwife (AMW) in my village often conducted health talk sessions. I gained information related to my pregnancy and about the health of my children. The AMW also kept a record of pregnant mothers and explained to us about the Migrant Friendly Voucher Scheme (MVS) implemented by IOM. She gave us a voucher and encouraged us to access ante-natal care, the voucher to pay the midwife instead of giving money. Initially, I was not convinced about the MVS, but when I saw and heard about this service from other pregnant mothers, my interest grew.

I went to the sub-centre and showed the voucher, and the midwife explained again about this service. I was examined by the midwife and underwent an abdominal examination, blood testing, urine testing, blood pressure testing, and my weight was measured. She also gave me a TT injection as well as other necessary drugs related to my pregnancy. I was informed that both I and my baby are both in good condition. This made me feel assured and safe about my pregnancy. After this experience, I decided to continue with the next ante-natal care visit and also to deliver with basic health staff. I am really very pleased with this service. I will share this information to other pregnant mother about the MVS to access health service and I will encourage them to take this service. I also want to say again, thanks so much, I am happy for my future family."

5.2 INFORMATION - SHARING AND LISTENING TO COMMUNITY FEEDBACK

5.2.1 Engaging communities in harm reduction – SARA

As part of 3MDG's support to the National Strategic Plan for HIV and AIDS, in 2015 3MDG financed harm reduction activities implemented by Substance Abuse Research Association (SARA) in five field sites in Kachin State for people who inject drugs (PWIDs). This is a population with diverse ethnic, religious and social backgrounds in project areas characterized by conflict and high physical vulnerability.

The work of SARA, to provide harm reduction services in the face of community resistance, provides an example of how community participation, information-sharing and education can be used to reduce significant societal barriers and discrimination, to foster community acceptance and harmony, and enable vulnerable people to access healthcare.

Having had more than a decade of experience in this field, SARA is aware of the sensitivities and concerns of communities when harm reduction activities are introduced. SARA has learned that community engagement and openness to feedback need to start well before the implementation of project activities rather than occurring as an afterthought at a later stage.

Before providing services in Kachin State, SARA informed community leaders about what they were aiming to do with their harm reduction services, why they were doing it, and how they could go about reducing concerns along the way. This played a major role in alleviating the likely resistance of the community to harm reduction services. Moreover, SARA focused on understanding community views and needs in relation to drug abuse, and the emotional and financial toll experienced by families and the wider community. SARA discussed how they could help in handling this problem, an approach that was vital in ensuring that the community would accept harm reduction initiatives.

In other words, creating space for dialogue and building trust with the community was crucial, and was undertaken by SARA well before harm reduction operations started, both in Kachin and northern Shan State. Trust was built with community leaders through SARA's visits to church community and youth gatherings, provision of health education talks about

prevention of drug use among youth, the importance of parenting skills in preventing drug use and on addiction. It was this regular communication and information-sharing at the ground level that provided a basis for SARA to establish trust with the community.

Additionally, SARA made a point of involving a respected member of the community in project operations from the start. Requests were made to a local faith-based organization to elect a representative from the community to assume the post of Community Mobilisation Assistant in setup at each project site. This arrangement provided SARA with invaluable feedback from the community, and strengthened the level of trust between the community and project teams. At the same time, it provided SARA with the opportunity to provide information and technical guidance to the community through the Community Mobilisation Assistant.

SARA has taken care to properly acknowledge and not undermine the sentiments held by the community about drug abuse, noting the importance of flexible programmatic approaches to enable them to genuinely respond to the ground realities and specific needs of the communities in which they work. SARA asserts that communities are mostly concerned with the impact of drug use among family members, often experienced as a daily problem and potentially for years on end, so they are pleased to receive assistance from NGOs to address this issue.

Looking forward, SARA feels that more attention should be given to addressing the concerns of the wider community in which harm reduction services are provided, even if this element is not included in the 'Nine Core Components of Harm Reduction'.²⁰ While these components are essential from a biomedical standpoint in the reduction of HIV transmission among PWIDs, for the greatest impact harm reduction activities need to address the concerns of the community and provide opportunities for community members to take an active part in harm reduction initiatives. More attention should be given to addictive behaviors that can lead to ill-health, rather than focusing on the virus itself. This will contribute to broader 'Community Systems Strengthening (CSS)' objectives, and ultimately to better health outcomes.

5.2.2 Engaging leaders to improve access to contraception – MSI

The work of 3MDG partner, Marie Stopes International (MSI), serves as an example of how working with community and religious leaders in Chin State is enabling greater reach of services by addressing community attitudes to contraception. It shows how participatory and inclusive approaches can result in greater health access for vulnerable groups, in particular women.

In Myanmar, many people currently access health care services through the private sector. The 3MDG Fund supports interventions that both improve the quality and availability of private sector services and are complementary to public health services. MSI provides complementary private sector support, largely to increase access to a broad range of contraception, including long-term methods.

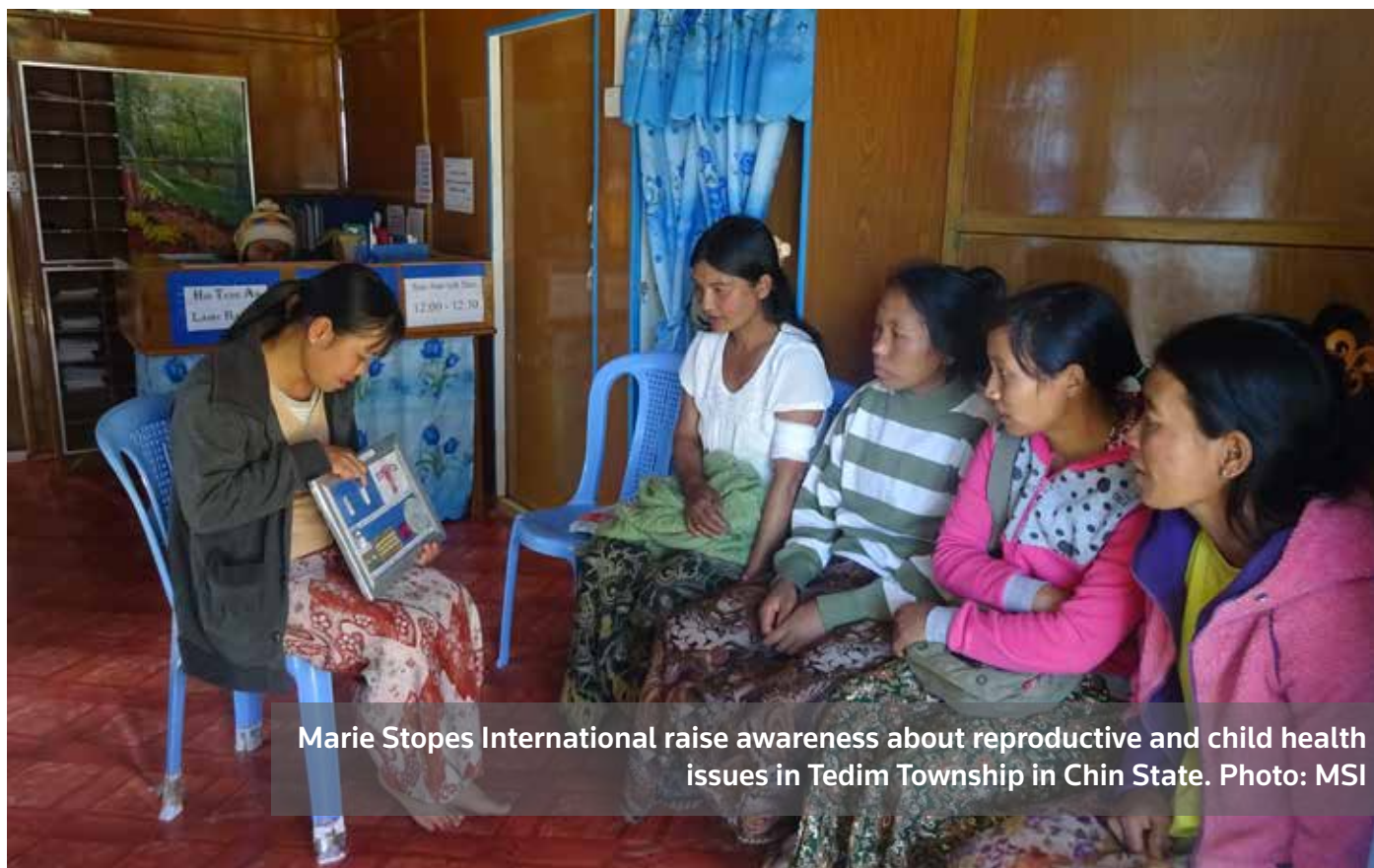
This includes in remote areas like Falam Township in Chin State, with 50,000 mainly rural residents dispersed over 188 villages. Around 96% of the population is Christian (Baptist, Methodist, Presbyterian and Roman Catholic), often with traditional views around the use of contraception and family planning methods.

MSI observes that in Chin State, many women are in need of accurate health information, improved knowledge, and confidence to make decisions about their reproductive health. Women typically have many children although they do not always want to, and cannot always afford to do so. The reasons include a lack of knowledge about contraception and family planning, but sometimes even when women are aware of these options they feel pressured to fulfil their husband's wishes or to meet societal expectations about having many children. This results in women having continuous pregnancies, often resulting in miscarriages and other health complications. In Falam, the MSI team provides sexual and reproductive health related services, including family planning counselling, behaviour change communication, and health education talks. Clients are presented with a wide

variety of contraception options: condoms, contraceptive pills, emergency pills, depo injections, implants and intrauterine contraceptive devices.

This work to promote access to contraception is quite sensitive, in a community that is strongly religious and where comprehensive education on sexual and reproductive health is not widespread. Accordingly, MSI has worked closely with local Civil Society Organizations with established relationships in the community to undertake awareness-raising activities, for example at International Women's Day, Chin National Day and World Contraception Day. They have also built relationships in the community by talking to religious leaders in church or during mobile clinic trips.

Information-sharing and transparency has been crucial to MSI's project success due to the sensitive nature of their work. After a period of relationship and trust building, and the provision of clear information, support from religious leaders has improved significantly. The MSI team contacts peers, village heads, midwives, and the religious leaders before going on mobile clinic trips, demonstrating an inclusive approach. MSI has found that by working collaboratively and sensitively with religious leaders, more men in the community are now participating in behaviour change sessions. They hope this will lead to greater support of women within families about decisions relating to family planning, noting that women need ongoing support to assert their reproductive and health rights.



Marie Stopes International raise awareness about reproductive and child health issues in Tedim Township in Chin State. Photo: MSI

5.3 CONFLICT SENSITIVITY

5.3.1 Partnering with EHOs in hard-to-reach areas - CPI

Community Partners International (CPI), a 3MDG partner, has been working in difficult, hard to reach areas in Myanmar for 17 years, closely collaborating with community leaders and non-state partners. CPI has also forged a strong partnership with government health agencies, and is committed to building trust and peace through community-driven health interventions. CPI's work provides one example of working respectfully and collaboratively with local and ethnic health organizations (EHOs) to expand access to quality health services in conflict-affected areas.

CPI has been implementing a 3MDG funded project with six local partners²¹ since September 2013 in Karen State, near the border with Thailand. Two are faith-based organizations (FBO) inside Myanmar that have strong existing relationships with their communities and provide health services in hard to reach areas. The other four partners are Thailand border-based and have been providing health services in non-state actor (NSA) areas where government services have been absent for decades due to conflict between government forces and armed ethnic groups. The value of these partners working in border areas is their knowledge of communities largely hard to access and the use of local languages.

Funding for the 3MDG malaria control and prevention was the first institutional grant for CPI's partners from a funding source based inside Myanmar. With this funding, the following key activities are undertaken: 1) Training of Trainers for partner staff; 2) Multiplier training for volunteers; 3) Malaria testing and treatment as per the National Malaria Control Program Treatment Guideline; 4) Malaria health education; 5) Long Lasting Insecticide Nets to malaria high risk groups; and 5) Supervision site visits to target areas.

The partners' work provides an example of how 3MDG Health for All principles - responsibility, fairness, inclusion, and do-no-harm – can underpin implementation efforts to ensure accountability of their actions. Their work proactively supports non-discrimination and participation of disadvantaged people in rural communities, ethnic and other vulnerable groups, by improving their access to information and services, and by strengthening their capacity to take an active role in community action for health. By fully aligning with other actors, the project works to ensure fairness of distribution of resources to beneficiaries. The project also promotes accountability and

transparency through community-based structures, such as community networks, support groups, Village Health Committees and community feedback mechanisms, including representatives of vulnerable population groups and women in decision-making and local governance.

At the start of the project, there was no direct cooperation and collaboration between the Ministry of Health and EHOs serving remote, hard to reach communities. There was limited sharing of essential information about community health needs as well as malaria data due to lack of trust after decades of war.

To promote more regular and sustained discussions between the Ministry and EHOs, CPI encouraged its EHO partners to participate in malaria coordination meetings organized by the State Health Department and National Malaria Control Program. As the result, CPI's partners were able to raise the voices of communities and integrate field-based challenges into the planning of future malaria priorities of the National Malaria Control Program.

At State/Regional levels, CPI and its partners shared project progress reports on a quarterly basis. This was a significant step forward as longstanding conflict had diminished trust between EHOs and the government to the extent that sharing project and health information was previously considered untenable. This project helped bridge critical gaps and promote dialogue. CPI also seized opportunities for deepening collaboration, including support for EHOs to participate in immunization and TB activities with the State/Regional Health Departments.

CPI and its partners utilize their presence in the villages to enable health outreach. For example, malaria health workers provide one-on-one health education to people when they come for malaria testing. CPI has learned that to access remote and conflict-affected areas requires diligence, trusted dialogue and a profound commitment to transparency.

21. Burma Medical Association (BMA), Karen Department of Health and Welfare (KDHW), Karenni Mobile Health Committee (KnMHC), Kachin Baptist Convention (KaBC), Karen Baptist Convention (KBC), and Mon National Health Committee (MNHC).



A 3MDG commodity tracking system review with Mon National Health Committee and Community Partners International in Mon State. Photo: CPI



Moving Forward

The Fund reflected on lessons learned in 2014 and carefully considered how to refine its approach in 2015, with greater attention given to simplifying key language, tools and processes. Early in 2015, 3MDG articulated its rights-based approach as “Health for All”, and simplified its framework to include four interrelated principles (responsibility, fairness, inclusion and do-no-harm) and four implementation-focused standards (participation, information-sharing, beneficiary feedback, and conflict sensitivity). Attention was paid to finding the right type of technical assistance to support health organizations in building capacity and mainstreaming the Health for All principles, and to address capacity gaps in gender equality, social inclusion, and conflict sensitivity.

Building capacity to implement the Health for All approach was shifted so that it was provided primarily by local specialists, in addition to some ongoing international support, and through the establishment of regular learning groups with 3MDG implementing partners. 3MDG learned that tools and capacity development are most effective when adapted to local realities, and the use of local specialists and cross-learning groups continued in 2016.

In line with adapting to local and national needs, a major milestone came late in 2015 with a request from the then Ministry of Health to receive training from 3MDG-supported civil society organizations to build staff capacity on participatory community engagement methods. This brought together local CSOs and government, and provided an opportunity for health staff to learn about responsibility, fairness, inclusion and do-no-harm in health planning and delivery. This development demonstrated that entry points for working with the Ministry arise when there is a flexible approach to enable support to be adapted to their specific needs.

The 3MDG Collective Voices initiative was also launched early in the year, supporting CSOs and community-based organizations to explore and better understand how healthcare is sought and understood across communities in six states and regions of Myanmar. The results of this work offered valuable insight into what the Ministry for Health and Sports refers to as “knowing the ground reality” and “listening to the voices of the people”. Through the Collective Voices initiative, 3MDG learned about the many complex social determinants of health that are perceived as limiting access to health

in Myanmar. The results from the Collective Voices community consultations will be shared with the Ministry and other stakeholders at a forum in 2016.

Moving forward, there are areas requiring more focus. While capacity building on gender and social inclusion were given greater attention in 2015, there is now a need to move towards more sophisticated and nuanced approaches to gender equality. For example, this might include strategies and tools that recognize the differences in power relationships and health outcomes between women and women, not just between women and men. At the same time, more consideration is needed of robust measures to capture the outcomes and impact of gender initiatives, and mechanisms to facilitate men’s role in achieving equitable access to health. There is also a need to strengthen awareness on the gendered dimensions of conflict, and the specific needs and rights of women in conflict affected areas, including within 3MDG’s own conflict sensitivity tools and approaches.

There have also been ongoing challenges in establishing effective feedback and response mechanisms, due to issues on both the health provider and user sides. In 2016, 3MDG will engage a consultant to qualitatively assess the effectiveness of community feedback and response mechanisms in improving the quality of services and access to better health outcomes, including for the most vulnerable people. This will include identifying and documenting successes and challenges of different models and approaches, and providing recommendations on how to improve the accessibility and inclusivity of the mechanisms, and the responsiveness of health service providers.



Community Partners I



International conduct a field visit to Karen Baptist Convention villages in Kayin State. Photo: CPI

It is now also an opportune time for a review of the overall Health for All portfolio, looking back on two years of implementation and potentially informing the future strategy of a successor Fund. Such a review could include an assessment of how well the framework, the four standards, the assessment tool, and the capacity building interventions have worked to date in strengthening the practices of 3MDG implementing partners to contribute towards a more responsible, fair and inclusive health sector.

Given the political history, socio-cultural environment and enormous diversity in the country, there is clearly a need to find unique ways of working, and tailoring rights-based approaches in health delivery. 3MDG implementing partner case studies in 2015 showed that bringing about change in health systems must go beyond written rules and policies, and extend to the more 'invisible' elements that impact on health, such as trust-building, inclusion, and addressing societal attitudes and norms.

The various approaches used by implementing partners provide valuable evidence and insight into effective and participatory ways to mobilize community voices to inform health policy-making, programming and budgeting. The examples in this report also highlight the importance of a health system that allows for active and informed participation including people's access to information on public health issues, and their inclusion in decision-making. Flexible approaches remain paramount, recognizing the diverse organizational and operational contexts faced by health actors in Myanmar, without requiring everyone to reach the Health for All goals in the same way, and at the same time.

3MDG will remain committed to reducing inequalities in health and improving access to affordable, quality healthcare, especially among poor and vulnerable groups, through a rights-based approach. Efforts will continue to be directed towards ensuring that the Health for All principles do not stand alone merely as good intentions but are supported by a strong focus on implementation and the strengthening of people-centered health systems. The Fund will concentrate on practical measures that can facilitate positive change, and deepen the understanding of what a people-focused, rights-based approach to change might look like in the health sector in Myanmar.

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ANNEX I

WORK UNDERTAKEN UNDER HEALTH FOR ALL TO BUILD CAPACITY IN 2015

ACTIVITIES		OUTPUTS
TRAINING		
1	Accountability, Equity, Inclusion and Conflict Sensitivity Training of Trainers	42 attendees (24 Male & 18 Female) from 23 implementing partners (IPs)
2	Information Sharing, Participation and Feedback and Response Mechanisms	25 attendees (13M & 12F) from 21 IPs
3	Gender and Project Cycle Management	34 attendees (18M & 16F) from 16 IPs
4	Gender and Conflict Sensitivity	64 attendees (38M & 26F) from 26 IPs
5	Disability and Social Inclusion	61 attendees (32M & 29F) from 22 IPs
6	3MDG Orientation and Introduction to Participatory Learning Action (PLA) Tools for Collective Voices organizations	65 attendees (38M & 27F) from IPs and partner community-based organizations.
7	Collective Voices Monitoring & Evaluation Strategy Workshop	27 attendees (11M & 16F) from IPs
8	Community Engagement Training for Ministry of Health staff	298 attendees (151M & 147F) from Ministry of Health
9	Training of Trainers on Accountability, Equity, Inclusion and Conflict Sensitivity (AEI&CS) Assessment 2015	3 sessions facilitated by Pact with Maternal, Newborn and Child Health (MNCH) and HIV/TB/Malaria IPs in November and December
PARTNER LEARNING AND SHARING SESSIONS		
1	Accountability, Equity, Inclusion Focal points learning and sharing	2 sessions
2	Conflict Sensitivity Learning Group	2 sessions
3	Collective Voices Quarterly Forum	1 session
ASSESSMENTS		
Accountability, Equity, Inclusion and Conflict Sensitivity Assessment		18 out of 20 IPs completed an AEI&CS Assessment
ORGANIZATIONAL CAPACITY DEVELOPMENT (OCD) SUPPORT		
Tailored OCD support		Provided by Pact Myanmar to 13 local 3MDG partners (financial management, human resources management, advocacy, fundraising strategies, administrative and logistics support, programme management and strategic planning)
PARTNER EXCHANGE PROGRAMME		
To enhance the capacity of partner organizations and create stronger linkages and synergies between MNCH, HIV/TB/ Malaria and Collective Voices partners, 3MDG facilitated exchange visits between organizations.		One exchange in 2015, more scheduled for 2016



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