

Gender and Equity

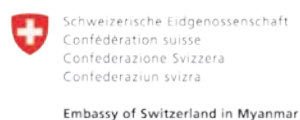
3MDG Annual Report 2017





Gender and Equity

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3MDG IS MANAGED BY  UNOPS



A mother in Chin State nurses her new baby who was born in the hospital thanks to a 3MDG emergency referral. John Rae/UNOPS



Mothers and their babies at the health centre where they gave birth in Sagaing Region.



A father and son wait to be examined at a mobile TB clinic. John Rae/UNOPS

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A woman walks down the street outside a mobile TB clinic. Mobile teams operate around the country to proactively find hidden cases of TB. John Rae/UNOPS



Midwives dash through the rain at their midwifery school in Ayeerwady. 3MDG is financing Jhpiego to improve education for midwives in Myanmar, with a focus on hands-on skills. Jhpiego



Women in Kachin State walk with their belongings across a difficult landscape. Drug use is a major problem in the state due to high levels of opium production and poverty. AHRN

Foreword

Gender equality is about equal rights, equal opportunities and equal access to the resources needed for a fulfilling life. This includes alleviating the barriers faced in access to health. This year's annual report highlights the progress that the Three Millennium Development Goal Fund (3MDG) and its partners have made in advancing gender equality within 3MDG-funded programmes and through institutionalizing gender equality in partner organizations and communities. This work contributes to the empowerment of women and girls (Sustainable Development Goal 5) and supports Myanmar's Strategic Plan for the Advancement of Women (2013–2022).

Through a commitment to fairness and inclusion, 3MDG also extends access to groups who may express non-conforming sexual behaviour or gender identity. This includes transgender persons and men who have sex with men. Support is also extended to people with disabilities, women who migrate, women in hard-to-reach areas and women from minority ethnic and religious groups.

3MDG and partners enhance gender equality in many ways:

- | Through women's participation in township and village-level decision-making bodies;
- | Through feedback mechanisms that enhance women's voices;
- | Through the dismantling of barriers to health care;
- | Through the provision of appropriate health care for women, including for pregnancy and childbirth when they are particularly vulnerable to health emergencies;
- | Through the promotion of sexual and reproductive health and rights for all people, including family planning and birth spacing, safe sex and protection from violence.

A country's progress towards gender equality can often be reflected in maternal and child mortality rates. In Myanmar, these rates are far too high. To make sure that women have healthy pregnancies and healthy babies, 3MDG partners support the Ministry of Health and Sports at the township, state and central level to improve pregnancy care,

promote safer childbirth and institutional delivery, and provide family planning and sexual and reproductive health services.

These interventions mean that a woman in a 3MDG-supported township has a better chance of surviving childbirth; she has the resources she needs to nourish herself and her children with nutritious food; and she has the space and confidence to make decisions about her own body, health and fertility. Engaging men in health care and caring roles can bring about better health for the whole family and supports gender equality.

Health conditions impact people in different ways. For example, though most people who use drugs are men, as their spouses, women are affected because of exposure to sexually transmitted diseases, stigma, and marginalization. HIV may be passed on to children through pregnancy or breastfeeding. 3MDG partners have expanded services that provide spouses with the sexual and reproductive health services they need.

3MDG invests in training to extend services to all populations. Trainings on gender, accountability, equity, social inclusion and conflict sensitivity have led to changes in projects. For example, conducting health education and gender sensitization in local languages, or adjusting the opening hours of clinics to accommodate women's childcare schedules.

There is much more that we can do. In 2018, our commitment to gender equality will be strengthened through new grants in nutrition and sexual and reproductive health and rights. We will continue to analyze our gender-disaggregated data to understand where our interventions need adjustment so that we can equally serve all populations in need. Our partners will continue to receive training in gender equality and inclusion. Community voices

(including and especially those of women) will continue to shape project interventions.

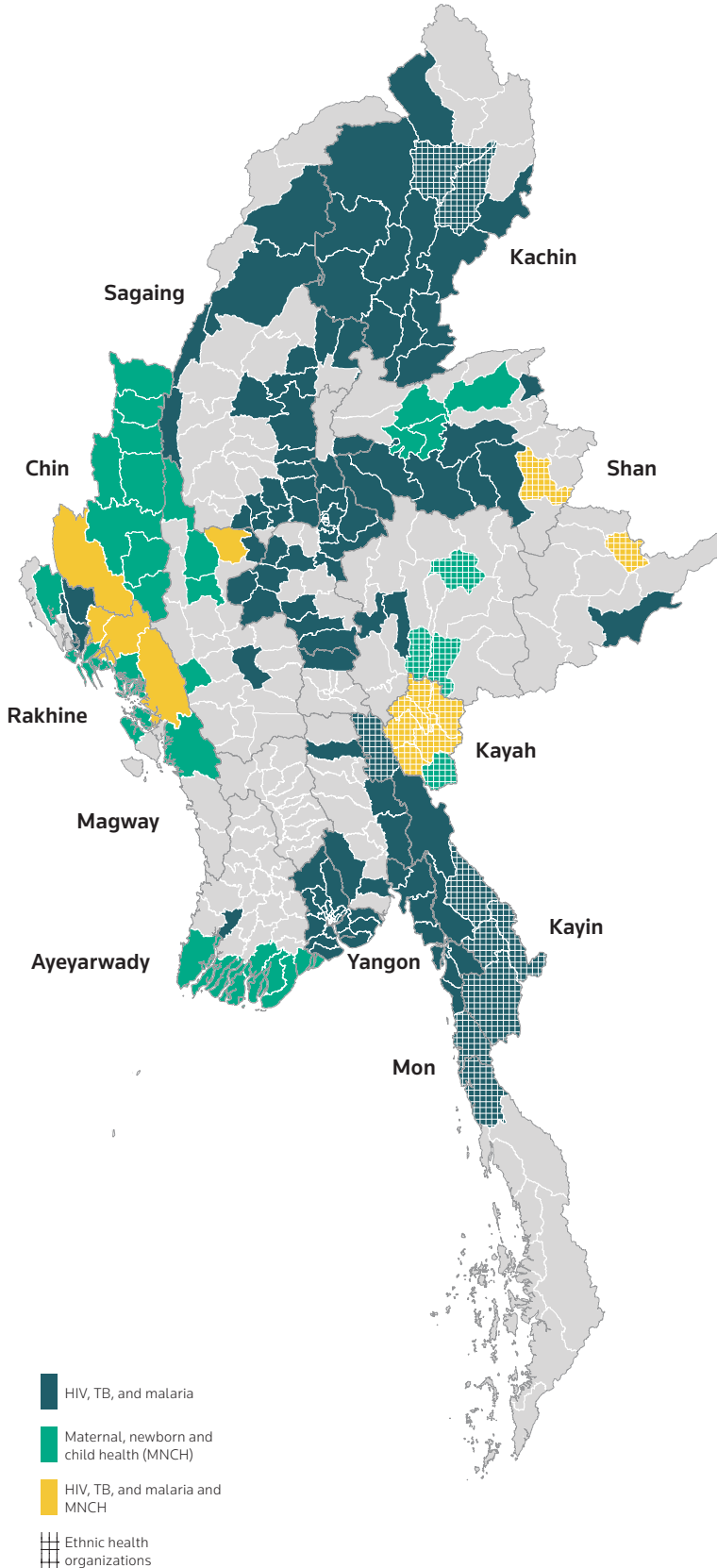
In this report, we have profiled inspiring women implementing gender-sensitive programmes, furthering gender equality, and serving as role-models to other young women and men working in health. We hope they inspire you, as they have inspired us, to continue to fight for equality in health care in Myanmar.



Tomas Lundström
3MDG Fund Board Chair

Coverage

States and Regions



Nationwide Activities

Midwifery strengthening—Jhpiego worked with the Ministry of Health and Sports to improve midwifery education, including upgrading skills labs in all 22 midwifery schools and one lady health visitor school.

Tuberculosis—321 townships were covered by active case finding mobile teams, implemented by the National TB Programme.

Infrastructure—82 rural and sub-rural health centres have been constructed to provide healthcare to poor and vulnerable communities in remote areas, TB health facilities were constructed.

Public financial management—Training of Ministry of Health and Sports staff at central, state/region and township levels, in partnership with the World Bank.

Supply chain management—Helping to ensure essential medicines and health commodities are available when needed through strengthening logistics management systems.

National health information systems—Support to District Health Information System and the Volunteer Recording System.

Health in prisons—Support to improvement of prison health, with construction of four clinics, new Standard Operating Procedures and service delivery.

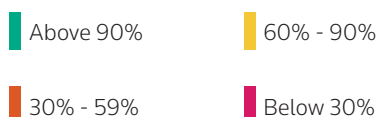
Improving policy—Focus on improving the enabling environment for vulnerable, for example development of the law on rights of people living with HIV.

Nutrition—Alongside sharing of nutrition information and products as part of service delivery grants, support to the National Nutrition Centre began in 2018.

2017 Results at a Glance

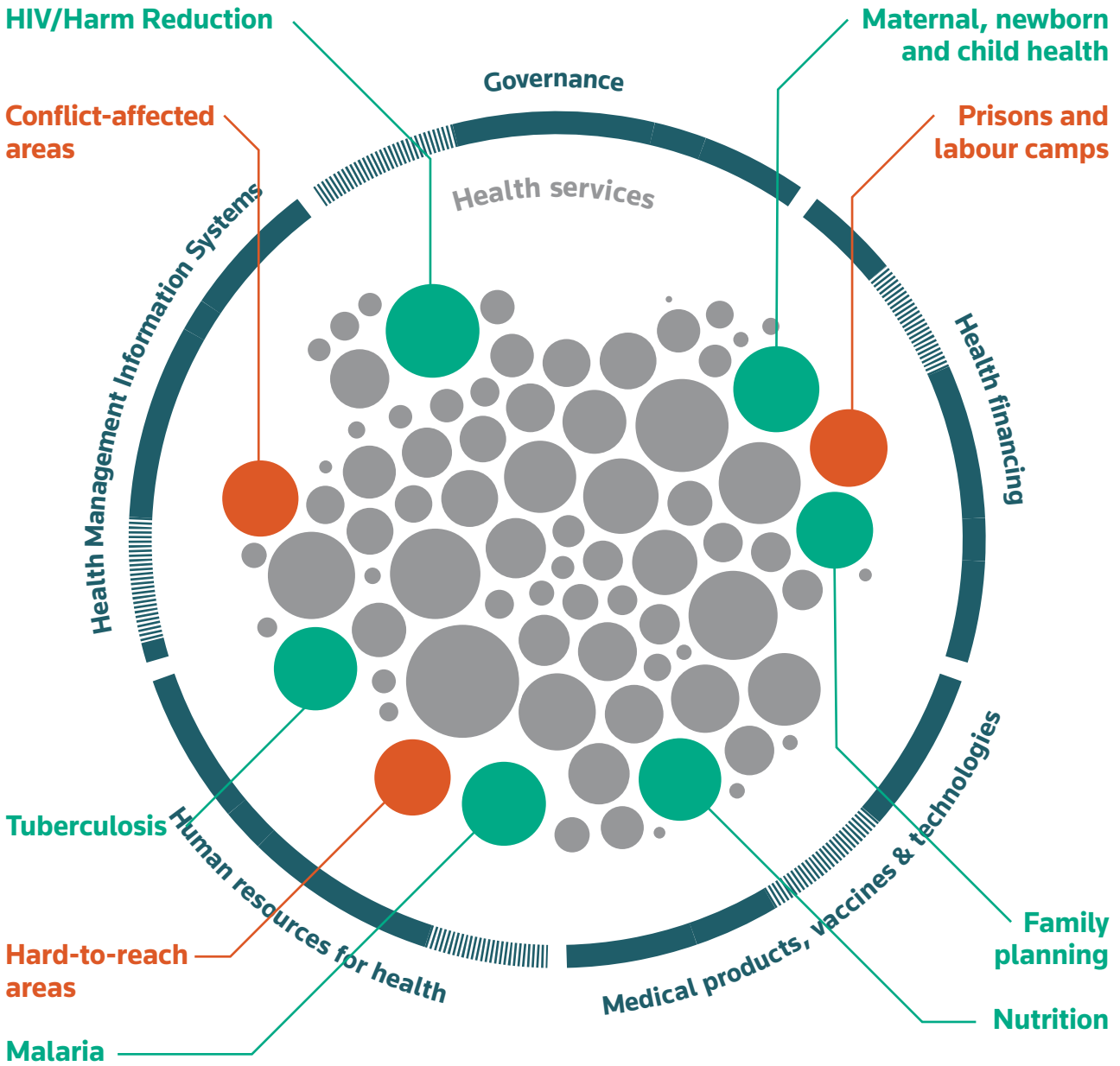


Measuring performance against target (% of target achieved)



See more results in Annex II: Results Matrix.

Areas of work



Strengthening the health system

We work at all levels and with key stakeholders—Ministry of Health & Sports, Ministry of Planning & Finance, development partners, ethnic health, non-government and civil society organizations.

Governance—Including technical support for laws, policies, strategies and plans, such as the National Health Plan 2017 – 2021, the *Law for People Affected by HIV*, and national strategic plans for maternal health, HIV and TB (among others).

Medical products, vaccines and technologies—Including cold chain improvement, helping implement logistics management information system at health centres, construction of health centres, TB laboratories and prison health clinics.

Human resources for health—Including midwifery strengthening and the improvement of village based health workforce, and a Consolidated Human Resources Information and Planning System, using Business Intelligence model

Health financing—Including training in public financial management, strategic purchasing pilot, and analyses to support health financing strategy.

Health management information systems financing—including development of the Strategic Action Plan for Strengthening Health Information, support to the roll out of DHIS2, Volunteer Recording System, and deployment of OpenMRS (medical records system).

Delivering services that are needed now

Maternal, newborn and child health—Including antenatal and postnatal care, immunization, skilled birth attendance and health education.

Family planning—Including the provision of contraceptives and health information about birth spacing.

Nutrition—Including micronutrients and nutrition education about the first 1,000 days.

HIV/Harm Reduction—Including needle and syringe exchange, prevention programmes and Methadone Maintenance Therapy, provided through drop in centres and outreach.

Tuberculosis—Including active case finding via mobile teams, community referrals and treatment support for multi-drug resistant tuberculosis.

Malaria—Including testing and treatment for malaria, vector control and personal protection.

Supporting people who are hard-to-reach

Primary health services are provided to some of the hardest-to-reach, most vulnerable populations in the country – people in prisons and labour camps, people living in remote and inaccessible areas, people living in conflict-affected or non-government controlled areas. Implementing partners receive training,

guidance material and support to make sure services include everyone, including women, people with disabilities and vulnerable populations and feedback mechanisms help the community keep health providers accountable.

Executive Summary

Introduction

Myanmar is in a period of reform and transition. The country is being swept by dramatic social, political and economic changes with movement towards democratization. The journey towards peace and reconciliation continues.

The right to health is proclaimed in Myanmar's Constitution, as well as multiple international instruments to which the country is a signatory. Without health, deep changes in the landscape of the country cannot take their fullest effect. Investing in health enables people to fulfill their potential, reduces the burden of preventable disease, and increases life expectancy. Furthermore, global evidence shows that investments in health stimulate productivity and economic growth.

However, significant inequalities remain in Myanmar's health system. There are wide and troubling disparities on the basis of location (for example, rural-urban), gender, age and ability. Advancements in health indicators over the past few years have not necessarily reached all groups in all places. For example, despite significant reductions in HIV prevalence, rates in vulnerable groups (men who have sex with men, people who inject drugs and sex workers) remain constant or are increasing.

This report, covering the period January to December 2017, focuses on 3MDG efforts to strengthen the health system and promote equality through the delivery of health services. In particular, the focus of the report is on gender equality, highlighting efforts which reach more women with sexual and reproductive health services; empowering more women to make personal and family health decisions; and increasing their participation in the planning and delivery of health services.

Men's role, particularly in nutrition, health education and domestic work, such as cooking and caring, is explored on page 39. 3MDG's 'Health for All' work, in promoting accountability, equity and inclusion through projects is detailed on page 64. A story on the same page highlights the importance of including people with disabilities. Stories of six inspiring women who work with 3MDG implementing partners can be found throughout the report.



At a mobile clinic in Yangon Region, a mother and her child attend a health education session. Nine mobile teams travel around the country to conduct the clinics, looking for cases of tuberculosis and treating other health conditions. John Rae/UNOPS

Our approach

3MDG's approach is underpinned by key principles, aligned to the activities and priorities of the Ministry of Health, in particular those articulated through the National Health Plan 2017–2021. These are: a rights-based approach to health which emphasizes inclusion and fairness, especially for women and people with disabilities; conflict sensitivity and close collaboration with non-government health providers; value for money; and building interventions on evidence. 3MDG supports health systems that put people at the centre, by understanding their needs and hearing their voices.

Results in 2017

The activities and highlights from 2017 are presented geographically. Detailed results by thematic area (maternal, newborn and child health, HIV, tuberculosis, malaria, health systems strengthening) are presented in 'Annex I: Analysis of Results' (see page 96).

In 2017, programmes were running at full speed. The 'Results at a Glance' (see page 7) shows that most indicators met or exceeded targets. Nevertheless, there were geographic disparities, particularly as a result of increased conflict in some states and regions.

States and Regions

Chin

3MDG finances health services and health promotion via eight partners—six implementing partners and two Collective Voices partners. With low uptake of family planning and high maternal mortality, emphasis is on contraceptive prevalence, birth spacing and pregnancy care. In 2017, for the first time on record, there was a significant improvement in contraceptive prevalence rate.

Kachin

With high amounts of drug use due to opium production, conflict, working conditions and poverty, 3MDG delivers services which intend to reduce harm for people who inject drugs. This includes the distribution of safe injection equipment, and provision of prevention programmes to 22,775 people who inject drugs. A women-only drop-in centre helps women who use drugs to access the comprehensive Harm Reduction and sexual and reproductive health services they need.

Kayah

In Kayah State, due to conflict, there are areas that government health services have difficulty reaching. Different health actors deliver health services across the state. To leave no gaps, 3MDG helps to bring actors together to coordinate and plan activities. The Japanese Encephalitis campaign was an example of this—ethnic health organizations, civil society and the Ministry of Health and Sports worked together to vaccinate

nearly all of the children in the state. 3MDG also directly supports basic health staff and volunteer health workers in the state to deliver primary health care services, with a particular focus on maternal, newborn and child health. Results in the state continue to steadily improve, for example 80 percent of women in 3MDG-supported townships had their births attended by a skilled person.

Rakhine

Unrest and restricted access continue in Rakhine State, which contributed to low results across most maternal, newborn and child health services. One positive development was the clearing of some administrative and security hurdles for women using emergency referrals to travel across township borders, helping them access the closest available health services.

Shan

Conflict was also a significant issue in northern parts of Shan State, which affected the ability of implementing partners to deliver health services. For example, only 55 percent of women had their births attended by a skilled person. Community-based approaches did continue to strengthen in the state, which was a positive sign, alongside collaboration with ethnic health organizations which culminated at the Shan State Health Forum at the beginning of 2018.

Ayeyarwady

2017 was a year of transition for Ayeyarwady Region, as health workers in the region and 3MDG implementing partners focused on how to sustain the gains made during the time of the 3MDG Fund. In particular, focus was on the emergency referral programme and strengthening village health funds to ensure sustainable financing and access to emergency care.

Spotlight on Gender

3MDG applies four steps to promote gender equality and access to health in all of its programmes.

Step 1 Understand how gender impacts health status and issues, health seeking behaviour and access to health services, and implement responses

Step 2 Provide essential health services for women and at-risk men, such as sexual and reproductive health and rights services and Harm Reduction

Step 3 Increase access to health with financial support, such as emergency referrals and village health funds

Step 4 Strengthen women's voice and representation, particularly for planning and implementation of health services

Alongside these steps, 3MDG sensitizes and trains implementing partners, Ministry of Health and Sports staff, and community members on the importance of gender-sensitive programming.

3MDG partners encourage men to attend activities that are mainly attended by women, such as health education sessions. Men may be responsible for family decision-making, so giving them the information they need to make good decisions can bring about better health for the family. Partners also introduce concepts like gender equality and encourage men to be involved in domestic work. Bringing families together to make collective decisions can promote more equal gender roles and empower women. See more on page 19.

"I want every woman in Chin State to know that they have rights."

Daw Om Khaw Ti, Deputy Director of COLDA.

Read her story on page 73.

“I knew how much someone’s life could be improved if they were given the right treatment.”

Dr Ni Ni Tun, co-founder of Medical Action Myanmar. Read her story on page 37.

Magway

Magway continues to strengthen its health service delivery, showing improvements again in 2017, especially in regard to institutional delivery (from 19 percent in 2014 to 46 percent in 2017). This is due in part to the 3MDG emergency referral programme. Much like Ayeyarwady, focus in 2017 was in transitioning this programme to full government and community ownership to ensure its sustainability.

Kayin

3MDG works together with ethnic health organizations and implementing partners in Kayin State in active case finding of tuberculosis, diagnosis and treatment of malaria, and other basic health services. Focus in 2017 was also on improving the link between health volunteers and higher level services, especially for tuberculosis which has traditionally been weak.

Mandalay

3MDG supports the delivery of tuberculosis and Harm Reduction services in Mandalay Region. In 2017, community resistance to Harm Reduction services has reduced as a result of continued advocacy. As a result, services have expanded and more people who inject drugs are able to access the care they need to stay healthy.

Mon

With malaria still problematic in Mon State, 3MDG works with three partners to improve vector control and personal protection, as well as test and treat for the disease. Collective Voices partners are also active in the state, uncovering barriers to health care access and ensuring health provider accountability through community feedback mechanisms.

Sagaing

3MDG works with a number of implementing partners to deliver Harm Reduction, tuberculosis active case finding and maternal, newborn and child health services in Sagaing Region. 2017 also saw a new project to deliver health services in prisons which have traditionally been places where health care is limited and prisoners remain vulnerable.

Yangon

3MDG delivers Harm Reduction services in Yangon Region, where there is a high number of people who inject drugs. In 2017, a drop-in centre was relocated, which increased access in a new part of the region. The fight against tuberculosis, (TB) especially drug-resistant forms, is bolstered through community-based care, peer support groups and active case finding.

Thematic areas

Maternal, newborn and child health indicators were stronger across the country, except for in Rakhine State and pockets of Shan State and Chin State. Broadly speaking, however, in townships that 3MDG supports, women are now more likely to access skilled care before, during and after their pregnancy. Women and children under five are better able to access emergency care when it is needed.

It is notable that the contraceptive prevalence rate in 3MDG-supported townships in Chin State has increased for the first time in a number of years (from 25 percent in 2014 to 33 percent in 2017). However, this still lies significantly below overall figures in 3MDG-supported townships in the country (70 percent) and geographic disparities for the indicator are stark. The indicator also increased for other states and regions.

3MDG’s HIV Harm Reduction programme is performing well across all indicators and contributing to national targets. It is mainly delivered in Kachin and Shan states, as well as in Yangon and Mandalay regions. The distribution of needles and syringes—at

17 million in 2017—represents 52 percent of the national achievement. This is an average of 400 per person who injects drugs in 3MDG-supported areas.

3MDG was able to reach nearly 43,000 people who inject drugs—52 percent of the estimated number of people who inject drugs in Myanmar according to the IBBS 2014 (83,000) and 104 percent of people who inject drugs in the coverage area. This number is over target because partners expanded services to previously unreached areas and nearby townships, and continuing advocacy has increased uptake of services (and reduced community resistance). People who use drugs are a mobile population, which also makes the total number difficult to estimate and may mean people access services outside of the area where they live. To reach these mobile populations, 3MDG uses a combination of facility-based services and trained peer outreach workers to provide services.

Tuberculosis (TB) results were strong in 2017. Active case finding activities continued with nine mobile teams making more than 230 visits to nearly 160 townships and 43 prisons and work sites. There were over 55,000 presumptive TB cases referred to township TB centres by community volunteers and health workers. Active case finding continues to be an important way to reach these hard-to-reach populations in prisons, work sites and urban slums, where TB is prevalent. In 2017, 3MDG also supported interventions for multi-drug resistant tuberculosis, such as improvements to community-based care and establishment of self-help groups and construction of new infrastructure to diagnose difficult cases.



A young woman in Yangon Region is relieved after she finds out her son does not have tuberculosis. He was tested after she was found to have the disease. Her treatment began immediately and she was referred on to the township healthcentre for further testing and care. John Rae/UNOPS

In 2017, 3MDG supported 366,002 rapid diagnostic tests (RDT) for malaria; the tests showed increased positivity (through better targeting) and an overachievement of treatment targets (10,821 compared to a target of 7,500). Efforts must continue towards supporting those living in drug-resistant areas and ultimately,

“Everyone, no matter their gender, should have equal access to health care.”

Dr. Aye Muyar Kyaw, Township Medical Officer, Yangon Region. Read her story on page 47.

towards elimination of the disease, to which Myanmar has committed by 2030.

Nationwide activities and systems strengthening

Prison health

The construction and renovation of health facilities in four prisons began in 2017 and will be completed in 2018. Standard operating procedures were finalized and implementation has begun. In one prison, Asian Harm Reduction Network provides primary health care, HIV and TB testing and care, Hepatitis B screening and vaccination and chronic disease management. The project aims to strengthen linkages with health and social services outside prison through referrals. These interventions, detailed further on page 69, are critical to ensuring health

services can reach people in prisons and labour camps, who remain some of the most marginalized populations in the country in terms of access to health care.

Criminalized populations

Despite some progress, barriers remain in ensuring that health services are available for people who inject drugs, people engaged in sex work, men who have sex with men and transgender people in Myanmar. Much of this is due to criminalization of some behaviours, the absence of legally supported rights, and the absence of appropriate services and providers responsive to sexual and reproductive health and rights issues for vulnerable and discriminated populations.

Through UNAIDS, 3MDG invests to reduce legal and policy barriers to effective HIV prevention and harm reduction. In 2017, the *Law on the Rights of People Affected by HIV* worked its way through Parliament (expected to be passed in 2018). UNAIDS and 3MDG played an important role in advocacy and formulation of the draft law. UNAIDS also provided hands-on training to lawyers and police—all professions who are called upon to defend or protect people who use drugs.

Nutrition

Under nutrition rates in Myanmar are among the highest in the region.¹ 3MDG supports partners active in maternal, newborn and child health to provide health education and supplies for good nutrition in the community. These are delivered to the community by basic health staff and volunteer health workers who have been trained on ‘Essential Nutrition Action.’ This is a package of preventive nutrition interventions focused on young children, pregnant

women and micro-nutrients. In 2018, 3MDG will increase its nutrition activities with a specific emphasis on capacity development of the National Nutrition Centre. 3MDG also works together with the Livelihoods and Food Security Trust Fund (LIFT) to provide maternal cash transfers for women in remote areas to access the nutrition they need during pregnancy and for their baby in the first 1,000 days.

Health systems strengthening

In 2017 the 3MDG Fund continued supporting the Ministry of Health and Sports in strengthening governance and stewardship, evidence-based policy making, infrastructure, human resources for health, supply chain management, health information systems, and people-centered healthcare at national and sub-national levels.

Achievements included support to the launch of the National Health Plan 2017–2021 and the establishment of the National Health Plan Implementation Monitoring Unit (NIMU), and the commissioning of two critical studies to help policy makers and implementers better understand the health issues facing the population. Logistics management systems were rolled out in 79 townships and trainings in six states and regions in improved financial management. All but one rural health centre financed by 3MDG has been handed over to the Ministry of Health and Sports and construction of infrastructure key to the fight against multi-drug resistant tuberculosis, including part of a National Reference Laboratory, has been completed. In support to a well-functioning health information system, 3MDG financed the development of the Strategic Action Plan for Strengthening Health Information 2017–2021 led

“I have always believed in the work that we do, but this is not an easy job!”

Ma Thinzar Tun, Programme Director at AHRN. Read her story on page 76.



Young women in Shan State attend the opening of a rural health centre, built by UNOPS and financed by 3MDG. At the ceremony, the Minister of Health and Sports, Dr Myint Htwe noted the importance of collaboration between all health stakeholders to ensure all populations are reached.

by the Ministry of Health and Sports and supported by the World Health Organization. This included support to the roll-out of the District Health Information System (DHIS2) and the Volunteer Recording System.

3MDG continues to support the Ministry of Health and Sports and the broader health sector with implementation research and pilot programmes which intend to test new and innovative ways of delivering and paying for health services. In 2017 this included the strategic purchasing pilot project, village based health workforce and emergency referrals.

The procurement unit purchased just over USD 15 million worth of stock in 2017. 3MDG was covered 131 times in digital media, and 119 times in print media,² including in the Guardian, Frontier, the UNOPS website, and Myanmar news and social media sites.

Lessons learned

From its inception, the 3MDG Fund has been a learning organization. Projects and approaches require monitoring and adjustments to make sure they are responsive to the needs of the population. The lessons learned shape future actions of 3MDG and the Successor Fund, and are shared with other health actors in Myanmar.

In 2017, 3MDG has learned several key lessons, particularly related to accessing hard-to-reach and conflict-affected populations. For example, in Paletwa Township in Chin State, conflict caused displacement from one village to a neighbouring village in November. The 3MDG partner supported the delivery of extra health services from the rural health centre in that village. One medical officer from Paletwa Township Health Department was able to conduct supportive supervision visits to Shin Let Wa. Mobile clinics were able to operate with 3MDG funding.

In Kayin State, buffer stocks were provided in advance for areas not reachable in the rainy season, and the implementing partner staff made arrangements to meet with village health workers at ‘kissing points,’ or accessible areas, to transfer medical supplies, data and provide other support.

“I just want to serve them as long as I can”

Meet Ma Lei Lei Moe, a midwife working in Kayah State. Read her story on page 63.

Fund Status

As one of the largest contributors of external assistance for health in the country, 3MDG has combined the resources of seven donors: Australia, Denmark, the European Union, Sweden, Switzerland, the United Kingdom, and the United States of America to provide around USD 332.9 million in the period 2012–2017. By bringing key donors together in a single fund, 3MDG increases efficiency, achieves scale, pools risks, and provides co-ordinated support to government priorities. It is managed by the United Nations Office for Project Services (UNOPS).

Results since the start of the Fund

6.2 million

People covered by maternal, newborn and child health services in 43 townships, including remote and conflict-affected areas

221,675

Births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)

232,831

Women received ante-natal care four times

261,187

Women received post-natal care visit within three days of childbirth

319,502

Children under one immunized with DPT3/Penta3

312,103

Children under one immunized against measles in 3MDG-supported townships

67,771

Emergency maternal referrals

53,141

Emergency referrals for children under five

42,977

People who inject drugs reached by prevention programmes

52,977,041

Needles and syringes distributed

14,105

People who inject drugs given HIV testing and voluntary counselling

55,571

Notified TB cases (all forms)

2,287,852

Malaria rapid diagnostic tests taken and read

140,239

Confirmed cases of malaria treated

Our Approach

3MDG's work is underpinned by principles under five key areas:

Alignment to the Ministry of Health and Sports

3MDG supports the Ministry of Health and Sports' priorities and operational plans including the National Health Plan 2017–2021 and its annual operational plans, which reinforce commitment to primary health care and equal and universal access to health services. The Fund also works under the umbrella of the national strategic plans for malaria, HIV and tuberculosis, as well as sexual and reproductive health.

3MDG also furthers the Ministry of Health and Sports' progress towards universal health coverage through support to health service delivery in areas where the government simply cannot go. This includes under served communities, remote and border areas and areas affected by conflict. In these places, 3MDG works with ethnic health organizations, community-based and civil society organizations and international and national non-government organizations to make sure that people who are least able to access quality health care have a better chance at a healthy life.

'Health for All': A rights-based approach to health

3MDG is committed to increasing equity in health and improving access to affordable, quality healthcare, especially in rural and hard-to-reach areas and among poor and vulnerable groups.

3MDG's rights-based approach is underpinned by the principles of responsibility, fairness, inclusion and 'do no harm.' The four principles form the basis of the 3MDG Accountability, Equity and Inclusion Strategic Framework, and are reflected in the Fund's financing decisions, which target resources to those who cannot otherwise access services or afford healthcare, including women and children, people living with HIV, people with disabilities and those in conflict-affected areas.

Inclusion of people with disabilities is supported in a number of ways. This includes training for



A nurse at a mobile TB clinic prepares for the arrival of patients. John Rae/ UNOPS

implementing partners and health staff in delivering health services that are responsive and sensitive to the needs of people with disabilities; community-level awareness-raising and advocacy; inclusion of people with disabilities in planning and implementation of health services; and accessibility considerations including and beyond physical access. This work will be strengthened in 2018.

3MDG is committed to ensuring people of all genders can equally benefit from interventions, as well as furthering gender equality through our work. This is framed by 3MDG's Gender Sensitive Steps, which were developed based on 3MDG's Description of Action, Accountability, Equity and Inclusion Strategic Framework, and Gender Approach.

3MDG's Gender Sensitive Steps

The first step is to improve understanding of how gender affects health in Myanmar to inform activities and to build the capacity and knowledge of health staff. The Collective Voices project, for example, aims to understand how gender impacts health-seeking behaviour. Partners are supported to understand the principles of gender equality and inclusion through trainings and capacity development. From

2016 to 2017 attendance of Ministry of Health and Sports' staff in this kind of training has increased. Out of the 5,121 people trained, 2,765 were Ministry staff.

The second step is to provide essential health services for women and at-risk men. Through its implementing partners, 3MDG supports women and children with immunization, nutrition support, pregnancy care and health education and promotion. Contraception and family planning services are also provided via regular service delivery and at drop-in centres, providing sexual and reproductive health services to people who use drugs and their partners. This helps everyone to better plan their pregnancies and family size, and protect against sexually transmitted infections. Men who may be particularly vulnerable are also supported through 3MDG's Harm Reduction programme, tuberculosis and malaria active case finding and health education.

The third step is to increase access to health with financial support.

3MDG currently funds the cost of emergency referral services to hospitals for pregnant women who develop a complication during pregnancy or childbirth in 3MDG-supported townships. This programme is in the process of being transitioned to government ownership. In 2017, 3MDG also supported the establishment of revolving funds to help communities cover their own health costs in emergencies, and supported civil society organizations to improve health-seeking behaviour in communities. This includes empowering women to make health decisions.

The fourth step is to strengthen women's voice and representation. 3MDG works with implementing partners to facilitate the equal engagement of women and men, focusing on information-sharing, participation, and feedback mechanisms that reach women and girls. This is reinforced with behaviour change initiatives for women, men and communities. More women participated in community health education sessions and village health committees in 2017 than in previous years.

Strategy for 3MDG to operate in conflict-affected areas

In 2017, and continuing through 2018, 3MDG has carefully expanded beyond 'do no harm' to maximize opportunities where the Fund and its partners can contribute to peacebuilding and cooperation across conflict lines. 3MDG provides health services to populations in areas with difficult access, in close coordination with partners.

Specifically, 3MDG supports ethnic health organizations and local authorities in Special Regions. These organizations are critical partners in the delivery of health services in these areas as they can often access areas where government health staff cannot.

3MDG has focused on three areas for the expansion of conflict sensitivity activities. The first was to develop conflict sensitivity capacity across the Fund. The reformed Fund structure brings with it an opportunity to streamline 3MDG's conflict sensitivity approach and embed it within programme teams—equipping all teams with the understanding

and sensitivity that is required for conflict-affected areas and work.

In December 2017, the Fund conducted the first two parts of the training with a focus on overall context and history of Myanmar's long-standing conflict and good practices for implementing partners' conflict sensitive approaches. The session will be followed up as the Fund transitions to its successor, ensuring that the approach remains aligned to realities on the ground.

The second area is the provision of assistance to 3MDG partners. Partners operating in conflict-affected areas have requested targeted support to respond to their rapidly changing contexts. In late 2017, the Fund started working with a team of technical experts from CDA Collaborative Learning Projects. The project aims to provide tailor-made assistance to partners, building on pre-established good practices. It began with a consultation with partners, and from this an implementation plan will be developed alongside the Fund's transition.

The third area focuses on advancing towards a peacebuilding outcome. The health agenda brings different actors together around specific, result-oriented discussions. Progress on shared goals has the potential to build trust for further dialogue and collaboration. Some implementing partners have undertaken similar initiatives but not to a sustained, large scale. Building on their work, 3MDG will facilitate advocacy and dialogue to enhance cross-learning opportunities with a wide range of partners, governmental and non-state actors.

In October 2017, the Fund organized a 'Lessons Learned Workshop on engagement of service providers in conflict-affected areas' in one state, in collaboration with the Ministry of

Health and Sports, ethnic health organizations and implementing partners. 3MDG also completed the first round of consultation with other major multi-donor funded programmes under the UNOPS umbrella. This will enable 3MDG to accelerate its contribution towards peacebuilding.

Value for money

By pooling the contributions of several bilateral donors, 3MDG promotes the efficient and effective use of development funds. 3MDG is managed by the United Nations Office for Project Services (UNOPS), resulting in increased efficiency and economies of scale through shared services in procurement, human resources, finance and other support services.

The findings of the benchmarking study commissioned by the 3MDG Fund Board in early 2017 assessed various Fund Management options for the future fund. The study concluded that UNOPS' management of the Fund was competitive and presented good value for money.

Similarly to previous years, in 2017, 3MDG reviewed the management costs of implementing partners and conducted negotiations to streamline them and to increase the share of national human resources, where feasible. At 3MDG, a number of international positions were converted into national positions.

3MDG is guided by evidence and best practice, and by ensuring that the money with which we are entrusted is well-spent. For example, a value for money assessment conducted in 2016

by Hera (based on 2015 data)³ showed that interventions to improve maternal, newborn and child health are cost effective and good value for money.

3MDG calculates 'in-house' costs per DALY (disability-adjusted life years) averted for HIV, tuberculosis and malaria (see table 1) using the Population Services International impact calculator:

HIV

The 3MDG HIV Harm Reduction programme has been continuously improving in terms of cost effectiveness over the past four years. The increased distribution of needles and syringes among people who inject drugs has led to the reduction of cost per DALY.

Tuberculosis

The unit cost of treatment for tuberculosis and cost per DALY have decreased between 2014 and 2016. The increase in 2017 is linked to the increasing difficulty of finding TB cases. Thus, implementing partners have been trying to access unreached populations in more remote locations which is naturally more costly.

Malaria

The cost per DALY was the lowest cost per DALY averted and per case treated in 2014, due to (i) malaria positivity being much higher (i.e. higher number of cases) and (ii) the National Malaria Programme being one of the main implementers with lower operating costs than other implementing partners. After a three-fold cost increase in 2015, costs have reduced year by year.

The final evaluation of the 3MDG Fund, which is due to take place in the second half of 2018, will include a value-for-money component to assess the cost effectiveness of selected interventions under maternal, newborn and child health and HIV, TB and malaria.

Building an evidence base

Basing health policy on evidence connects the needs and priorities on the ground with interventions at all levels. This helps policy-makers to understand which intervention responds best to which population need, allowing for context dependent implementation. This also supports the effective use of money, and ensures the most critical activities are prioritized. An evidence base enables programme performance assessments and can indicate a need for changes in programme design or for specific corrective actions.

In order to establish a sound evidence base, reliable data is essential. 3MDG uses data from both the national health information system and additional systems established by its implementing partners. For instance, 3MDG supports the District Health Information System (DHIS2) through providing overall support to 32 townships and HIV, TB and malaria support to all townships. This leads to better collection of quality data. It is supplemented by the recent roll-out of the Volunteer Recording System. An update of progress for these two systems can be found in the Monitoring and Evaluation chapter on page 77.

3MDG finances research into the work of the Fund and innovative activities. In 2017, 3MDG supported the production and dissemination of 17 operational research studies and case studies. 3MDG results were presented and discussed in 57 policy dialogues and technical and strategic forums in 2017. Both these figures are well above targeted figures and indicate 3MDG's impact and influence within the health sector in Myanmar.

Implementation research through pilot programmes continued in 2017 in the following areas: the expanded use of misoprostol to prevent post-partum haemorrhage (see page 24); the role of village health volunteers (see page 59); the transition of the emergency referral programme to government-ownership (see page 43); strategic purchasing to test a new method of paying for health care and to increase health seeking behaviour (see page 55); and the implementation of health care in prisons via an implementing partner (see page 69).

Table 1—Cost per DALY averted for HIV, tuberculosis and malaria in USD*

	2014	2015	2016	2017	Average 2014-2017
HIV	74	53	50	41	51
Tuberculosis	102	51	44	47	51
Malaria* (each case)	824** (136)	2,657 (437)	2,557 (421)	2,092 (344)	2,435*** (398)

*Total malaria cases treated with national guidelines are divided by the total expenses by the implementing partners for a particular year to calculate the cost of each case.

**The cost per DALY and per case was significantly lower in 2014, as (a) malaria positivity was much higher (i.e. higher number of case) and (b) National Malaria Control Programme with lower operating costs was one of the main implementers.

***The average is based on data for 2015-2017, as 2014 is not comparable to 2015-17 (National Malaria Control Programme was one of the 3MDG IPs in 2014).

Why Gender?

“States Parties shall... eliminate discrimination against women in the field of health care to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.”

Article 12, Convention on the Elimination of All Forms of Discrimination against Women

“Every citizen shall, in accordance with the health policy laid down by the Union, have the right to health care.”

Article 367, Constitution of Myanmar

Woman and girls' health in Myanmar

Inequality is a major barrier to women's health, and together with location, age, class, ethnicity or ability means that good health and wellbeing elude the majority of the women in the world.⁴ In Myanmar, under-investment negatively impacts both women and men's health.

Following global trends, women in Myanmar have a higher life expectancy than men (69.9 compared to 63.9 years), but in both cases this is low compared to global standards.⁵ Despite improvement, the maternal mortality ratio remains far too high at 282 deaths per 100,000 live births, with wide disparities based on ethnicity, class or the rural-urban divide. Maternal mortality is largely due to avoidable complications.⁶ In 2010, only 38 percent of women with complications were referred to a hospital. Of these, 14 percent died en route due to late referral or transportation delays.⁷

Despite increased uptake, service utilization for birth spacing and contraceptive prevalence still needs improvement. There are significant disparities across the country. Despite a nationwide rate of 40 percent, in Chin the figure was only three percent.⁸ Unmet need for birth spacing services can result in unwanted pregnancies and unsafe abortions,⁹ resulting in increased maternal morbidity and mortality, exacerbated by delays in seeking care.¹⁰ These needs can be more pronounced amongst young women due to health services which are not sensitive to their needs—for example, they may be unable to access contraceptives if they are unmarried.¹¹

HIV prevalence has dropped significantly for the general population, but the disease still remains high in certain populations, including people who inject drugs, female sex workers and men who have sex with men.¹² The number of women living with HIV was estimated as 34 percent of the total in 2013.¹³ Women with low-risk behavior have been infected by partners who inject drugs or engage with multiple sex partners.¹⁴

Though a much lower proportion of the total, there are women who inject drugs. They are also at risk.

Stigma and discrimination may be heightened as they transgress cultural norms related both to their drug-taking activity and their gender and may impede access to health services.¹⁵

Obstacles to women's health status

Poor quality of health services, especially in rural areas, may impact women's ability to achieve good health status. This is worsened by their unequal status which can result in inability to access care.¹⁶ Out-of-pocket expenditure (at about 70 percent in Myanmar, the highest in Southeast Asia) is a barrier to health care for poor people.¹⁷ This may be worsened for women, who are often less able to command household resources to cover costs, exacerbating inequalities.¹⁸

Discrimination in access to health care may be exacerbated in areas with large ethnic minority communities. That's because traditional social values limit women's ability to make their own decisions regarding resource allocation, and coupled with extensive under-development and lack of service availability, civil unrest and hard-to-reach locations, can result in lower health outcomes.¹⁹ The inability to exercise choice over birth spacing means a woman may face risks associated with pregnancy more often.²⁰

Women's health may also be impacted by the focus on reproductive health. For example, less attention is paid to the impact of domestic violence on women, as well as on statistics that suggest more women are overweight and have higher levels of cholesterol than men in Myanmar.²¹

Why invest in women's health?

Women and girls have the right to a healthy life. The enjoyment of this right is vital to their life, well-being, and ability to participate in all parts of public and private life.²²

Women make up a vital part of Myanmar's productive and reproductive workforce. Without good health, the potential of Myanmar's human resources cannot be realized. Investing in women's health may also have multiplier effects. The health of a mother has direct impacts on the health of her child, during pregnancy, childbirth and thereafter.

Women also pass on knowledge of hygiene, sanitation and how to take care of themselves

to their children and to other members of the community. With the responsibility of primary care-givers and nurturers in their community, women impact the health of others—but they need good health themselves to perform this role²³ and to have a better chance of leading a fulfilling life.

Our Work

States and Regions

Chin

Context and health needs

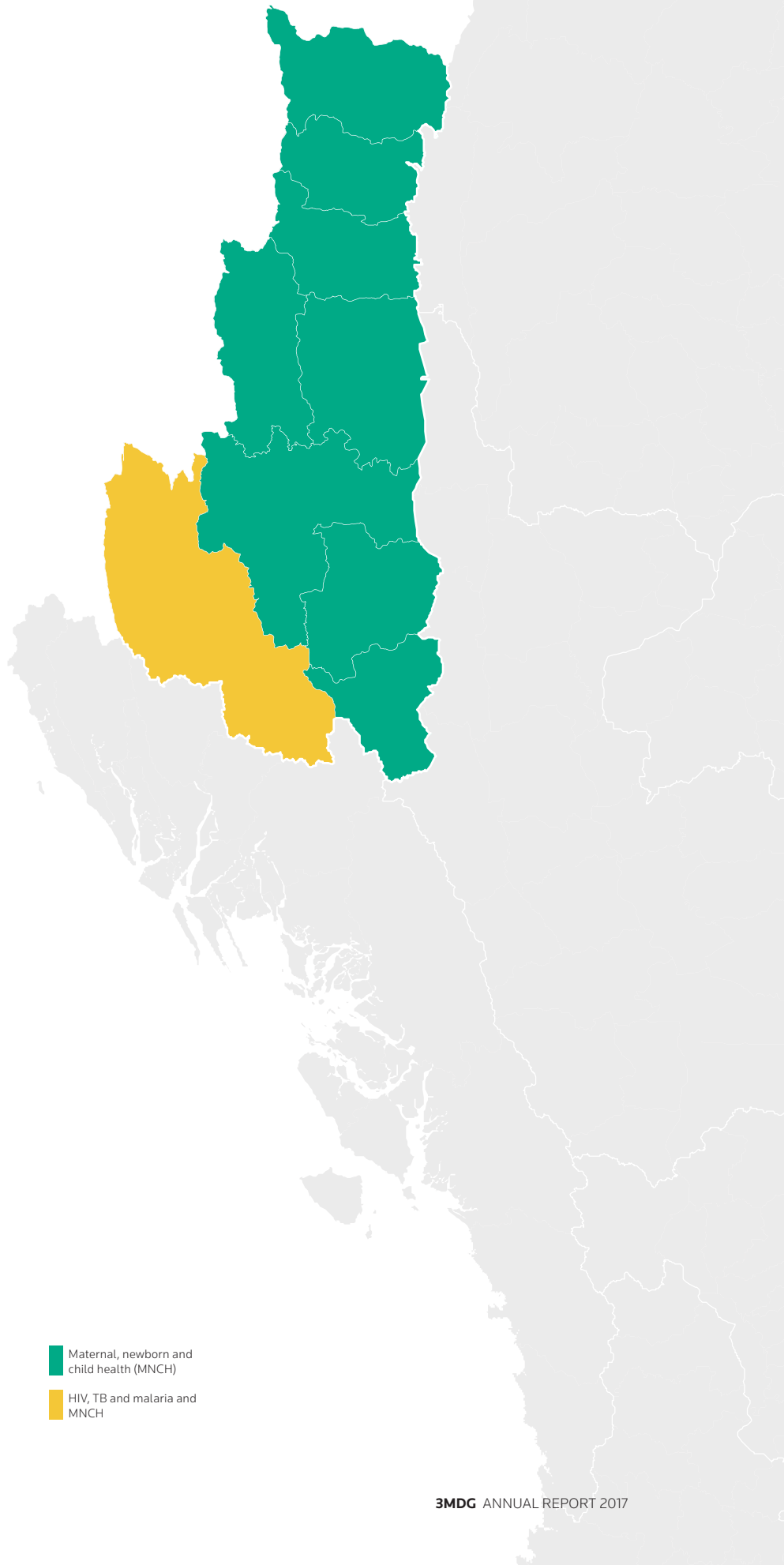
Poor transport and roads, a mobile population and high levels of poverty mean access to healthcare can be difficult in Chin State. Chin has the highest infant and under five mortality rate, maternal mortality ratio and total fertility rate in Myanmar. Family planning and contraception use is the lowest in Myanmar.²⁴

Activities and partners

In 2017, 3MDG financed the delivery of maternal, newborn and child health services in Chin. This included improving immunization, pregnancy care, childbirth, newborn and under five care, emergency care via maternal and young child referrals, family planning, nutrition education, health promotion and community mobilization. 3MDG and partners aimed to strengthen the township health system in line with national guidelines and policies, as well as provide support to the State Health Department.

Local organizations, implementing partners and community volunteers were also supported in 2017. This helps to create widespread impact and strengthen the health system into the future. Activities included training and supervision of the health workforce, capacity development of target communities to enhance accountability, distribution of essential medicines and services, outreach, emergency referrals and supporting mobile teams. Collective Voices partners helped overcome barriers to healthcare, including language and health knowledge. See more about the Collective Voices project on page 66.

3MDG worked in all nine townships in Chin State in 2017. There were six partners: Save the Children, Danish Red Cross, International Rescue Committee, Population Services International, Marie Stopes International, Myanmar Health Assistant Association, and two Collective Voices partners: Ar Yone Oo Social Development Association and Community Agency for Rural Development.





A father and his infant in Mindat in Chin State. The child was saved as the result of an emergency referral which his mother received during childbirth. John Rae/UNOPS

Voices

“Luckily, all the patients got better day by day.”

U Hlun Khis is a community health worker in Thangaw Village, Thantlang Township in Chin State. He was recruited in 2014 by the Township Health Department with the support of Save the Children. He was instrumental in ensuring that an outbreak of acute respiratory infection did not spread further.

“On the first day of September, some of the children from my village came to see me as they were suffering from fever and cough. I examined them and gave them the right medicines, telling their parents to come back for follow-up if they did not get better.

“When I recorded everything in the Volunteer Recording System, I saw just how many patients who were under five years of age I treated on that day. I quickly organized a meeting with villagers, the health committee members and basic health staff to inform everyone of what I had seen.

“A few days later, one villager informed me that some of the people from their village were also suffering from fever and cough. With the basic health staff, we went there immediately—but we did not have enough medicines to treat everyone, so we got in touch with Save the Children and the Township Health Department, who arrived that evening to help.

“In total, treatment was provided to 52 patients (43 children under five) with acute respiratory infection. But this wasn't the only issue. There was also upper respiratory infections and gastroenteritis disease: 11 cases of children under five and 104 cases of people above five years of age. Five cases needed to be referred to the hospital and received referral support. Luckily, all the patients recovered.

“To make sure everyone knows how to prevent this sort of outbreak in the future, we have concentrated on sharing health information about good ventilation, nutritious foods and clean water with the community.”

Spotlight on Gender

Mothers' clubs improve health knowledge in Chin State

The facts

| Since 2015, Danish Red Cross and Myanmar Red Cross Society have introduced the Mothers Club model programme in Mindat and Matupi townships

| For each club, 15 mothers are selected to increase their health knowledge, improve health seeking behaviour and further disseminate what they learn to other villagers

| 15 clubs have been formed in each township. They meet monthly for health education sessions

| The mothers are trained by Basic Health Staff on primary health care. They share experiences with each other about how the knowledge they have learned has been applied in their lives. One of their main activities in 2017 was to set up cooking demonstrations to educate the community on proper nourishment for mothers and babies

Why it matters

The objective of the group is to enhance the health knowledge of mothers through a learning system that is appropriate to their needs and level of education. Ultimately, the goal is to improve the health status of children under the age of five, their mothers and pregnant women, especially those in hard-to-reach areas.

Results

7,574 (60%)

Births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)

2,193

Emergency maternal referrals

7,789 (61%)

Women received antenatal care at least four times before delivery

11,906 (95%)

Children under one immunized with DPT3/Penta3

See more results in Annex II: Results matrix.

Highlights in Chin

Changing attitudes to contraception—

Religious and cultural factors have contributed to resistance to contraceptives in Chin State, creating stagnation in usage. Marie Stopes International is working to change attitudes to contraception and provide contraceptives in seven townships in Chin State. Core activities are awareness-raising and behavior change communication, working particularly with young people and local churches with continuing advocacy to key gatekeepers. The contraceptive prevalence rate has increased from 27 percent in 2016 to 33 percent in 2017—the first notable increase for many years.

Giving women more options through more accessible contraceptives with a new delivery method—

Long term contraceptive Depo Provera can only be administered by midwives and doctors, creating difficulties in access in hard-to-reach areas. A new delivery method (called ‘subcutaneous DMPA’) is a lower dose of injectable contraceptive that is administered every three months under the skin rather than into the muscle. Following advocacy with the state and central level Ministry of Health and Sports, it was agreed that auxiliary midwives could also administer this method. Training was done in 2017 at state and township levels, managed by the Maternal and Reproductive Health Division with commodity support from UNFPA and training support from 3MDG.

Preventing post-partum haemorrhage

Chin State has the highest maternal mortality ratio in the country with 357 deaths per 100,000 live births. Most are a result of post-partum haemorrhage. A new study undertaken by the Ministry’s Maternal and Reproductive Health Division and 3MDG aims to increase the use and availability of misoprostol—a drug which prevents post-partum haemorrhage thus potentially saving the lives of many women. Presently, auxiliary midwives are not allowed to provide misoprostol, however

results from this study may change that. To date, auxiliary midwives have received initial training in its use.

Making strides in malaria prevention and control—

Myanmar Health Assistant Association (MHAA) is implementing community-based malaria prevention, diagnosis and treatment activities in Paletwa and Kanpalet townships. The focus has been on the provision of integrated services to make the most of the skills and effort of volunteer health workers. A total of 120 volunteers have been trained to provide integrated services under the Integrated Community Malaria Volunteer (ICMV) model. MHAA also joined together with township health departments and other partners to carry out larval and adult mosquito control activity in all project townships and have organized one township-level advocacy meeting in Kanpetlet (where malaria is particularly problematic) to discuss programme coverage. These activities have increased the range of routine service coverage for malaria services to 20 extra villages.

Achievement of key indicators in maternal, newborn and child health—

The achievements of the emergency referral, immunization, skilled birth attendance and health facility delivery indicators are particularly significant in a state which has shown difficulty in making these improvements. Health services are becoming more accessible, due in part to 3MDG support to the transportation costs of basic health staff on their outreach visits. Health data is being better analyzed to develop plans which reach people most in need.

Roll-out of death surveillance systems—

With the guidance of the Maternal and Reproductive Health Division and together with UNFPA, 3MDG helped facilitated the roll-out of Maternal Death Surveillance Review System in Chin State and other 3MDG-supported townships in the country. The Child Death Surveillance Review System was also established through collaboration with Child Health Division and UNICEF. These systems are crucial to reducing preventable maternal and children deaths through continuous identification, notification, review of cases and responses to any patterns or trends.

Chin

Activities and partners

	Activities	Partners	Townships	2017 Expenditure in USD
Collective Voices	To enhance women's decision-making power in personal and family health decisions, the Collective Voices organizations focus on increasing women's representation and strengthening the capacity of Village Health Committee members, increasing male involvement in nutrition and health education for shared roles in family health, and establishing pooled community health funds to cover emergency health needs.	Ar Yone Oo Social Development Association	Mindat, Matupi, Kanpetlet	83,226
Family planning	Sexual and reproductive health services (family planning, cervical cancer screening, prevention and treatment of sexually transmitted infections) provided through static clinics and outreach teams; awareness-raising, behaviour change communication and social marketing.	Marie Stopes International	Hakha, Thantlang, Paletwa, Mindat, Matupi	757,011
Malaria	Testing and treatment for malaria, trainings to community-based volunteers, community awareness-raising sessions, vector control activities conducted jointly with township health departments.	Myanmar Health Assistant Association	Paletwa, Kanpetlet (+ 3 townships in Kayin, 1 township in Bago, 5 townships in Rakhine, 1 township in Kayah)	Under Rakhine Grant
Maternal, newborn and child health	Maternal, newborn and child health activities implemented in the framework of township health plan, including support to midwives for outreach services for hard-to-reach and accessible areas, training and commodity support to volunteers, community-based referral services for pregnant women and children under five years, and delivery of behaviour change communication interventions.	Danish Red Cross	Mindat, Matupi	756,118
	Support to midwives for outreach services for hard-to-reach and accessible areas, training and commodity support to volunteers, community-based referral services for pregnant women and children under five years, and delivery of behaviour change communication interventions.	International Rescue Committee	Kanpetlet, Paletwa	1,048,807
		Save the Children International	Tedim, Falam, Hakha, Thantlang, Tonzang	2,497,072

*USD 1,178,778 is the budget for MHAA malaria activities in Kayin, Bago, Rakhine and Chin in 2017. Due to the nature of the budget, we cannot separate only for Chin.

Kachin

Context and health needs

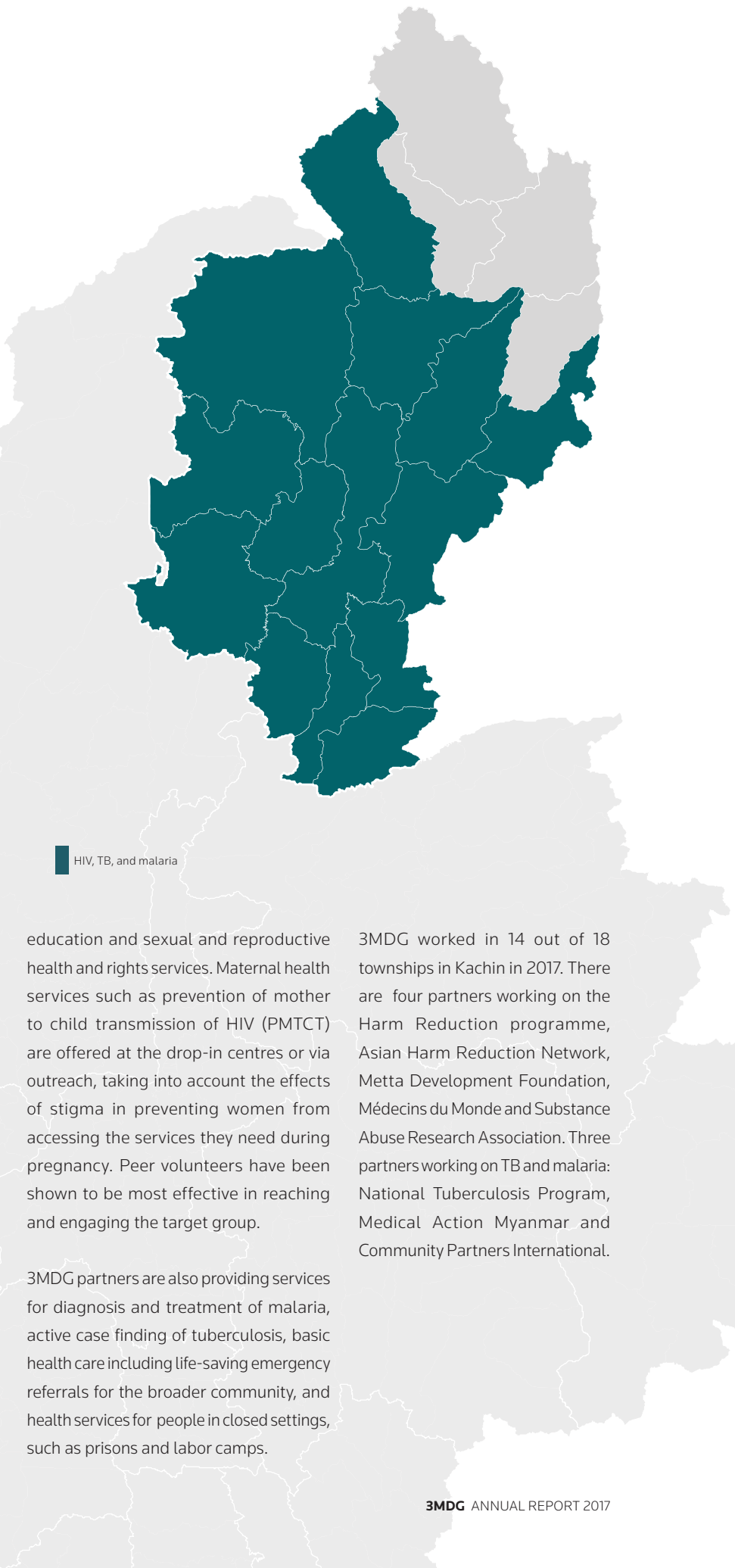
As one of the producers of Myanmar's opium, in a complex context of vulnerability and risk, Kachin State has a HIV rate about five times higher than the national average. In some parts of the state, nearly one out of two people who inject drugs is living with HIV. These people may also face a higher risk of other diseases such as tuberculosis and Hepatitis B and C, discrimination and criminalization. For women who inject drugs or who are living with HIV, this can be particularly challenging as they fear stigma, gender stereotypes and compounded discrimination.

Kachin State is also the location of one of the world's longest running conflicts, which has an immediate impact on the availability of health facilities and quality of health services. This context of disadvantage extends to education, welfare and livelihood services and options. The gap in health and other facilities and services has, to a certain extent, been filled by local people and organizations, which are critical to ensuring health and other services can be delivered to some of the most difficult areas. Involving the community in health activities can reduce resistance and increase understanding.

Activities and partners

To reduce the harmful consequences of drug use, 3MDG's implementing partners offer a package of health services in high risk areas of Kachin State. This is known as 'Harm Reduction', and is part of a broader right to health agenda. Services are offered at clinics, drop-in centres or through mobile outreach programmes. In 2016 and 2017, one in every two people reached by a Harm Reduction intervention was supported by 3MDG.

To make sure that people who use and inject drugs have access to the services they need, 3MDG partners offer a comprehensive set of services on top of the typical Harm Reduction package (see 'What is Harm Reduction' on page 28). 3MDG partners also offer diagnosis and referral for treatment of tuberculosis, as well as health



education and sexual and reproductive health and rights services. Maternal health services such as prevention of mother to child transmission of HIV (PMTCT) are offered at the drop-in centres or via outreach, taking into account the effects of stigma in preventing women from accessing the services they need during pregnancy. Peer volunteers have been shown to be most effective in reaching and engaging the target group.

3MDG partners are also providing services for diagnosis and treatment of malaria, active case finding of tuberculosis, basic health care including life-saving emergency referrals for the broader community, and health services for people in closed settings, such as prisons and labor camps.

3MDG worked in 14 out of 18 townships in Kachin in 2017. There are four partners working on the Harm Reduction programme, Asian Harm Reduction Network, Metta Development Foundation, Médecins du Monde and Substance Abuse Research Association. Three partners working on TB and malaria: National Tuberculosis Program, Medical Action Myanmar and Community Partners International.

Reaching the spouses of people who inject drugs

Ma Doi Ja* knew her husband was injecting drugs. But one day at the hospital, she found out he also had HIV. She was immediately tested too; the result was negative. Though they were given condoms to prevent transmission, “He didn’t want to use them,” Doi Ja said. “I didn’t discuss again so as not to upset him.” When she later became pregnant, she was screened again. This time the result was positive.

Injecting drug use is a major health issue in Myanmar, particularly in areas rife with opium cultivation and drug production and along transportation routes. People who inject drugs face a much higher risk of HIV, other sexually transmitted infections and Hepatitis C infection than the general population,²⁵ but their partners are often forgotten. They are also at high risk, and for female partners, they also risk transmitting HIV and other communicable diseases to their children during pregnancy, delivery or breastfeeding.

Condom use can help prevent the spread of HIV, but only around a quarter of the people who inject drugs in Myanmar practice safe sex, according to the World Health Organization. They may be reluctant to carry and use condoms because they are scared of stigma and discrimination.

“People insult us. They call me the ‘wife of a drug user’. They suspect that I have HIV so they discriminate against me,” said a woman from a village in Kachin State whose husband uses drugs.

Women who want to practice safe sex might live far away from health facilities, or not know where to get condoms. Those decisions might be made by their partners, leaving their health in someone else’s hands. Many healthcare workers also display prejudicial attitudes towards affected populations.

In 2017, 3MDG financed two studies into spouses and intimate partners of people who use drugs.

Report recommendations are being implemented in 2018, including the delivery of comprehensive sexual and reproductive health services via drop-in centres and outreach, women-friendly centres and more health education.

*Name has been changed

What is Harm Reduction?

People who inject drugs need health services, but they often face stigma, discrimination and criminalization. There are services which can help, known as ‘Harm Reduction,’ which approach drug dependence as a health issue rather than a criminal issue. The rights of people who use drugs are respected, and services are delivered in a non-judgmental and inclusive way. Services focus on prevention, education, treatment and support, and may include HIV and Hepatitis B and C testing, counselling and treatment, needles and syringe exchange and condom distribution. A move towards integration of testing and treatment for TB begins the long journey to address the high rate of HIV and TB co-infection.

Harm reduction interventions do not stop with people who inject drugs. 3MDG partners offer access and referral to comprehensive sexual, reproductive and maternal and child health services in recognition of the vulnerability of people who inject drugs, their intimate partners and children. This includes prevention of mother-to-child transmission, provision of condoms, screening of sexually transmitted diseases, family planning, counselling and health education. Unfortunately, health facilities and services are limited and often provided in a stand-alone, vertical manner, and funding is similarly limited, so services do not cover all people needing support or their full range of needs.

Spotlight on Gender

A hidden population: women who inject drugs The facts

Three women outreach workers (13 percent of all outreach workers) and six women peer support workers (17 percent of all peer support workers) were recruited to reach women who inject drugs in 3MDG-supported townships in Kachin State.

A women-only drop-in centre opened in Kachin State and a separate room for women opened in another centre.

A women’s peer support group was formed, comprised of current and former women who inject drugs. They assemble safe-injection needle and syringe packages to generate income.

Why it matters

Women who inject drugs are a hidden population. Stigma and marginalization, common for all people who inject drugs, is compounded by their gender, as they defy social and cultural norms and gender roles. They may avoid health services, which often do not cater to their specific needs.

A women-only drop-in centre and more women employees increase access for women who inject drugs to Harm Reduction and sexual, reproductive, maternal and child health services. This reduces their risk of HIV and other infectious diseases and allows them to access care needed if they are pregnant. They receive support from their peer group, and can better access health services in a safe and comfortable space.

Results

22,775

People who inject drugs reached by prevention programmes

8,823,514

Needles and syringes distributed

4,359

People who inject drugs given voluntary confidential counselling and testing for HIV

26,223

Suspected TB cases examined

1,539

Notified TB cases (all forms)

300

Notified bacteriologically confirmed TB cases

33,479

Malaria rapid diagnostic tests (RDT) taken and read

165

Confirmed *Plasmodium falciparum* malaria cases treated

156

Confirmed *Plasmodium vivax* malaria cases treated

See more results in Annex II: Results matrix.



Backbreaking conditions in the mines, easy access to opium and crippling poverty have led to an epidemic of drug use in parts of Kachin State, resulting in high levels of HIV amongst people who use drugs. 3MDG implementing partners are working hard to minimize harms associated with drug use. AHRN

Highlights in Kachin

Community-based Harm Reduction work—A programme implemented by Metta has sensitized the community to Harm Reduction work in Kachin State, particularly critical due to past community resistance impeding service delivery and access. Metta has been able to counterbalance this local resistance by working at all levels of society: advocacy with the government allowed the administration of HIV testing and counselling at drop-in centres, advocacy with the community for implementation of Methadone Maintenance Treatment (MMT) for people in remote areas and advocacy with the Pat Jasan led to a good relationship with the community. As a result, people who inject drugs are better able to access health and social services and increasingly benefit from the support of more informed and understanding families and communities.

Services are delivered in two main ways: outreach and drop-in centres. In both, health personnel are joined by peer volunteers—who may be people who formerly used drugs themselves—to conduct activities. This allows people who use drugs to be supported by others who understand their experience, and peer volunteers to gain meaning and empowerment while earning an income.

Drop-in centres provide a sense of community and a supportive environment for all. The women-only centre offers a space for women’s specific needs to be met in a comfortable environment. This also includes comprehensive services related to women’s health, such as pregnancy care.

Local AIDS Committees—Eight new village-level AIDS committees were established in Kachin State, with aims to raise support for people who inject drugs. Activities included income generation, sports and recreation, trash collection campaigns, community education and social events. The committees helped to introduce a *de facto* decriminalized approach to drug use and drug dependence by developing closer relations with local police and intervening when people who use drugs are apprehended.

Working in Special Regions—3MDG partner Health Poverty Action is working in Wa and Mongla Special Regions in Shan State. From 2018, Health Poverty Action is also working in Kachin Special Region 1 and Kachin Special Region 2, taking over from a DFID-funded project. In 2018, project activities will continue to expand based on collaboration with the Ministry of Health and Sports, ethnic health organizations and other partners. This includes strengthening local health systems, generating health services, and linking ethnic health organization systems and the government health system through planning, technical support, medical supplies and health information integration.

Kachin

Activities and partners

	Activities	Partners	Townships	2017 Expenditure in USD
HIV/Harm Reduction	Providing technical support to Metta for addressing drug use and health-related consequences through community engagement	Médecins du Monde	Waimaw, Moenyin, Tanai	164,248
	Addressing drug use and health-related consequences (HIV, Hepatitis B etc) through community-based harm reduction services with community engagement and mobilization	Metta Development Foundation (Metta)	Waimaw, Moenyin, Tanai	329,986
	Addressing drug use and health-related consequences, through HIV and TB referral, viral Hepatitis B screening and vaccination, health education	Substance Abuse Research Association (SARA)	Moegaung, Moenyin, Moemaik	608,942
HIV/Harm Reduction and Prison health	Addressing drug use and health-related consequences (HIV/TB, malaria, viral hepatitis, sexually transmitted infections) integrated with sexual and reproductive health and rights services. Provision of health services including HIV counselling and testing, TB screening, Hepatitis B diagnosis and vaccination	Asian Harm Reduction Network Myanmar (AHRN)	Hpakant, Waimaw, Shwegu, Bahmo (+ 1 township in Shan, 5 townships in Sagaing)	3,072,445*
Improving prison health infrastructure	Construction of prison health infrastructure (men's clinic and women's clinic in Myitkyina and Lashio Prisons.	UNOPS	Myitkyina, Lashio, Yangon	1,218,213
Integrated health services including malaria, TB, and basic health care services	Providing community-based integrated health services including early diagnosis and prompt treatment of malaria cases, tuberculosis active case finding, emergency referral and basic health care in hard-to-reach areas.	Medical Action Myanmar (MAM)	Bhamo, Chipwi, Mansi, Momauk, Myitkyina, Shwegu, Tanai, Puta-O, Waingmaw (+ 4 townships in Mon, 3 townships in Kayin, 3 townships in Kayah, 1 township in Tanintharyi)*	2,043,565**
Malaria	Providing community based early diagnosis of malaria and prompt treatment services in hard-to-reach areas	Community Partners International (CPI)	Injayang, Sumprabum (+ 6 townships in Kayah, 5 townships in Kayin, 2 townships in Kachin, 1 township in Mon, 1 township in Tanintharyi)**	1,013,702***

*USD 3,072,445 is the budget for AHRN activities in Kachin, Shan and Sagaing. Due to the nature of the budget, it cannot be separated only for Kachin.

**USD 2,043,565 is the budget for MAM activities in Kachin, Kayin, Kayah, Mon and Tanintharyi in 2017. Due to the nature of the budget, it cannot be separated only for Kachin.

***USD 1,013,702 is the budget for CPI activities in Kayin, Mon and Tanintharyi in 2017. Due to the nature of the budget, it cannot be separated only for Kachin.

Kayah

Context and health needs

Kayah State in eastern Myanmar has been affected by conflict for nearly 70 years. This has severely impacted infrastructure, roads and the availability and delivery of health services. The maternal mortality ratio in Kayah (and Kayin) State is 276 per 100,000 live births.²⁶ This is the eighth highest in Myanmar and high compared to countries in the region and global standards. The case notification rate (CNR) for all forms of tuberculosis is 196 per 100,000 people,²⁷ which is not high within the country but is unacceptable compared to global standards.

Much of the state is out-of-reach for government health workers, and health services are delivered by ethnic health organizations. They are often under-resourced and health services do not adequately meet the needs of communities. In the most remote areas, there are also difficulties in accessibility, high transportation costs and insufficient human resources for health. High levels of ethnic and linguistic diversity and low literacy levels can mean it is difficult to communicate health information, concerns or feedback.

Activities and partners

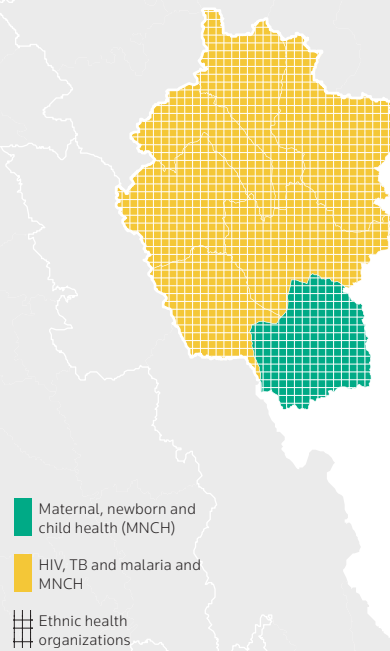
3MDG support helps to bring together a large number of actors in Kayah State, including ethnic health organizations, the Ministry of Health and Sports, civil society and community-based organizations and non-government organizations. Each plays an important role in ensuring that health services—in particular maternal, newborn and child health, malaria and tuberculosis testing and treatment—reach even the most remote and isolated places, including conflict-affected areas.

3MDG supports township health departments and the State Health Department in planning and coordination and the implementation of township health plans. Additionally, it funds activities to improve the capacity of basic health staff and provides supervision and monitoring. However,

there are areas where the government cannot reach. 3MDG supports ethnic health organizations (who have joined to form the Civil Health and Development Network (CHDN)), as well as civil society (CSOs) and community-based organizations (CBOs), to provide health services, education and promotion in these areas. To bolster these efforts, a CSO health network and representatives for the Myanmar Health Sector Coordination Committee (MHSCC) have been established and principles of accountability, equity, inclusion and conflict-sensitivity introduced through their work.

3MDG worked in all seven townships of Kayah State in 2017. There are three partners working on malaria and active

case finding of tuberculosis: Myanmar Health Assistant Association, Medical Action Myanmar and Community Partners International, coordinating with the Karenni Mobile Health Committee, Burma Medical Association and Kayin Baptist Convention. International Rescue Committee together with the State Public Health Department, International Organization of Migration and Civil Health Development Network (CHDN), work on maternal, newborn and child health services.





Saw Ae Kaw testing community members for malaria. MHAA has given him the skills he needed to be a health volunteer—a job he treasures. MHAA

Spotlight on Gender

The facts

- | In Nan Phe Village, Bawlakhe Township in Kayah State, community engagement meetings were organized to ensure the community could receive information about health services and provide feedback
- | Women were invited and encouraged to attend the meetings; they made up about half of all attendees
- | By having at least one woman facilitator during meetings and paying special attention to women attendees, women have been encouraged to speak up and actively participate

Why it matters

Making sure that women can attend and actively participate in meetings enhances their role in the community and ensures they receive health information in an engaging manner. Through this participation, women can become more empowered. This was the first time they have been able to provide feedback about maternal, newborn and child health services directly to basic health staff.

This open feedback process has improved the relationship between health service providers and the community and has had positive impacts on health-seeking behaviour.

A health assistant in Bawlekh Township in Kayah notes, “Women in the project community asked us to renovate the delivery room and improve the beds. Once it was done, they felt more confident to deliver their babies at the clinic.”

Voices

“MHAA built up my capacities so I could be a good volunteer.”

When Saw Ae Kaw stepped on a landmine, he thought his chance to help his community was over. That wasn't the case – Myanmar Health Assistant Association gave him the skills he needed to be a malaria volunteer, a job he still has to this day.

“My name is Saw Ae Kaw. I live in Padauk Myaing village in Hpa-pun Township in Kayah State. A few years ago, when I was going into the forest to chop wood, I stepped on a landmine. I had to have my right leg amputated.

“When Myanmar Health Assistant Association (MHAA) started the malaria project in my village, they selected me as a volunteer. The villagers selected me too. They knew I could do the job.

“I could provide the right services for my community, which included testing with rapid diagnostic tests (RDT), treating patients and referring any suspected cases to health facilities. It didn't matter that I was disabled.

“MHAA empowered me and built up my capacities so I could be a good volunteer. I have saved the lives of many members of my community. I have prevented, tested and treated for malaria. I am very proud to be a malaria volunteer and to work together with MHAA.”

Results

987

Emergency maternal referrals

80%

Births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)

72%

Women received antenatal care four times before delivery

98%

Children under one immunized with DPT3/Penta3

3,804

Suspected TB cases examined

132

Notified TB cases (all forms)

23

Notified bacteriologically confirmed TB cases

22,336

Malaria rapid diagnostic tests (RDT) taken and read.

13

Confirmed Plasmodium falciparum malaria cases treated

17

Confirmed Plasmodium vivax malaria cases treated

See more results in Annex II: Results matrix.



Highlights in Kayah

Better collaboration through learning and doing—Information exchange workshops, joint trainings, project visits and regional and stakeholder coordination meetings have enhanced collaboration between ethnic health organizations, the Kayah State Health Department and township health departments. For example, in 2017 ethnic health organizations and township health departments organized crash immunization campaigns and mobile health teams, including a nationwide Japanese Encephalitis vaccination campaign. See more on page 56.

Building technical capacity—3MDG partners have helped to strengthen the technical capacities of ethnic health organizations. This has included supporting the establishment of medical treatment protocols, and promoting standardized reporting formats and guidelines in line with established protocols. This increases the quality of care, staff confidence and the ability of ethnic health organizations to link up with the broader health system.

Kayah Activities and Partners

	Activities	Partners	Townships	2017 Expenditure in USD
Malaria	Improving early diagnosis and quality treatment of malaria according to the national treatment guidelines. Limiting the transmission of malaria by vector control and personal protection and improving health outcomes by addressing the social factors which limit access to health services.	Myanmar Health Assistant Association (MHAA)	Hpruso (+ 3 townships in Kayin, 1 township in Bago, 5 townships in Rakhine, 2 townships in Chin)	1,178,778*
Malaria and tuberculosis active case finding	Improving access to and use of early diagnosis and quality treatment for malaria and tuberculosis (TB). Partners aim to limit the transmission of malaria by vector control and personal protection. They support containment of artemisinin resistant malaria parasites through advocacy and behaviour change communications. They also strengthen community awareness of TB and assist the National TB Programme in active case detection and referral of presumptive cases to nearest township health facilities.	Community Partners International (CPI) coordinates with Karenni Mobile Health Committee (KnMHC), Burma Medical Association (BMA) and Kayin Baptist Convention (KBC)	Loikaw, Demoso, Hpruso, Shadaw, Bawlakhe, Hpasawng (+ 2 townships in Kachin, 5 townships in Kayin, 1 township in Mon, 1 township in Tanintharyi)	1,013,702**
Maternal, newborn and child health services	<p>Township health departments are supported to provide maternal and child health, nutrition and sexual and reproductive health services, boosts the capacity and coordination of basic health staff, volunteer health workers and village health committees, and strengthen township health departments' monitoring and supervision mechanisms.</p> <p>Service delivery in the most remote and isolated villages of Kayah State was carried out by the CHDN and its members. Key interventions include provision of reproductive, maternal and child health (RMNCH) services at CHDN health posts and through outreach service activities by backpack teams; joint trainings and regular coordination meetings; and referral services for pregnant women and children under five from hard-to-reach villages together with respective township</p>	International Rescue Committee Myanmar (IRC) leads the consortium in the coordination role with the State Public Health Department together with International Organization of Migration (IOM) and Civil Health & Development Network (CHDN)	Loikaw, Demoso, Hpruso, Shadaw, Bawlakhe, Hpasawng, Mese	1,758,090
Tuberculosis active case finding and basic health care services	Establish a link between the existing (and to be expanded) network of village health workers in remote villages and National TB Programme services in Ministry of Health and Sports' hospitals, to locate and refer missing TB cases; support TB active case finding in remote villages where the Ministry of Health and Sports' network is not (yet) present and provide a basic health care package.	Medical Action Myanmar (MAM)	Loikaw, Hpasawng, Demoso (+ 8 townships in Kachin, 3 townships in Kayin, 1 township in Tanintharyi)	460,697***

*USD 1,178,778 is the budget for MHAA malaria activities in Kayin, Bago, Rakhine and Chin in 2017. Due to the nature of the budget, this cannot be separated only for Kayah.

**USD 1,013,702 is the budget for CPI activities in Kachin, Kayah, Kayin, Mon and Tanintharyi in 2017. Due to the nature of the budget, this cannot be separated only for Kayah.

***USD 460,697 is the budget for MAM activities in Kachin, Kayin, Kayah and Tanintharyi in 2017. Due to the nature of the budget, this cannot be separated only for Kachin.

Rakhine

Context and health needs

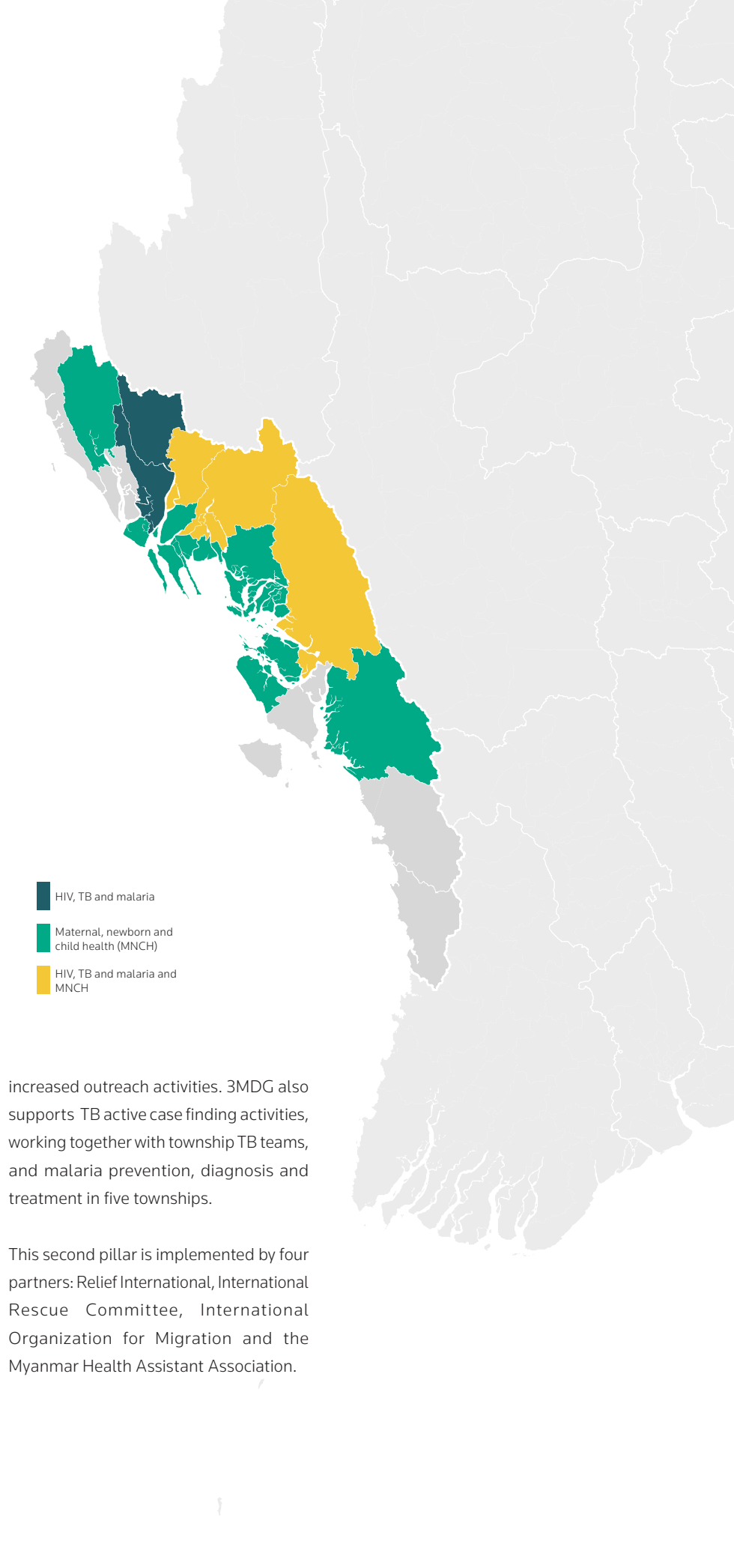
Over the last few years, Rakhine State has been characterized by a protracted crisis, longstanding communal tensions, chronic poverty, under-development and limited livelihood opportunities. It is currently the site of an acute crisis of great proportions. The situation in Rakhine has deteriorated dramatically over the last 14 months and since unrest in August 2017, there has been displacement of especially Muslim populations on a massive scale. Access for implementing partners was limited in some townships, though in some areas it has now resumed.

With much of the population displaced, and many of those who remain suffering human rights abuses, health needs in the area are dire. In some areas, there is a severe lack of population data about health needs and access to available services, and health information. The situation has led to disruptions of essential services and many people rely on community-based mechanisms, if existent. There has also been a negative effect on health care activities such as vaccination and nutrition services for malnourished children.

Activities and partners

3MDG support in Rakhine State has two main pillars. The first pillar, implemented by UNICEF, aims to identify state-wide system strengthening needs and provide technical assistance, including planning and co-ordination, capacity building in financial management, supply chain and human resources for health, to the State Health Department.

The second pillar focuses on service delivery. The main goal is to overcome barriers in accessing health care services for all populations in Rakhine State. In this pillar, 3MDG supports township health departments in nine townships across northern, central and southern Rakhine. Activities include maternal, newborn and child health services with emergency referrals, capacity building of health staff, training and supplies for volunteers and



increased outreach activities. 3MDG also supports TB active case finding activities, working together with township TB teams, and malaria prevention, diagnosis and treatment in five townships.

This second pillar is implemented by four partners: Relief International, International Rescue Committee, International Organization for Migration and the Myanmar Health Assistant Association.

Situation in Rakhine State

Longstanding communal tensions and intercommunal violence, combined with restrictions towards the Muslim minority, have escalated into a humanitarian crisis in Rakhine. The overwhelming response of the Myanmar military to attacks by a militant group on security targets in northern Rakhine in August 2017 resulted in mass displacement of all populations. The most recent UNHCR report in March 2018 stated that approximately 671,000 Muslims have been driven into neighbouring Bangladesh, and up to 27,000 ethnic Rakhine are internally displaced in the State.²⁸ The displaced people, mostly Rohingya, have reported systematic killing, sexual violence and destruction of homes.²⁹

The United Nations Human Rights Chief, Zeid Ra'ad al-Husseini has said that considering this as an act of genocide against Rohingya Muslims by state forces in Myanmar cannot be ruled out.³⁰ According to Human Rights Watch, the most damage occurred in Maungdaw Township between 25 August and 25 September 2017. As recently as February 2018, Amnesty International was reporting fresh evidence of ongoing ethnic cleansing in the State.³¹ In September of 2017, the Government of Myanmar responded that security operations had ended and they were working to protect all people of Rakhine.

Following the unrest, humanitarian activities across Rakhine State were suspended or severely interrupted due to administrative constraints, restrictions on movement and safety. Though some activities have restarted, including, to an extent, 3MDG work, humanitarian needs exceed the current levels of provision.³² There are concerns as to whether the safe return for the displaced persons is possible.³³

3MDG's activities in respective townships are at a lower scale than before August 2017 due to difficulty in accessing areas and populations, staff safety and human resource gaps in the health system. There are many vacancies for midwives and basic health staff in particular townships. Many of the people that 3MDG intended to serve have fled. Resentment towards international non-government organizations and the United Nations has increased, making work more difficult.

The current climate in Rakhine State is volatile, and requires an approach that combines political, development, security and human rights elements to address the concerns of all communities.

Highlights

Resuming health care services in a post-conflict situation—The events of August 2017 resulted in the shutdown of health facilities and interruption of health services, especially in Buthidaung, Maungdaw and Rathedaung townships. Implementing partners have worked with township health departments to resume services. For example, the International Organization for Migration began discussions with the Township Medical Officer in Buthidaung to re-establish essential health services including immunization, pregnancy care and emergency referral. 13 mobile clinics covered under served populations and 205 emergency referrals were supported. However, challenges remain, as reflected in underachieving coverage figures for key indicators, such as antenatal care and skilled birth attendance. See more in Lessons learned on page 89 and Annex I on page 98.

More effective referrals—To allow access to basic services in a context of severe travel and access restrictions, partners collaborated to support cross-border emergency referrals. Patients were referred into another administrative area when needed, with expenses covered by partners working in the township where the referral was admitted. There were 6,784 maternal and under five children referrals in 2017.

Refurbishment of Sittwe General Hospital—3MDG is supporting the extension and refurbishment of Sittwe General Hospital, for the benefit of all populations in Rakhine State. This is in line with the recommendations from the Advisory Commission.

Results

51%

Births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)

55%

Women received antenatal care four times before delivery

77%

Children under one immunized with DPT3/Penta3

4,161

Emergency maternal referrals

2,815

Referral TB cases for screening by community health worker and volunteers

7,231

Suspected TB cases examined

1,500

Notified TB cases (all forms)

192

Notified bacteriologically confirmed TB cases

26,787

Malaria rapid diagnostic tests (RDT) taken and read

1,295

Confirmed Plasmodium falciparum malaria cases treated

363

Confirmed Plasmodium vivax malaria cases treated

Rakhine

Activities and partners

	Activities	Partners	Townships	2017 Expenditure in USD
Health Systems Strengthening	Improve state-wide capacities on planning and coordination, health information management, human resources for health, supply chain and public financial management.	UNICEF	State-wide	1,193,606
Malaria; maternal, newborn and child health; and tuberculosis	<p>Continued efforts towards malaria eradication are supported by testing and treatment, distribution of long lasting insecticide bed nets, referrals of positive cases, health education and Direct Observed Treatment (DOT).</p> <p>To support the prevention, diagnosis and care of tuberculosis, active case finding activities are supported in three townships. This includes referral for positive cases, home visits and contact tracing, treatment, and patient support. Trained volunteers also provide Direct Observed Treatment (DOT) supervision, and health education.</p> <p>Community feedback mechanisms are implemented to ensure community voices are heard.</p>	Myanmar Health Assistant Association	Ponagyun, Ann, Myauk-U, Minbya, Kyauktaw, Toungup, Kyaukphyu	3,144,583
Maternal, newborn and child health	Implementing partners support planning and coordination, helping to formulate plans and review and analyze data; support supervision and monitoring at various levels; support midwives for routine outreach; support maternal, newborn and child health related technical training for basic health staff, for community health workers and auxiliary midwives; provide essential medicines and supplies for volunteer health workers; and support emergency referral for mothers and children under five.	Relief International International Organization for Migration	Mrauk-U, Myebon Pauktaw, Buthidaung	1,405,102 1,512,116
		International Rescue Committee	Sittwe, Minbya	1,850,065



Dr. Ni Ni Tun is the co-founder of Medical Action Myanmar—she started the non-government organization to help people living with HIV to access the treatment and support they needed.

Inspiring Women

“I knew how much someone’s life could improve with the right treatment.”

Dr. Ni Ni Tun is a doctor and co-founder of Medical Action Myanmar. When she isn’t working to help rural and urban poor people access needed health care, she is supporting other women and pressing forward towards gender equality.

“My name is Dr. Ni Ni Tun. I started my professional career working as an internship doctor in a state hospital in Myanmar. My salary was quite low and we didn’t have enough equipment and medicine available to treat our patients. I wanted to do something about it.

“In the beginning, I asked my mother for a donation—but I knew that this was a short term solution, so I decided to start working at Médecins Sans Frontières (MSF-Holland). My first posting was in Shan State, where I spent most of my time treating and supporting female sex workers.

“This experience was eye-opening for me. HIV was very common where we were working, but people did not really know what it was, how it spread, and where they could be treated. Being able to help gave me immense satisfaction and I loved my job, but around that time in Myanmar, funding was limited for HIV prevention, diagnosis and treatment.

“I knew how much someone’s life could be improved if they were given the right treatment. So, in 2009 I founded a new medical organization called Medical Action Myanmar together with the former director of MSF-Holland, Dr. Frank Smithius. We wanted to improve and expand access to quality health care for the poorest people in Myanmar.

“When we started our work in Hlaingtharya Township in suburban area of Yangon Region, we noticed that there were many single women coming to our clinic. Their husbands had left them and they didn’t have any work or money. I believe that all women should be independent, but when you are a single mother and have no work, that can be difficult. We support these women with free health care and support for vocational training, so they have a path to financial independence. We also provide food, shelter and school support for their children.

“Women can do whatever they put their mind to. I see many women through my work who are persistent and ambitious and if they meet obstacles or challenges, they never give up.”

Shan

Context and health needs

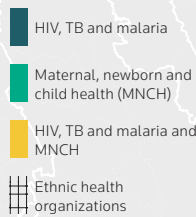
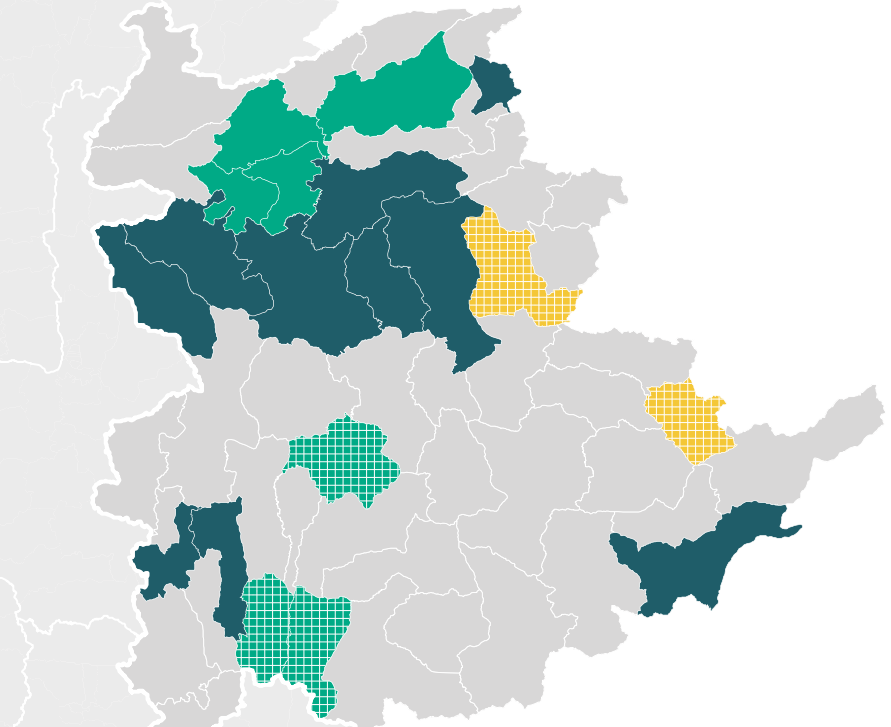
Parts of Shan State have been affected by conflict for many years and in some areas fighting continues. This impacts Shan people's access to public education, social welfare and other services, and their livelihood options. It also has a serious impact on their health status. About 74 percent of the state lives in rural, hard-to-reach and conflict-affected areas. Many are beyond the reach of government facilities and services, and health care are often provided by ethnic health organizations.

Activities and partners

In Northern Shan State, 3MDG focuses on maternal, newborn and child health services (MNCH). The aim is to increase access to and availability of services and strengthen systems for the delivery of these services. Capacity development of target communities, civil society organizations and the public sector is also a key focus. The increased involvement of civil society organizations, increased flexibility following 3MDG meetings on conflict-sensitivity, and Programme Monitoring Assessment visits show positive progress in this programmatic area.

3MDG finances Population Services International (PSI) to deliver mother, newborn and child health services with a focus on childhood case management and family planning through social franchising, social marketing and outreach. Through PSI's Sun Quality Network, private providers are offered trainings, subsidized products, quality assurance, common branding, and demand generation activities.

Community-based approaches are also used by Health Poverty Action to fight TB and HIV, contributing to health service development in Wa of Northern Shan State and Special Region 4 of Eastern Shan. This includes providing nutrition packages and deworming pills for children, health services for pregnant women and HIV testing for prisoners.



3MDG also finances Harm Reduction activities in Shan State, which is severely affected by drug use. Services, which include prevention programmes, and needle and syringe exchange, are delivered via peer volunteers, drop-in centres, and outreach activities.

In 2017, 3MDG worked in 26 out of 80 townships in Shan State, together with six partners: Cesvi, Relief International, Save the Children, Health Poverty Action, Asian Harm Reduction Network, Myanmar Anti-Narcotics Association, and Population Services International.



Participants from ethnic health organizations at the Shan State Health Forum, which saw the coming together of stakeholders from across the health sector—government, non-government, civil society and more. The event was supported by 3MDG.

Voices

U Sai Maung Yu is the Chairman of the Shan Literature and Cultural Association. He works in Kutkai Township, which is a conflict-affected area. There are severe difficulties for the Township Health Department and Save the Children to deliver health services, but the support of local civil society organizations can help.

“After attending the meeting organized by the Township Health Department in Kutkai, I became aware of what health services were available. I learned more about emergency referrals. But, I also learned that it is hard to provide services to people in our community because of security and limited transport. Even if health providers can get to some hard-to-reach villages, they may still face

difficulties in community participation due to language barriers.

“Local people who know the context, like us, can help. But before we know what we can do, we need to know more about the project. Save the Children helped with that, explaining more about their work and asking for our support.

“We agreed that we could support the transportation of drugs and supplies for basic health staff and volunteer health workers when the security situation is unstable.

“We can help the community learn more about health activities, especially emergency referrals. We really believe that community participation will increase because of our support!”

Spotlight on Gender

Getting men involved in nutrition

The facts

- | In Hu Hsar village in Namtu Township in Northern Shan State, a cooking competition and demonstration was organized—with prizes!
- | CESVI put in a special effort to encourage men to attend. Events were organized on Sunday, when men do not travel to the farm. Holding these events straight after church increases attendance numbers, ensuring both men and women can attend.
- | Eight men attended (out of 33 total participants) the first cooking demonstration following these efforts. One man (out of 12 participants) joined the second.

Why it matters

Men and women may have different preferences in decision-making, which means it is important for women’s choices to be heard for governance to be equitable.³⁴ However, it is often men who are key decision-makers in their families’ health choices. This is particularly true in rural areas, where women may be economically dependent on men and their ability to negotiate is not strong. Charity Oriented Myanmar found that 60 percent of women interviewed in 30 communities felt they had less power than their male counterparts.

3MDG implementing partners are responding—helping women to have the confidence and space to make decisions; ensuring that men have the knowledge they need to make informed choices and to better understand the importance of gender equality. Men are encouraged to attend cooking and health education sessions where they can appreciate women’s knowledge, reinforcing gender equality and partnership.

“Men are important in nutrition and health. A cooking demonstration is successful if men participate, support and attend the health talks,” said Dr. Swe Swe Win from CESVI in Lashio. Nevertheless, low attendance shows there is still much work to be done to ensure male involvement in family health. These efforts continue in 2018.

Results

55%

Women had their births attended by a skilled person

63%

Women received antenatal care four times before delivery

87%

Children younger than one year immunized with DPT3/Penta 3

2,466

Emergency maternal referrals

6,279

People who inject drugs reached by prevention programmes

3,025,000

Needles and syringes distributed

3,829

People who inject drugs given voluntary confidential counselling and testing for HIV

27,474

Suspected TB cases examined

1,797

Notified TB cases (all forms)

546

Notified bacteriologically confirmed TB cases

1,247

Malaria rapid diagnostic tests (RDT) taken and read

17

Confirmed *Plasmodium falciparum* malaria cases treated

5

Confirmed *Plasmodium vivax* malaria cases treated

See more results in Annex II: Results matrix.



Mothers and babies at the Ban Yin Hospital in Hsieseng Township in Shan State.

Highlights in Shan

Growing partnerships with ethnic health organizations—Relief International is working with Shan State Development Foundation (SSDF) in Maukmai and Laikha Townships in Southern Shan and with Pa-Oh Health Working Committee (PHWC) in Maukmai Township. The aim is to promote better health in ethnic areas, strengthen the capacity of ethnic health organizations, and create better collaboration and partnership among ethnic health organizations and the Ministry of Health and Sports

New health centres handed over—Eight new health centres were handed over to the Ministry of Health and Sports in

2017, improving the access to health services in hard-to-reach parts of Southern Shan State. To find the best locations for the centres, factors including population coverage, availability of staff and supplies, accessibility, local needs and lack of existing services were considered. The centres will serve all community health needs.

Working in Special Regions—3MDG partner Health Poverty Action is working in Wa and Mongla Special Regions in Shan State. In 2018, project activities will continue to expand. This will include strengthening local health systems and creating better links between ethnic health systems and the government health system in terms of planning, technical support, medical supply provision and health information integration.

Shan

Activities and partners

	Activities	Partners	Townships	2017 Expenditure in USD
HIV/Harm Reduction	Addressing drug use and health related consequences (HIV/ TB, sexually transmitted infections, Hepatitis B screening and vaccination, health education, behaviour change communications) through drop-in centres and outreach. Active case finding of tuberculosis in Wa and Kokang Special Regions through mobile health services in hard-to-reach and remote areas.	Asian Harm Reduction Network (AHRN)	Laukaing (+ 4 townships in Kachin, 5 townships in Sagaing)	3,072,445*
	Addressing drug use and health related consequences (HIV/ TB, sexually transmitted infections, Hepatitis B screening and vaccination, health education, behaviour change communications) through drop-in centres and outreach	Myanmar Anti-Narcotics Association	Lashio, Tangyan, Kyaukme, Hsipaw, Mongyai, Nawngkhio, Tachileik, Taunggyi, (+ 3 townships in Mandalay, 3 townships in Sagaing)	2,009,568**
Maternal, newborn, and child health (MNCH)	Supporting the implementation of maternal, newborn and child health services by township health departments	Cooperazione Sviluppo (CESVI)	Namtu, Namsan, Manton	705,190
	Supporting the implementation of maternal, newborn and child health services by township health departments and ethnic health organization partners (Pa Oh, Shan)	Relief International	Laikha, Maukmai, Hsesing	1,501,501
Maternal, newborn and child health and infectious disease control	Maternal, newborn and child health services and disease control (TB and HIV) in marginalized areas on the Myanmar-Chinese border by supporting the ethnic health system to generate better health services	Health Poverty Action	Wa Special region 2— Mongyang, Pang sang, Narphan, Pangwaun, Mongmao, Hopang, and Matman. Special Region 4— Mongla, Mongyang, and Mongyawng	2,258,646
Maternal, newborn and child health and integrated health services	Supporting the implementation of maternal, newborn and child health services by township health departments covering most vulnerable, hard-to-reach populations such as internally displaced people in camps	Save the Children	Kutkai	887,101
Prison health infrastructure	Improving prison health infrastructure in Lashio Prison	UNOPS	Lashio (+ Yangon and Myitkyina)	1,218,213

Ayeyarwady

Context and health needs

Many parts of the Ayeyarwady Region are hard-to-reach due to waterways, and flooding which peaks during the rainy season. Access to health services was severely impacted by Cyclone Nargis in 2008, which uprooted lives and destroyed homes.

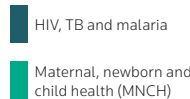
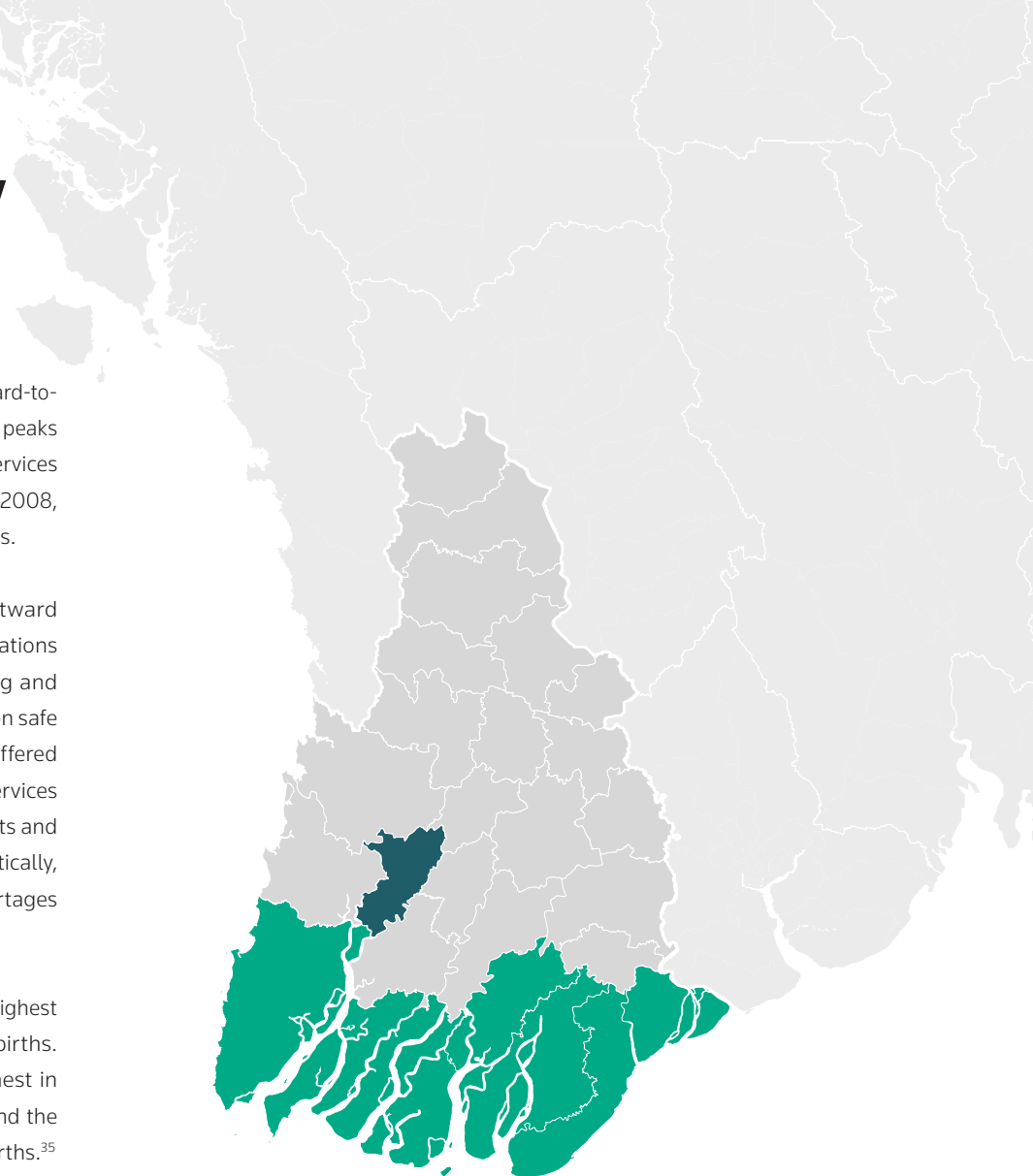
There are high levels of inward and outward migration, which creates unstable populations who may not be included in the planning and execution of health services. Information on safe behaviors and where health services are offered may not be readily available. Ensuring services are 'migrant-friendly' in their delivery points and sensitivity is still challenging. Most dramatically, outward migration has manifested in shortages of health staff, especially midwives.

The maternal mortality ratio is the second highest in the country at 354 per 100,000 live births. The under five mortality rate is the highest in the country at 104 per 1000 live births, and the infant mortality rate is 86 per 1000 live births.³⁵

Activities and partners

In 2017, 3MDG activities covered six out of 26 townships in Ayeyarwady Region. Together with township health departments, 3MDG's implementing partners assisted with the development and operationalization of township health plans, reporting of health information, capacity building of basic health staff, training of volunteer health workers and community-based referrals for pregnant women and children under five. Underway is a plan for developing a sustainable, government-owned referral model (see page 43).

3MDG works with three partners: Save the Children, Relief International and the International Organization for Migration. Relief International took over from Médecins du Monde in July 2017. 3MDG efforts in this area were scaled back at the end of 2017, with focus shifting to transitioning the emergency referral programme to a community-based programme. The positive impacts of 3MDG-support in strengthening the township



health system will resonate through better coordination, higher amounts of institutional delivery and stronger community-based financing for health.

Highlights

Reaching migrant workers—3MDG has been working to overcome barriers to health for migrants with trainings in accountability, equity and inclusion for health staff and implementing partners, who then go on to conduct awareness-raising sessions for migrants to know what services are available to them. In Bogale, migrant voucher schemes have been used since 2015, and handed over to the Village Tract Health Committee in 2016. The vouchers have built trust and encouraged health seeking behaviour.

Results

21,817 (73%)

Births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)

9,795

Emergency maternal referrals

25,652 (86%)

Women received antenatal care four times before delivery

29,874 (97%)

Children under one immunized with DPT3/Penta3

See more results in Annex II: Results matrix.



A nurse in Ayeerwady immunizes a baby. MSI

Voices

“Guaranteeing the sustainability of the health plan beyond 3MDG.”

The International Organization for Migration (IOM) has been focused on transition with the closure of most 3MDG grants in Ayeerwady at the end of 2017 and all of them by the end of 2018. The handover process in Mawlamyaingyun was challenging but ultimately successful. Township Health Supervisor, Dr. Thant Htet Yee Mon, shares how improvements in maternal, newborn and child health will be sustained.

“During the handover, we realized that the Village Health Committee and Village Tract Health Committee did not have experience in asking for, listening to, and responding to feedback. So, we conducted trainings for three IOM staff, 118 basic health staff, and 249 village health workers on how to ensure accountability, equity and social inclusion in the delivery of health services.

“We also supported a project review and lessons learned workshop to make sure that everything that was learned is carried forward. Participants discussed roles and responsibilities, and committed to continued collaboration between all stakeholders, including community groups. This will guarantee the sustainability of the township health plan beyond 3MDG support.”

Sustaining Emergency Referrals

The 3MDG Fund Board and Ministry of Health and Sports decided in June 2017 to accelerate the process of developing a road map and pilot to move the emergency referral programme away from dependence on external aid. This led to two key developments: the initiation of a Core Working Group on Emergency Referrals, and the establishment of the Community-based Emergency Referral Model for Mothers, Newborns and Children.

The Core Working Group is led by the Ministry of Health and Sports, and aims to establish what it costs to implement an emergency referral programme for pregnant women and young children nationwide. As an immediate step beginning in 2018, the Ministry of Health and Sports has agreed to cover all drug and investigation costs incurred at the hospital.

The Community-based Model focuses on building up the community structures which are at the centre of strong health systems, aiming to transition the management of the referral programme completely for sustainability. Civil society and community-based organizations and village health committees have an important role to play. For example, the village health committee manages the village health fund—a revolving fund contributed to by the community that can be used to cover emergency health costs.

Under the model, health staff receive trainings in referral. This is particularly crucial for volunteer health workers who are often the first port-of-call for village health needs. The readiness of station hospitals will also be improved.

Since the start of 2018, 3MDG has been piloting this new model in four townships in Ayeerwady and five townships in Magway.

For a number of years, delivery in a facility has been actively promoted to reduce the need for unplanned referrals, and increase the safety of the birth environment.

One of the places where the pilot programme is in operation is Min Thar Gyan, a small village next to a river bank in Ayeerwady Region. When it rains, it can only be reached by boat and transportation is expensive. The Village Health Committee has received training in fund raising and book keeping from IOM. With this training and a cash injection of only 300,000 kyat (about 225 USD), they have been able to support 26 patients to reach medical care. Now, they are focusing on taking full ownership of the referral programme. For the leader of the committee U Mya Win, this means they can “prioritize the needs of our village.”

Lessons learned from the 3MDG pilot programme will be used to inform the achievement of a goal of the National Health Plan 2017-2021:³⁶ to provide emergency medical services free-of-charge at township and station hospitals. Ultimately, emergency referrals will be available nationwide as part of the Essential Package of Health Services. The support will cover all communities, reduce out-of-pocket expenditure for health care, and contribute to gender equality by saving the lives of women during a particular period of health vulnerability—pregnancy.

Kayin

Context and health needs

Kayin is located in south-eastern Myanmar and borders Thailand. A long history of conflict, poverty, remoteness, poor accessibility, weak communication channels and traditional cultural norms has meant that health services are under developed and health status needs improvement.

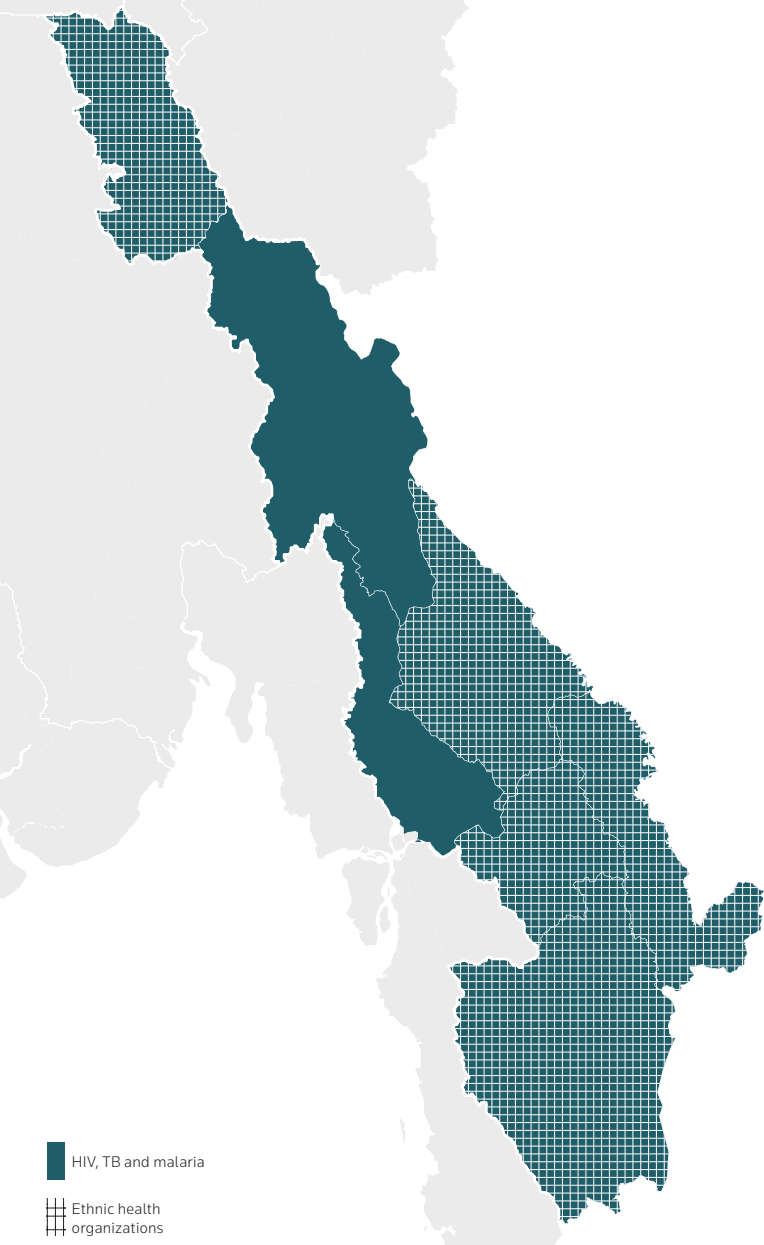
The maternal mortality ratio in Kayin (and Kayah) State is 276 per 100,000 live births.³⁷ Whilst only eighth highest in Myanmar, this is high compared to countries in the region and global standards. The case notification rate (CNR) for all forms of tuberculosis (TB) is 287 per 100,000 population, again not high within the country but unacceptable compared to global standards.³⁸

There are also wide disparities between and within townships, dependent on the level of security, accessibility, economic factors and whether the area is government or non-government controlled. In most areas, health services are provided by the Karen National Union (KNU). Health staff are trained by health care partners based in border area of Thailand, which can lead to difficulties with differing protocols, methods and data collection.

Activities and partners

3MDG worked in seven out of 18 townships in Kayin State in 2017. There were four partners: Community Partners International (CPI), Myanmar Health Assistant Association, Medical Action Myanmar and Population Services International. Main activities in Kayin State in 2017 were malaria prevention, diagnosis and treatment, TB active case finding and provision of basic health care services.

CPI is working to strengthen ethnic and community-based health organizations to develop, lead and manage health services. The particular focus is to develop an ecosystem in which non-state actors can build on the success of their malaria and TB programmes and actively participate in the evolution and implementation of the National Health Plan 2017-2021 in Myanmar.



Highlights

Improving the link between health volunteers and higher level health services—Health volunteers have been finding cases of TB and malaria in the community over a number of years. Severe malaria cases are referred to hospitals and TB presumptive cases to National TB Programme services for further testing and treatment. This creates a link between community-based and higher level health services. In 2017, 3MDG implementing partner activities strengthened this link through training and capacity development. Standardization with national treatment guidelines was ensured. The expansion of the village health worker network and solidification of this link is crucial to finding missing cases.

Improving collaboration between ethnic health organizations and the Ministry of Health and Sports—This has been strengthened in 2017 through provision of joint services. For example, National TB Programme active case finding mobile teams have visited ethnic health areas for TB case finding, diagnosis and treatment. Planning and coordination is executed together with the ethnic health organizations. Cases of TB that are diagnosed are also linked up with local ethnic health organizations volunteers to ensure adherence to treatment. General health care services are also provided to maximize community benefits.



Daw Khin Kyi meets with the mobile team team from Medical Action Myanmar in her village. MAM

Voices

“I love helping TB patients because we can save lives.”

Meet U Kyaw Wai, finding TB patients in Kayin.

“My name is U Kyaw Wai. I have been the referral coordinator for the 3MDG-supported Village Health Worker Programme of Medical Action Myanmar (MAM) in Kyainseikgyi Township since early 2015.

“One day, Daw Swe, one of our previous TB patients from Bay Dar Yi village visited my office with her sister, Daw Khin Kyi. Swe explained that her sister was very sick, suffering from cough, weight loss, fever and night sweats. They had been referred to me from the village health worker. I quickly realized that this could be TB.

“I brought her to the National TB Programme at Kyainseikgyi Hospital, where she was diagnosed with TB and put on treatment. I issued her a MAM food card to receive monthly rations.

“The MAM mobile team visited her at home three times. After six months, Khin Kyi was cured. She told me happily that she could work again.

“I love to help TB patients because we can save lives.”

Spotlight on Gender

Reaching women with women: Health volunteers in Kayin State

The facts

Across the country, health volunteers perform a critical role in the health of their community. They are able to fill gaps where there are no basic health staff, and identify illnesses and injuries which need referral to higher levels of care. The term ‘health volunteer’ or ‘volunteer health worker’ can refer to auxiliary midwives, community health workers and malaria volunteers.

In Myanmar, there are 24,160 auxiliary midwives, 15,112 community health workers³⁹ and 40,000 trained malaria volunteers⁴⁰ (with around 38 percent still active).⁴¹

In 3MDG-supported townships in Kayin State, Medical Action Myanmar places a special emphasis on recruiting women health volunteers

Out of 201 village health volunteers, 120 are women (60 percent of the total)

Why it matters

The benefits of women health volunteers are two-fold. The women themselves have the opportunity to take a larger role in their community, becoming more visible as active contributors. This is an empowering experience.

Dr Myo Min Than, the Operations and Accountability, Equity and Inclusion Officer at Medical Action Myanmar says, “Women volunteers want to learn more health information to disseminate to their family and neighbours. This is such an effective way to improve family and community health, and women become more confident and take a leading role in family and community health decision-making.”

Women volunteers also create safe spaces for other women to share their health concerns and learn more about health. In the beginning in Kayin State, the focus was on tuberculosis, but over time it was seen that women were consulting the women volunteers about issues like family planning and pregnancy care.

Making sure both men and women see themselves identified in volunteer health workers enhances their reach and effectiveness and promotes their importance and status in the community.

Results

7,682

Suspected TB cases examined

515

Notified TB cases (all forms)

83

Notified bacteriologically confirmed TB cases

95,448

Malaria rapid diagnostic tests (RDT) taken and read

1,266

Confirmed Plasmodium falciparum malaria cases treated

1,142

Confirmed Plasmodium vivax malaria cases treated

See more results in Annex II: Results matrix.

Magway

Context and health needs

Magway Region has one of the highest children under five mortality rate and maternal mortality ratios in Myanmar, and the percentage of children who are underweight is third highest in the country.⁴² About 85 percent of the population live in rural areas, meaning they are less accessible to health staff and sometimes further away from health facilities. The high number of migrants in the area can lead to high mobility, low health literacy and low awareness of available services.

Though there has previously been a shortage of health staff, reports from 3MDG implementing partners show that the Ministry of Health and Sports has filled many of these posts.

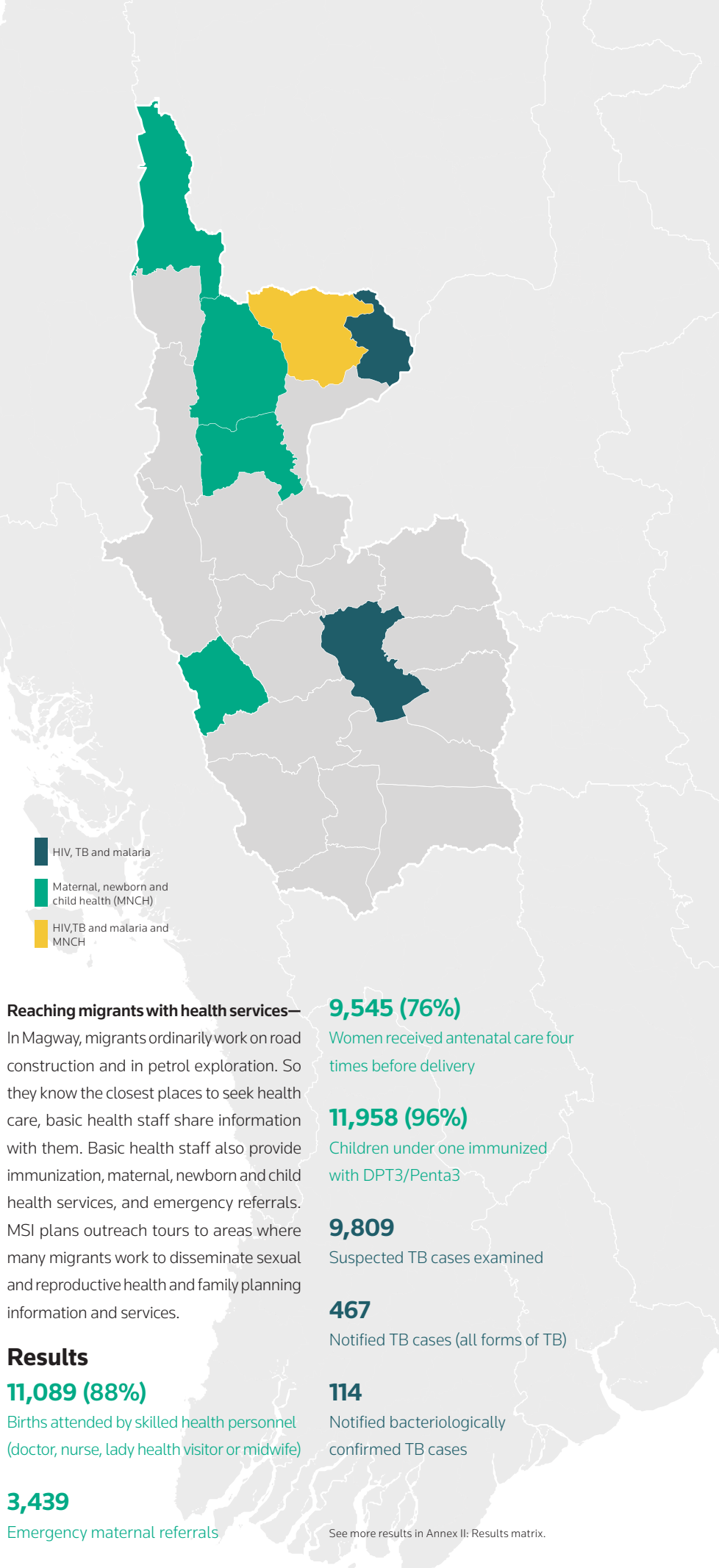
Activities and partners

3MDG activities covered five out of 25 townships in Magway in 2017. There are two organizations operating in Magway Region: Save the Children and Marie Stopes International. 3MDG programming transitioned to Ministry of Health and Sports ownership at the end of 2017.

Highlights

Institutional delivery increased, particularly in Magway—Percentages of institutional deliveries drastically improved compared with baseline data from 2013. For example, in Ngape Township, institutional delivery increased from 36 percent in 2014 to 67 percent in 2017. This rapid increase has been the result of renovations to health facilities, newly constructed health facilities, referral support, and awareness-raising and health education about the impact of giving birth in a facility. Similarly to Chin State, since the beginning of 2017, all maternal and child death surveillance systems are fully operational in Ngape Township; all cases have been managed and followed up according to these systems.

Sustainability of emergency referrals—Marie Stopes International (MSI) has established a hospital trust fund to help finance emergency referrals. See more on the transition of emergency referrals to government and community ownership on page 43.



Reaching migrants with health services—In Magway, migrants ordinarily work on road construction and in petrol exploration. So they know the closest places to seek health care, basic health staff share information with them. Basic health staff also provide immunization, maternal, newborn and child health services, and emergency referrals. MSI plans outreach tours to areas where many migrants work to disseminate sexual and reproductive health and family planning information and services.

Results

11,089 (88%)
Births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)

3,439
Emergency maternal referrals

9,545 (76%)
Women received antenatal care four times before delivery

11,958 (96%)
Children under one immunized with DPT3/Penta3

9,809
Suspected TB cases examined

467
Notified TB cases (all forms of TB)

114
Notified bacteriologically confirmed TB cases

See more results in Annex II: Results matrix.



Dr. Aye Muyar Kyaw is the Township Medical Officer in Dagon Seikkan in Yangon. She makes sure that everyone can access health facilities in her area by opening outside work hours and on Sundays.

Inspiring Women

“Everyone, no matter their gender, should have equal access to health care.”

Dr. Aye Muyar Kyaw is the Township Medical Officer in a peri-urban area of Yangon which faces many health challenges.

“My name is Dr. Aye Muyar Kyaw. For the past three years I have been working as the Township Medical Officer in Dagon Seikkan in Yangon. Here at the clinic I mainly work with preventative care, health promotion and curative care, but I

also help with rehabilitation for people suffering injuries or debilitating diseases.

“This township is very poor, and most of the inhabitants are migrant workers. They have to travel long distances from their families for six days of the week to work. The only time they are able to come for a health check-up is on Sundays, however, the clinic is supposed to be closed then. In order to provide necessary healthcare to all people in the township, including migrant workers, my team and I also work on Sundays. Together we cover a population of nearly 200,000 people here at the clinic.

“Every day we try our best to save lives. The decisions that we make and the way we structure our time and resources can directly affect whether someone lives or dies. I take this responsibility seriously.

“For me, gender equality means having rights, responsibilities, income and equal

opportunities no matter if you are born male or female. Women deserve a good quality education just as much as the guys! Some people think, especially in rural areas, that women should be home schooled and stay at home to help out in the house. That is not gender equality.

“Women should have the same rights as men do. Both men and women have the same potential to contribute to our society and should therefore have the same opportunities. We need to stop discriminating against women and stop seeing them only as mothers and not as equals in the workplace. Men often tend to hold management roles, but women are just as skilled for management roles as anyone.”

Mandalay

Context and health needs

Parts of Mandalay are seriously affected by HIV. The IBBS 2014 indicates that this is especially true for people who inject drugs with an HIV prevalence of 16 percent.⁴³ There are three townships in Mandalay with the highest concentration of injecting drug use due to large migrant populations and because they are central points of trade for upper Myanmar.

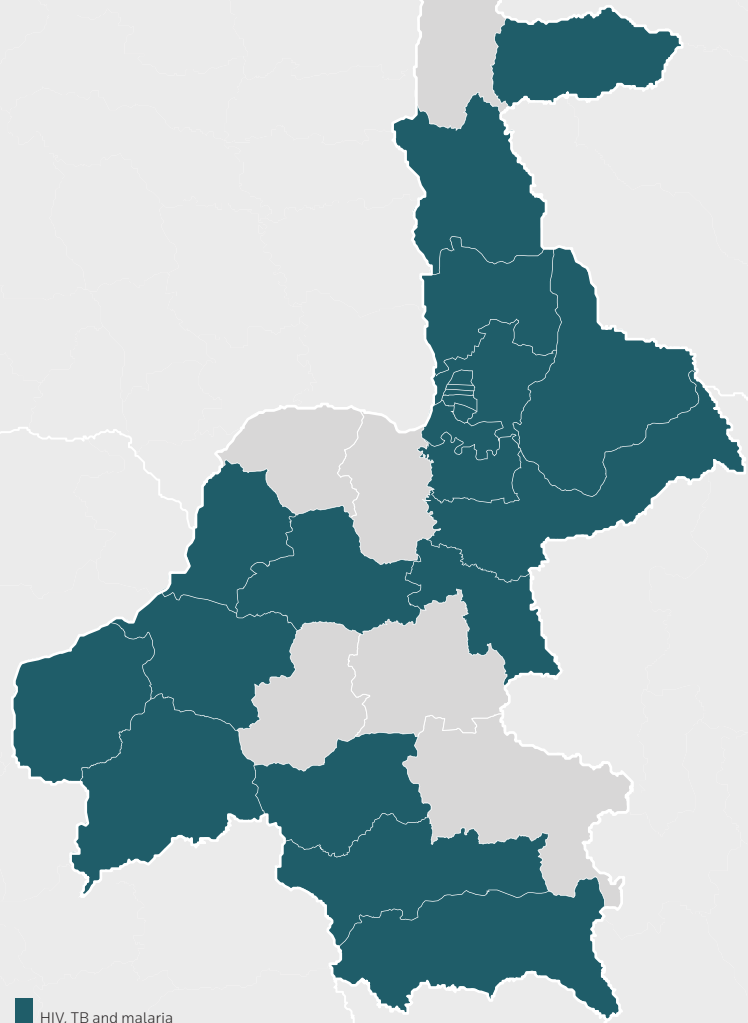
Activities and partners

Myanmar Anti-Narcotic Association (MANA) is operating a drop-in centre in the three most affected townships, offering comprehensive HIV, Harm Reduction and sexual and reproductive health services to people who inject drugs and their sexual partners. They include needle and syringe exchange programmes, condom distribution, HIV testing, methadone maintenance therapy, TB screening and treatment, Hepatitis B screening and vaccination, treatment of sexually transmitted infections, and overdose management. Population Services International and Myanmar Medical Association are also implementing TB prevention, diagnosis and care services in eleven townships.

Highlights

Access to Harm Reduction services has increased—Services provided via drop-in centres and outreach promoted access to prevention, early diagnosis and treatment for integrated services of HIV, TB and malaria among people who use drugs. Outreach services are particularly in focus in Mandalay. People who formerly injected drugs are involved as volunteers, assisting in prevention efforts, risk reduction, service provision and referrals. The community is also reached with advocacy, education and mobilization activities.

Bringing down community resistance to services—MANA has been conducting advocacy with the local authorities, especially local police and the anti-narcotic task force. The intention is to create an enabling environment for services and to build understanding of the nature of the project. In turn, utilization of services has increased.



HIV, TB and malaria

Results

5,876

People who inject drugs were reached by HIV prevention programmes.

2,729,148

Needles and syringes distributed to people who inject drugs.

490,918

Condoms distributed

3,024

People who inject drugs were tested for HIV

7,606

Referral cases for TB screening

23,219

Suspected TB cases examined

1,508

Notified TB cases (all forms of TB)

438

Notified bacteriologically confirmed TB cases

124

Malaria rapid diagnostic tests (RDT) taken and read

1

Confirmed Plasmodium vivax malaria case treated

See more results in Annex II: Results matrix



Midwives at the opening of the new tuberculosis outpatient department in Mandalay. The facility was financed by 3MDG and built by UNOPS and features a laboratory, medical storage and dispensary, and x-ray, counselling, consultation and emergency rooms.

Spotlight on Gender

Getting it all out in the open: using games and shows to reveal misconceptions about health

The facts

| 3MDG Collective Voices partner, Charity Oriented Myanmar, organized 'Women Talk Shows' in their project villages. They are gender awareness sessions for the community and were arranged specifically for rural women to openly discuss their health and gender issues and for facilitators to listen to their voices. Although it is called a 'Women Talk Show', men took part too!

| At the shows, basic health staff led the meetings and discussed gender issues, health issues, international instruments, gender based violence and women's protection laws.

| In 2017, Charity Oriented Myanmar and its local partner Social Care Volunteer Group (SCVG) conducted seven of these sessions; there were 92 women and 36 men who attended (24 percent male involvement).

Why it matters

'Women Talk Shows' provide an opportunity for basic health staff to learn about the obstacles to good health for rural women. They are also able to identify myths and misconceptions about health so they can be corrected and the right information provided in a clear and easily understandable way. Facilitators learned more about perceptions of gender and encouraged men and women to carry out activities which support equality and partnership.

Mon

Context and Health Needs

Mon State is located on the western coast of south-east Myanmar. Health status in Mon State is amongst the best in Myanmar, but there are still areas for improvement compared to regional and global standards.

Malaria remains a persistent health problem. Myanmar’s eastern townships are now the frontline in the global fight to contain the drug resistant Plasmodium falciparum malaria.

State and non-state actors are well-coordinated in the area, although most health facilities are located in the capital Mawlamyine. While the quality of services requires continued improvement and capacity building, the foundation is solid.

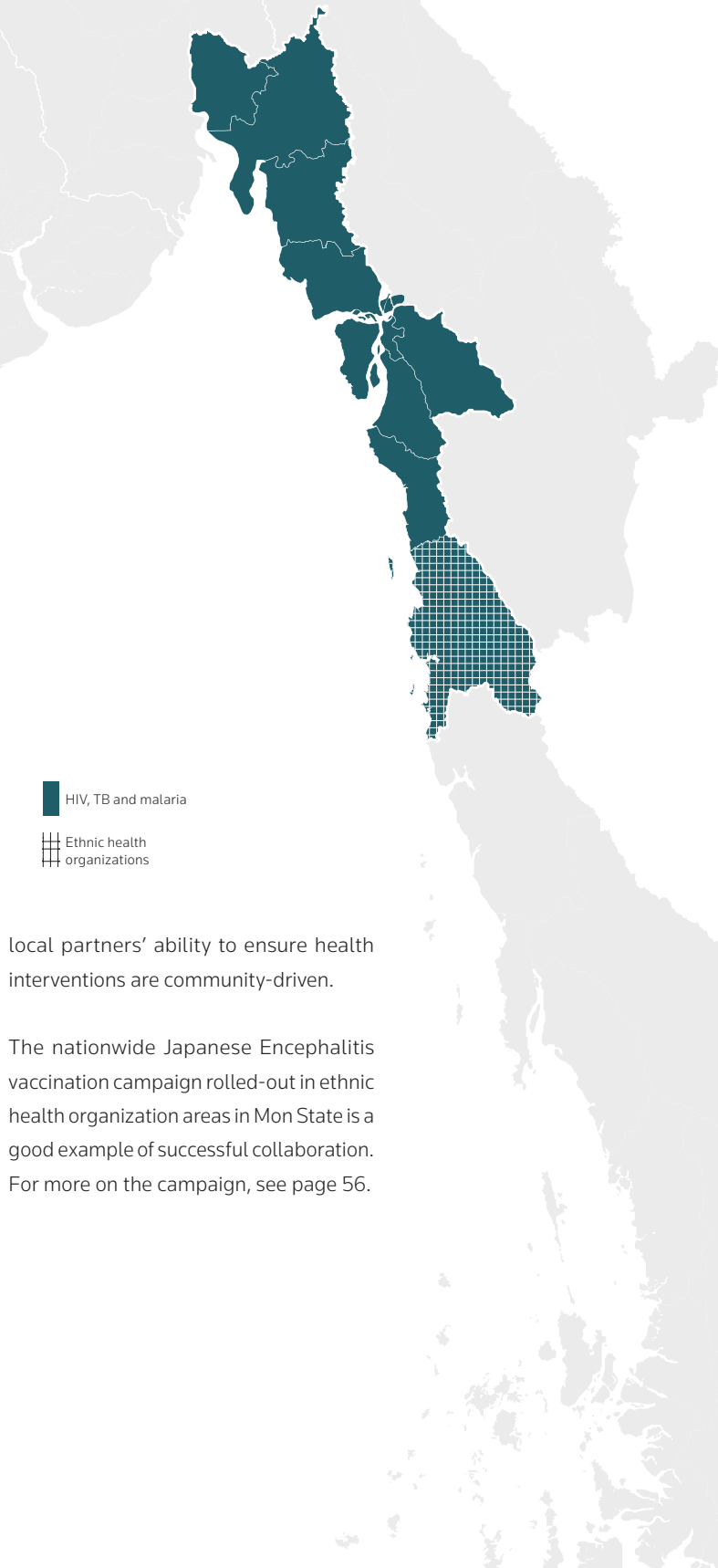
Activities and Partners

In 2017, 3MDG worked in ten out of 28 townships in Mon State. There are three partners: Medical Action Myanmar, Community Partners International and Population Services International working in Mon State and Tanintharyi Region. They aim to improve early diagnosis and quality treatment of malaria according to the National Malaria Treatment Guidelines, limit the transmission of malaria by vector control and personal protection, and support containment of artemisinin resistance through advocacy and communication.

Collective Voices partners in Mon State encourage community use of health services through health promotion, and discuss needs and challenges by listening to the community voices. For more on the Collective Voices programme, see page 68.

Highlights

Effective collaboration with ethnic health organizations—Community Partners International (CPI) ensures community participation and effective collaboration with ethnic health organizations to build an inclusive, effective and cohesive national health system. CPI has strong and unique relationships with ethnic health organizations and is able to build



local partners’ ability to ensure health interventions are community-driven.

The nationwide Japanese Encephalitis vaccination campaign rolled-out in ethnic health organization areas in Mon State is a good example of successful collaboration. For more on the campaign, see page 56.



A doctor pricks the finger of patient with suspected malaria, in order to conduct a rapid diagnostic test (RDT). In 2018, 3MDG conducted 366,002 RDT's, 71,611 in Mon State.

Voices

“Now people come for other health problems too!”

Naing Pai Chan is the village health worker in Abroing Village in Ye Township in Mon State. He has had this role for two years and before that, he was a medic. He has seen a lot of change over that time.

“Before the 3MDG and Community Partners International (CPI) CLEAR Project, there was such a high incidence of malaria. We were remote and transport to health facilities was difficult.

But, since 2013, we have had enough drugs and commodities for malaria. Thanks to CPI, I have had the chance to attend trainings to improve my skills and have conducted health education sessions. Malaria incidence has been declining and there have been no deaths from malaria in our area since the project began.

“Now, people come to me early for testing for malaria—and for other health problems too!”

Spotlight on Gender

Working towards gender equality and women’s empowerment in Mon

The facts

| 3MDG Collective Voices partner Community Driven Development and Capacity Enhancement Team (CDDCET) helps women in Mon State participate in their community, lead their peers and have the information and confidence they need to make health decisions.

| This has included developing the capacity of 20 village health committees and increasing women’s representation in the committees (now at 50 percent). Sessions have included advocacy, training, leadership, networking, and gender equality awareness-raising. Community engagement meetings between village health committees and township health authorities provide opportunities for open discussion, empowering women to speak up with health concerns and project feedback.

| CDDCET has established a small revolving fund for 20 village health committees to pay for referral services for emergency cases. They have identified focal points, transport channels and communication to get pregnant women to the nearest skilled birth attendants.

Why it matters

Through ensuring financial structures and safety nets such as revolving funds are in place, the most vulnerable members of society can be supported in accessing needed health services.

Initiatives to strengthen women’s voice and representation within their community helps women to have equitable participation in family and personal health choices and increases their representation and leadership in the community health decision-making process. A woman who is a member of the village health committee and treasurer of the village health fund said, “We learned how to properly

document and record financial expenses. We didn’t know how to record that before, and after receiving the training our skills improved.”

It was noted in a recent discussion paper based on a number of interviews and focus groups that “the higher the level of female participation within the communities they are working in, the more successful the projects tend to be.”⁴⁴ The study also showed a number of positive attributes associated with women leaders, such as attention to detail, motivation, good negotiating skills and sincerity. This is demonstrative of a willingness to accept women’s leadership in the community and highlights the need to further foster the skills and space needed for this to be realized.

Results

2,283

Suspected TB cases examined

201

Notified TB cases (all forms)

16

Notified bacteriologically confirmed TB cases

71,611

Malaria rapid diagnostic tests (RDT) taken and read.

23

Confirmed Plasmodium falciparum malaria cases

151

Confirmed Plasmodium vivax malaria cases treated

See more results in Annex II: Results matrix.

Sagaing

Context and health needs

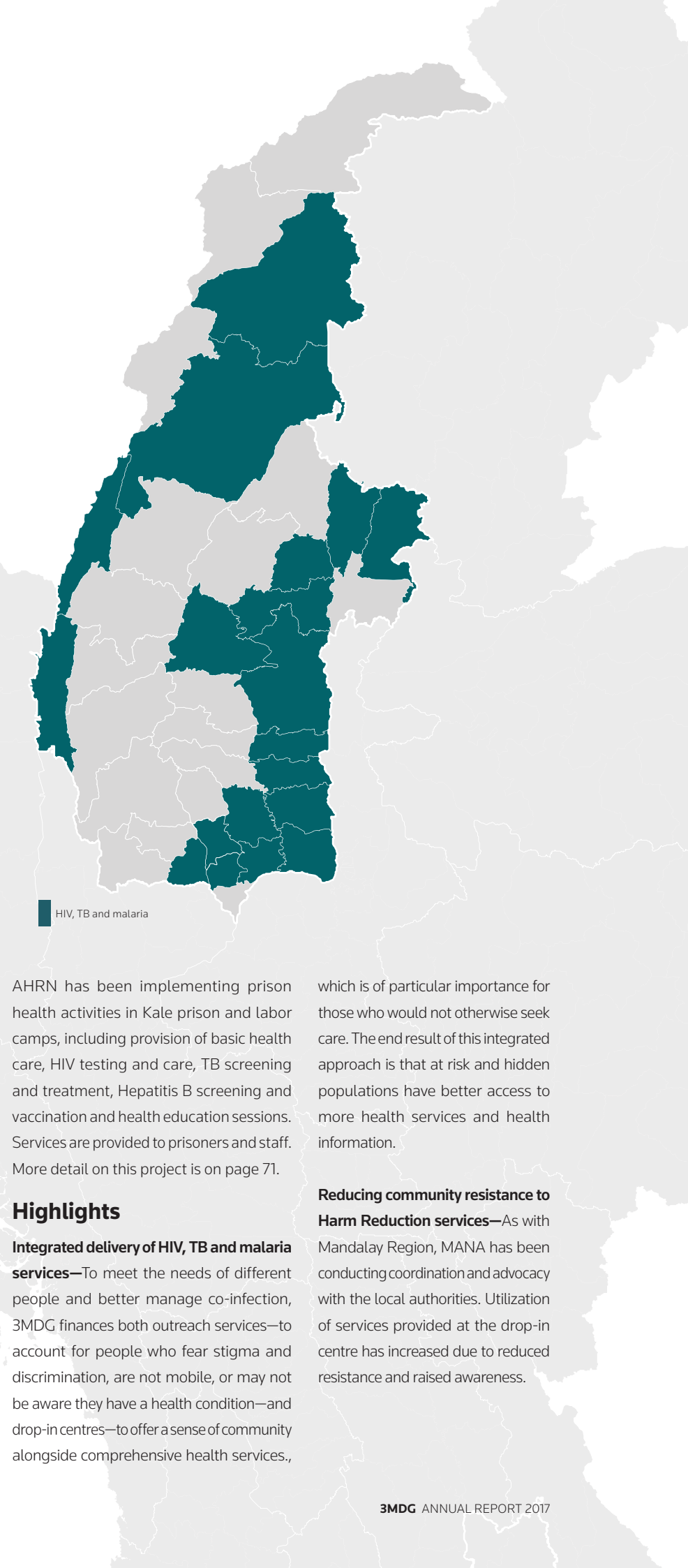
Though Myanmar has a significant public health programme for TB, Sagaing Region has continuing health needs in this area. The region also has significant challenges in HIV, especially among people who inject drugs. Sagaing Region is also home to a number of prisons, where health services are limited and populations are particularly vulnerable.

Activities and partners

3MDG is financing three implementing partners: Asian Harm Reduction Network (AHRN), Myanmar Health Assistant Association (MHAA) and The Union to provide TB active case finding activities and support comprehensive HIV prevention and care among people who use drugs. By providing these services in an integrated manner, the overlapping and compounding health problems of HIV and TB are addressed.

TB active case finding activities, provided by MHAA in ten out of 37 townships in 2017, was carried out in collaboration with the National Tuberculosis Programme (NTP). This collaboration improves the reach of the mobile clinics and enables community-based programmes to find more cases. Community health workers receive refresher training to keep their skills sharp and to help build community-based health systems.

AHRN and Myanmar Anti-Narcotics Association (MANA) offer a package of comprehensive Harm Reduction services to people who inject drugs and their sexual partners in eight townships of Sagaing. This includes needle and syringe exchange, dissemination of condoms, HIV testing services, Methadone Maintenance Therapy, TB screening and treatment, Hepatitis B screening and vaccination, screening and treatment of sexually transmitted infections and overdose management. They are provided via drop-in centres and outreach. Malaria testing and treatment is integrated into Harm Reduction services.



AHRN has been implementing prison health activities in Kale prison and labor camps, including provision of basic health care, HIV testing and care, TB screening and treatment, Hepatitis B screening and vaccination and health education sessions. Services are provided to prisoners and staff. More detail on this project is on page 71.

Highlights

Integrated delivery of HIV, TB and malaria services—To meet the needs of different people and better manage co-infection, 3MDG finances both outreach services—to account for people who fear stigma and discrimination, are not mobile, or may not be aware they have a health condition—and drop-in centres—to offer a sense of community alongside comprehensive health services.,

which is of particular importance for those who would not otherwise seek care. The end result of this integrated approach is that at risk and hidden populations have better access to more health services and health information.

Reducing community resistance to Harm Reduction services—As with Mandalay Region, MANA has been conducting coordination and advocacy with the local authorities. Utilization of services provided at the drop-in centre has increased due to reduced resistance and raised awareness.



Su Su in a health facility in Sagaing. The midwife, Daw Myint Myint Po has already shown her how to breastfeed and offered tips for taking care of her baby.

Voices

"I am not scared, the midwife will take good care of me."

More than 2,000 people live in Kan Taw Village in Sagaing Region. Before the new health centre was built, the midwife provided health services to the community at a house in the middle of the village. She had limited equipment and the house was old and difficult to keep clean.

Now, there is a new rural health centre that was designed and built by UNOPS Infrastructure Unit with funding from 3MDG. The midwife is Daw Myint Myint Po. She has been a midwife for 23 years. Since she was assigned to Kan Taw village two years ago, she has built trust and the community knows they can rely on her. In this village alone she has helped 20 women give birth.

Every day, Daw Myint Myint Po receives about ten phone calls from people with all kinds of symptoms. Sometimes she has to help women give birth in the middle of the night.

Su Su, 36, delivered her newborn baby at home with the help of the midwife. "When the baby was coming, I was really struggling; I knew I couldn't

deliver him alone. My relatives called the midwife," she says.

Daw Myint Myint Po went quickly to her house and helped her deliver. Su Su says, "After the delivery she stayed at our house, taking care of me and the baby. She came to my house every day the next week to check everything was going well."

The new health centre has a delivery room and an emergency room with medicine and equipment always on hand.

Births attended by a skilled person in a facility can contribute to reducing the dangers of childbirth for mother and baby. "With this new centre, it is easier for me to convince the pregnant women to deliver at a clinic instead of their houses because it's cleaner and more private," says Daw Myint Myint Po.

Results

6,422

People who inject drugs were reached by prevention programmes.

2,506,050

Needles and syringes distributed to people who inject drugs.

192,867

Condoms distributed

2,281

People who inject drugs were tested for HIV

10,491

Referral cases for TB screening

28,823

Suspected TB cases examined

3,502

Notified TB cases (all forms of TB)

629

Notified bacteriologically confirmed TB cases

1,840

Malaria rapid diagnostic tests (RDT) taken and read

13

Confirmed Plasmodium falciparum malaria cases treated

3

Confirmed Plasmodium vivax malaria cases treated

See more results in Annex II: Results matrix.

Yangon

Context and health needs

Yangon is the most densely populated region in Myanmar. Despite access to the best health services in the country, the region is challenged by high levels of poverty and crowded living conditions. TB and HIV are critical issues (along with co-infection) and Yangon Region has the highest burden of multi-drug resistant TB cases in the country.

Activities and partners

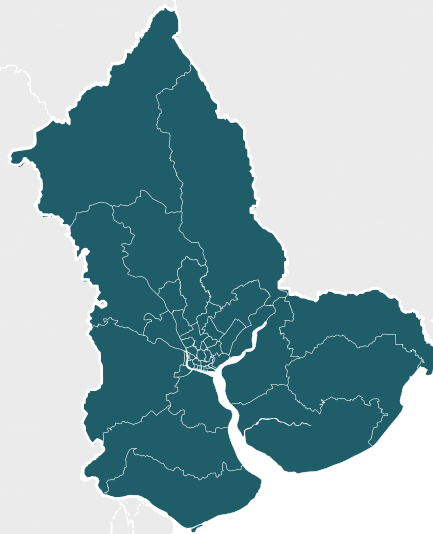
The nine mobile TB teams that work around Myanmar do considerable work in Yangon Region due to the high disease burden. Further, to tackle the multi-drug resistant TB (MDR-TB) crisis in Yangon, 3MDG supports the National TB Programme with infrastructure and human resources, and the strengthening of patient-centered community-based care. The electronic MDR-TB patient data management system was fully utilized in the main TB centre and decentralized sites in 2017.

3MDG activities covered 44 out of 45 townships in Yangon Region. There are seven partners—National TB Programme, Clinton Health Access Initiative, Burnet Institute, Population Services International, Myanmar Health Assistant Association, Pyi Gyi Khin and Myanmar Medical Association.

Highlights

Cutting TB transmission with early TB case finding and referral—Myanmar Medical Association has implemented community-based care in two townships of Yangon Region (Kyauktan and Khayan) for almost four years. As a result, the number of TB cases is now declining each year. This shows the successful interruption of the TB transmission chain through active screening of early TB cases and community referrals.

Reaching more people who inject drugs in Yangon—In previous years, the majority of Burnet Institute's beneficiaries came from the Eastern District of Yangon. In 2017, more people who inject drugs were reached in the Western District



HIV, TB, and malaria

after a small satellite clinic was opened in Kyeemyindaing Township. This meant that drop-in centre and outreach services could be expanded and the positivity rate has subsequently increased (from 14 percent in 2014-2015 to 20 percent in 2017).

Supporting 'self-help' groups in Yangon for drug resistant tuberculosis—In the past six months, 3MDG's partners working on multi-drug resistant tuberculosis have started supporting tuberculosis self-help and peer groups in peri-urban areas of Yangon. The groups facilitate sessions between patients, family members and health care providers to promote information sharing and treatment adherence. They also provide psychosocial support, nutrition support, evening Direct Observed Treatment (DOT), home based care, and health education. The role of

the self-help group is critical for community empowerment and sustainability of activities.

Strategic Purchasing Pilot in Yangon and Chin—2,506 low income households in two townships in Yangon were screened and issued health cards in early 2017. The cards enabled people to access a defined benefit package provided by members of the Sun Quality Health network, including under-five care, maternal and women health care, malaria, TB and sexually transmitted infections, family planning and other health services. The pilot will continue in Yangon in 2018 and expand to an additional township in Chin.



Dr Myo Myint Aung in front of his clinic. He is a general practitioner who is part of Population Services International's new project, and offers health services to poor households using a "blended payment" model.

Rethinking how health services are financed

High costs of health care may prevent people in Myanmar from seeking needed medical care. 3MDG partner Population Services International (PSI) is helping people in Yangon access affordable primary health care with a pilot programme which aims to change the incentives for health service providers, increase access to quality health care services and reduce out-of-pocket expenditure.

The programme uses what is called 'strategic purchasing' from private general practitioners in Myanmar to provide healthcare services. PSI, rather than the patient, acts as the 'purchaser' of health services. They buy the whole package of basic services up-front, which means better planning for what health care will cost.

In 2017, PSI registered 2,500 families (7,287 beneficiaries in total) from low-income areas in the programme. They went door-to-door to explain the benefits and sign people up. Once they register, members of the public receive a health care card which entitles them to a basic package of services at a specific doctor. The contents of the package was also confirmed in 2017.

Doctors who are part of the programme receive a set amount per patient who is registered with them. They then provide the basic package of services for a year, regardless of how often

the patient visits. Each visit, the patient provides a nominal payment (about 500 kyats) in a 'blended payment' model. The doctor also receives performance-based incentive payments to explore how private service providers can be engaged for improving access to primary health care.

In mid-2017, Ma Cho Pyone, a mother-of-three, gave birth in a health clinic for the first time. Her older children, aged twelve and six, were both born at home because the family could not afford the cost of any alternative. For her last pregnancy, she was enrolled in PSI's pilot project. She received affordable antenatal and post-natal care and she could give birth in a health clinic without the family suffering undue financial stress to cover the cost.

In line with the National Health Plan 2017-2021, PSI expects that a national purchaser will take over this role in the future and that the bundle of health care services will be aligned with the planned Essential Package of Health Services. Valuable lessons from this programme will contribute to the broader health financing agenda. More on the lessons that have been learned in the first year of implementation from page 88.

Results

1,625

People who inject drugs were reached by HIV prevention programmes.

156,290

Needles and syringes distributed to people who inject drugs

45,303

Suspected cases of TB examined

2,681

Notified TB cases (all forms)

645

Community health workers trained and actively involved in MDR-TB activities at community level

801

MDR-TB patients receiving Daily Observed Treatment (DOT) through volunteers

7,287

Beneficiaries registered by PSI; registration wrapped up clinic level registration at the end of 2017.

See more results in Annex II: Results matrix.



Children in Wa hold up their little finger, which has been stained purple, to show they have been vaccinated against Japanese Encephalitis as part of the nationwide campaign.

Immunizing children against Japanese Encephalitis in a nationwide campaign

In November and December of 2017, a campaign to immunize children under 15 years of age against Japanese Encephalitis was launched. This was in response to outbreaks of the deadly disease in Rakhine and Ayeyarwady. Roles and responsibilities for the campaign were determined at a planning meeting in September 2017, hosted by the Ministry of Health and Sports and supported by 3MDG.

3MDG implementing partners supported advocacy efforts, community mobilization through the engagement of influential persons, information sessions for health staff, transportation charges for vaccines and promotional materials. Implementing partners also supported supervision visits conducted by state/regional health departments and township health departments.

The 3MDG Monitoring and Evaluation team also supported the development of the Japanese

Encephalitis micro plan for schools and communities.

The results of the campaign were strong in many areas, but in others they were limited due to conflict and fear of side effects.

For example, in Labutta Township in Ayeyarwady Region, 97 percent of the target population was reached. In Rakhine State, in eight townships, more than 90 percent of the target population was reached, except for Buthidaung Township where only 30 percent was reached due to the unrest in August 2017.

In Kayah State, where 3MDG supported seven townships, results were high in government areas (95 percent) but lower in the ethnic health areas of Hpsaung (30 percent) and Shardaw (70 percent). The low result in Hpsaung was due to community fears stoked by rumoured

adverse effects from vaccinations in Mawchi Township.

Results in Wa Special Region and Special Region 4 were good –92.5 percent and 81.9 percent respectively. This was a result of outreach, involvement of local women’s associations, advocacy and broadcasting through local media.

Through 3MDG townships, including hard-to-reach and conflict-affected areas, there was more than 95 percent coverage. This is a significant achievement. 3MDG-supported townships are now better prepared to participate in nationwide campaigns in the future, as a result of this experience and the involvement of many different health actors.

Our Work Nationwide

Health Systems Strengthening

Context and health needs

Myanmar's public spending on health has grown by nearly nine times during the past five years, from 94 million USD in 2012 to 850 million USD in 2016/17. The country is undergoing a major democratic transition and rapid economic development. Initiatives to strengthen the health system continue at central, state/regional and township level.

The National Health Plan 2017–2021 aims to pave the way towards universal health coverage by 2030 by extending access to a Basic Essential Package of Health Services (EPHS) to the entire population by 2020/2021 and increasing financial protection. It is indicative of renewed leadership from the Ministry of Health and Sports.

Nevertheless, health problems in the country remain significant, with Myanmar recording some of the poorest health indicators in the region. Decades of armed conflict and low accessibility across ethnic states in Myanmar have had negative impacts on the health system and health outcomes, as well as on the mental and physical health of communities in conflict areas. Though investment in health has improved, it is still limited, constituting slightly over one percent of GDP in 2014.

Out-of-pocket payments for health remain among the highest in the world, at almost 73 percent of total health spending in 2017.⁴⁵ Out-of-pocket spending may drive large numbers of households (further) into poverty and prevent access to care, creating considerable inequities.

Activities and partners

3MDG supports the Ministry of Health and Sports to strengthen governance and stewardship, evidence-based policy making, infrastructure, human resources for health, supply chain management, health information systems and people-centered health care at national as well as sub-national levels. These investments are fundamental to ensure that all essential quality health services can be delivered effectively and efficiently at different levels of the system.



U Pyae Nyein has been the village health worker in his village in the Ayeyarwady Region for 30 years. He is a committed volunteer, having previously volunteered as a teacher.

Voices

“I have put my whole heart and soul into it”

U Pyae Nyein is a 68-year-old community health worker in Kan Chung Village in Ayeyarwady Region. He has seven children of his own; one of his daughters is the auxiliary midwife in the village too. Before he was a volunteer health worker, he volunteered as a teacher in the village.

“In 1986, when I was still a volunteer teacher, the midwife and village authorities approached me and asked me to be the community health worker in our village. The villagers supported me too, so I decided to attend the trainings organized by UNICEF and GAVI.

“The main challenge was cost because I had to sometimes pay for supply of drugs and transportation. I wanted to be the community health worker, but it was expensive for me. Luckily, since Save the Children started supporting us in 2013, this changed. Through them, I have

received refresher trainings and the supplies I need. I know more about recording patient data and I can attend more meetings at the rural health centre because the cost is covered.

“Recently, I learned more about health for children under five. That meant I could diagnose and treat diseases that I couldn't before—pneumonia and diarrhoea. I was taught when I could treat, and when a case should be referred. The villagers also grew to understand that I was able to help them with these conditions, so they came to me more quickly for treatment.

“I have seen the health of the community, especially children under five, improve during my years of work.

“I have been providing health services to this community since 1986. I have put my whole heart and soul into it, and I will keep going until the young and active volunteers take over my work.”

Improving human resources for health

Developing an HRIS

Information about human resources for health—for example, how many midwives are trained and ready to be deployed, or the retention figures for doctors working in the public system—is essential to meet the health needs of the population.

This is normally recorded and analyzed via a ‘Human Resource Information System,’ or HRIS. In Myanmar, there is no central HRIS, and the systems which are used are not integrated or up-to-date. This can lead to gaps and overlaps in trainings and deployment, reducing effectiveness and ultimately impacting the health of the communities which they serve.

In 2017, 3MDG began to support the development of an integrated HRIS. Many stakeholders have been involved in designing and developing the system. The management supervisory committee for the HRIS includes representatives from all Ministry of Health and Sports’ departments. From this system, decision-makers will have the information they require to efficiently plan for recruitment, training and retention of the health workforce.

The development process began with the review of existing systems and systems adopted in other countries in order to decide on a model. Because it is user-friendly, highly scalable and can integrate data from a number of different, fragmented systems, the committee settled on the Business Intelligence (BI) model. The next step was to recruit ‘champions’ (Consolidated HRH Information and Planning System Champions) to validate data, and manage, maintain and update the system. They are key to system sustainability and to strengthen coordination and collaboration among different departments.

Standardizing the village-based health workforce

Myanmar has a long history of village-based health workers,⁴⁶ including auxiliary midwives, community health workers, village malaria volunteers, and village health workers supported by ethnic health organizations. They

may have differing ways of working, including training, provision of supplies and supervision, which can result in duplication of services or service gaps. One village health worker may receive regular supervision and a monetary incentive, whereas another may receive virtually no support.

This situation cannot continue given the critical role of village-based health workers (VBHW) in providing access to the basic package of health services to the entire population, one of the main goals in the National Health Plan 2017–2021. The Ministry of Health and Sports, supported by 3MDG, has committed to developing a comprehensive, institutionalized approach to the village-based health workforce. It includes a national policy and operational plans.

In 2017, a comprehensive literature review of more than 80 documents was completed as an initial step in this process. The review was steered by the cross-departmental Ministry of Health and Sports working group. The review was informed by global evidence through use of the Community Health Worker Assessment and Improvement Matrix as an organizing framework. It looked at each essential dimension for a functional community-based programme.⁴⁷ 3MDG will continue to support policy development activities in 2018.



Midwives in training practice with simulation equipment at the Pyay Midwifery School in Ayeyarwady. *Jhpiego*

Results

20

Health centres built. Eight in Shan, three in Chin, three in Kayah, three in Yangon, two in Ayeyarwady, and one in Mandalay

2,772

Doctors, nurses and midwives who participated in at least one mother, newborn and child health training, including delivery and emergency obstetric care in 3MDG-supported townships

3,700

Health facilities have implemented Logistic Management Information System (LMIS) paper-based forms

88%

Townships with functional cold chain equipment and adequate storage space based on the new cold chain expansion

See more results in Annex II: Results matrix.

Highlights

Launch of the National Health Plan and implementation of key activities—

The National Health Plan and National Health Plan Implementation Monitoring Unit (NIMU) were launched in 2017. The development process, supported technically and financially by 3MDG, included consultation with a diverse set of stakeholders to ensure that the needs of all populations were met. In 2017, progress was made on a critical piece of the puzzle—the Basic Essential Package of Health Services (EPHS). Costing and development is supported by 3MDG. 3MDG has also worked with partners to strengthen supply side readiness, in particular availability of qualified health staff and supplies.

Building an evidence base—

3MDG commissioned two critical studies to help policy makers and implementers understand the health issues facing the population. The first was the Myanmar Demographic and Health Survey, co-financed by USAID and 3MDG and launched by the Ministry of Health and Sports in March 2017. The survey provides important input for the development of the Ministry's planning, policies, strategies and guidelines. Based on the analysis the Ministry is refining strategies to address malnutrition and limited access to maternal and child health care, particularly in rural areas.

The second study was a large-scale qualitative study on the effects of high out-of-pocket expenditure on families and health care providers. The dissemination of the findings will begin in 2018. 3MDG also financed the Ministry of Health and Sports to develop nine health sector policies, strategies and plans in 2017 covering areas like human resources, monitoring and evaluation and maternal mortality.

Logistics management systems rolled-out in 79 townships—

The Partnership for Supply Chain Management (PFSCM)

introduced Logistic Management Data aggregation tools in 79 townships in Bago, Magway and Ayeyarwady Regions in 2017. With a new approach to supply chain management, regional health departments will be able to forecast requirements for supplies and commodities based on consumption needs, mitigating stock-outs.

A supervisory committee for Human Resources for Health was developed, supported by Jhpiego. This committee produced a road map and tools for a user-friendly information system for human resources. This makes it easier for the Ministry of Health and Sports to maintain, update, and utilize human resource information and data, which in turn will inform forecasting of human resources for health and decision-making about human resource policies.

Improving clinical training sites with Jhpiego—

In 2016, an assessment of the clinical sites showed they were not adequate to meet the training needs of midwifery students. Jhpiego, the Department of Human Resources for Health, Department of Medical Science and Department of Public Health, worked together to re-select the sites and then rapid assessments were done at seven sites in March and April 2017.

Findings from these assessments was used to develop the plan to strengthen clinical sites; a major portion of which is the preceptorship programme. 'Preceptorship' means the practical experience or training for a midwifery (or medical) student that is supervised by an expert. The system and operational manual for the preceptorship programme was discussed, and then finalized in March of 2018. This strengthening work will continue in 2018—in particular to identify potential preceptors (or, supervisors) and improve infrastructure.

Accreditation for basic medical education—

The midwifery education programmes must now fulfill minimum requirements and standards in quality education and continuous training opportunities in a plan that has been endorsed by the Union Minister.

Improving public financial management—3MDG supported Public Financial Management training and mentoring for the Ministry of Health and Sports through the World Bank. Staff in 29 townships were reached through mentoring field visits and refresher financial trainings were conducted in six states and regions.

Building and renovating infrastructure—Since 2015, 3MDG has financed the construction of 82 health facilities in Myanmar. They are built by the Infrastructure Unit at UNOPS. All centres will be finalized in early 2018 (only one remains to be handed over). The completed facilities are furnished. Solar power is provided to those facilities that are not connected to the national grid.

Construction of multi-drug resistant tuberculosis infrastructure continued in 2017, including two outpatient departments in Yangon and Mandalay, and the Bio Safety Level 3 National TB Reference Laboratory in Yangon. The Mandalay Outpatient Department was opened and handed over to the National TB Programme in late 2017. The Outpatient Department and Bio Safety Level 3 in Yangon were completed during 2017 and handed over in early 2018.

Two trainings in project management of infrastructure were conducted for the medical doctors, township medical officers and engineers who oversee the health infrastructure projects from the Ministry of Health and Sports. The construction work began for the prison facilities at Insein, Lashio and Myitkyina Prisons and will be completed in 2018.



A midwife sits in a class where students practice with simulation equipment at the Pyay Midwifery School in Ayeeyarwady. *Jhpiego*

Spotlight on Gender

System strengthening and gender equality

A strong health system requires a focus on gender equity. Identifying gender inequalities and addressing gender equity are central to good stewardship of health systems. Strengthening Myanmar's health system with an emphasis on gender equity can be approached in three ways.

The regulatory approach requires the enactment of laws that support gender equality and participation of all genders in the public sphere. This may include anti-discrimination legislation, human rights protection, patient privileges protection, and legislation that encourages authorities in the public and private sector to address gender inequality. This approach includes advocacy at higher levels, such as amendments to the *Law on the Suppression of Prostitution* (see page 72) and support to the development of health strategies and plans such as the National Health Plan 2017–2021.

The organizational approach requires a focus on gender mainstreaming, gender budgeting, gender impact, and

gender-focused outcomes. Gender budgeting, for instance, focuses on and makes explicit the gender impact of budgetary decisions. 3MDG efforts under this heading include gender-inclusive indicators (such as 40 percent women in village health committees); and targeted recruitment and training of female service providers to empower and employ women and provide women-friendly services.

The informational approach prioritizes collecting effective data to enhance knowledge on gender inequities. Gender-sensitive indicators, for example, are able to identify key differences between women and men in relation to health and in the social determinants of health, in order to support policy change⁴⁸ and effective planning and resourcing of health service delivery to reach all people. 3MDG collects gender-disaggregated data and responds quickly and effectively to any noted differences or disparities. For example, when it was noted that only five percent of the people accessing Harm Reduction services were women, Asian Harm Reduction Network increased their outreach services and opened a women-only centre. They receive support from their peer group, and can ask health services in a safe space.

Health System Strengthening Activities and partners

	Activities	Partners	Townships	2017 Expenditure in USD
Midwifery	Policy and regulatory framework for guiding quality pre-service education and in-service training to improve midwifery education. Strengthening the continuing professional education system, including support structures for midwives in facilities and communities. Generating evidence, lessons and policy briefs.	Jhpiego	Nationwide	1,155,160
Support to strengthen human resources for health management	Support the Ministry of Health and Sports to develop a Human Resource for Health Information System. Strengthen the Accreditation System for Basic Medical Education and Quality Assurance Framework for health professions. Strengthen the management and leadership capacity of the Ministry of Health and Sports, related training institutions and professional bodies. Support Ministry of Health and Sports in the generation of Human Resources for Health strategies, policies and studies	Jhpiego	Nationwide	886,132
Regional Supply Chain Strengthening (RSCS)	Implementation of a harmonized logistics management information system (LMIS) for all essential medicines. Capacity building for supply chain management activities. Assist the Ministry of Health and Sports to introduce logistics management units (LMU) at the regional and township levels. Strengthen supply chain management with change from "push system" where production is based on long term forecasts to "pull system" where the entire process is based on the demands at the service delivery level.	Partnership for Supply Chain Management (PFSCM)	79 townships in Bago, Magway and Ayeyawaddy Regions	1,006,751
National Health Plan Implementation Monitoring Unit (NIMU)	Development of costed Basic Essential Package of Health Services. Support integrated township (ITHP) and state/region health plan (SRHP). Health Financing Strategy and National UHC Framework. Communication strategy. Stakeholder engagement. Support development and implementation of annual operational plans	NIMU	Nationwide	633,953
Reimbursable Advisory Services	Public financial management: bottleneck analysis and fiscal space analysis, capacity building. Costing of Essential Package of Health Services. Out-of-pocket expenditure qualitative study. Public expenditure tracking. UHC seminar and knowledge sharing	World Bank	Nationwide	3,518,000
Joint UN for Health Systems Strengthening	Support the Ministry of Health and Sports in policy development, planning and stewardship in both the public and private sectors. Support Ministry of Health and Sports in strengthening the health management information system, human resources for health and cold chain systems. Dedicated senior national technical assistance to assist technical strategy groups (TSG); annual health sector forums. Multi-sectoral coordination and capacity for Scaling Up Nutrition (SUN)	Joint UN UNICEF UNFPA UNAIDS WHO	Nationwide	5,178,056*
Infrastructure	Construction of 82 rural and sub-rural health centres. Two outpatient departments and a laboratory for tuberculosis. Support to prison health with construction of new facilities at prisons. Capacity development with Ministry of Health and Sports for project management	UNOPS	Nationwide	12,000,000**

*UNICEF and UNAIDS—total budget for three years divided by three
**Budget for entire life of the grant



Midwife Ma Lei Lei Moe performs a check-up on a baby in her health centre in Kayah State. She has been passionate about health since she was a young girl.

Inspiring Women

"I want to serve the community as long as I can."

Meet Ma Lei Lei Moe, a midwife working in Kayah State for an ethnic health organization.

Lei Lei Moe originally comes from Mese Township in Kayah State, but she has been working as a midwife for an ethnic health organization in Thar Yu Village in Demoso Township for about a year. In her village in Mese, she was a community

health worker, but after further training, she became a midwife.

"I have been passionate about health ever since I was young. I saw that people in my village, including my own family, had a hard time accessing health care. We didn't have any health practitioner and our village is hard to reach. Security wasn't good and transport cost a lot, so people couldn't get to hospital. I just knew I wanted to help as much as I could when I grew up.

"Now, I have delivered more than 30 babies. Whenever I can help deliver babies safely, I feel so proud.

"I work with three other midwives and together we are able to cover five villages.

Before we opened our clinic, the local people did not have access to health care services. The nearest hospital is at least three hours away and the roads cannot be used during the rainy season. If the case is too complicated for us to handle, we refer the patients through the emergency referral programme.

"I really like my job. I see how hard life is for the people I serve and I have so much empathy for them. That's what keeps me in this job, I want to serve the community for as long as I can."

'Health for All': A rights-based approach

Myanmar has a number of disparities in health status indicators. Access to health services may be impacted by location, gender, disability and language, among other factors. 3MDG is committed to increasing equity in health and improving access to affordable, quality health care, especially in rural and hard-to-reach areas and among poor and vulnerable groups. 3MDG's rights-based approach is underpinned by principles of accountability, equity, inclusion and conflict sensitivity, known as 'Health for All.' These principles shape the Fund's financing decisions and contribute to making the right to health a reality for all people.

The important role of the village health committee

Village health committees and volunteer health support groups are selected groups of village members who take care of health issues for their community. They are the entry-point for basic health staff in their villages. Because they are known to the community, they are able to bring people together more easily to participate in health activities.

A midwife from Yaung Daung village, Bilin Township, Mon State said, "My work has become easier after the establishment of the Village Health Committee. Previously, I had to do everything on my own—including notifying and gathering the village community for health education sessions and other health-related activities. Now, they support me in conducting health activities in the village and my work is running more smoothly."

Ar Yone Oo Social Development Organization strengthened 20 village health committees in Matupi Township, Chin State. With the Village Health Committee in Am Soi (B) Village, Ar Yone Oo focused specifically on environmental sanitation and hygiene promotion, and together they put a plan in place.

The chairman of the Am Soi Village Health Committee said, "We encouraged the communities to clean the environment, sanitation system, and protect the drinking water sources. We regularly check all the toilets in the village and agreed to renovate them as they didn't have proper latrine covers. Now all the toilets in the village have covers and are fly-proofed."



A mother and her child wait at a mobile clinic. During their wait to see a health worker, volunteers share health information and play games about sanitation and hygiene.

Spotlight on Disability

The facts

Relief International has been implementing the Comprehensive Township Health Plan together with the Township Health Department in Mrauk U Township

Together with Myanmar Independent Living Initiative (MILI), Relief International led a World Disability Day Campaign to raise awareness about disability in Mrauk U Township.

U Thein Aung, the secondary secretary of MILI, remembers the event.

"At a disability training, I interviewed women with disabilities. This showed me how important maternal, newborn and child health services were for them. They had so many challenges to access the services they needed; stigma also held them back.

"I wanted to help raise these issues. At the quarterly meeting for civil society and community-based organizations, I asked for support for a World Disability Day Campaign. Relief International and the Township Health and Education departments and local stakeholders agreed.

"58 people were part of the organizing team, including 11 people with disabilities. We put up posters, distributed awareness pamphlets, wrote and played songs about the status of people with disabilities, and prepared a speech about disability and equitable access to maternal, newborn and child health services for women with disabilities.

"The speech was delivered to the community on a megaphone on a vehicle, meaning more people could hear it! This included people with disabilities, who might not have been able to travel to the event.

"People came from all over to see our event. People with disabilities had the chance to show what they could do – they have capabilities just like everyone and can play an important role in the community. We hope that the campaign can reduce stigma."

Highlights

Mainstreaming principles of accountability, equity, inclusion, gender and conflict sensitivity—As a result of continued advocacy, the ‘Health for All’ principles were included in the National Health Plan 2017–2021. The Plan also highlighted the importance of community engagement in health and formalized this intention with the introduction of ‘Township Health Working Group’ with seats for civil society organizations. These types of initiatives enhance the responsiveness of the system by increasing checks and balances and fostering social accountability.

Implementing partner ‘accountability, equity and inclusion’ officers and programme focal points continued to receive work-relevant training in 2017, sharing this with colleagues and basic health staff. The number and percentage of Ministry of Health and Sports’ staff at ‘Health for All’ related trainings increased from 46 percent of all staff trained in 2016 (1,477 out of 3,192) to 54 percent in 2017 (2,765 out of 5,121).

Community feedback and response—Community feedback mechanisms are a key means of seeking out beneficiary views and addressing their concerns to improve service quality. Implementing partners incorporate feedback and use it to adjust programming. In 2017, implementing partners received 14,648 pieces of feedback from communities. This indicates

widespread usage and responsiveness at the township level. Of these, 10,753 were positive, 492 were negative, 2,508 were suggestions, and 895 were classified as other. 92 percent (13,534 in number) of the feedback was addressed in 2017.

Support to village-level and community-based health structures—3MDG maternal, newborn and child health implementing partners work to strengthen the capacity of village health committees. This connects communities with service providers, especially basic health staff. More women are being included as committee members (15,636 out of 36,687 members or 43 percent) and knowledge on gender equity has increased. This is a result of training and information sharing sessions.

To achieve universal health coverage, capacity strengthening of ethnic health organizations and local civil society organizations is increasingly important because they are able to reach the hardest-to-reach places and people. In 2017, organizational capacity development support for these organizations was provided by Pact Myanmar through training sessions, workshops and forums, technical assistance and coaching, based on partner needs.



Women in a village health committee meeting at Amswe Village in Matupi, Chin State. Supporting more women to become involved in these sort of committees has been a goal for the 3MDG Fund, in 2017, more women than ever participated.

Results

100%

Implementing partners (28 out of 28) included participation and engagement between health care providers and target communities as one of their activities

14,648

Pieces of feedback received by implementing partners from community members. 13,534 (92%) pieces of this feedback have already been addressed, a significant improvement on the 2016 result (66%).

29%

Members of township health committees are women (139 out of 473), exceeding 3MDG’s target of 20%.

43%

Members of village health committees are women (15,636 out of 36,687).

72%

Attendees of the annual review workshop on the comprehensive township health plans were women (1586 out of 2199). Many of them were midwives.

5,121

People were trained in accountability, equity, inclusion and conflict sensitivity, including 2,765 staff members from the Ministry of Health and Sports.

See more results in Annex II: Results matrix.

Collective Voices

What is Collective Voices?

Collective Voices grants aim to better link services with the communities that need them. They focus on understanding and overcoming barriers to health care and increasing health seeking behaviour through health promotion. Working with local civil society and community-based organizations, they boost participation in township-level planning, budgeting, and monitoring and encourage community inputs into national policies and processes; enhancing accountability and responsiveness of health services via community feedback mechanisms. In 2017, the programme also contributed to developing the capacity of local implementers to support township-level referral systems and community-based health service models.

The principles

| Listening: The project engages the community and listens to voices, strengthening beneficiary accountability and responsiveness.

| Strengthening capacity: To strengthen the capacity of village health committees, Collective Voices partners facilitate face-to-face workshops, bringing together different health stakeholders, such as providers, committees, administrators, basic health staff, non-government organizations, ethnic health organizations and private practitioners. They meet quarterly to discuss bottlenecks, challenges and share community feedback.

| Better health services: Realized through supporting immunization campaigns, informing the midwife or township medical officer when there are cases or outbreaks of disease, and capacity building of informal health service providers to help them know when to refer and apply basic first aid.

| Stronger financial protection: Setting up revolving village health funds with self-financing components, so that villagers are able to access money for transport and care in an emergency.

| Promoting health and health education: Lessons are conducted in local languages to ensure everyone can understand, and include adolescent sexual and reproductive health for high school students, and social mobilization campaigns to reach vulnerable communities, migrants and diverse ethnic groups.



Women in Bilin Township in Mon State participate in exercises designed to encourage active involvement and engagement. Ultimately, the goal is to make sure women are more involved in family decision-making and move towards gender equality.

Highlights

3MDG Collective Voices initiatives cover 169 villages and 58 migrant clusters in Myanmar. They are located in:

- | Chin - 110 villages in Mindat, Kanpetlet, Matupi, Hakha and Thantlang
- | Mon - 44 villages and 58 migrant clusters in Mudon and Bilin
- | Ayeyarwaddy - 10 villages in Labutta and Myanaung
- | Magway – 5 villages in Magway Township

There are five Collective Voices project civil society organization leads, working in partnership with 16 partner community-based organizations. There are two working in Chin State, Ar Yone Oo Social Development Organization

and Community Agency for Rural Development; two in Mon State, Community Driven Development and Capacity Enhancement Team, and Bright Future; and one in Magway and Ayeyarwady regions, Charity Oriented Myanmar.

'Health for All': Collective Voices Activities and partners

All Collective Voices partners:

Complement 3MDG service delivery grants for maternal, newborn and child health and HIV, TB and malaria, creating linkages between communities/users and providers.

Increase demand for services by addressing social barriers to access affecting vulnerable populations.

Enhance social accountability, equity, gender sensitivity and social inclusion

Increase participation of local civil society and community-based organizations in township-level participatory planning, budgeting and monitoring

Work to include community input into national policies and processes.

Contribute to developing the capacity of local implementers (civil society and community-based organizations) to support township-level referral systems and community-based health services models.

Conduct health literacy promotion sessions in collaboration and technical supports from local health staff and 3MDG maternal, newborn and child health and HIV, TB and malaria partners.

Set up of village health committees and emergency village health funds.

Lead partners Civil society organizations

Ar Yone
Oo Social
Development
Association
(AYO)

Bright Future
(La Yee Anar
Gut)

Community
Driven Develop-
ment & Capacity
Building
Enhancement
Team (CDDCET)

Charity
Oriented
Myanmar
(COM)*

Community
Agency for
Rural
Development
(CAD)

Partner organizations Community-based organizations

| Matupi Women
Group
| 'K' Cho Land
Development
Association
| Khawnumthung
Rural Development
Organization

| La Wee Mon
Rainmanya Charity
Foundation
| Hnee Padaw
Education Support
Group

| Lanpyakyesin
| Paung Ku
| Ah Lin Yaung
| Lanpyakye

| Social Care
Volunteer Group
| Development
Parami
| Ayeyarwady
Social Development
Organization

| Love In Action
| Greenland Social
Development
Organization
| Chin Youth
Organization

Townships

Kanpetlet, Mindat,
Matupi (Chin)

Target—General
community in 60
villages

Mudon (Mon)

Target—General
community in 24
villages and 58 migrant
clusters

Bilin and Kyaik Hto
(Mon)

Target—General
community in 20
villages and grade 8-11
students from eight
state high schools in
Bilin and two state high
schools in Kyaik Hto

Magway (Magway)
Labutta, Myanaung
(Ayeyarwaddy)

Target—General
community in 15
villages

Hakha, Thantlang
(Chin)

Target—General
community in 50
villages

2017 Expenditure in USD

84,143

90,747

90,383

137,466

89,521

*Charity Oriented Myanmar (lead civil society organization partner) provided Community Engagement training of trainers to 123 state regional and township level health staff in three states/regions: Nay Pyi Taw, Myitkyina (Kachin) and Lashio (Southern Shan).



Shu Shu Wai is a M&E Co-ordinator at Relief International. She switched over from programmes only a few years ago but is picking up her new responsibilities quickly.

Inspiring Women

"I really like sharing our challenges."

Shu Shu Wai is a Monitoring and Evaluation (M&E) coordinator at Relief International. With 3MDG financing, Relief International has been supporting maternal, newborn and child health services in hard-to-reach and conflict-affected areas of Ayeyarwady and Rakhine through 3MDG's grants.

"My name is Shu Shu Wai. I am responsible for collecting reports, building the M&E framework

and compiling donor reports. Soon, I may take on the additional role of accountability, equity and inclusion (AEI) focal point for the conflict sensitivity project.

"After graduating from the University of Nursing, I joined a Masters course for primary health care management. I spent almost six years in programme management, and then I decided to make a change in my career. I wanted to explore the monitoring and evaluation sector as I thought it might be good for my future career development.

"I have only been in the M&E sector for nine months. It was 'reporting time' when I first joined the M&E team, so it was challenging for me. I got so much feedback

when I submitted my report, but I have learned so much! In the next reporting period I improved a lot. And, because I have worked for many years in programme management, I can understand their challenges and can support them efficiently.

"I really like sharing our challenges and success stories with partner organizations at learning and sharing sessions hosted by 3MDG.

"I think if we support the capacity of local organizations they can be sustainable for a long time even when there aren't any other health projects in the area. People living in those areas see many long-term benefits."

Health in prisons

Context and health needs

Prisons in Myanmar are overcrowded, with more than 60,000 prisoners in 45 prisons. Criminalization of drug dependence and sex work still result in large numbers of men and women receiving long mandatory prison sentences and causes overcrowding (48 percent of prisoners are there for drug-related offences).

People in prisons and labour camps are highly vulnerable and marginalized. Health needs are immense. They may be more susceptible to communicable diseases and may have difficulty in accessing the quality health services they need. They face an often hostile regulatory environment and discriminatory laws. Meeting the health needs of people in closed settings is critical to meeting Myanmar's health goals.⁴⁹

Activities and partners

3MDG strengthens the facilities and services for health in prisons together with seven partners: Ministry of Health and Sports, Ministry of Home Affairs (MoHA), United Nations Office of Drugs and Crime (UNODC), UNAIDS, World Health Organization, Asian Harm Reduction Network (AHRN) and Health Poverty Action. In one prison, AHRN provides primary health care, HIV and TB testing and care, Hepatitis B screening and vaccination, chronic disease management and methadone maintenance therapy services.

Infrastructure for prison health facilities is being improved in four selected prisons: Insein, Myitkyina and Lashio in 2017, and Mandalay in 2018. This was identified as a priority by the recently established Project Board, comprised of senior officials from the Ministry of Health and Sports and the Ministry of Home Affairs (Prison Department). Their role is to coordinate priority actions on prison health.

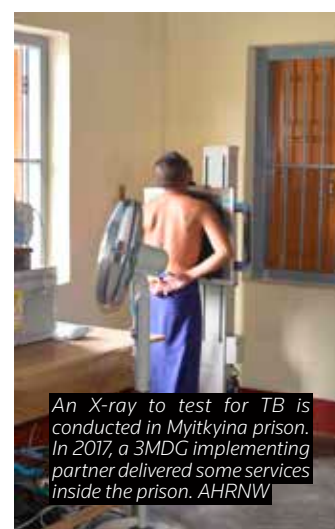
Highlights

Development of standard operating procedures (SOPs)—Previously, there were no guidelines or standards for delivery of health services in prisons. The SOPs, supported by the Project Board, were finalized at the end of 2017. The next step is implementation to improve health facilities and services for closed settings across Myanmar in 2018.

Support to reform in punishment and prisons—Advocacy continued throughout the year to reduce overcrowding in prisons, including developing alternatives to the imprisonment of people who use drugs in proposed amendments of the *1993 Drug Law* and draft National Drug Control Policy. Investment in prison reform to address prison management and improve access to health services, including drug treatment services, was also included in the draft National Drug Control Policy.

Study visit to Indonesia to review policies and practices for prison health—As part of the support for reform and improvement in the legal and prison systems, 3MDG funded a study visit to Indonesia. Participants learned about Indonesia's legal framework and policies and practices regarding prison health. They shared technical expertise on implementing health services in prison settings.

The trip was focused on HIV, TB, hepatitis and drug-dependency related services, observing prison-based Methadone Maintenance Treatment, community-based services, and alternatives to prison for people who use drugs.



An X-ray to test for TB is conducted in Myitkyina prison. In 2017, a 3MDG implementing partner delivered some services inside the prison. AHRNW

Opening closed door—more services in prisons

There are more than 3,500 inmates in two prisons in Bhamo, Kachin and in Kalay, Sagaing and more than 200 in two labour camps (eight percent women). With limited health human resources and infrastructure, prison authorities allowed AHRN to implement health care services for inmates and staff.

In just six months, they were able to:

- | Vaccinate 1,245 inmates and staff against Hepatitis B
- | Provide 252 inmates with HIV testing and counselling
- | Provide HIV care to 210 people (Cotrimaxazole preventive therapy)
- | Screen 246 inmates for TB; seven are receiving TB treatment
- | Provide basic health care to inmates, including women's health
- | Provide health education sessions to staff and inmates

There is further opportunity to expand. Resource constraints limit full coverage of ante-retroviral therapy, there is poor infection control, further standard procedures can be implemented, more TB testing is needed and prison staff can receive more training.

Improving policy for vulnerable people

Context and health needs

Despite some progress, some health services are still unavailable for people who inject drugs, people engaged in sex work, men who have sex with men and transgender people in Myanmar. Much of this is due to the criminalization of some behaviours, the absence of legally supported rights, and limited services and service providers available to vulnerable and discriminated populations for sexual and reproductive health and rights issues. This is compounded by public conservatism and tendency to be discriminatory towards young people, especially where it involves sex work, sexual activity outside of marriage and men who have sex with men. 3MDG invests to reduce legal and policy barriers to effective HIV prevention and Harm Reduction.

Activities and partners

3MDG supports UNAIDS to create an environment where it is possible for stigmatized and marginalized groups to access the health care that they need. This is known as 'creating an enabling environment.' UNAIDS works together with local non-government and community-based organizations, focusing on making changes to often old, punitive and discriminatory laws and supporting policies towards decriminalization, anti-discrimination and rights-based approaches. This includes advocacy for the establishment of one-stop service delivery which is receptive to the needs of such populations.

Achievements to date have included an amendment to the 1949 *Suppression of Prostitution Act*, reorienting it towards rights and anti-discrimination and away from harsh punishments for sex workers, and amendments to the 1917 *Excise Act* to remove restrictions on who could legally carry needles.



A training conducted by UNAIDS about human rights based and gender sensitive approaches to HIV treatment and care in Myeik in Tanintharyi. Participants also learned about how to modify care services to be more accessible for people from minority groups, particularly those based on their sexual orientation and gender identity. UNAIDS

Highlights

A new law focused on the rights of people living with HIV—*The Law on the Rights of People Affected by HIV* is working its way through parliament. Specifically, the law focuses on their right to health and their right to be free from discrimination. In 2017, there were over twenty meetings attended by a wide range of stakeholders to review the legal language, aims, penalty and complaint mechanisms. The review process was largely completed by the end of 2017 and a draft law will be submitted to the *Pyitaungsu Hluttaw* in 2018.

Legal and policy changes won't take hold without actual activities on the ground. To increase legal representation for this marginalized population, lawyers and legislators need to have a proper understanding of the issues. UNAIDS organized a three-day training workshop for 36 lawyers and legislators to give them the skills they need to ensure the rights of their clients to access continuous care and receive fair treatment.

Raising awareness and mobilizing influencers—UNAIDS kept this issue at the front of the agenda in 2017 through continuous activities, meetings and advocacy with families, communities, health care

workers, police, parliamentarians and the media. The aim is to reduce stigma and discrimination and raise awareness and understanding of sexual and reproductive health and rights, and ultimately improve access to services.

A programme to mobilize journalists resulted in the publication of 18 stories in support of Harm Reduction in a range of Myanmar media outlets. A policy brief on the draft HIV law for parliamentarians and an advocacy toolkit for community-based organizations were produced, along with six policy briefs, some of which were targeted to the police.

Development of national strategic framework begins—The Ministry of Health and Sports approved a submission calling for the development of a national strategic framework on drug use and its health consequences. The aim is to use an integrated approach to bring together the common elements of sexual and reproductive health and rights and Harm Reduction for highly vulnerable populations.



Daw Mar Mar Khaing is a community health worker who finds cases of potential tuberculosis in the community and refers them to the nearest TB centre or township hospital. She has been doing this job for nearly five years.

Inspiring Women

"I raise awareness about tuberculosis in the community."

Myanmar Health Assistant Association (MHAA) has been implementing TB activities in 16 townships in Rakhine, Bago and Sagaing since 2014. The project aims to find more cases and raise awareness of TB in rural communities with health education and campaigns. Daw Mar Mar Khaing is a community health worker with MHAA. She works on the tuberculosis active case finding project in Kan Taw Village in Sagaing Region.

"I am a volunteer for MHAA. My job is to identify suspected TB patients through home visits. If I find a person that might have TB, it is important to share the symptoms of TB with their whole family. I advise the person to visit the mobile team or the hospital to confirm the diagnosis.

"Then, I report suspected cases to our community facilitator. During the first week of treatment, I visit the patients' houses every day to help them take their medication and monitor their health.

"I have always wanted to help people, even before working as a volunteer. That's why I decided to join the auxiliary midwife training course in Myinmu Hospital in Sagaing. After the training, the midwife told me that MHAA was recruiting TB volunteers for our village. It sounded really interesting, so I applied for the job.

"Before I was a volunteer, most of the people from my village were frightened of TB. If someone had TB in the village, no one wanted to go that patient's house. They knew that TB could spread through the air, so it was very scary.

"I didn't know much about TB before either! But after receiving the training, I knew that people didn't have to be afraid because we can cure this disease. I am really happy to be able to share this knowledge to everyone around me!

"Now the people from my village know more about TB. They are no longer afraid."

Nutrition

Context and health needs

Under nutrition rates in Myanmar are among the highest in the region.⁵⁰ About one third of all children in Myanmar are stunted.⁵¹ Their growth and development is impaired as a consequence of poverty, lack of access to good nutrition and limited nutrition knowledge. Stunting has long term harmful effects on children and adults, including diminished mental and physical capacity and poor health. Stunting also results in lost opportunities and high health costs. The Global Nutrition Report 2015 estimates that countries with a high level of stunting lose three to eleven percent of their gross domestic product (GDP) per year due to stunting. For Myanmar this equates to between 1.9 and 6 billion US dollars.

Activities and partners

3MDG supports its maternal, newborn and child health partners to provide nutrition education and supplies in the community. These are delivered by basic health staff and volunteer health workers, trained on 'Essential Nutrition Action.' This means they can conduct interactive health education sessions in the community: promoting exclusive breast feeding, health seeking behaviour and improving feeding practices for young children.

3MDG enables better access to micro-nutrient supplies in the community through volunteer health workers. This includes the provision of iron, folic acid, vitamin B1 and de-worming drugs. During outreach activities—including immunization and ante and post-natal care—the midwife teaches best practices on breastfeeding and nutrition.

The Livelihoods and Food Security Trust Fund (LIFT) (also managed by UNOPS) and 3MDG work closely together on nutrition projects, including maternal and child cash transfers. These projects support families to maintain a nutritious diet by giving a small amount of money each month while a woman is pregnant, accompanied by health education sessions.



In Ayeeyarwady Region, a midwife weighs a baby to check it is getting the nutrients it needs to grow.

In 2018, 3MDG investments will focus on community-based nutrition activities such as social behaviour change communications, establishing mother-to-mother support groups and referrals. 3MDG will also support the National Nutrition Centre with capacity development, procurement of commodities such as micro-nutrient powder and nutrition promotion activities.

Highlights

Commitment to additional investments in 2018—In consultation with the Ministry of Health and Sports, 3MDG proposed an additional investment of USD 2.53 million, funded through existing maternal, newborn and child health grants and direct support to National Nutrition Centre focusing on the first 1,000 days of life. Approval was provided in the final 2017 Fund Board Meeting.

Meeting to plan and prioritize—A consultation meeting with the National Nutrition Centre was organized to plan and prioritize nutrition interventions in 2018, including integration with existing activities. The strategic framework of multi-sectoral National Plan of Action on Nutrition (2018-2022) (MS-NPAN) was initiated in November and finalized in

January 2018. One national lead facilitator was funded by 3MDG to coordinate with different ministries, MS-NPAN taskforce members and other relevant stakeholders.

Results

15,638

Children under five were treated with oral rehydration salts + Zinc at community by volunteers

77%

Newborns initiated immediate breastfeeding within one hour after birth in 3MDG targeted townships

1,135

Multi-drug resistant tuberculosis patients were enrolled for nutritional support/treatment

See more results in Annex II: Results matrix.



Daw Om Khaw Ti, the Dupty Director of COLDA, is a firm believer in women's rights—a message she has been sharing with her community for years.

Inspiring Women

"I want every woman in Chin State to know that they have rights."

Daw Om Khaw Ti is the Deputy Director of K'Cho Land Development Association (COLDA). She has been advocating for gender equality in the state for many years.

"We are part of 3MDG's Collective Voices project here in Chin State. We want to better understand health issues and needs in the community. As a Chin person, it is important for me to be able to support my people and have open dialogue with villagers about challenging issues.

"Since 2008, I have been advocating for women's rights and empowerment in Chin State. There is no doubt that is one of the best parts of my job.

"But still, unfortunately, gender equality is not the norm here in Chin State and it negatively affects women's health seeking behaviour. Women tend not to be the decision-makers when it comes to getting health care, and they heavily rely on their husbands for guidance and approval. This also applies for the use of contraceptives—the cultural norm is that most women are not encouraged to use contraceptives before they have given birth to a son.

"Women in the state also have low literacy rates because, in most cases, only sons have the opportunity to go to school. That makes it hard to learn about health, keeping health literacy low.

"We encourage women to speak up during our women-only discussion groups in the villages. We also hold workshops and trainings for the whole community where we talk about human rights and women's rights. In order to push for real change for women in Chin State, we work closely with the parliamentarians, state authorities, Chin women's rights groups, and community-based organizations.

"In the last five years, we have seen changes in education with more young Chin women now allowed to go to school. Participation is also increasing, with more opportunity for women to raise their voices in rural development projects, community meetings and in the political sector. Now we also have women parliamentarians in Chin State Parliament—that's real progress!"

Tuberculosis

Context and health needs

According to the 2017 WHO Global Tuberculosis Report, Myanmar is among the 30 countries with the highest disease burden for TB. Myanmar's 2009/2010 nationwide TB prevalence survey reported a significantly higher burden of TB than earlier estimated, particularly in urban and ethnic areas. The country's National Strategic Plan 2016–2020 emphasizes that active case finding is critical to control and reduce the levels of transmission.

Activities and partners

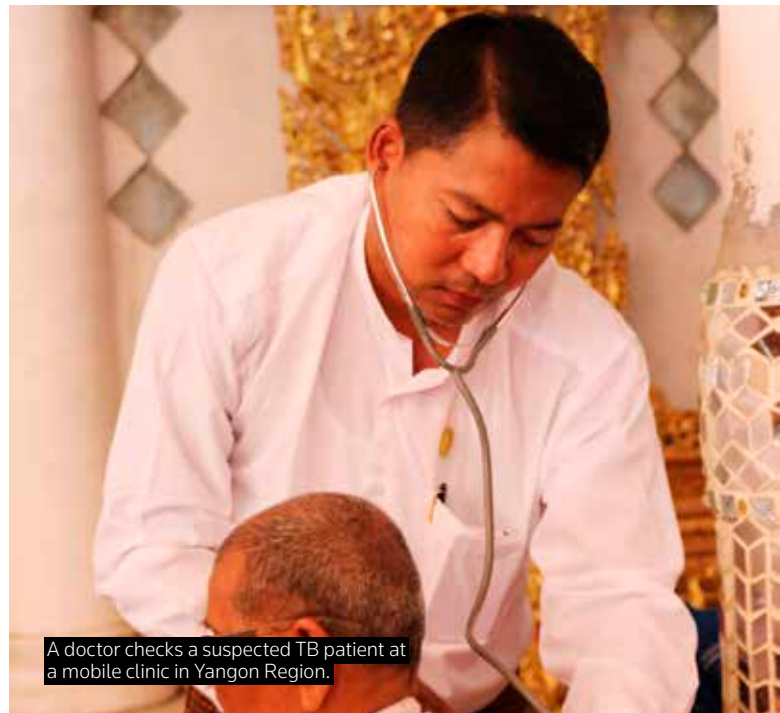
In Myanmar, TB especially affects the urban poor and migrant populations. To address the epidemic within these groups, the Ministry of Health and Sports, supported by 3MDG and partners, sends mobile teams out to find cases of TB. There are nine mobile teams working around the country. 3MDG supported the National TB Programme with nearly five million US dollars to facilitate their work in 2017.

Highlights

Better collaboration for even more testing in more places—In 2017, mobile teams continued to bring tuberculosis testing capabilities to vulnerable populations in prisons and work sites, the urban poor, and hard-to-reach areas. To facilitate this, collaboration was strengthened between relevant ministries and departments including the Prison Department. There were 43 visits to prisons and worksites financed by 3MDG. In total, 234 visits to 157 townships across the country were conducted by the mobile teams.

New vehicles for mobile TB testing—Two TB vehicles, purchased and handed over in 2017, are one-stop-shops for TB testing and improve the efficiency of active case finding programmes. These mobile clinics are one element of the overall national strategic plan for TB control, being implemented by the Ministry of Health and Sports.

Reaching more people with TB testing in a variety of locations—The community-based TB active case finding programme has been



A doctor checks a suspected TB patient at a mobile clinic in Yangon Region.

implemented by five partners since 2014. Community volunteers who are recruited and trained by these partners are the key players in this model. In 2017, these volunteers screened and referred 47,384 presumptive TB cases to township TB centres and 6,961 confirmed TB patients were diagnosed in 79 townships.

TB screening is also provided at diabetes clinics in two public hospitals, and critically, in maternal and child health clinics to reach women. These clinics were added after a study in 2014 revealed that only 34 percent of the nationally reported cases of TB were in women.⁵² Gender disparities were also noted in the 234 mobile teams visits carried out by the National TB Programme in 2017 (1,590 cases found in women and 2,623 in men).

In response, the 3MDG Fund considered how case detection for women could be improved. This included the introduction of TB testing at maternal and child health clinics, and the results have been significant. In 2017, 3,499 TB patients were diagnosed in in maternal and child health clinics, which is 45 percent of the total detected cases. At diabetes clinics, 86 TB patients were diagnosed. See more in the Lessons learned on page 98.

Results

9

Mobile teams. 234 visits to 157 townships. 43 visits to prisons and work sites.

55,393

Presumptive TB cases referred to township TB centres.

15,780

Confirmed TB patients

3,499

TB patients diagnosed at maternal and child health centres (about 40% of the total number).

See more results in Annex II: Results matrix.



A woman in Loikaw Township in Kayah State speaks at a community meeting.

Spotlight on Gender

Women in decision-making roles

3MDG emphasizes including women in decision-making roles at community level, such as participating in village and village tract health committees and township health committees. But why does it matter?

The first reason is equity. Men and women might have different preferences for what actions should be taken in a given situation. Women in decision-making roles are more likely to respond to women's preferences, so a lack of representation may mean that women's needs are left out and inequity persists.⁵³

Including everyone also means that decision-making is of a higher quality. The process is more efficient and, because more people feel included, decisions themselves may be seen as more legitimate.⁵⁴

Research has also shown that women in decision-making roles are more likely than men to address social issues, such as food security, education and health. This is believed to be a result of their socially mediated roles as nurturers and caregivers.⁵⁵ This has been shown in parts of India, where women-led councils had 60 percent more water projects,⁵⁶ and in Norway, where women-led councils had a positive effect on childcare coverage.⁵⁷

The ability to participate in public decision-making and exercise control over one's future and one's body provides people with agency.⁵⁸ The effects are most pronounced when participants are engaged; just being there isn't enough. This includes the ability of people to voice their views and the extent to which those views are taken seriously. Gender is not the only factor which impacts this quality—it may also be affected by age, disability and location.⁵⁹

Ensuring that decision-making channels are open to all people helps to hold leaders accountable, builds agency and reduces the risk of corruption and elite capture of subnational decision-making—all crucial for Myanmar in a period of transition. Quality participation at all levels can help improve the quality of planning and decision-making due to better information on needs, constraints and preferences.⁶⁰

3MDG supports trainings on gender equality, participation and representation to government and non-government health staff, implementing partners and the community to increase the quality of participation. High quality participation

and opportunities for women to take leadership roles are available through township and village health committees, village health funds, mothers' clubs and women health promoters.

Persons with disabilities are increasingly included in project planning. The role of men in nutrition, care and support to gender equality is emphasized. Finally, the community is given a chance to raise concerns using the community feedback mechanism that is built into every project. In 2017, 14,648 pieces of feedback were received, and 92 percent have been responded to.



Ma Thinzar Tun is the Programme Director at Asian Harm Reduction Network. She believes in the importance of gender sensitive approaches to health service delivery, including for Harm Reduction.

Inspiring Women

“I have always believed in the work we do, but this is not an easy job!”

Ma Thinzar Tun is the Programme Director at Asian Harm Reduction Network (AHRN), Myanmar. AHRN has implemented Harm Reduction projects in Myanmar for 15 years.

“We aim to reduce the spread of HIV and TB among people who inject and use drugs, their partners and communities. We aim to promote access to quality health care for them.

“We work in 16 project sites where conflict, mining and drug use are common. As the first locally recruited staff member, I have grown up with

AHRN through all the challenges we have encountered during the past fifteen years.

“I have always believed in the work we do. I want to develop better programmes for our clients, and I want to change the community perspective on drug dependence. I want to help them see that this is a public health issue.

“I am proud that I am a woman who is working for a group of people who are so unpopular in society. They really need health services. I am proud of the impact we have made over the past 15 years. We have fought so hard for our clients, and they are fighting hard too. It is the challenge of their lives to manage their drug dependence.

“I have so many role models—all of them are women! They all have one thing in common—having a strong mind to fight what they believe in. They believe in our country. I try to stay resilient like them in difficult moments at work or in my personal life.

“I think that to get more women into roles like mine we need to give them more responsibility, ownership and support when they need it. This is empowerment and we need more of it!

“Gender equality is very important, but sometimes it can be forgotten or neglected. At AHRN, we try to support equality and empower women. We recruit people no matter their gender, we give women more and more responsibility and we provide women-friendly services for women who inject drugs.

“We have had so many achievements. Community resistance can be strong, but that doesn’t stop us. Now, we have reached 30,000 people who inject drugs, and nearly 20,000 people who use drugs. Those milestones are our biggest achievements.”

Monitoring & Evaluation

A strong health information system is critical to a well-functioning health system. Policies, guidelines, projects and interventions can be built on evidence as well as an in-depth understanding of both the country's health profile and the issues faced.

Highlights

3MDG financed the development of the Strategic Action Plan for Strengthening Health Information 2017–2021 led by the Ministry of Health and Sports, and supported by the World Health Organization. 3MDG's support to the health information system strengthening in Myanmar continued:

| The health management information system (HMIS) module of the electronic District Health Information System (DHIS2) was rolled-out with 3MDG support in 49 townships including 17 townships in Rakhine.⁶¹ 3MDG encourages usage of the data at quarterly rural health centre meetings and monthly township level meetings. This enables reviews of service coverage and the identification of problematic areas. 3MDG has also supported the roll-out of HIV and TB modules of DHIS2 (funded by the Global Fund).

| The Volunteer Recording System (VRS) is a community health information system that collects data about services provided by volunteers and basic health staff, stocks, supplies and other health information. It was rolled-out in 27 townships in 2016. In 2017 the completeness and quality of VRS reporting improved compared to 2016, although challenges still remain. The VRS information and implementation experience can assist the Ministry in the planning and development of the government's information system for community-based health programmes.

| 3MDG funded the development and deployment of OpenMRS (Medical Records System)—an open-source data management system for MDR-TB patients, and a reporting platform for the National Tuberculosis Programme which aims to support provision of quality care and services for MDR-TB patients

and improve data management and reporting. By the end of 2017, the system was rolled-out in 26 MDR-TB facilities of four states/regions, of which 21 facilities were supported by 3MDG. Close coordination with the Global Fund has ensured continued funding support for Open-MRS support in 2018.

Monitoring progress throughout the review period

3MDG monitors progress of its partners in two ways. The first is regular performance review meetings with implementing partners upon submission and review of six-monthly and annual reports. This is an opportunity for thorough review of progress, discussion of issues and potential follow-up where there is poor performance or major challenges, and identification of additional programming opportunities.

The second method is through programme monitoring visits. These aim to assess service delivery, data quality and systems. Results and recommendations are shared with implementing partners and followed up. Where relevant, opportunities for enhanced data utilization and improved coordination between specific partners are pursued. For example, an implementing partner that supports emergency referrals was encouraged to share data with another implementing partner focused on family planning about areas with high numbers of abortion cases.

In 2017, 3MDG conducted 48 monitoring missions (including 18 routine data quality assessments). This was 86 percent of the target. The trips covered 18 organizations in 13 states and regions.

External data quality assessment

In addition to data quality assessments done by 3MDG on implementing partners, the Independent Evaluation Group

undertakes external Data Quality Assessments annually. These focus on the strength of data collection and reporting systems, and verification of reported results both at the Fund Management Office and implementing partner level.

The Independent Evaluation Group concluded that the findings of the external data quality assessment in 2017 were "very positive." Their key observations included that the follow up from the 2016 Data Quality Assessment was appropriate and adequate, there were exact matches between the results from implementing partners and those published by 3MDG for select indicators, and neither 3MDG nor three out of the four assessed implementing partners had any significant issues. The exception had some data discrepancies which are being followed up.

External evaluation of the Fund

In line with the Fund Board decision of June 2017, the final evaluation will be undertaken by a competitively selected evaluation provider in the second half of 2018. The objectives of the final evaluation will be to evaluate performance, value for money and impact; to document 3MDG's experiences and lessons learned, identify potential improvements for the future, and assure accountability for targeted use of resources.

Procurement

In 2017, the total amount purchased by the 3MDG Procurement Unit was just over USD 15 million. Of this, 55 percent was purchased under Long Term Agreements (LTAs) from UNOPS or other United Nations agencies, resulting in faster, more efficient processes.

Stock with a value totaling USD 1.1 million was distributed from two UNOPS-managed warehouses, which allows health supplies to be

prepositioned through the country and then distributed to partners to support volunteer health staff working in maternal, newborn and child health.

These amounts are lower than normal because warehouses are being emptied of prepositioned stocks purchased in 2016.

Communications

In 2017, 3MDG was covered 131 times in digital media, and 119 times in traditional (print) media.⁶² This included articles in the Guardian, Frontier Myanmar, Missima and the UNOPS website, as well as coverage in Myanmar news media, including the Myanmar Times, Eleven Media, 7News Daily and the Global New Light of Myanmar. Topics ranged from maternal health, handover of infrastructure, Harm Reduction, sexual and reproductive health and rights, and tuberculosis.

The unit provided critical support to the Ministry of Health and Sports with the development of a communications and outreach strategy for the dissemination of the National Health Plan, as well as an Universal Health Coverage Day event. 3MDG also ran a number of social media campaigns, drawing attention to the symptoms of tuberculosis, Universal Health Coverage and nutrition facts and figures.



Participants at the 3MDG and LIFT nutrition event post at the photo booth. At the event, members of the public and the media learned more about proper nutrition for mums and babies, and the importance of breastfeeding.

Promoting nutrition in the community

In August 2017, mothers and their families attended an event in Yangon aimed at sharing key messages with the media and educating the public on the importance of good nutrition for mothers and babies during the first 1,000 days of life.

“When children receive good nutrition in the first 1,000 days they are ten times more likely to overcome childhood diseases, are likely to complete at least four more grades at school and receive 21 percent more wages

as an adult,” the UK’s Department for International Development (DFID) Country Director Dr Gail Marzetti said.

A panel discussion at the event informed the audience about the importance of nutrition for pregnant women and their babies. The event was organized jointly by the Three Millennium Development Goal Fund (3MDG Fund) and the Livelihoods and Food Security Trust Fund (LIFT).

Fund Status

Governance and alignment

Since 2014, the Ministry of Health and Sports has been a member of the 3MDG Fund Board, alongside donors and independent experts. This has strengthened governance and stewardship of the health sector, made the 3MDG Fund more relevant and accelerated delivery of the work of the Fund. The relationship and alignment to the Ministry of Health and Sports continues to strengthen each year. The design of the extension year was aligned to the National Health Plan and guided by Ministry priorities.

Financial status

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 has promoted the efficient and effective use of development funds. The Fund is managed by the United Nations Office for Project Services (UNOPS). UNOPS also manages the Livelihoods and Food Security Trust Fund, the Joint Peace Fund and is Principal Recipient for The Global Fund to Fight Aids, Tuberculosis and Malaria.

By managing all four funds, aid effectiveness, efficiency and quality, and value for money are increased. Risks are lowered through increased knowledge, standardized procedures and greater transparency. The funds share facilities, procedures and standards. At the same time, comprehensive monitoring and financial controls ensure transparency in the pricing of shared services.

Four bilateral donors—Sweden, Switzerland, the United Kingdom and the United States—are supporting the establishment of a follow-on mechanism that will allow them, and possibly other development partners, to continue pooling resources in support of the Myanmar health sector, sustain the gains achieved by the 3MDG Fund, and continue to promote equity in access to health. This ‘Successor Fund’ will contribute to improving equity and inclusiveness, aligned with and in support of the National Health Plan 2017-2021 and the Ministry of Health and Sports.

Donor Contribution Status as at 31 Dec 2017

	Total Commitments		Disbursements Received
	Million USD	% of total contribution	2012–2017 Million USD
UK Department for International Development	175.3	53%	175.3
Australia	48.2	15%	48.2
European Commission	31.4	10%	31.4
Sweden	38	12%	27.9
Denmark	9.2	3%	9.2
Swiss Agency for Development and Cooperation	13.2	4%	10.2
United States Agency for International Development	8.7	3%	8.6
3DF Rollover	2.1	1%	2.1
JIMNCH Rollover	1.6	0.5%	1.6
Total donor's contribution	327.7	100%	314.6
3DF Procurement Rollover	3.3		3.3
Interest and income earned	1.9		1.9
	332.9		319.8

Note: Donor commitments not yet disbursed to the 3MDG Fund are subject to exchange rate fluctuations, hence the total value of the Fund varies over time until all commitments are met and disbursed.

The total volume of resources committed to the 3MDG Fund as of December 2017 stands at USD 332.9 million. The Fund has received USD 314.6 million in disbursements from contributing donors since its inception. Total spending in 2017 was USD 45.9 million. The total to date delivery amounts to USD 262.6 million, out of which USD 235.7 million has been used for programme activities, and USD 26.9 million for programme management, governance, monitoring, evaluation, and fund management overhead costs.

Annual audit for the 2016 financial year

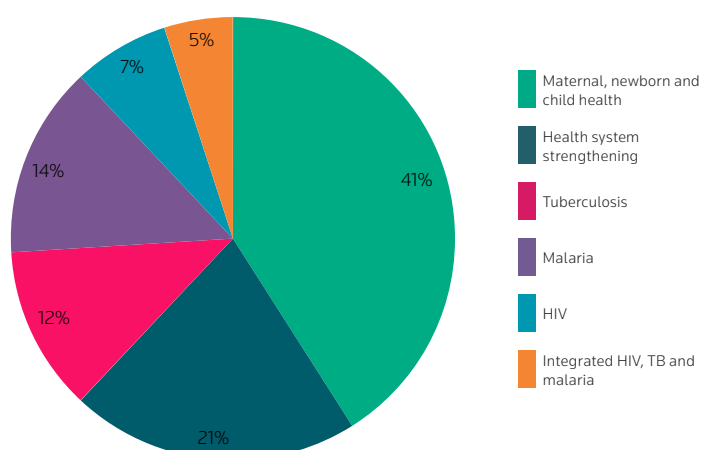
As a custodian of public funding, 3MDG adheres to international best practices in transparency and accountability, using strongly defined anti-fraud and anti-corruption policies, monitoring missions and capacity assessments. Fund Manager Audit reports are published on the UNOPS website and are publicly accessible.

An annual audit of expenditure for the 2016 financial year was conducted on the Fund Manager. The audit report listed one medium-priority audit recommendation on the functional areas of procurement and supply chain. A management action has been implemented already.

3MDG also conducts yearly audits on implementing partners. In 2016, the auditors identified 148 observations, of which two were high impact and 97 were considered as medium impact.

Only ten medium impact recommendations remain from the previous year's audit. The Fund Management Office continuously monitors and follows up on these recommendations in order to ensure they are addressed and closed. It is important to note that audits serve as an opportunity to build capacity of implementation partners and ensure continuous improvement.

Funding breakdown by component as legally committed in grants under the 3MDG Fund (2012–2017)



3MDG Expenditures in 2017

	Budget (USD)	Expenditures (USD)	Variation	Variation Percentage
1. Programme Implementation	45,059,320	40,164,664	-4,894,656	-11%
1.1 Component 1 Grants	12,837,912	9,577,282	-3,260,630	-25%
1.2 Component 2 Grants	19,227,921	20,802,145	1,574,224	8%
1.3 Component 3 Grants	10,045,681	7,401,591	-2,644,090	-26%
1.4 Implementing Partner/Fund Management Office Indirect Costs to 1.1-1.3	2,947,806	2,383,645	-564,161	-19%
2.1 Operations of the Fund Manager's Office	5,808,069	5,181,103	-626,966	-11%
2.2 Support to the Fund Board	165,356	119,583	-45,773	-28%
2.3 Independent Evaluation Group	330,000	73,290	-256,710	-78%
2.4 FMO Indirect costs to 2.1-2.3	441,240	376,195	-65,045	-15%
	51,803,985	45,914,834	-5,889,151	-11%

Lessons Learned

Lessons learned

The 3MDG Fund is committed to confronting head-on the many challenges facing health service delivery and health system strengthening in Myanmar. This section outlines a selection of the lessons we have learned from project implementation.

Many of these lessons are being used to guide the extension year of the Fund in 2018 and the development process of the Fund which will follow the 3MDG Fund, the 'Successor Fund.'

Different health systems and procedures in border areas

Challenge—In border areas, particularly in Kayin and Kayah States, differing treatment guidelines, data management practices and limited integration into existing systems can introduce challenges in health service delivery and monitoring.

For ethnic health organizations in Thai-Myanmar border areas, reporting can be challenging. They may not have the required reporting formats and aggregated databases in their health management information system (HMIS) or may have differing indicator definitions from the national HMIS. Health staff may have received different training, leading to differing capacity, responsibilities and skills, and there may be resource limitations and political considerations which impact efficacy.

Actions and their impact—There has been an effort to standardize treatment guidelines in border areas. For example, trainings supported by Community Partners International have been delivered to ethnic health organizations on Myanmar-specific malaria elimination activities.

Systematic data collection and reporting systems have been encouraged and reinforced through trainings to ethnic health organizations to ensure consistency. However, flexibility in implementing custom-made solutions has also been necessary. For example, the implementing partner in Southern Shan provided technical support, creating a register and reporting forms for ethnic health organizations to record their achievements.



A volunteer health worker in Kayah State checks the lungs of a child. Volunteers health workers have a high rate of turnover, which makes knowledge retention and training more challenging. 3MDG is working with the Ministry to develop better systems for the village based health workforce.

Increased collaboration and coordination between ethnic health organizations, and state and township health departments have also been encouraged to reduce these gaps. For example, cross-visits have been encouraged, joint mobile visits conducted and coordination meetings facilitated. The result has been a reported increased in service provision in these areas.

Lessons learned—Both systematic and custom-made solutions are necessary to reduce this treatment and data reporting gap. Therefore, 3MDG, implementing partners and ethnic health organizations must remain flexible. Integration into existing systems is challenging, but necessary to achieve universal health coverage.

High staff turnover for implementing partners and volunteers

As with all previous years of 3MDG operations, staff turnover amongst implementing partners and volunteer health workers remains high, and with it, associated challenges in training and institutional knowledge retention.

High turnover of implementing partner staff

Challenge—For implementing partners, staff who are centrally recruited but with posts in remote areas may face unexpected challenges which means their time in the position is short. This can include difficulties of remoteness such as lengthy travel, poor basic living conditions, and limited access to communication networks. It can also be difficult for implementing partners to plan for the future due to the uncertainty of funding from 3MDG, and staff may feel a lack of job security as a result.

Actions and their impact—To increase the longevity of staff in their posts, implementing partners such as Myanmar Health Assistant Association have tried to prioritize hiring local people. They are not only more likely to stay, but will also be better able to communicate with community members and understand local traditions and customs, which may impact health practices and access. Implementing partners have offered more attractive salary and benefit

packages to encourage staff retention, which has shown some positive effects.

Lessons Learned—Employing people from the local area has a positive impact on retention, as well as their ability to offer context-sensitive and language-specific services.

Limited retention of institutional knowledge

Challenge—High turnover of implementing partner staff can in turn reduce the ability of 3MDG-funded services to meet standards of accountability, equity and inclusion, and conflict sensitivity. Turnover has traditionally included Accountability, Equity and Inclusion (AEI) officers/focal points.

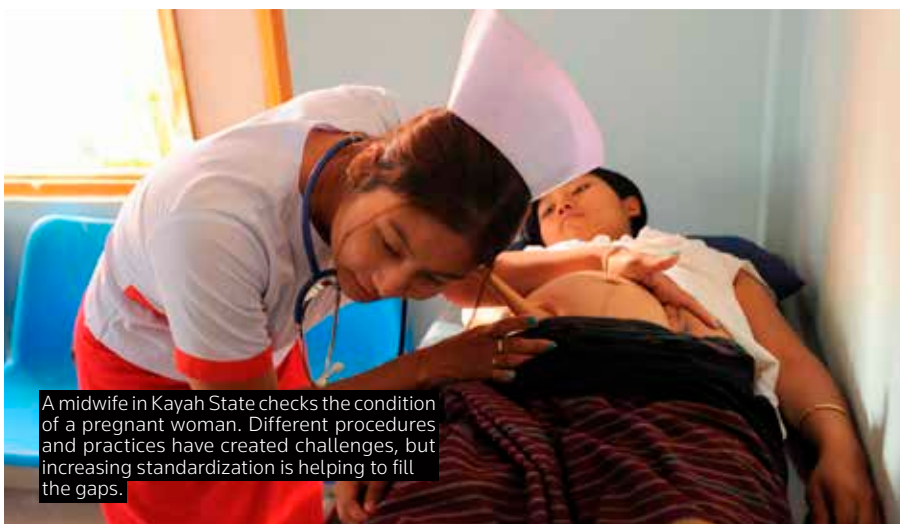
Actions and their impact—Different implementing partners have approached the issue of knowledge retention and mainstreaming of AEI issues in different ways. For example, the Population Services International (PSI) ‘Consumer Insight Officer’ (who takes the AEI role) supports the PSI Insight Unit to explore the views of health service providers and consumers, with feedback being used to improve products and services.

On the other hand, International Rescue Committee teams in Chin State work receive

strong support from their Senior Management Team, meaning their AEI practice cycle is well functioning even without employing a specific AEI officer in the organization. Everyone in the field team commits to the principles and takes shared responsibility for outcomes.

For Save the Children in Kutkai Township in Shan State, the key to achieving these principles is coordination between all stakeholders, including the Township Health Department and civil society organizations. Inter-agency meetings provide an opportunity to exchange information and maximize collaborative working relationships. Save the Children maintains constant communication with these organizations, who in turn support the basic health staff and Save the Children to reach ethnic communities in conflict-affected areas. This means Save the Children is able to access areas outside of government control, ensuring inclusion and fairness for all people to reach health services.

Lessons learned—Where AEI Officer Positions have been successful, they have both had the full support and strategic guideline of their senior management team as well as the capacity to adapt AEI requirements to their own organizational approach.



A midwife in Kayah State checks the condition of a pregnant woman. Different procedures and practices have created challenges, but increasing standardization is helping to fill the gaps.

High dropout of volunteer health workers

Challenge—There is a high dropout of volunteer health workers across the country. For example, in Ngapudaw in Ayeyarwady Region, 29 percent of auxiliary midwives and 47 percent of community health workers left their volunteer work during the project period (2014 – 2017). In Gangaw Township in Magway Region, 17 percent of village health workers dropped out this year alone. While Myanmar Medical Association has trained 295 multi-drug resistant tuberculosis (MDR-TB) volunteers, only 256 remain (13 percent attrition).

There are many reasons for volunteer dropout, including volunteers moving for work or livelihood, health issues, pregnancy and lack of work (for example, no MDR-TB patients in close proximity). Myanmar Medical Association also noted that inconsistent or non-existent quarterly coordination meetings led to de-motivation of volunteers.

It has been noted that the attrition rate for community health workers is higher than auxiliary midwives. This is thought to be because the auxiliary midwife has a stronger relationship to the midwife.

Actions and their impact—There have been a number of efforts which aim to decrease volunteer dropout rates. This starts from the selection of candidates—a more careful selection in some places has resulted in reduced dropout. Once volunteers are hired, they are encouraged to continue their work and enhance their skills through the provision of refresher trainings, essential medicines and medical supplies and incentives such as rain coats and bags. They are given regular feedback on their performance and skills during quarterly supervisions, improving confidence and enjoyment in their work. Transportation costs for health activities are also provided.

Volunteers engaged in capacity building activities, were encouraged to attend quarterly meetings at the state and regional levels, and were invited to participate in township or region-led campaigns, such as the Japanese Encephalitis campaign. Myanmar Medical Association conducted refresher trainings and quarterly coordination meetings in their townships, and ensured volunteers felt continuously supported via township health and programme teams. They are also supporting transportation costs for health activities.

More involvement of volunteer health staff in these co-ordination activities has a positive impact on their motivation and enables them to become crucial providers of health services. For example, in Ngapudaw in Ayeyarwady Region, volunteers have been included in rural health centre meetings since 2016. Through this regular contact, they have impressive results of reporting in the Volunteer Recording System (73 percent in 2017), and were able to treat high numbers of pneumonia and diarrhoea in children under five.

3MDG has also been working with the Ministry of Health and Sports to standardize the volunteer health worker system in Myanmar (see more on page 61). Standardized incentivization, capacity development and a clear future career pathway will lead to better retention.

Lessons learned—Capacity development and onward opportunities are critical for volunteer health workers. Further work is needed to encourage their mentorship and recognition to ensure retention or graduation through the health sector. Involving volunteers more closely leads to positive benefits for both them and the community.

Data collection and monitoring and evaluation (M&E) systems

Despite significant improvements in many areas, there remain issues with reliable data quality and management, quality of reporting and the analysis of data needed to transform it into evidence.

Issues with M&E systems in Rakhine State

Challenge—In Rakhine State, where 3MDG partners scaled up activities in 2017, a number of issues in their M&E systems have been detected such as inconsistent categorization of emergency referral causes, vacant M&E positions and data back-up procedures not being followed.

Actions and their impact—During Routine Data Quality Assessment (RDQA) assessments, 3MDG provided specific recommendations to address these weaknesses which are being followed up by implementing partners. For example, many emergency referral cases in Sittwe had been



categorized as a woman being pregnant for the first time (primigravida) and referred for a Caesarean section.

A detailed review of referral documentation revealed such emergency causes as fetal distress and failure to progress. To ensure correct categorization going forward it was recommended to the implementing partner to assign technical staff to verify primary causes of referral. The implementing partner has subsequently followed the recommendation and thus improved the categorization of referrals. The implementing partner also assigned a Senior M&E officer to fill in the diagnosis moving forward. This is then reviewed by the Project Manager and M&E Manager for consistency.

Volunteer Recording System

Challenge—While the completeness of reporting based Volunteer Recording System has improved in most townships, some challenges still remain. Most common mistakes are in filling in treatment data and stock status.

Actions and their impact—3MDG has discussed with implementing partners that they should prioritize field supervision of the weakest volunteers. More corrections should be made during supervision, and more field supervisions conducted. During the RDQA visit, depending on the findings of the 3MDG team, a recommendation may be made for the implementing partner to develop a checklist for reviewing the forms that the volunteers fill out.

Lessons Learned—Challenges in data collection remain in different locations. Identifying issues early on in project delivery and following up with immediate and practical actions to rectify is critical in ensuring data quality and high levels of service provision.



3MDG procurement pre-positioning modality

Challenge—When 3MDG procurement activities were designed, the decision was made to pre-position stocks to ensure that supplies did not run out and could be distributed quickly and effectively. Within the maternal, newborn and child health component, this was not as effective as expected for a number of reasons.

Firstly, the continuous roll-out of the programme and the regular addition of new activities meant that consumption rates did not stabilize and were difficult for 3MDG to forecast.

Secondly, new implementing partners had a difficult time estimating their requirements in the first year due to a lack of historical data. In combination with the fear of running out of supplies, there were surplus quantities requested in initial requisitions. This led to a drastic reduction in requirements in the second year as partners had excess stocks from the first year. This in turn triggered insufficient stocks to be prepositioned in the third year which caused stock-outs in the fourth year.

Actions and their impact—In recognition of this learning, an opportunity for the Procurement Unit to introduce a new procurement and distribution modality has arisen with the extension of 3MDG after 2017.

Procurement budgets would no longer sit with implementing partners but instead be managed by the Procurement Unit itself. This new modality would significantly reduce workload and costs. This lean supply chain allows procurement to be conducted prior to finalization of individual grants, making the prepositioning modality unnecessary. The intention is that procurement on-demand will reduce wastage, improve accuracy and ensure sufficient quantities of supplies.

To date, the modality has worked well, with reduced workload and faster processes. For example, it has meant that the temperature controlled warehouse was no longer required. It was replaced with two customized containers for temporary storage of temperature sensitive supplies, providing savings of approximately USD 26,000 per year. Hence, this method is the preferred way forward for the Successor Fund.

Lessons learned—Despite potential positive impacts, the pre-positioning modality was not as successful as first assumed for 3MDG. Responding to this learning by taking advantage of the extension-year to test a new approach is a positive development for the Successor Fund.



A woman in Hlaingtharya Township is screened for TB during a mobile clinic in Yangon Region.

Supply chain strengthening

The supply chain—a vital piece of the health system—does not operate efficiently or effectively in Myanmar because it is fragmented and staff do not have the knowledge and capacity that is needed. This can lead to a lack of availability of drugs and supplies.

Fragmentation of the Logistics Management Information System (LMIS)

Challenge—The LMIS is operated in pieces by different organizations and programmes. In Myanmar, at the central level, there are a number of different systems (mSupply, iStock, other online dashboards) used by different units. There is similar fragmentation at regional and township levels.

Actions and their impact—The Regional Supply Chain System (RSCS) Project has had extensive discussions with other non-government organizations and donors to coordinate their work. Since these discussions, a number of actions have been taken to improve harmonization.

These include:

- | Design of the health facility stock report form to include elements that UNFPA/John Snow International's reproductive health project was using in other parts of the country.
- | Usage of Sussol's mSupply software was driven by its use by the Clinton Foundation in their Global Fund HIV, TB, and malaria program
- | The Supply Chain Management System project's decision to use mSupply in the Mandalay warehouse to avoid duplication and

promote an integrated approach among partners. The resulting information streams make it easier for managers to avoid stock-outs, excess stock or expired medicines. For example, generating data so stock can be reallocated from one facility to another or from one township or region to another.

By the end of December 2017, 3,715 facilities had an LMIS in place, which was a 99 percent increase from the 2016 baseline. Of the total facilities reporting to the township level, 98 percent were on time. In a recent 3MDG data quality audit, the reports from 213 of 301 sampled facilities (71 percent) met the accuracy indicator value of 85 percent.

Lessons learned—A harmonized supply chain system is more effective in ensuring that supplies are available when and where they are needed. It is critical to continue to find solutions to the remaining high number of systems in use.

Strategic purchasing pilot

The strategic purchasing pilot being implemented by Population Services International (PSI) will help inform the government's long-term universal health coverage plan by testing a different strategic purchasing mechanism. Instead of fee-for-service payments, this pilot implements capitation payments and a pay-for-performance bonus. The project aims to assess whether increasing the range of services private practitioners can offer decreases out-of-pocket payments among low-income households; increases service utilization from quality providers; and decreases the time it takes clients to seek treatment from the onset of symptoms. See more on page 55.

Challenge—The primary challenge is that only about half of eligible beneficiaries have gone to the clinic for screening and registration. Uptake of service is still low.

Potential reasons for these challenges include: low awareness and weak information dissemination, perceptions

of discrimination from assigned general practitioners towards beneficiaries, community practices of self-medication, difficulties in accessing the clinic during working hours, and transportation costs. In Shwepyithar Township in particular, transportation costs remain a major barrier for beneficiaries. It is the same price to visit a local health practitioner as it is to travel and visit their assigned GP.

Actions and their impact—In response to the low uptake of services, PSI has taken a number of actions. Contracts with unsatisfactory medical providers have been terminated. Beneficiaries have been transferred to better and fairer providers. Community mobilization events have been conducted, leading to an increase in visits. Pamphlets were redistributed and PSI staff visited every household to explain the package. A mobile team was created to visit community members during evening hours, who were not able to complete their clinic registrations during regular hours. This was done in coordination with the local authorities. As a result, the number of beneficiaries reached the targeted 251 by July 2017 and there was an increased number of clinic visits by November 2017.

Lessons learned—To introduce change and new practices, significant effort is needed. Messages need to be repeated in different ways, and potentially negative outcomes and perceptions managed. Responding to community feedback with visible actions is important.

Reaching hidden, hard-to-reach and difficult places

There are many factors which make people and places difficult to access in Myanmar. In 2017, this included surges in conflict and political and security restrictions, challenges in road and transportation access due to flooding and landslides, and stigma and discrimination.

Difficulties in access in Kayin and Kayah

Challenge—Volunteer health workers face challenges in recording malaria data in ethnic armed organization areas because of security, limited access, language barriers, low literacy rates and poor communication networks. Travelling in the rainy season is very difficult in Kayin and some sites cannot be reached regularly. Rising tension between the Tatmadaw and the Karenni National Progressive Party (KNPP) at the end of 2017 meant that rural villages in Demoso, Hspasaung, Shadaw, Hpruso and Mese in Kayah State were not accessible.

Actions and their impact—In response, implementing partners hired local staff so that they could communicate in the same language as the community, and partners worked with ethnic health organizations (EHOs) and civil society to maintain access as much as possible.

In Kayah State, although there was temporary restriction on the movement of project staff, they continued remote follow-up and re-established health care activities quickly through the implementing partner, ethnic health organization and township health department communication and coordination network. 3MDG undertook regular consultation with these organizations to maintain understanding of the context and changing situation in both mixed and EHO-controlled areas. Movement has now been reestablished.

In Kayin State, buffer stocks were provided in advance for areas not reachable in the rainy season, and the implementing partner staff made arrangements to meet with village health workers at 'kissing points,' or accessible areas, to transfer medical supplies, data and provide other support.



Health education as part of Harm Reduction services in Kachin State. Services—which also include prevention programmes, peer support and needle and syringe distribution—are offered through outreach and drop-in centres.

Lessons learned—Working with local organizations can enable the delivery of health care services in hard-to-reach areas. A coordinated network is the key to maintaining and re-establishing minimal health care services in remote conflict areas.

Difficulties in access in Rakhine State

Challenge—Activities across Rakhine State remain severely interrupted following the humanitarian crisis (Aug-Oct 2017). This is marked by the mass-displacement of 671,000 refugees⁶³ into neighbouring Bangladesh. Depending on the township, this has resulted in varying degrees of interruption to 3MDG activities due to difficulty in accessing areas and populations, staff safety and human resource gaps.

Actions and their impact—Though 3MDG-supported interventions were temporarily stopped in August, they resumed again in late September, except for Buthidaung where a reduction in support continues due to access difficulties. In this township, the International Organization for Migration (IOM) remains in the area to work with the township health department to support mobile clinics, outreach, township monthly meetings and emergency referral support.

Referral support to all communities has been reduced. Additional administrative procedures have hindered partner progress and some 3MDG implementing partners, especially in conflict-affected areas, are not able to conduct regular activities nor support the township health department.

Despite these challenges, the 3MDG approach and township and state-wide support model has meant that work in most townships has been able to continue. This comes as the result of understanding local context, building strong relationships at ground level with local administrative and health departments, and working with partners who are well-briefed and experienced in conflict-sensitive approaches to health service delivery.

Lessons learned—It is critical to maintain flexibility and respond to developing opportunities to continue to support recommendations made in the Advisory Commission on Rakhine State.

Difficulties in access in Kachin State

Challenge—Armed conflict in Kachin State restarted in 2011 and since then has displaced over 91,000 people. About 43 percent of the displaced people are located in areas beyond government control and where international actors have limited humanitarian access. Even in government controlled areas, but especially outside, international humanitarian organizations encounter severe access restrictions. Local humanitarian organizations continue to operate, despite increasing constraints.

The sustained threat to physical security contributes to reduced freedom of movement and access to critical services, including health services and referral systems. In mid-2017, only 33 percent of the target population in Kachin had access to basic health care, largely due to logistic and security constraints, inadequate health facilities, medical supplies and skilled health staff.⁶⁴

Actions and their impact—In response, 3MDG implementing partners have conducted a situation analysis of the area, and update the 3MDG Fund Management Office on a regular basis. A conflict-sensitive approach to planning, programming and project implementation has been strengthened. For example, contingency stocks for malaria treatment have been supplied to volunteers in affected villages. Volunteers in IDP camps have been recruited and trained to provide diagnosis and treatment for malaria and tuberculosis.

Discussions continue with local actors on where they can support the implementation of conflict-sensitive health services. For example, in Sumprabum Township, 3MDG is in discussions with Kachin Baptist Convention to determine what contribution they can make.

In the future, technical support and training will be provided to local partners via CDA—an international non-profit organization working to improve the effectiveness of peacebuilding, development, and humanitarian organizations as well as corporations working in fragile and conflict-affected contexts. This was noted and planned in 2017 as important for implementing partners and thus will be carried forward in 2018.



Maternal death follow-up in Ayeyarwady Region. A more rigorous follow-up practice has resulted in a reduction in deaths in 2017 after the numbers spiked in 2016.

Lesson learned—To continue to operate in conflict-affected areas when conflict is heightened, responsiveness and flexibility to align with the rapidly changing context are required. The principles of conflict-sensitivity and ‘do-no-harm’ must already be embedded in the work of implementing partners. They may require further and continuous technical support in order to develop solutions on-the-ground.

Difficulties in accessing populations in Paletwa in Chin State

Challenge—Armed conflict broke out in November and December of 2017 between the Tatmadaw and the Arakan Army in the northern part of Paletwa Township. Hundreds of people were displaced from their villages to a neighbouring village, Shin Let Wa, and some fled to India. Many health services could not be delivered to these people in accordance with the Township Health Plan. Staff from Marie Stopes International could not conduct mobile team visits. Consequently, family planning and sexual and reproductive health services could not be offered.

Actions and their impact—Some services were able to be delivered from the basic health staff at the Shin Let Wa rural health centre. One medical officer from Paletwa

Township Health Department was able to conduct supportive supervision visits to Shin Let Wa. Mobile clinics were able to operate with 3MDG funding.

3MDG staff visited Paletwa in January 2018, and it was noted that frequent armed conflict undermined the delivery of health services. Alongside remoteness and difficulty in access, the health status in the community is severely affected. After discussion with implementing partner staff, it was decided to bolster their experience working in conflict-affected areas via the CDA (who are contracted by 3MDG for technical assistance in conflict areas). Meetings have begun and interventions will continue throughout 2018.

Lesson learned—Flexible solutions must be sought in conflict-affected areas, which still adhere to the principles outlined in 3MDG’s conflict sensitivity strategy. Technical support from CDA will improve the ability of implementing partners to find and implement solutions.

Difficulties in accessing hidden and vulnerable populations

Challenge—The most complex aspect of Harm Reduction activities is finding people who inject drugs and ensuring they are aware of the services which are available. This is because they remain highly stigmatized and marginalized. They may also be highly mobile, potentially engaging in seasonal migration to pursue livelihood opportunities. This is especially true in Mandalay, which has a high migrant population. Women who use drugs may find it especially difficult to seek care due to high levels of stigma.

Bad weather and poor road infrastructure also contribute to the difficulty in reaching people. Further access to ante-retroviral therapy remains difficult and there is no available Hepatitis C treatment in Sagaing.

Actions and their impact—3MDG's implementing partner Asian Harm Reduction Network (AHRN), has opened up a women-only drop in centre to ensure that women who inject drugs have a safe and comfortable place to seek Harm Reduction services. They may experience double discrimination on account of their drug use and their gender, therefore these spaces are critical. AHRN employ more women staff, undertake more sensitivity training, and also offer other sexual and reproductive health services (such as antenatal care) to ensure that support is comprehensive.

Outreach services are used to reach people where they are, overcoming stigma and difficulties for clients to cover transportation costs. For example, MANA conducted more frequent visits to outreach contact sites in 2017.

Community resistance to Harm Reduction and stigma against people who use drugs remains strong. Metta's community sensitization project continues in Kachin State and other implementing partners also undertake community activities to increase acceptance. This includes local authorities, community members and the police.

Lessons learned—Responsiveness in service delivery is critical for Harm Reduction services to overcome the challenges of stigma, distance and cost. This means more outreach, community sensitization and women-only centres.

Reduction in maternal and under five deaths in Labutta

Challenge—In 2016, the number of maternal and under five deaths was high in Labutta in Ayeyarwady Region.

Actions and their impact—To respond to these high figures, a number of trainings were provided to the basic health staff (BEmONC training, Child Death Surveillance Training and Maternal Death Surveillance orientation sessions) throughout 2016. All deaths were thoroughly investigated and appropriate responses were made.

3MDG's implementing partner, Save the Children, assisted with field investigation, data entry, analysis, reviewing of death cases and response activities. They found that the most common cause was preterm/low birth weight. In response, basic health staff were encouraged to improve the coverage of four antenatal care visits, ensure the proper supplementation of iron, folic acid, Vitamin B1 and Vitamin A during pregnancy and conduct early referrals of high risk pregnancies. Posters of danger signs for pregnant mothers and newborns were posted in all villages in the township to increase awareness. Basic health staff shared the importance of delivery with

skilled persons and at health facilities to the community.

As a result of these activities, the number of maternal deaths reduced from 13 maternal deaths in 2016 (194 per 100,000 live births) to five maternal deaths 2017 (83 per 100,000 live birth). The number of under-five deaths reduced to 106 child deaths in 2016 (16 per 1,000 live births) to 82 child deaths in 2017 (14 per 1,000 live births).

Lessons learned—Maternal and under five deaths can be reduced with targeted training, information sharing of danger signs with the community, and constant surveillance and monitoring. These efforts should continue in 2018 to further reduce maternal and under five deaths with particular emphasis on handover from implementing partners to township health departments and basic health staff to facilitate sustainability.



A new baby in Chin State. His mother gave birth in the nearest health facility, thanks to a referral financed by 3MDG and facilitated by implementing partners Danish Red Cross and Myanmar Red Cross Society.

More understanding of HMIS procedures needed

Challenge—There have been limited levels of understanding around indicators, collection methods and data sources in the health management information system for basic health staff. In Magway, for example, through attending monthly basic health staff meeting and data collections for progress reports, a 3MDG implementing partner observed the need for capacity development.

Actions and their impact—HMIS training was organized through coordination with the implementing partner, township health departments and Regional Health Department. The training was practical and used many examples and exercises. The confusing, disputed and misunderstood points in the HMIS were cleared up and discrepancies in data collection made uniform. This has resulted in stronger data validation mechanisms and better quality data for the project.

DHIS2 training was covered at the same time, which meant health assistants were able to become more engaged in service coverage and death surveillance activities. This prepared health staff for the ultimate handover of the DHIS2 from the implementing partner to the township health department.

Lesson learned—Targeted, practical and hands-on training on specific issues can be effective. Solid understanding of the systems and procedures in place must be gained; refresher trainings may be necessary. Health staff in Magway need to have continued support during this transition period to ensure the gains made are sustained.



Participatory Learning and Action exercises are ways for the community to share their thoughts and feedback about health services and projects. Here, women and men take place in an exercise in Bilin Township in Mon State.

Lack of access to community feedback mechanisms

Challenge—Community feedback mechanisms may not be accessible to all people, especially those whose feedback may be most critical.

Community feedback mechanisms have been implemented by all 3MDG partners since 2015. Results have been strong. However, people who are poor, or who have low literacy levels, may find it difficult to access some feedback methods (such as suggestion boxes and feedback forms) and community meetings may not be conducted in a language they understand or feel confident using.

Actions and their impact—In 2016, 3MDG conducted an assessment into the use of feedback mechanisms. It was noted that most feedback was received via implementing partner health staff in meetings, rather than through formal methods, including forms, suggestion boxes and hotlines. In response, partners were encouraged to shift their focus to different methods. For example, in Gangaw and Ngaphe in Magway,

community members noted that they preferred giving oral feedback, so implementing partners focused on this instead.

Awareness raising sessions were also conducted in 3MDG-supported areas, including posters and pamphlets and demonstrations of how to use the suggestion box. More meetings were scheduled in order to hear more community voices and attempts were made to conduct meetings with local leaders so they could take place in the local language.

Lessons learned—When it comes to giving feedback, the community must feel confident in how the feedback is collected. Context-specific methods are required.

Improving management of village health funds

Challenge—Despite the critical role of village health funds in encouraging health-seeking behaviour by covering health costs at community level, it was noted that many village health committees have never received training in how to manage these financial instruments.

Actions and their impact—In 2017, 3MDG supported the implementation of village health funds through supportive supervision and appropriate capacity building of the community-based organizations and village health committees that partner with Collective Voices.

This essential capacity building has been trickled down to the village health committees and volunteer health support groups who are now better able to manage, maintain, and revolve the fund so that the capital can be increased. This support includes effective book-keeping and fundraising training and monitoring and coaching to continue to help develop competencies. With this support, many village health funds have achieved success, even revolving to be greater than their initial amount, and are on a path of self-sufficiency.

Lessons learned—Village health committees can help communities cover emergency medical costs under a sustainable model, but they need targeted support and training in financial management.

Integration of accountability, equity and inclusion in the health system

Challenge—Limited integration of accountability, equity and inclusion principles for 3MDG has been observed due to high staff turnover, limited resources dedicated to this area, and lack of recognition of its importance.

Actions and their impact—Advocacy and commitment to these principles on the part of 3MDG and many other stakeholders has resulted in a remarkable shift at the Ministry of Health and Sports central level. The Union Minister's commitment was noted in his attendance and keynote speech in late 2016 at the launch of 3MDG's Collective Voices report. It was cemented in the inclusion of these principles in the National Health Plan 2017–2021, Annual Operational Plans and their associated Monitoring and Evaluation framework. These documents also indicated that community feedback mechanisms should be set up at the township level to systematically capture the voices of the community and enhance the responsiveness of the health system.

Continued efforts of 3MDG and implementing partners mean there is increasing understanding among all stakeholders that the 'Health for All' approach is integral to providing effective health programmes and improving health outcomes in Myanmar; it cannot be treated as a separate or additional stream of work. This has been reinforced through developing and sharing a 3MDG-guidance note of "community feedback mechanisms" and "gender and social inclusion awareness and sensitivity" to all implementing partners.

Lessons learned—Persistent advocacy for these principles has had a positive impact, but this commitment must continue to ensure these issues stay on the agenda for the Myanmar health system.



A cooking demonstration in Namtu Township in Shan State. CESVI, the implementing partner, has been working to involve more men to encourage gender equality, in line with 3MDG's commitment to accountability, equity and inclusion.



A volunteer health worker at a mobile clinic shares health information with attendees.

Inappropriate use of medications

Challenge—High antibiotic use by village health workers was discovered by the 3MDG Monitoring and Evaluation team via regular programme monitoring. It has been known to be an issue by 3MDG for a number of years. It is not surprising given a number of factors such as difficulties in diagnosing pneumonia, community pressure to provide treatment, remoteness of health facilities for referral and challenges of regular supervision of volunteers.

Actions and their impact—Data was closely reviewed with the relevant implementing partners and follow-up actions taken. For example, training in community case management (CCM) of diarrhea and pneumonia and Volunteer Recording System refresher trainings were organized in some townships.

In addition, 3MDG has discussed prioritizing field supervision to volunteers who over-prescribed antibiotics during the year with implementing partners. They have also been requested to distribute antibiotics as per epidemiological trend, not per consumption.

The findings from the Volunteer Recording System have also been shared at the state-level coordination meeting, in order to advocate for better supervision of volunteers. This will

be supported by refresher trainings in supervision for basic health staff.

Lessons learned—It is important that basic health staff and volunteer health workers understand the potential impacts of over-prescription of antibiotics, and have the training and knowledge they need to accurately prescribe medication. They may need support against community pressure from higher level health staff.

Tuberculosis testing and detection

Challenge—Lower case detection rates for TB were noted for women compared to men in two reviews in 2014 and 2015.

A study in 2014 revealed that only 34 percent of the nationally reported cases of TB were women, and there were also gender disparities in the 149 mobile teams visits carried out by the National TB Programme in 2015 (1,419 cases found in women and 1,953 in men). This was despite the majority of TB mobile clinic attendees being women and children.

Different screening methods were thought to have contributed to this disparity. For example, fewer women were routinely screened by chest x-ray. Some studies

also indicated that tuberculosis stigma has greater socioeconomic consequences for women, which affected their care-seeking decisions.

Actions and their impact—The findings of the 2014 study highlighted the need for a modified programme design to account for the differences in case detection and care seeking behaviour for men and women.

3MDG undertook significant efforts in subsequent years to improve this. The introduction of TB screening in 2016 at maternal, newborn and child health clinics has meant that the number of women reached and TB cases detected have significantly increased. In 2017, 3,499 TB patients were diagnosed at maternal and child health clinics—45 percent of the total—highlighting the importance of the adjustments made.

Lesson learned—Constant review of sex-disaggregated indicators and timely and effective response is critical to ensure that services reach all people.

Endnotes

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Annexes

- I Analysis of results
- II Results matrix
- III 3MDG-funded implementing partner grants
- IV Overview of lessons learned
- V Research completed in 2017

I—Analysis of results

As evident in 'Results at a Glance' on page 7, results for 3MDG indicators in 2017 were strong. Nevertheless, there were—as always—notable disparities between states and regions, some under performing indicators, and some interesting areas for reflection and analysis. This section of the report outlines those issues and provides analysis of the Results matrix which follows.

There are three types of indicators in the 3MDG logframe. They are: impact level indicators, outcome level indicators and output level indicators. This analysis will focus on outcome and output level indicators in four areas of work: maternal, newborn and child health; HIV, TB and malaria; health systems strengthening; and accountability, equity and inclusion.

Impact level indicators target setting is national, rather than 3MDG-specific. It is most often not reported yearly, as figures are determined from nationwide surveys and censuses, hence the lack of inclusion in this analysis. More detail can be found in the Results matrix.

Maternal, newborn and child health

Across most 3MDG-supported townships, maternal, newborn and child health indicators are showing good results and improvements from 2016. This includes births attended by skilled health personnel, ante-natal care, post-natal care, and breastfeeding within one hour after birth.

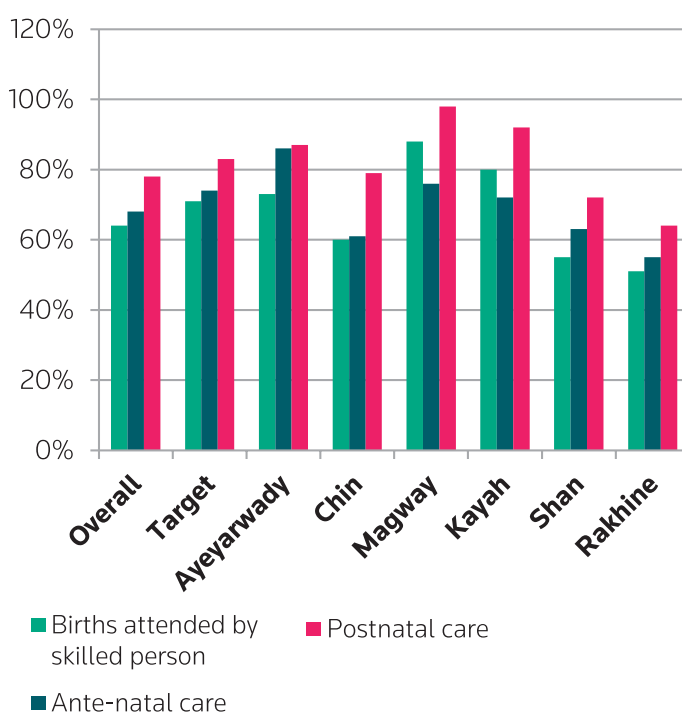
The addition of Rakhine townships in late 2016 had a serious impact on overall performance. For each of the indicators, when calculated without Rakhine townships, indicators are met for 2017. The state has a large population, so under performing indicators make a significant contribution to overall performance. This is especially true in Sittwe, with a large population and many internally displaced person camps, where people do not receive many government-recorded services.

Results in Rakhine State are low, as demonstrated by the graphs below. This was because of the

Table 4: Maternal, newborn and child health indicators in 3MDG-supported townships

	2017 Target	2017 Result	Cumulative Result
Number and percentage of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)	71%	64% (72,307)	221,675
Number and percentage of women attended at least four times during pregnancy by skilled health personnel for reasons related to the pregnancy	74%	68% (76,884)	232,831
Number and percentage of mothers and newborns who received postnatal care visit within three days of childbirth	83%	78% (87,375)	261,187
Number and percentage of children under one immunized with DPT3/Penta3.	92%	89% (100,150)	319,502
Number and percentage of children under one immunized with measles	93%	82% (92,385)	312,103
Number and percentage of appropriate maternal (EmOC) referrals	18,600	23,041 (18% of all estimated pregnancies)	67,771
Number and percentage of appropriate child (ECC) referrals	(Nil)	17,822	53,141

Graph 2: Births attended by a skilled person; ante-natal and post-natal care across 3MDG-supported townships (divided by state/region)

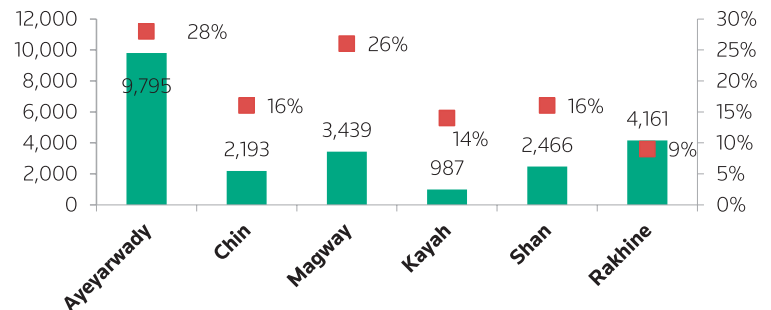


conflict in Northern Rakhine, which led to low referral numbers due to restricted movement of pregnant mothers and limited access for basic health staff. Other challenges include the high number of vacant basic health staff positions in Pauktaw and Kyaukphyu, floods and landslides in Ann townships and low coverage of midwives in geographically hard-to-reach areas in Myebon townships. 2017 was also a start-up year for 3MDG support in Rakhine State. 'Lessons learned' on page 89 identifies how implementing partners have worked to overcome access barriers; nevertheless, continuing unrest and restrictions mean the situation is likely to continue into the foreseeable future.

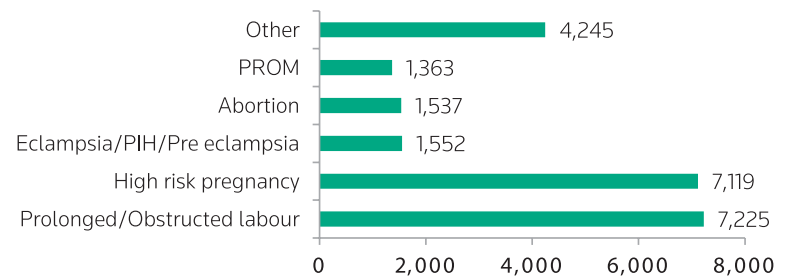
Lower results were also shown in Chin State and Shan State, though both showed slight improvements from 2016. In Chin State, this was the result of basic health staff vacancies in five out of nine townships and low midwife coverage in very hard-to-reach areas in Paletwa. In Shan State, the eruption of sustained conflict in northern parts of the state meant that travel by basic health and the community was limited. 'Lessons learned' on page 84 addresses this challenge and how implementing partners worked with civil society organizations to increase their reach.

The immediate breastfeeding indicator (see Annex II: Results matrix) did not meet the target. Significant under performance is again noted in Rakhine State. Nevertheless, this indicator can be improved across the country as it is less dependent on access and staffing. As such the Fund Management Office will address methods for improvement in 2018, including potential communication campaigns and refresher training for basic health staff and the village health workforce. Some difficulties in reporting have also been noted for this indicator, for example, how can the health worker record breastfeeding within one hour if they have not attended the birth? Is the recall of the mother enough? These will be included in the data quality assessment for the 3MDG Final Evaluation.

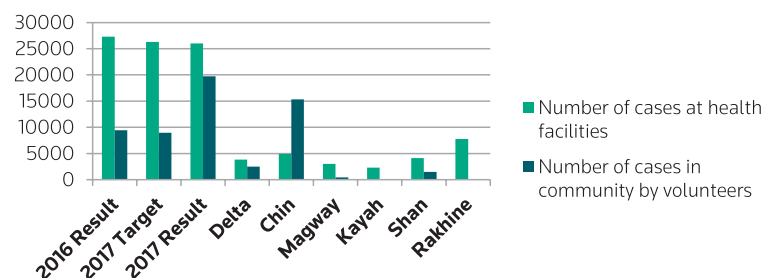
Graph 3: Number and percentage of maternal (EMoC) referrals disaggregated by state/region



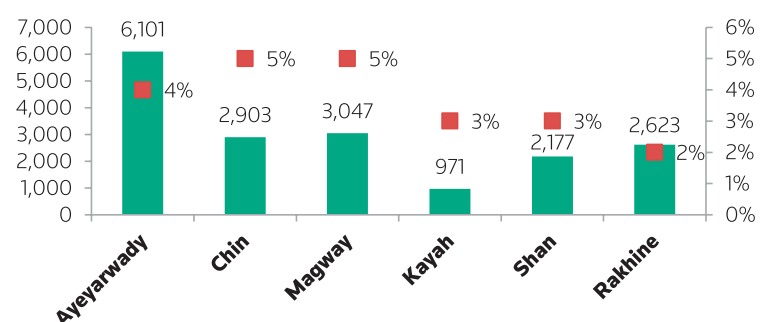
Graph 4: Top five causes of maternal (EMoC) referrals



Graph 5: Number of under five children diarrhoea cases i) treated with ORT at Health Facilities ii) treated with ORS + Zinc at community by volunteers



Graph 6: Number and percentage of children under five (ECC) referrals disaggregated by state/region



A similar review will be conducted for the antenatal care indicator. To be recorded as ‘met,’ pregnant women must attend antenatal care four times at specific points in her pregnancy. There is comparatively lower attendance at antenatal care in the first trimester indicating a need for continued effort to enhance health seeking behaviour.

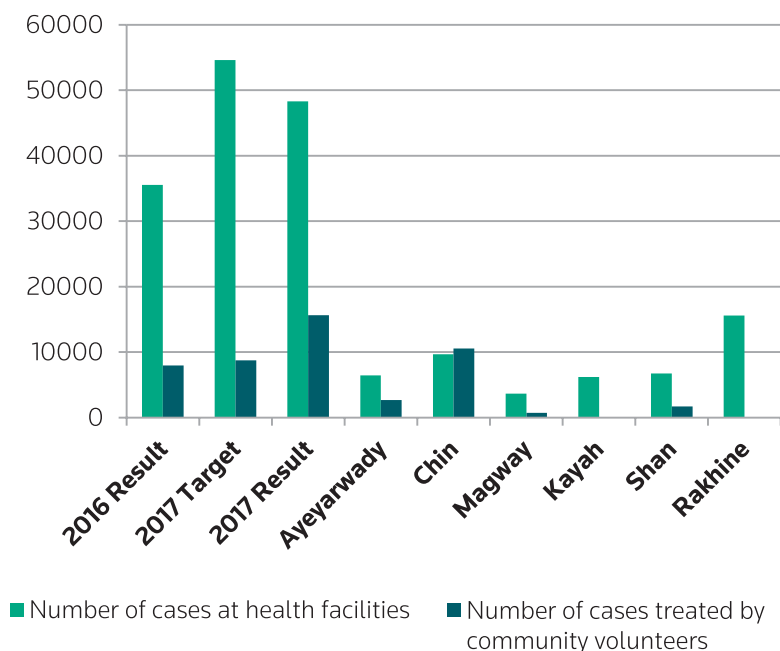
The number and percentage of emergency referrals for pregnant women, which get women to hospital to deliver their baby when they need emergency care, met targets in 2017 with 23,041 referrals. Targets were met in all states and regions, though significantly different percentages of pregnant women were referred (from 28 percent in Ayeyarwady to nine percent in Rakhine). The aim is to refer around 15 percent based on global figures that estimate that this many women will experience an obstetric emergency.

High percentages in Ayeyarwady and Magway are most likely a result of women crossing into different townships as a result of emergency referral support. This may be because their township is not supported by 3MDG, or health facilities in a neighbouring township are closer. This raises the percentage as they are not included in the denominator (expected pregnancies in a township), though they are counted in the numerator (number of referrals). This is also happening in other places such as Rakhine, often due to access or conflict. It is a positive development, allowing women to access care when and where they need it, as efficiently as possible. For Rakhine, the overall percentage does not increase as much because the women come from townships which are also 3MDG-supported. It should also be noted that the target for Rakhine State was 5-10 percent, so this was also met.

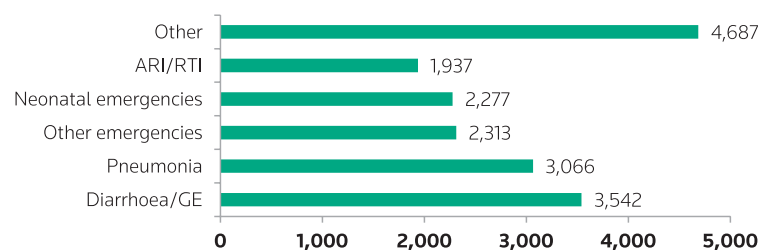
Child health

3MDG implementing partners report on two immunization indicators: DPT3/Penta3 and measles. Over the years of implementation, results in this area have been strong. In 2017, the DPT3/Penta indicator met the target. Lower results are recorded in Rakhine, again due to conflict, basic health staff vacancies and access difficulties during floods. Lower achievement in Shan is also due to conflict.

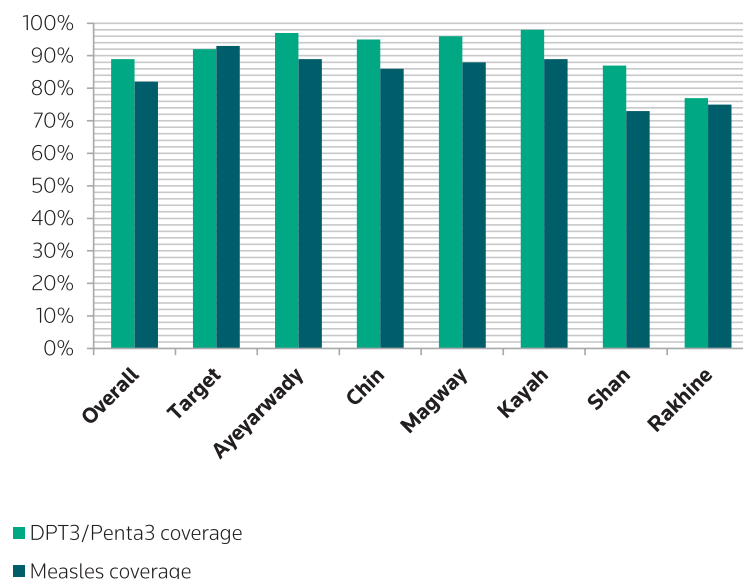
Graph 7: Number of under five children suspected pneumonia cases treated with antibiotics i) at Health Facilities ii) at community by volunteers



Graph 8: Top five causes of child (ECC) referrals



Graph 9: Children under one immunized with DPT3/Penta3 in 3MDG-supported townships; Children under one immunized against Measles in 3MDG-supported townships



For the measles indicator, moderate achievement is reported. The number is considerably lower than 2016. This was a result of the Japanese Encephalitis immunization campaign, which caused the postponement of measles vaccination activities. Health staff were concerned about negative interactions between the two vaccines as well as limited human resources.

17,822 children received emergency referrals across the country when they experienced health emergencies.

Family planning

In 2017, 3MDG continued to support family planning services across the country. This is measured in two ways: the total number of 'couple years of protection' delivered, and the contraceptive prevalence rate.

In 2017, Population Services International primarily distributed commodities procured in previous years which were not counted in the Output 1.1 indicator, hence the overachievement. This is shown in Table 5.

Contraceptive prevalence rate had positive results in 2017, with the overall rate at 70 percent. This is the percentage of women of reproductive age who are currently using, or whose sexual partner is currently using, at least one contraceptive method, regardless of the method used.

There has been considerable improvement in all states and regions, with the most notable improvements in Chin State (from 27 percent to 33 percent), Magway Region (from 64 percent to 71 percent) and Shan State (from 59 percent to 64 percent). Though the numbers are still low, this is a significant achievement in Chin State, where the number has been stuck in the mid-20's for a number of years. Large disparities between states and regions and urban and rural areas continue to require concerted effort.

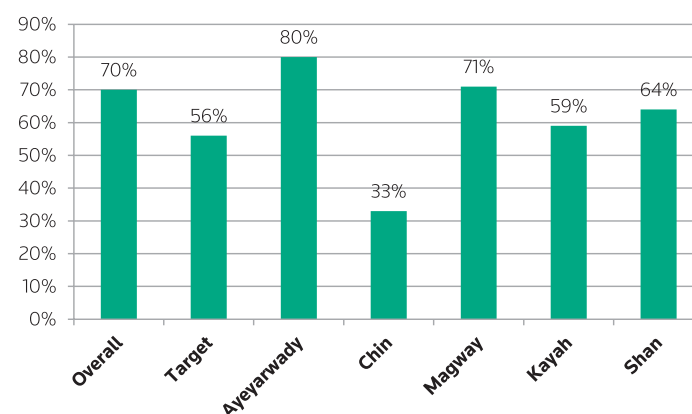
Table 5: Total number of Couple Years of Protection (CYPs) delivered through public sector services and private sector channels in i) Component 1 townships ii) non-Component 1 townships

	2014		2015		2016		2017	
	Target	Achievement	Target	Achievement	Target	Achievement	Target	Achievement
MSI 15 Townships	31,730	9,485	36,901	51,573	32,540	50,011	9,409	12,156
PSI 42 Townships	38,017	17,642	38,017	52,630	43,949	33,399	0	33,678
PSI Additional 247 Townships	17,250	0	156,750	222,187	240,000	141,782	0	0
Total	86,997	27,127	231,668	326,390	316,489	225,192	9,409	45,834

Table 6: Disability-Adjusted Life Years

	2014		2015		2016		2017	
	Target	Achievement	Target	Achievement	Target	Achievement	Target	Achievement
MSI 15 Townships	2,975	1,414	3,017	2,816	3,270	4,591	1,141	1,115
PSI 42 Townships	10,000	8,664	17,758	17,423	25,319	20,866	0	3,909
PSI Additional 247 Townships	1,764	0	14,124	20,231	26,439	12,785	0	0
Total	14,437	10,078	34,899	40,470	55,028	38,242	1,141	5,024

Graph 10: Contraceptive Prevalence Rate



HIV, tuberculosis and malaria

HIV Harm Reduction

Strong results continue to be demonstrated by 3MDG's Harm Reduction partners. In 2017, they have reached more people who inject drugs within the coverage area than in 2016, and significantly more than the target of 70 percent. This was a result of expanding to areas that were previously unreached. People who inject drugs working in these areas may be highly mobile, and the influx of new people who inject drugs also contributed to increased delivery of services. Advocacy directed at community leaders has also supported this high result.

Targets have also been exceeded in the distribution of needles and syringes, with more than 17 million units. This was partly a result of reaching more people who inject drugs who required this support, and increasing community and leadership acceptance of services.

Tuberculosis

The case notification rate, reported as 'substantially not meeting expectations' is currently not available to report on (it is based on national reporting by the National TB Programme). The number from 2016, however, does demonstrate a gap between indicator and target. Investigations continue into the reason for this gap, which may be the result of an overly high target or lack of reporting from the private sector.

In 2017, there was no initiation of treatment for multi-drug resistant tuberculosis. However, some treatment that was initiated early (2015) continued and its success was reported on.

Malaria

Malaria activities continued in 2017 with testing and treatment. An area of particular concern was Paletwa in Chin State, where morbidity was high and a number of deaths have been reported. Paletwa has a high malaria case load with 29 percent positivity (an increase from 25 percent in 2016) and contributed nearly half (47 percent) of all cases of 3MDG.

Overall, 3MDG slightly underperformed in the number of tests that were taken. These was primarily due to a change in testing criteria from one implementing partner. They were more

Table 7: HIV 2017 Results and Targets

	People who inject drugs reached by prevention programmes	Needles and syringes distributed	People who inject drugs given voluntary confidential counseling and HIV testing
2017 Target	70% of PWID in target area—29,050*	8,000,000	13,248
2017 Achievement	42,977 (104% of target coverage)	17,240,002	14,105
Cumulative 2013–2017	42,977	52,977,041	14,105

*It was estimated that 41,500 PWID exist in programme area. 3MDG targeted to cover 70% of PWID in Programme area, which is equivalent to 29,050 PWID (annual target).

Note—Cumulative targets are not included because they can count twice the same person accessing the services each year.

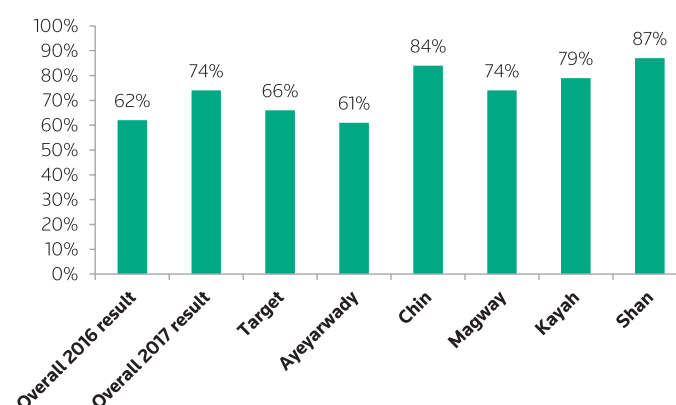
Table 8: Tuberculosis 2017 Results and Targets

	Notified TB cases	Number of referrals to TB centres by community health workers/volunteers
2017 Target	19,470	62,150
2017 Achievement	15,780	55,393
Cumulative 2013–2017	55,571	143,010

Table 9: Malaria 2017 Results and Targets

	Number of malaria tests taken and read	Number of confirmed malaria cases treated	Number of confirmed malaria cases treated within 24 hours of fever
2017 Target	415,000	7,500	60%
2017 Achievement	366,002	10,821	72.3% (8,002)
Cumulative 2013–2017	2,287,852	140,239	-

Graph 11: Average percentage auxiliary midwives and community health workers receiving quarterly supervision and monitoring



strict, only testing cases with a history of fever and conducting active case finding only in areas with a malaria positivity rate above 20 percent. But there was actually a higher positivity rate than in previous years. This is both a result of high prevalence in Paletwa and Rakhine State as well as more targeted testing.

All of the long lasting insecticide nets that were procured (two million) were distributed with the support of the Global Fund Principal Recipient, UNOPS, and the National Malaria Control Programme. Focus areas included prison work sites in malaria endemic areas, as well as Kachin, Kayah, Kayin, Mon and Tanintharyi.

Health Systems Strengthening

3MDG supports the strengthening of the health system in a number of ways, including supporting health staff with training, supervision and supplies, as well as providing broader technical support towards the development of policies and plans at central and state and regional level. Across all areas, 3MDG was showing strong results in 2017.

The number of doctors, nurses and midwives who attended at least one maternal, newborn and child health training (2,772) was higher than 2016 (1,985) and higher than the 2017 target (2,200). The percentage of auxiliary midwives and community health workers who received quarterly supervision and monitoring also increased from 62 percent in 2016 to 74 percent in 2017. This met targets, but it was noted that more emphasis on field supervision is required.

Results which require improvement included the number of midwifery students demonstrating competency, which, though representing a significant increase from 24 percent to 60 percent, still means that only three out of five midwives are competent to perform their role upon graduation. A concerted effort is required to understand which areas are the most difficult, to emphasize further on practical skills, and to fill knowledge gaps.

Improvement is also needed for stock-out data, which shows that despite improvement from 32 percent in 2016, only 43 percent of auxiliary midwives and community health workers reported no stock-out in 2017. This is the number for all auxiliary midwives and community health workers

in 3MDG-supported townships who are implementing the Volunteer Recording System. When counting only those who report (59 percent of the total), 73 percent reported no stock-out.

Ayeyarwady and Shan show particularly low figures. Commodity supply to volunteers needs improvement. Stock-outs were also reported as common by 3MDG implementing partner the Partnership for Supply Chain Management. In fact, they have actually increased from 2016 figures (65 percent to 71 percent). More positively, the percentage of townships with functional cold chain equipment and adequate storage space over-achieved compared to target in 2017 and is at 88 percent.

3MDG met targets in support to the development of health sector policies, strategies and plans. The Essential Package of Health Services has been developed and is in the process of being costed.

Accountability, equity and inclusion

Performance over target was also achieved for health staff (including Ministry, implementing partners and civil society and community based organizations) for training in accountability, equity and inclusion principles. In total 5,121 participants attended the trainings.

Accountability at community level was supported with accessible and well-used feedback mechanisms (14,648 pieces of feedback). Of this feedback, 92 percent was addressed. This is a strong result. The number and proportion of women on township and village health committees, and the Comprehensive Township Health Plan review workshop also remained steady with 2016 figures, and again met or exceeded targets.

II—Results matrix

January–December 2017

Meeting or exceeding expectation
(above 90% of the target achieved)

Moderate achievement
(60–90% of the target achieved)

Weak but potential demonstrated
(30–59% of the target achieved)

Substantially not meeting expectations
(below 30% of the target achieved)

Nº	Indicators	2016	2017	2017		Comments	
		Result	Target	2017 Result	Results Vs Targets		Cumulative Result
Impact Improved maternal, newborn and child health and a reduction in communicable disease burden (HIV, TB, malaria) in areas and populations supported by the 3MDG Fund							
1	Maternal mortality ratio per 100,000 live births	See **	Not available*	Not available***	-	Not applicable	*For impact-level indicators, target-setting is national as opposed to 3MDG-specific. These targets were set by the UN Inter-agency group (UNAIG for maternal and child health) based on modelling of available data. In July 2017, the UNIAG for maternal and child health) based on modelling of available data. In July 2017, the UNAIG advised that estimations beyond 2015 have not been made yet.
2	Under-five child mortality per 1,000 live births (disaggregated by sex)	50**	Not available*	Not available***	-	Not applicable	**Maternal mortality was not measured in the Myanmar DHS (2016). Pregnancy-related Mortality was 227 (MDHS) indicating that Maternal Mortality would be even higher. The MMR Union-level data from the Census (2013-14) = 282 per 100,000 live births, from the lowest of 157 per 100,000 live births in Tanintharyi to the highest of 357 in Chin and Ayeerwady.
3	Neonatal mortality rate per 1,000 live births (disaggregated by sex)	25**	Not available*	Not available***	-	Not applicable	*** There were no national-level surveys to report the 2017 result.
4	HIV prevalence among people who inject drugs in programme areas	26%**	Not available*	Not available**	-	Not applicable	*For Impact-level indicators the target-setting is national, as opposed to 3MDG-specific. In the national HIV National Strategic Plan 2016-2020 this indicator was replaced with an indicator "Number of new infection per 1,000 PWID among the uninfected population of PWID" by using AEM-modelled data, as this indicator may better reflect success of prevention efforts. The GF Concept Note still contains the original indicator but does not set a target due to challenges of population size estimates. ** The 2017 IBBS survey results on this indicator will be available in 2018. The latest available result of 26% is from 2016 HIV sentinel surveillance. The latest target was set in 2015 at 22%.
5	National TB (all forms) mortality per 100,000 population per year in programme areas	47	45	Not available*	-	Not applicable	* 2017 reported mortality figure is not available currently. The 2016 result was 47, at the same level as in 2015 (Source: Global TB report 2017). The 2016 target was 48.
6	Malaria mortality rate	0.04	0.06	Not available	-	Not applicable	The 2017 data is not available yet. In 2016 there were 21 reported malaria deaths. (Source: World Malaria reported 2017). Based on the population of 53 millions, malaria mortality rate per 100,000 is 0.04 (Source: WHO/NMCP). The 2016 target was 0.07. (Note: The indicator denominator is total population and not population-at-risk, as stated in the M&E Plan. This is due to the challenges of estimating population-at-risk, as village-level microstratification is not done in all villages yet)

N ^o	Indicators	2016 Result	2017 Target	2017 Result	2017 Results Vs Targets	Cumulative Result	Comments
Outcome		Increased access to and availability of (i) essential maternal and child health services for the poorest and most vulnerable in areas supported by the 3MDG Fund and (ii) HIV, TB, and malaria interventions for populations and areas not readily covered by the Global Fund					
1	Number and percentage of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife) in Component 1 townships	68% (51,358 out of 75,401 total deliveries)	71%	64% (72,307 out of 112,863 total deliveries)	Meeting or exceeding expectation	221,675	<p>State & Region Achievement</p> <p>Ayeyarwady - 73%, Chin - 60%, Magway - 88%, Kayah - 80%, Shan - 55% and Rakhine - 51%</p> <p>All states and regions show increased coverage of skilled birth attendance compared with 2016, except for Rakhine state. The Rakhine state coverage at 51% has significantly impacted the overall result in 3MDG-supported townships which dropped from 68% in 2016 to 64%. (The overall result without Rakhine - 71%).</p> <p>Rakhine: Low coverage results in numerator with high contribution in denominator (including IDP camp population) from Rakhine resulted in underachievement. The conflict in Northern Rakhine resulted in restricted movement of Basic Health Staff in the second half of 2017 and low referral support due to restricted movement of pregnant mothers. Other challenges included vacant BHS positions in Pauktaw and Kyaukphyu, flood and landslides in Ann townships, and low coverage of midwives in geographically hard-to-reach areas in Myebon township. In addition, 2017 is a start-up year for Implementing Partners in Rakhine.</p> <p>Chin and Shan: Although the SBA coverage at 60% and 55% respectively is notably lower than in Magway, Kayah and Ayeyarwady, it slightly increased compared to 2016 (57% and 54%). Low coverage in Chin is mainly contributed by BHS vacancies (highlighted by 5 out of 9 townships) and low midwife coverage in very hard to reach areas in Paletwa. Northern Shan state is affected by conflict during the reporting period, limiting travel by BHS and community.</p> <p>Additional contribution: 2,234 (All)- Ref.notes (1) and (2) at the bottom of the table.</p>
2	Number and percentage of women attended at least four times during pregnancy by skilled health personnel for reasons related to the pregnancy in Component 1 townships.	71% (53,319 out of 75,401 total deliveries)	74%	68% (76,884 out of 112,863 total deliveries)	Meeting or exceeding expectation	232,831	<p>State & Region Achievement</p> <p>Ayeyarwady - 86%, Chin - 61%, Magway - 76%, Kayah - 72%, Shan - 63% and Rakhine - 55%.</p> <p>All states and regions show increased coverage of ante-natal care compared with 2016, except for Chin and Rakhine states. The Rakhine state coverage at 55% has significantly impacted the overall result in 3MDG-supported townships which dropped from 71% in 2016 to 68%. (The overall result without Rakhine - 75%).</p> <p>Low coverage results in numerator with high contribution in denominator from Rakhine affected the overall result and resulted in underachievement. The key reasons for low coverage in Rakhine state are the conflict in Northern Rakhine and restricted BHS and population movements, BHS vacancies and data quality issues (e.g. data on births from camps in Sittwe is included into HMIS in 2017 resulting in high denominator).</p> <p>BHS vacancies, certain health seeking behaviours and improvements in HMIS data quality resulted in low coverage in Chin and Shan States, although Shan has shown a slight increase from 62% in 2016.</p> <p>Additional contribution: 3,446 (All)- Ref.notes (1) and (2) at the bottom of the table.</p>

Nº	Indicators	2016	2017	2017		Cumulative	Comments
		Result	Target	2017 Result	Results Vs Targets		
3	Number and percentage of mothers and newborns who received postnatal care visit within three days of childbirth	82% (60,734 out of 74,120 total livebirths)	83%	78% (87,375 out of 111,387 total live births)	Meeting or exceeding expectation	261,187	<p>State & Region Achievement Ayeyarwady - 87%, Chin - 79%, Magway - 98%, Kayah - 92%, Shan - 72% and Rakhine - 64%.</p> <p>All the state and regions show increase in % in compared with 2016, except in Chin and Rakhine states. The Rakhine state coverage at 64% has significantly impacted the overall result in 3MDG-supported townships which dropped from 82% in 2016 to 78%. (The overall result without Rakhine - 85%).</p> <p>Rakhine - Low coverage results in numerator with high contribution in denominator affected the overall result and resulted in underachievement. Lower coverage is found mainly in townships affected by conflict (Buthidaung and Sittwe).</p> <p>Chin - BHS vacancy, geographic difficulty (in Paletwa) and tight schedule with training/JE campaign are most causes contributing to reduced coverage in Chin.</p> <p>Shan - in northern Shan state, the unstable security condition is reported as a key reason for low coverage (Manton, Kutkai). However, the coverage in Shan increased from 69% in 2016,</p> <p>Additional contribution: 5,375 (All) - Ref.notes (1) and (2) at the bottom of the table.</p>
4	Number and percentage of newborns that initiate immediate breastfeeding within one hour after birth in Component 1 townships	84% (62,330 out of 74,120 total livebirths)	85%	77% (86,224 out of 111,387 total livebirths)	Meeting or exceeding expectation	210,869	<p>State & Region Achievement Ayeyarwady - 86%, Chin - 92%, Magway - 99%, Kayah - 93%, Shan - 70% and Rakhine - 58%.</p> <p>All the state and regions show increase in % in compared with 2016, except in Shan and Rakhine states. The Rakhine state coverage at 58% has significantly impacted the overall result in 3MDG-supported townships which dropped from 84% in 2016 to 77%. (The overall result without Rakhine - 87%).</p> <p>Rakhine - low coverage results in numerator with high contribution in denominator affected the overall result and resulted in underachievement. The reasons reported for low achievement are less awareness session by BHS, traditional misbelief of breastfeeding practice in community and HMIS data quality issues.</p> <p>Shan - the coverage dropped by a few % drops in compared with 2016 achievement. It is related mainly due to HMIS data issues and security situation in Kutkai.</p> <p>Additional contribution: 1,067 (EHO only) - Ref.notes (1) and (2) at the bottom of the table.</p>
5	Contraceptive prevalence rate in Component 1 townships	66% (413,187 out of 627,502 married couples)	56%	70% (451,861 out of 648,776 married couples)	Meeting or exceeding expectation	1,684,396	<p>State & Region Achievement Ayeyarwady - 80%, Chin - 33%, Magway - 71%, Kayah - 59% and Shan - 64%</p> <p>The 2017 target is considerably exceeded. Contraceptive prevalence rate in all State and Regions has improved compared with 2016, with most notable increases in Chin State (from 27% to 33%), Magway (from 64% to 71%) and Shan (from 59% to 64%).</p> <p>There is no reporting from Rakhine as there are no family planning commodity supplies by both private/public sectors.</p>

N ^o	Indicators	2016 Result	2017 Target	2017 Result	2017 Results Vs Targets	Cumulative Result	Comments
6	Percentage of under-five children who had diarrhoea receiving ORT (disaggregated by sex and age)	63%	78%	Not available*	-	Not applicable	* Target-setting for 2015-2017 is aligned with the National Child Development Health Strategy (2015-18). Reporting is survey-based. Given that a survey in 3MDG areas was not feasible, reporting is based on the national survey. No national survey is expected in 2017 and there are no alternative mechanisms to collect this data. This indicator is complemented by output-level indicator #1.3.
7	Percentage of under-five children with suspected pneumonia who received appropriate antibiotics (disaggregated by sex and age)	43%	66%	Not available*	-	Not applicable	* Target-setting for 2015-2017 is aligned with the National Child Development Health Strategy (2015-18). Reporting is survey-based. Given that a survey in 3MDG areas was not feasible, the reporting is based on the national survey. No national survey is expected in 2017 and there are no alternative mechanisms to collect this data. This indicator is complemented by output-level indicator #1.4.
8	Number and percentage of children under one immunized with (i) DPT3/Penta3 and (ii) Measles in Component 1 townships	95% (72,803 out of 76,962 children under 1 year old)	(i) 92%	89% (100,150 out of 112,491 children under 1 year old)	Meeting or exceeding expectation	(i) 319,502	State & Region Achievement Ayeyarwady - 97%, Chin - 95%, Magway - 96%, Kayah - 98%, Shan - 87% and Rakhine - 77%. All states/regions except Rakhine and Magway have shown slight increases in coverage compared to The Rakhine state coverage at 77% has significantly impacted the overall result in 3MDG-supported townships which dropped from 95% in 2016 to 89%. (The overall result without Rakhine - 95%). Rakhine - Low coverage results in numerator with high contribution in denominator from Rakhine affected the overall result and resulted in underachievement. Low achievement in Rakhine state is due to conflict situation which limits BHS to travel in semester 2 (Sittwe, Mrauk-U, Minbya), Midwife vacancy (Toungup, Kyaukphyu) and difficulty to access during flood (Toungup). Conflict situation during reporting period in Shan, together with vacant BHS positions and prioritizing JE campaign activities in Q4 have contributed to lower achievement. <i>Additional contribution: 3,811 (Wa+SR4) - Ref.notes (1) and (2) at the bottom of the table.</i>
		96% (73,650 out of 76,962 children under 1 yr old)	(ii) 93%	82% (92,385 out of 112,491 children under 1 year old)	Moderate achievement	312,103	State & Region Achievement 89%, Chin - 86%, Magway - 88%, Kayah - 89%, Shan - 73% and Rakhine - 75%. The coverage of measles immunisation is significantly under the 2017 target and notably reduced compared to 2016. This is attributable to: 1) The reduction of coverage in all state and regions compared to 2016. This is due to the postponement of measles immunization in all states and regions from Nov/ Dec 2017 to 2018. The decision to postpone is driven by the Japanese encephalitis (JE) immunisation campaign and concerns of undesirable interaction between the two vaccines. 2) Low coverage in Rakhine also impacts the overall result. (The overall result without Rakhine - 86%). <i>Additional contribution: 4,347 (Wa+SR4) - Ref.notes (1) and (2) at the bottom of the table.</i>

N°	Indicators	2016	2017	2017		Cumulative Result	Comments
		Result	Target	2017 Result	Results Vs Targets		
9	Number and percentage of people who inject drugs (PWID) reached by HIV prevention programmes in programme areas	Number: 40,033 Coverage: 96% (40,033 / 41,500 PWID in programme area).	70% of PWID in programme area (29,050)	Number: 42,977 Coverage: 104% (42,977 / 41,500 PWID in programme area).	Meeting or exceeding expectation	42,977	Partners expanded their services to unreached areas and nearby townships for comprehensive reach to beneficiaries. Gaining momentum in advocating to community leaders also has a synergistic affect on the high achievement of the harm reduction beneficiary reach. Furthermore, PWID who are working in this area are mobile in nature and influx of the new PWIDs also contributed to the increased service delivery.
10	Case notification rate of all forms of TB per 100,000 population (bacteriologically confirmed plus clinically diagnosed)	263	292	Not available	-	Not applicable	2017 CNR data is not available yet. This indicator is based on national reporting by NTP. The 2016 NTP CNR (all forms) of TB is 263/100,000 against the target of 294/100,000 for 2016 (Global TB Report 2017). Indicator targets are from the TB NSP and are based on the global commitment to End-TB strategy. The gap between the 2016 target and result could be attributable to one or more reasons, such as (i) declining TB prevalence and/or (ii) missing cases from private sector / military hospitals / conflict-affected areas. TB Prevalence Survey on-going in 2018 is expected to bring in more clarity and, if necessary, re-set the target at more realistic level.
11	Percentage of confirmed MDR TB cases successfully treated (disaggregated by sex and age)	Not reported for 2016	81%	78.4%	Meeting or exceeding expectation	-	Treatment success rate of NTP for Q2 and Q3 2015 cohort (Yangon and Mandalay) supported by 3MDG was 78.4% from routine reporting. This data has not been published yet. For comparison, treatment success rate was 80% on cases starting treatment in 2014 (Global TB Report 2017)
12	Number and percentage of confirmed malaria cases treated in accordance with national malaria treatment guidelines within 24 hours of onset of symptoms (fever) in 3MDG supported townships	64% Number: 5,312 Denominator: 8,337	60%	72.3% Number: 8,002 Denominator: 11,070	Meeting or exceeding expectation	Not applicable	Partners were trying to improve BCC activities focusing on prompt health seeking behaviour for early diagnosis and prompt treatment of Malaria.
14	Number of IPs/% of all IPs (including C1, C2 and CVs), reporting events/meetings that include participation and engagement between health care providers and target communities	76% (baseline)	80%	100%	Meeting or exceeding expectation	-	Also included in Rakhine IP.

N ^o	Indicators	2016 Result	2017 Target	2017 Result	2017 Results Vs Targets	Cumulative Result	Comments
Output 1 Delivery of essential services, with a focus on maternal and child health, strengthened in target townships							
1	Total number of Couple Years of Protection (CYPs) delivered through public sector services and private sector channels in i) Component 1 townships ii) non-Component 1 townships	(i) 107,302	9,409	62,154	Meeting or exceeding expectation	333,536	Target is significantly over-achieved due to more than half of the 2017 result coming from commodities procured by PSI in prior years the remainder of which was distributed in 2017. Moreover, (i) MSI private sector - 12,156 (15 Tsps). PSI private sector - 33,678 (34 Tsps); Public Sector 16,320 (43 Tsps + Wa and SR4)
		(ii) 141,782	0	N/A	-	363,969	*There was no 2017 budget allocation for contraceptive procurement/ franchising work by MSI and PSI, hence the 2017 target was set at 0. NB: Cumulative achievement for 2014-2016 was 363,969 against the target of 414,000 (Moderate achievement)
2	Number and percentage of appropriate EmOC referrals supported in Component 1 townships	16,612 (19% of estimated pregnancies 86,384)	18,600	23,041 (18% of 130,557 estimated pregnancies)	Meeting or exceeding expectation	67,771	State & Region Achievement Ayeyarwady 6 Tsps - 9,795 (28%), Chin 9 Tsps - 2,193 (16%), Magway 5 Tsps - 3,439 (26%), Kayah 7 Tsps - 987 (14%), Shan 7 Tsps - 2,466 (16%) and Rakhine 9 Tsps - 4,161 (9%). Results achieved exceed the annual target considerably. In Ayeyarwady townships, achievement coverage is considerable high as referral support has also been provided to those emergencies referred from other townships, and migrants and mobile populations were also covered. <i>Additional contribution = 504 (All) - Ref.notes (1) and (2) at the bottom of the table.</i>
3	Number of under five children diarrhoea cases i) treated with ORT at Health Facilities ii) treated with ORS + Zinc at community by volunteers	(i) 35,542	54,600	48,277	Moderate achievement	(i) 141,764	State & Region Achievement Ayeyarwady 6 Tsps - 6,457, Chin 9 Tsps - 9,641, Magway 5 Tsps - 3,646, Kayah 7 Tsps - 6,197, Shan 7 Tsps - 6,745 and Rakhine 9 Tsps - 15,591 Targets are not met due to under-achievement of the targets in Rakhine and Chin States. In Rakhine this is explained by restricted population movement due to conflict. In Chin, there is an increase in diarrhoea treatment by volunteers (ref: Output 1.3 (ii) significantly overachieving the target) <i>Additional contribution: 6,252 (All) - Ref.notes (1) and (2) at the bottom of the table</i>
		ii) 7,938	8,758	15,638	Meeting or exceeding expectation	(ii) 23,576	State & Region Achievement Ayeyarwady 6 Tsps - 2,694, Chin 9 Tsps - 10,539, Magway 5 Tsps - 716, Shan 7 tsps - 1,689 Results achieved exceed the annual target considerably. This is due to increased utilization of community-based treatment, better VRS reporting and improved stock status during 2017. Additionally, there is an improvement in volunteer supervision and refresher trainings in Community Case Management. Target-setting for community-based programming is challenging due to the lack of the reference data and low reporting rates in 2016 (baseline year). <i>Additional contribution: 6,015 (Wa + SR4) - Ref.notes (1) and (2) at the bottom of the table.</i>

Nº	Indicators	2016	2017	2017	2017 Results Vs Targets	Cumulative Result	Comments
		Result	Target	Result			
4	Number of under five children suspected pneumonia cases treated with antibiotics i) at Health Facilities ii) at community by volunteers	(i) 27,323	26,300	25,991	Meeting or exceeding expectation	(i) 95,928	State & Region Achievements Ayeyarwady 6 Tsps - 3,830, Chin 9 Tsps - 4,923, Magway 5 Tsps - 3,043, Kayah 7 Tsps - 2,283, Shan 7 Tsps - 4,143 and Rakhine 9 Tsps - 7,769. Additional contribution: 4,811 (All) - Ref.notes (1) and (2) at the bottom of the table.
		(ii) 7,433	8,944	17,491	Meeting or exceeding expectation	(ii) 24,924	State & Region Achievement Ayeyarwady 6 Tsps - 1,792, Chin 9 Tsps - 13,989, Magway 5 Tsps - 230, Shan 7 Tsps - 1,480 Results achieved for 2017 exceed the annual target considerably. A number of reasons contributed this: 1) Target-setting for community-based programming is challenging due to the lack of reference data and low VRS reporting rates in 2016 (baseline year). 2) 2016 was the first year for VRS data collection and reporting has improved since. 3) Improved community awareness about services at community volunteer level. 4) Instances of pneumonia over-diagnosis & over-prescription of antibiotics. While BHS and IP staff tried providing guidance on this during supervision visits, this is not easy to resolve due to challenges in differentiating common cold from pneumonia, pressure from community members to receive treatment, and challenges of conducting volunteer supervision at reasonable frequency, especially in hard-to-reach areas. 5) VRS reporting challenges exist among community volunteers, resulting in data inconsistencies. NB: The reported figure represents the cases treated only by CCM-trained volunteers. Total number of case treated by ALL volunteers is 19,725.
Output 2 Strengthened systems for delivery of essential MNCH services							
1	Number of doctors, nurses and midwives who participated in at least one MNCH training including delivery and emergency obstetric care in Component 1 townships	1,985 (coverage = 62% of total functioning 3,184) (achievement = 90% of 3MDG 2016 target 2200)	2,200	2,772 (Coverage = 67 % of total eligible functioning 4,134) (Achievement = 126%)	Meeting or exceeding expectation	Not applicable	State & Region Achievement Ayeyarwady - 575, Chin - 607, Magway - 371, Kayah - 286, Shan - 320, Rakhine - 613 The result is overachieved (126%) because of newly recruited staff in 2017, and participation of hospital staff (e.g. staff nurses) in some of the trainings (e.g. MDSR, CDSR) The trainings include Immunization in Practice, Community based newborn care (CBNBC), Healthy Baby Breath (HBB), HMIS multiplier, Implant training, Subcutaneous DMPA training, Basic Emergency Obstetric Care (BEMOC), Maternal Death Surveillance Review (MDSR), Child Death Surveillance Review (CDSR).
2	Average percentage of auxiliary midwives and community health workers receiving quarterly supervision and monitoring	62%	66%	74%	Meeting or exceeding expectation	Not applicable	State & Region Achievement Ayeyarwady - 61%, Chin - 84%, Magway - 74%, Kayah - 79%, Shan - 87%, (In Rakhine only 2 townships report this indicator Buthidaung 19%, Pauktaw 51%) Significant improvement in the volunteer supervision compared to 2016, particularly in Chin and Shan. Efforts of Implementing Partners and supporting BHS in conducting supervision are the key reasons for such improvement. Supervision is provided partially through volunteer visits in the field and partially through quarterly RHC meetings depending on the availability of BHS. In contrast, there is a decrease in volunteer supervision in Ayeyarwady and Magway township compared to 2016 because of budget reduction and prioritizing the phase-out of activities in the region.

N ^o	Indicators	2016 Result	2017 Target	2017 Result	2017 Results Vs Targets	Cumulative Result	Comments
3	Number and percentage of functioning AMWs and CHWs who report no stock-outs of essential medicines and supplies	32%	44%	43%	Meeting or exceeding expectation	Not applicable	<p>State & Region Achievement Ayeyarwady - 34%, Chin - 55%, Magway - 46% and Shan - 37%</p> <p>This indicator performance has significantly improved compared to 2016. This is attributable to (a) Significant increase of VRS reporting rate in 2017, at 59% compared to 48% in 2016. (b) Improved distribution of commodities to volunteers in 2017</p> <p>Notes—(1) the reported result reflects % of volunteers who had no stock-out among all functioning volunteers who were supposed to submit VRS reports. Out of those who actually submitted VRS reports, even a greater % (73%) of the volunteers had no stock-out during the reporting period; this is a notable improvement from 57% in 2016. (2) In Kayah region (using not VRS but a commodity tracking system) 47% of the functioning volunteers reported no stock-out.</p>
4	Proportion of midwifery students demonstrating competency	24%	80%	60%	Moderate achievement	Not applicable	Significant improvement from the baseline (24%) is seen. Strengthening pre-service education efforts have benefited the midwifery students. However, there are still some knowledge gaps in certain areas such as clinical decision making, antenatal care visits, management of uncomplicated endometritis and recommendation for antenatal corticosteroid.
5	Number of health facilities built and renovated per annum with 3MDG support	44	15	20	Meeting or exceeding expectation	81	Shan - 8, Chin - 3, Yangon - 3, Kayah - 3, Ayeyarwady - 2, Mandalay - 1 81 out of 82 total targeted facilities were completed. The remaining one facility in Chin state will be complete in 2018.
<p>Output 3 Prioritised HIV, TB and malaria interventions not readily covered by the Global Fund provided to targeted populations or areas</p>							
1	Number of sterile injecting equipment distributed to people who inject drugs	12,978,384	8,000,000	17,240,002	Meeting or Exceeding expectation	52,977,041	<p>During this period, harm reduction partners managed to expand their activities including needle distribution activities to unreached areas and neighbouring townships. Advocacy with community leaders has facilitated the reach to more beneficiaries. Overall, nearly 43,000 PWID were reached vs. the targeted 29,000 (as explained in Outcome 9).</p> <p>Due to the expanded reach of PWIDs, there was proportionate need of the needles and syringes for drug users. AHRN and Metta in particular were contributing higher percentage of needle distribution than targeted number. For example, AHRN had distributed around 4 millions more needle and syringes than their target, reaching 3,936 more PWID than targeted.</p>
2	Number of bacteriologically confirmed DR TB cases who began second line treatment.	654	Not reported*	Not reported*	-	2,054	*No MDR-TB treatment initiation in 2017 under 3MDG Program.
4	Number of RDTs taken and read	444,482	415,000	366,002	Moderate achievement	2,287,852	<p>Most of the malaria partners have achieved or over-achieved their testing targets in 2017. Underachievement is primarily attributable to one of the implementing partners (MAM) applying more strict testing criteria to test only on cases with fever history and to conduct active case-finding only in areas with malaria positivity rate above 20%.</p> <p>Despite increased testing in the July-December 2017 reporting period, proposed RDT was not achieved for annual testing target. However, due to the proper testing focus of the partners, targeted treated cases were achieved.</p>

Nº	Indicators	2016	2017	2017		Cumulative	Comments
		Result	Target	2017 Result	Results Vs Targets		
5	Number of people with confirmed malaria (disaggregated by sex and age) treated as per the national treatment guidelines.	8,194 Male-4,808 Female-3,386 <5 yrs-1,021 5-9 yrs-1,225 10-14 yrs-1,066 >15 yrs-4,882	7,500	10,821 Male-6,305 Female-4,516 <1 yr-15 1-4 yrs-1,561 5-9 yrs-1,925 10-14 yrs-1,355 >15 yrs-5,965	Meeting or exceeding expectation	140,239	Overall, in 2017, slide positivity rate was higher than the 2016 rate (3% vs. 1.8%). This is attributable to a high burden in Paletwa (Chin), Rakhine and Kayin area. Another factor was reduction of RDT testing in some areas. In Paletwa, there remains a high malaria case load with 29% positivity (an increase from 25% in 2016) and represented nearly half (47%) of all 3MDG cases. Increased RDT testing in Paletwa yielded an increased case load. Excluding Paletwa, the positivity is 1.7% a slight increase from 1.5% in 2016.
6	Number of LLINs distributed (i) total (ii) migrant/mobile populations in high priority areas not readily covered by the Global Fund	Not reported in 2016	2,000,000	2,013,938	Meeting or exceeding expectation	2,965,665	In 2017 3MDG procured 2 million LLINs. Along with the LLIN stock 2,000,000 LLINs were distributed to beneficiaries with support of UNOPS-PR and NMCP; as planned, they were distributed to the field sites including prison work sites in malaria endemic areas. Additionally, due to the LLIN stock availability of LLIN, 3MDG partners distributed 13,938 LLINs in villages of Kachin, Kayah, Kayin, Mon and Tanintharyi.
Output 4 Prioritised components of the health system are strengthened for greater sustainability							
1	Specific health sector policies, strategies and plans that the 3MDG is supporting are developed and delivered to the MoHS.	Final drafts completed and submitted to MoHS.	Implementation plans developed and costed	Implementation plans developed	Meeting or exceeding expectation	Not applicable	The following deliverables were accomplished with the 3MDG's support during 2017: <ul style="list-style-type: none"> Supported the development of the first year Annual Operational Plan for the National Health Plan Draft NHP M&E framework developed Human Resources for Health Policy (2017-2026) developed (WHO) Human Resources for Health Strategic Plan (2018-2021) was developed by the end of 2017(WHO) Accreditation System Roadmap for Basic Medical Education (BME) developed (Myanmar Medical Council with support from JHPIEGO) Accreditation Standards for BME developed (Myanmar Medical Council with support from JHPIEGO) Guideline on Standards and Criteria for Accreditation of Nursing and Midwifery Education Programs developed (JHPIEGO) Strategic Action Plan for Strengthening Health Information (2017-21) endorsed and published (WHO) National Health Accounts (2014-15) developed and published in November 2017 The Strategy towards Ending Preventable Maternal Mortality in Myanmar (2017-2021) was finalized and disseminated (WHO) <p>Costed plans for some of the above deliverables will be prepared in 2018.</p>
2	The national Essential Package of Health Services has been defined, costed and submitted to the MoHS with support from 3MDG.	The final package is submitted to MoHS	Implementation plans developed and costed	Implementation plans developed	Moderate achievement	Not applicable	MoHS is in the process of developing the costed EPHS package and a phased implementation approach over 15 years. The package that was submitted to MoHS in 2016 includes Public Health content only. MoHS decided in 2017 to extend the package to include clinical content to the EPHS package The specific outputs in 2017 are: <ul style="list-style-type: none"> Public Health content (except TB, Malaria and HIV related services) finalized and costing completed. Consultations conducted by Department of Medical Services to develop clinical contents for the package. Finalization and costing of the clinical content will be completed in 2018.

N ^o	Indicators	2016 Result	2017 Target	2017 Result	2017 Results Vs Targets	Cumulative Result	Comments
3	Percentage of townships with functional cold chain equipment and adequate storage space	80%	80%	88%	Meeting or Exceeding expectation	Not applicable	The result is calculated based on CEPI/MoHS annual evaluation reports, and comprehensive cold chain equipment inventory. The achievement was attained due to engagement with cold chain companies outsourced to provide support in repair and maintenance of equipment especially in areas where there is no Government employed cold chain technician.
4	Percentage of stock-out incidents at health facilities in 3 PFSCM-supported States/Regions	65% (baseline)	Decline of 2% per year	71%	Weak but potential demonstrated	Not applicable	<p>The facility entline survey conducted in 2017 reported 71% stock-out incidence which in an increase from the baseline of 65% in 2016. As a finding from the endline study and additional discussion with each state/regional departments at the end of 2017, this result is attributable to multiple factors, such as delays in budget allocation, insufficient funding, lengthy procurement processes, inadequate information for forecasting, poor planning, policy for distributing free medicines, continued push supply system and lack of storage space.</p> <p>These issues were highlighted in the end line report and were reinforced at the final evaluation dissemination workshop conducted in February 2018 in Nay Pyi Taw. It was also recommended to USAID Global Health Supply Chain Program (GHSC-PSM) which will provide transition support to MOHS to continue addressing these issues until the LMIS activities are finally handed over to the MOHS.</p>
Output 5		Enhanced health services accountability and responsiveness through capacity development of target communities, civil society organisations and the public sector					
1	Number of staff from Ministry of Health (MoH), Implementing Partners (IPs), local Non-Governmental Organisations (NGOs) and Community-Based Organisations (CBOs) (at central, regional and township level), trained in Accountability, Equity, Inclusion and Conflict Sensitivity (AEI & CS)	3,192	500	5,121	Meeting or exceeding expectation	11,104	<p>Significant overachievement of the targets can be attributed to (1) increased numbers of BHS attended the trainings in Rakhine State, (2) the AEI&CS related trainings covered more MoHS staff due to in line with NHP guiding principles and more accepted of community engagement/AEI &CS concept by MoHS in 2017 and (3) three Community Engagement TOT were provided to 123 regional and township level MoHS staff.</p> <p>C1: 3,260(M:1,145, F:2,115) C2: 1,563 (M: 681, F: 882) CV:298 (M:114, F:184)</p> <p>More than half of all training participants were from MoHS (2765)</p>
2	i) Number of feedback received by IPs from community members, and	7,673	(i) -	14,648	Meeting or exceeding expectation	Not applicable	<p>Successful performance of this indicator is attributed to (1) community feedback mechanisms of all IPs being better functioning by using more engagement approach to stimulate two way discussion</p> <p>(2) community is more aware of the existence of the mechanism and they are empowered to provide feedback by awareness raising and information sharing by IPs.</p> <p>Moreover, in some townships successful advocacy efforts of IPs are believed to have encouraged THDs to become more responsive to community feedback and more collaborative in addressing issues raised by the community.</p>
	ii) Percentage of feedback from community members addressed by the implementing partners.	66%	(ii) 55%	92%	Meeting or exceeding expectation	Not applicable	

Nº	Indicators	2016	2017	2017 Result	2017	Cumulative	Comments
		Result	Target		Results Vs Targets		
4	Number and proportion of women representatives attending the annual Comprehensive Township Health Plan (CTHP) review workshop	79%	45%	72%	Meeting or exceeding expectation	Not applicable	There were 1,586 female participants in CTHP review workshop among 2,199 total participants. 25 townships reported the data. The rest townships did not conduct CTHP meeting in 2017. Over-achievement of this indicator is attributable to the fact that the majority of the CTHP review workshop participants were midwives because they are main implementers of CTHPs.
5	Proportion of women representatives on (i) township health committee (ii) village tract health committees/ village health committees	28%	(i) 20%	29%	Meeting or exceeding expectation	Not applicable	There were 139 women among 473 participants. Data is reported from 37 townships where township and village health committees are already established.
		44%	(ii) 40%	43%	Meeting or exceeding expectation	Not applicable	Overall, 15,636 women participated in village health committees out of total 36,687. The data is reported from 35 townships in C1 and 3 Collective voice projects. Successful performance of this indicator is attributed to proportion of women representatives in VHC/VTHC being stated in VHC/VTHC guideline/TOR and actively promoted by IPs. As a result, number of women representatives increased in forming/revitalizing the committees. Moreover, women committee members were exposed to capacity building and empowerment opportunities by IPs.
Output 6 Fund Management demonstrates value for money and cost-effectiveness, generates evidence to inform policy, funding and programming decisions, and strengthens aid effectiveness							
1	Fund Manager performance: (i) Percentage of Fund Manager annual work plan milestones achieved (ii) Percentage of FMO monitoring visits conducted as planned	96%	90%	97%	Meeting or exceeding expectation	Not applicable	Out of 77 deliverables in 2017, 75 have been achieved.
		110%	90%	86%	Meeting or exceeding expectation	Not applicable	Overall, 48 out of targeted 56 missions were conducted. MNCH :24/30 (Including 4 H4A and 1 ATM); ATM : 18/20 (Including 2 H4A and 1 MNCH); H4A: 6/6. Compared to the target of 90%, the performance of this indicator is in the range 'Meets or exceeds expectations' despite some underachievement.
3	Number of operational research studies and case studies produced and disseminated	17	10	17	Meeting or exceeding expectation	71	Overall, 17 studies were completed: MNCH- 4 , HIV- 5 , TB-1 and HSS -7. In addition to operational research they include national surveys and project evaluation reports. See Annex V for detailed list of the studies.
4	Number of policy dialogue and technical and strategic forums where 3MDG Fund results are presented and discussed	50	10	57	Meeting or exceeding expectation	Not applicable	These reflects meetings across all 3MDG components, mainly at Central and State/Region level.

Notes

Indicators and targets are based on 3MDG Log Frame version 5 approved by the Fund Board in August 2016.

* Additional contribution: 2017 Jan-June Achievement figures for MNCH indicators are based on HMIS township level data. Achievement figures other than HMIS source are presented as additional contribution under 'Comments' column. These additional contribution may have some operational definition inconsistencies of indicators, therefore they are not included in coverage % calculation of concerned indicator.

** Shan = a) HPA (Health Poverty Actions) contributed MNCH activities at Shan special region 4 and Wa, b)3 ethnic health organizations (EHOs) working as consortium with RI (Relief International) contributed activities in Laihka and Mawkmai

Townships. Kayah = CHDN (Civil Health & Development Network), a local EHO working as consortium with IRC (International Rescue Committee) contributed activities in all Kayah 7 townships. *** Rakhine 9 townships started up in different month of 2016 last quarter. Their achievement results were presented as additional contribution under 'Comments' column instead of direct merging into existing 34 townships' result to avoid misinterpretation in overall coverage calculation.

III—3MDG-funded IP grants

All figures are in USD

	Implementing Partner	Description	Strategic direction	Grant period		Total amount (US\$)	New in 2017
				Start date	End Date		
Mother, Newborn and Child Health (MNCH)							
MNCH	Save The Children Fund (SC) (formerly Merlin)	Supporting implementing Maternal Newborn and Child Health services (MNCH) in the Ayeyarwady Region	Strengthening service delivery both public and private	01-01-2013	31-12-2018	6,701,207	
MNCH	Médecins du Monde (MdM)	Supporting implementing Maternal Newborn and Child Health services (MNCH) in the Ayeyarwady Region	Strengthening service delivery both public and private	01-01-2013	30-06-2017	4,048,693	
MNCH	Save the Children Fund (SC)	Supporting implementing Maternal Newborn and Child Health services (MNCH) in the Ayeyarwady Region	Strengthening service delivery both public and private	01-01-2013	31-03-2018	4,387,603	
MNCH	Relief International (RI)	Supporting implementing Maternal Newborn and Child Health services (MNCH) in the Ayeyarwady Region	Strengthening service delivery both public and private	01-01-2013	31-03-2018	6,514,739	
MNCH	Save The Children (SC) (formerly Merlin)	Supporting implementing Maternal Newborn and Child Health services (MNCH) in Chin State	Strengthening service delivery both public and private	01-09-2013	31-12-2018	10,651,251	
MNCH	Danish Red Cross (DRC)	Supporting implementing Maternal Newborn and Child Health services (MNCH) in Chin State	Strengthening service delivery both public and private	01-09-2013	31-12-2018	4,536,647	
MNCH	Save the Children Fund (SC)	Supporting implementing Maternal Newborn and Child Health services (MNCH) in the Magway Region	Strengthening service delivery both public and private	01-02-2014	31-03-2018	3,746,155	
MNCH	Marie Stopes International (MSI)	Supporting implementing Maternal Newborn and Child Health services (MNCH) in the Magway Region	Strengthening service delivery both public and private	01-02-2014	31-12-2018	4,604,873	
MNCH	International Organization for Migration (IOM)	Supporting implementing Maternal Newborn and Child Health services (MNCH) in the Ayeyarwady Region	Strengthening service delivery both public and private	01-01-2013	31-12-2018	8,348,188	
MNCH	Marie Stopes International (MSI)	MSI private sector MNCH project	Strengthening service delivery both public and private	01-01-2014	31-12-2018	4,462,762	
MNCH	Population Services International (PSI)	PSI private sector MNCH project	Strengthening service delivery both public and private	01-01-2014	31-12-2018	5,897,554	
MNCH	International Rescue Committee (IRC)	Supporting implementing Maternal Newborn and Child Health services (MNCH) in Chin State	Strengthening service delivery both public and private	01-02-2014	31-12-2018	4,638,691	
MNCH	Population Services International (PSI)	PSI Contraceptive Procurement Project	Strengthening service delivery both public and private	18-03-2014	31-12-2018	1,620,100	
MNCH	International Rescue Committee (IRC)	Supporting implementing Maternal Newborn and Child Health services (MNCH) in Kayah State	Scale up services in conflict affected areas	01-07-2014	31-12-2018	6,645,699	
MNCH	Relief International (RI)	Supporting implementing Maternal Newborn and Child Health services (MNCH) in Southern Shan State	Scale up services in conflict affected areas	01-12-2014	31-12-2018	4,508,701	
MNCH	Cooperazione e Sviluppo <i>Cooperation and Development</i> (CESVI)	Supporting implementing Maternal Newborn and Child Health services (MNCH) in Northern Shan State	Scale up services in conflict affected areas	01-01-2015	31-12-2018	2,576,947	
MNCH	Save the Children Fund (SC)	Supporting implementing Maternal Newborn and Child Health services (MNCH) in Northern Shan State	Scale up services in conflict affected areas	01-01-2015	31-12-2018	2,435,160	

	Implementing Partner	Description	Strategic direction	Grant period		Total amount (US\$)	New in 2017
				Start date	End Date		
MNCH	Health Poverty Action (HPA)	Improve women and children's health and fight TB and HIV to contribute to peace and development in Wa of Northern Shan and Special Region 4 of Eastern Shan, Myanmar	Support to Health Care in Special Regions	02-04-2015	31-12-2018	6,899,622	
MNCH	International Organization for Migration (IOM)	International Organization for Migration (IOM) MNCH Project in Rakhine State	Scale up services in conflict affected areas	15-10-2016	31-12-2018	644,345	
MNCH	International Rescue Committee (IRC)	International Rescue Commission MNCH Project in Rakhine State	Scale up services in conflict affected areas	01-11-2016	31-12-2018	666,973	
MNCH	Relief International (RI)	Relief International MNCH Project in Rakhine State	Scale up services in conflict affected areas	15-10-2016	31-12-2018	629,122	
MNCH	Myanmar Health Assistant Association (MHAA)	Myanmar Health Assistant Association MNCH Project in Rakhine State	Scale up services in conflict affected areas	15-10-2016	31-12-2017	534,084	
Subtotal for MNCH						95,699,116	
HIV, Tuberculosis and Malaria							
HIV	Joint United Nations Programme on HIV and AIDS (UNAIDS)	Creating an enabling environment: Addressing policy, legal and social barriers in order to expand and improve HIV prevention for people who inject drugs, people engaged in sex work and men who have sex with men and transgender people in Myanmar.	Support to the National Strategic Plan on HIV/AIDS (Harm Reduction)	05-07-2013	31-12-2018	2,621,400	
Malaria	Community Partners International (CPI)	Containment of Artemisinin Resistance in Eastern Myanmar	Support to the National Strategic Plan on HIV/AIDS (Harm Reduction)	16-09-2013	31-12-2018	4,458,360	
Malaria	Myanmar Health Assistant Association (MHAA)	Community-based malaria prevention, control and MARC project	Support to the National Malaria Strategy	01-04-2014	31-12-2018	2,243,631	
Malaria	Population Services International (PSI)	Community-based malaria prevention, control and MARC project	Support to the National Malaria Strategy	01-04-2014	31-12-2017	2,247,171	
TB	Myanmar Health Assistant Association (MHAA)	MHAA TB ACF project	Support to the National TB Strategy (MDRTB and ACF)	01-04-2014	31-12-2018	2,343,496	
TB	Myanmar Medical Association (MMA)	MMA ACF TB project	Support to the National TB Strategy (MDRTB and ACF)	01-04-2014	31-12-2017	1,842,431	
TB	Medical Action Myanmar (MAM)	TB ACF in Hard to Reach areas	Support to the National TB Strategy (MDRTB and ACF)	01-04-2014	31-12-2017	1,661,750	
TB	Population Services International	Accelerated TB active case finding among urban slum dwellers and clients of MNCH services	Support to the National TB Strategy (MDRTB and ACF)	01-04-14	31-12-2018	3,479,329	
HIV, Malaria, TB	Asian Harm Reduction Network (AHRN)	Harm Reduction and HIV/TB Health Promotion Services for PWID/PWUD and their partners and household members	Integrated HIV/AIDS, TB, Malaria	01-04-2014	31-12-2018	9,992,227	
HIV	Burnet Institute Myanmar	Enhancing education and health services to reduce harms related to drug use	Support to National Strategic Plan on HIV/AIDS (Harm Reduction)	01-04-2014	31-12-2017	1,175,339	
HIV	Myanmar Anti-Narcotics Association (MANA)	Comprehensive HIV prevention and care among drug users with effective harm reduction intervention	Support to the National Strategic Plan on HIV/AIDS (Harm Reduction)	01-04-2014	31-12-2018	7,158,785	

	Implementing Partner	Description	Strategic direction	Grant period		Total amount (US\$)	New in 2017
				Start date	End Date		
HIV	Substance Abuse Research Association (SARA)	Consolidating the momentum to develop the capacities of communities to deliver HIV and drug abuse prevention and support activities in high-risk townships of Kachin Region	Support to the National Strategic Plan on HIV/AIDS (Harm Reduction)	01-04-2014	31-12-2018	2,276,891	
TB	National TB Programme	Implementation of a Grant in Myanmar provided by the 3MDG Fund	Support to the National TB Strategy (MDRTB and ACF)	01-04-2014	31-12-2018	4,427,245	
Malaria	Medical Action Myanmar (MAM)	Malaria MARC project	Support to the National Malaria Strategy	01-04-2014	31-12-2018	5,675,072	
TB	International Union against Tuberculosis and Lung Diseases	Program to Increase Catchment of Tuberculosis Suspects (PICTS) 2	Support to the National TB Strategy (MDRTB and ACF)	01-5-2014	31-12-2017	1,057,247	
TB	World Health Organization (WHO)	Technical support for TB Care and prevention activities	Support to the National TB Strategy (MDRTB and ACF)	15-09-2014	30-06-2018	586,962	
TB	National TB Programme	Implementation of a Grant in Myanmar provided by the 3MDG Fund	Support to the National TB Strategy (MDRTB and ACF)	01-10-2014	31-03-2018	13,045,870	
HIV	Population Services International (PSI)	Pilot Distribution of Needles and Syringes, Kachin State, Mandalay Region and Sagaing Region	Support to the National Strategic Plan on HIV/AIDS (Harm Reduction)	01-01-2015	31-12-2017	839,099	
TB	Pyi Gyi Khin	Patient-centred Community-based MDR TB care model	Support to the National TB Strategy (MDRTB and ACF)	05-02-2015	31-12-2017	1,183,138	
TB	Myanmar Health Assistant Association (MHAA)	Patient-centred Community-based MDR TB Care Model	Support to the National TB Strategy (MDRTB and ACF)	05-02-2015	31-12-2018	993,156	
TB	Myanmar Medical Association (MMA)	MMA-MDR-TB Project (Patient-centred Community- based MDR-TB Care and treatment support Model)	Support to the National TB Strategy (MDRTB and ACF)	05-02-2015	31-12-2018	1,281,607	
TB	International Union against Tuberculosis and Lung Diseases	Community Based Care for Multi-Drug Resistant Tuberculosis Cases [CBCMDR-TBC] in Mandalay Region	Support to the National TB Strategy (MDRTB and ACF)	01-04-2015	31-12-2017	1,082,890	
TB	Clinton Health Access Initiative (CHAI)	Strengthening MDR-TB patient data management system of National TB Program	Support to the National TB Strategy (MDRTB and ACF)	15-07-2015	31-12-2017	668,042	
HIV	Metta Foundation	Reduction of HIV prevalence among People Who Inject Drugs(PWID) through Community-led Harm Reduction in Kachin State	Support to the National Strategic Plan on HIV/AIDS (Harm Reduction)	01-04-2016	31-12-2018	651,999	
HIV	Médecins du Monde	Reduction of HIV prevalence among People Who Inject Drugs(PWID) through Community-led Harm Reduction in Kachin State	Support to the National Strategic Plan on HIV/AIDS (Harm Reduction)	01-05-2016	31-12-2018	295,386	
HIV	United Nations Office on Drugs and Crime (UNDOC)	Programme on Improving Prison Health	Support to the National Strategic Plan on HIV/AIDS (Harm Reduction)	01-09-2016	31-12-2018	569,860	
Malaria	Malaria Consortium in Myanmar	Strengthening an integrated iCCM Pilot implementation in three hard-to-reach townships of Sagaing Region	Support to the National Malaria Strategy	01-09-2016	31-01-2017	260,000	
Malaria	Population Services International (PSI)	Mapping of Private Medical Doctors to inform Future Malaria Control and Elimination Efforts	Support to the National Malaria Strategy	01-09-2013	31-08-2015	200,000	
Subtotal for HIV, TB and malaria						74,318,383	

	Implementing Partner	Description	Strategic direction	Grant period		Total amount (US\$)	New in 2017
				Start date	End Date		
Health systems strengthening							
HSS	World Bank	Reimbursable Advisory Services Agreement	Governance and Stewardship	29-05-2013	29-11-2017	2,818,000	
MNCH	JHPIEGO Corporation	Improved Midwifery for Maternal, Newborn and Child Health Services	Human Resources for Health	01-07-2014	31-12-2018	6,500,000	
HSS	PACT	Improved Midwifery for Maternal, Newborn and Child Health Services	Community Engagement	24-10-2014	31-12-2017	1,950,000	
HSS	Joint United Nations Programme on HIV and AIDS (UNAIDS)	UN joint assistance to strengthen health systems in Myanmar	Governance and Stewardship	07-11-2014	31-12-2017	1,074,001	
HSS	Charity Oriented-Myanmar (COM)	Supporting the Accountability, Equity and Inclusion (AEI) in the access to health services in Ayeyarwady and Magway Regions	Community Engagement	02-03-2015	31-12-2018	301,219	
HSS	Ar Yone Oo Social Development Association (AYO)	Supporting the Accountability, Equity and Inclusion (AEI) in the access to health services in Southern Chin State	Community Engagement	02-03-2015	31-12-2018	250,000	
HSS	Bright Future (La Yee Anar Gut) (BF)	Supporting the Accountability, Equity and Inclusion (AEI) in the access to health services in Southern Chin State	Community Engagement	02-03-2015	31-12-2018	250,000	
HSS	Community Agency for Rural Development (CAD)	Supporting the Accountability, Equity and Inclusion (AEI) in the access to health services in Northern Chin State	Community Engagement	02-03-2015	31-12-2018	250,000	
HSS	Community Driven Development & Capacity Building Enhancement Team (CDDCET)	Supporting the Accountability, Equity and Inclusion (AEI) in the access to health services in Northern Chin State	Community Engagement	02-03-2015	31-12-2018	250,000	
HSS	Partnership for Supply Chain Management (PFSCM)	Regional Supply Chain Strengthening (RCSC) Myanmar	Systems Support	23-03-2015	31-03-2018	3,600,000	
HSS	United Nations International Children's Fund (UNICEF)	UN Assistance to Health System Strengthening (HSS) in Myanmar; Activities in support of the 3MDG Fund	Systems Support	01-01-2015	31-12-2017	12,389,413	
HSS	World Health Organization (WHO)	UN Assistance to Health System Strengthening (HSS) in Myanmar; Activities in support of the 3MDG Fund	Support to Evidence Based Policy	01-01-2015	31-12-2017	2,674,447	
HSS	United Nations International Children's Fund (UNICEF)	Health System Strengthening Support to the Rakhine State Health Department	Systems Support	01-10-2016	31-12-2018	1,093,444	
HSS	JHPIEGO	Support to Strengthen Management of Human Resources for Health	Support to the Ministry of Health Human Resource for Health Strategy	13-12-2016	31-12-2018	2,000,000	
HSS	The National Health Plan Implementation and Monitoring Unit	Implementation of a Grant in Myanmar provided by the 3MDG Fund	Systems Support	01-04-2017	31-12-2018*	1,000,000	*
Subtotal for HSS						36,400,524	

Total 206,418,023

Notes

*The above list includes the total value (as of December 2017) of grants which were active in 2017 including those that closed during 2017.

**Implementation rate indicates FMO disbursement / reported IP expenditure against total grant value
The figures include overhead charged by Implementing Partners, but excludes overhead charged by the FMO (on pass through and procurement)

IV—Overview of lessons learned

Challenges	Actions taken and their impact	Lessons learned
Differing treatment guidelines, data management practices and limited integration into existing systems in border areas can create challenges in health service delivery and monitoring.	<p>Effort to standardize treatment guidelines with trainings.</p> <p>Technical support to data collection and reporting systems.</p> <p>Increased collaboration between government health providers and ethnic health organizations.</p>	<p>Systematic and custom-made solutions are necessary to reduce this treatment and data reporting gap. 3MDG, implementing partners and ethnic health organizations must remain flexible. Integration into existing systems is challenging, but necessary to achieve universal health coverage.</p>
High staff turnover amongst implementing partners, accompanied by challenges to retention of institutional knowledge.	<p>Prioritizing hiring local people, as they are more likely to stay and can communicate more easily with the people they serve.</p> <p>More attractive salary and benefit packages in some cases.</p> <p>Contextualized approaches to accountability, equity and inclusion (AEI) improved impact and retention of knowledge despite turnover.</p>	<p>Employing people from the local area has a positive impact on retention, as well as the ability to offer context sensitive and language-specific services.</p> <p>Where accountability, equity and inclusion have been more successfully mainstreamed, officers have both had the full support and strategic guideline of their senior management team as well as the capacity to adapt AEI requirements to their own needs.</p>
High dropout of volunteer health workers.	<p>More careful selection of candidates.</p> <p>More capacity development and skills building of volunteers, more feedback provided to them.</p> <p>Increased involvement of volunteers in planning activities.</p> <p>Increased standardization of the volunteer based health workforce at central level.</p>	<p>Capacity development and onward opportunities are critical for volunteer health workers. Further work is needed to encourage their mentorship and recognition to ensure retention or graduation through the health sector. Involving volunteers more closely leads to positive benefits for both them and the community.</p>
Issues with data quality and management, quality of reporting, analysis of data. This includes inconsistent categorization of referral cases and data back-up procedures not being followed in Rakhine State, and challenges to filling in the Volunteer Recording System (VRS) forms. There have also been low levels of understanding of health management information system (HMIS) procedures.	<p>Recommendations provided to implementing partners after Routine Data Quality Assessment for improvement.</p> <p>Detailed review of referral documentation in Rakhine State to uncover the problems, and subsequent assignment of technical staff and the Senior M&E officer to oversee referral in the future.</p> <p>Implementing partners have been advised to prioritize field supervision to weakest volunteers, and more corrections have been made during supervision. A checklist for filling in the VRS form may be required.</p> <p>More trainings offered in HMIS, with a focus on the practical skills needed</p>	<p>Challenges in data collection remain in different locations. Identifying issues early on in project delivery and following up with immediate and practical actions to rectify is critical in ensuring data quality and high levels of service provision.</p>
There were challenges with pre-positioning stocks as part of the 3MDG procurement modality, including unstable consumption rates and difficulties in forecasting and estimating requirements. This led to stock-outs in some cases.	<p>3MDG Procurement Unit introduced a new procurement and distribution modality for 2018, where procurement budgets are managed by the Procurement Unit rather than implementing partners. It reduces workload and cost and to date is working well.</p>	<p>Despite positive aspects, the procurement pre-positioning modality was not as successful as first assumed for 3MDG. Responding to this learning by taking advantage of the extension year to test a new approach is a positive development for the Successor Fund.</p>
The supply chain—a vital piece of the health system—does not operate efficiently or effectively in Myanmar because it is fragmented and staff do not have the knowledge and capacity that they need. This can lead to a lack of availability of drugs and supplies.	<p>Recognition of the need for a standardized system, and actions taken following advocacy from the Regional Supply Chain System (RSCS) Project:</p> <p>Design of a health facility stock report form completed.</p> <p>Use of mSupply software in some locations.</p> <p>Logistics management system in 3,715 facilities by end of 2017, a 99 percent increase.</p>	<p>A harmonized supply chain system is more effective in ensuring that supplies are available when and where they are needed. It is critical to continue to find solutions to the remaining high number of systems in use.</p>
Strategic purchasing pilot has seen a low uptake of services, and only about half the eligible beneficiaries have gone to the clinic for screening and registration.	<p>Contracts with unsatisfactory providers have been terminated, and beneficiaries transferred to better and fairer providers.</p> <p>Community mobilization events, pamphlets, PSI re-visited households.</p> <p>Mobile team created to visit community members during the evening when they could not attend during regular hours.</p> <p>Positive end result, with targeted number of beneficiaries reached.</p>	<p>To introduce change and new practices, significant effort is needed. Messages need to be repeated in different ways, and potentially negative outcomes and perceptions managed. Responding to community feedback with visible actions is important.</p>

Challenges	Actions taken and their impact	Lessons learned
Reaching people in hard-to-reach and difficult locations remains challenging, especially when there is an increase in conflict.	<p>3MDG implementing partners have strengthened relationships with civil society organizations in some areas, so that they can continue to provide some services and medical supplies when access is limited.</p> <p>In Kayin and Kayah states, more local staff have been hired so that they can communicate in local languages. Remote follow-up has continued when access has been restricted.</p> <p>In Kayin State, buffer stocks were provided in advance for areas not reachable in the rainy season, and exchanges of stocks were done at accessible places.</p> <p>In Rakhine State, the state-wide and township models have been able to continue though at lower levels in some cases. It has been critical to build strong relationships and ensure people who are experienced in conflict-sensitive approaches are at the ground level.</p> <p>In Kachin State, where conflict has intensified, 3MDG partners have conducted a situation analysis, provided contingency stocks, recruited health volunteers in IDP camps, and worked with local partners.</p> <p>In Paletwa in Chin State, when hundreds of people were displaced to a neighbouring township, health services were offered via that township instead, and through mobile clinics.</p> <p>Technical support is available via CDA, an organization well-versed in delivery in fragile and conflict-affected environments.</p> <p>To reach people who use drugs, implementing partners have emphasized integrated and comprehensive approaches, outreach and drop-in centres and have worked with communities to reduce resistance to services</p>	<p>Working with local organizations through a coordinated network enables the delivery of health care and the maintenance of minimal services in remote conflict areas.</p> <p>Responsiveness and flexibility to align with rapidly changing contexts must be sought in conflict-affected areas, while adhering to the principles of conflict-sensitivity and 'do-no-harm' outlined in 3MDG's conflict sensitivity strategy. Technical support from CDA will improve the ability of implementing partners to develop solutions on the ground.</p>
High levels of maternal and under five deaths in Ayeyarwady Region.	<p>Training provided to basic health staff in death surveillance and basic emergency obstetric skills.</p> <p>Implementing partner also support with child death investigations, and when found to be low birth weight, coverage of antenatal care and micronutrients was improved, as well as early referral. Health information was also shared about danger signs. The result was a reduction in deaths.</p>	<p>Maternal and under five deaths can be reduced with targeted training, information sharing of danger signs with the community, and constant surveillance and monitoring. Efforts must continue and be handed over to ensure sustainability post-3MDG support.</p>
Limited access to community feedback mechanisms for people who are poor, illiterate or speak a different language.	<p>Partners encouraged to emphasize alternative and context-specific methods of giving feedback. More meetings were held for giving feedback in person.</p> <p>Awareness-raising sessions were held to introduce the feedback mechanism.</p>	<p>When it comes to giving feedback, the community must feel confident in how the feedback is collected and feel that they can contribute. Context specific methods are required.</p>
Management of village health funds may be challenging for people who may have no financial background.	<p>Supportive supervision and capacity development of financial management skills were offered in 2017, which have been shared with the health committees who manage village health funds. This will be increasingly important as village health funds step in with the government to fill the gap in financing the emergency referral model.</p>	<p>With the right support, village health committees can help communities cover emergency medical costs under a sustainable model.</p>
Limited integration of accountability, equity and inclusion (AEI) in some locations.	<p>Advocacy at central level has seen the inclusion of these principles in the National Health Plan 2017 – 2021.</p> <p>Continued training and capacity development.</p> <p>Reworking of 3MDG guidance material to have more definitive actions for implement community feedback mechanisms and gender and social inclusion.</p>	<p>Persistent advocacy for these principles has had a positive impact, but this commitment must continue to ensure these issues stay on the agenda for the Myanmar health system.</p>
High and inappropriate use of medications, especially antibiotics in Chin State.	<p>Review of data to see where the problem is, and why it might be happening.</p> <p>Recommendation made to prioritize field supervision to volunteers who have over-prescribed, and to distribute antibiotics due to epidemiological trend not consumption.</p> <p>Results shared at state-level to advocate for better supervision of volunteers.</p> <p>Refresher trainings to be conducted for basic health staff.</p>	<p>It is important that basic health staff and volunteer health workers understand the potential impacts of over prescription of antibiotics, and have the training and knowledge they need to accurately prescribe medication. They may need support against community pressure from higher level health staff.</p>
Gender inequities in case detection in tuberculosis, due in part to different testing methods being used.	<p>Addition of TB testing at maternal, newborn and child health clinics resulted in a significant upswing in the numbers of women being tested.</p>	<p>Constant review of sex-disaggregated indicators and timely and effective response is critical to ensure that services reach all people.</p>

V—Research completed in 2017

Overall, 17 studies were completed in 2017. There were seven in health systems strengthening, five in HIV, four in the area of maternal, newborn and child health, one in tuberculosis.

Health systems strengthening

- | Situational Analysis of Existing Policies and Quality Assurance Frameworks for the Human Resources for Health in Myanmar (Jhpiego (HRH grant))
- | Global Human Resources for Health Policy Review (lessons learned from Brazil, Ethiopia, Mozambique, Sri Lanka and Thailand) (Jhpiego (HRH grant))
- | mSupply Pilot Evaluation for LMIS Aggregation tool implementation in 15 townships (March 2017) (PFSCM)
- | Demographic and Health Survey - Report, Executive Report, and informatics (ICF Macro)
- | RSCS mSupply Evaluation for LMIS Data Aggregation Tool Phase (2) Implementation in 64 townships of Bago, Magway and Ayeyarwady Regions, Myanmar (PFSCM)
- | RSCS Project Evaluation Report- Endline study on health commodity supply at basic health facilities in Ayeyarwady, Bago, and Magway Regions, Myanmar (PFSCM)
- | Qualitative Study of Out-of-Pocket Expenditures (OOPE) on Health: Further expanding knowledge and evidence base of health financing in Myanmar (Save the Children)

Maternal, newborn and child health

- | Myanmar Strategic Purchasing Brief Series No.1 - Package of Services (PSI)
- | Myanmar Strategic Purchasing Brief Series No.2 - Calculating a Capitation Payment (PSI)
- | Myanmar Strategic Purchasing Brief Series No. 3 (Targeting Poor Households) (PSI)
- | “Quality improvement for maternal and Newborns Health Care Services: Clients and Provider Perspectives” survey (RI)

HIV

- | Six revised policy briefs;(1) Expanding access to HIV services for men who have sex with men through mobile phone and web-based platforms in Myanmar,(2) Increasing uptake of HIV testing and counselling among men who have sex with men and transgender persons in Myanmar,(3) Best police practices in support of HIV prevention, care and treatment among people who inject drugs in Myanmar,(4) Expanding the role of law enforcement in the HIV response among people who inject drugs in Myanmar,(5) Expanding the role of law enforcement in the HIV response among sex workers in Myanmar,(6) Innovative and impactful strategies to accelerate the HIV response among sex workers in Myanmar (UNAIDS)
- | “Experiences of Spouses or Intimate Partners of People Who Inject Drugs” (preliminary) and “Qualitative Study on Predicaments of Spouses of PWID” (full report) (SARA)
- | Year 2016 Annual Assessment (MANA)
- | Project end evaluation report (PSI)
- | Policy brief on HIV law (The proposed HIV law: protecting the right to education of children affected by HIV) (UNAIDS)

Tuberculosis

- | Assessment of Community-Based MDR-TB care in Yangon Region: An Operational Research (MMA)



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