Myanmar’s transition to democracy, a complex peace process, and a new drive towards openness are emblematic of a country that has a long way to go, but has made great strides and has great hopes for the future. Opportunities for socioeconomic development under the civilian government have expanded, but the effects of the ongoing conflict persist. They affect not only the border areas where the conflicts take place — or the people who live there — but the entire country, sculpting the political trajectory and stunning human and economic development. The effects of the conflict are apparent on Myanmar’s health system too: relatively low levels of financing, poor coordination between government and non-government health providers, and on-the-ground difficulties in delivering and accessing services, because of security, geography, or language barriers.

3MDG operated through many of these challenges and changes, with the Fund starting in earnest in 2013 and transitioning to the Access to Health Fund at the beginning of 2019. Crucial to the successes you will see documented in these pages has been an approach with flexibility, responsiveness, and agility in the face of a rapidly changing context, but never straying from the core objective to bring better health care to people in need.

To make this possible, Conflict Sensitivity Program Management (CSPM) has been both a principle, an approach, and a defining feature of the Fund’s DNA. At the core of the approach is the commitment to ‘do no harm’, ensuring that the Fund’s interventions do not exacerbate social tensions by providing one-sided support. This was strengthened in 2017 with the provision of practical technical support and financing for service provision to partners working in conflict situations, including ethnic health organizations. The Fund emphasized working with all partners in a spirit of transparency, considering health as a bridge to peace with the potential to build social cohesion, bringing together key actors from all sides to coordinate, plan, and implement health services.

Lessons learned from this work will be of great importance as the Fund transitions into the more targeted Access to Health Fund, which will be operating almost exclusively in conflict-affected areas. In Kachin, for example, active conflict interrupted the delivery of services in 2018. By providing food and non-food relief items, we could help meet needs, and interrupted the delivery of services in 2018. By providing food affected areas. In Kachin, for example, active conflict Fund, which will be operating almost exclusively in conflict-affected areas, as they often have the most access, and have already established relationships and trust with their communities. The Access to Health Fund will increase support to these organizations.

The work is not yet done, with access and equity in some places, especially Rakhine State, still severely restricted and the right to health not being realized by all people. Stubborn, foundational challenges in the health sector persist: in the supply chain, human resources and budget execution. However, the increase of the health budget signals a growing commitment from the Government of Myanmar to take responsibility for the health of its people; there are more and more signs of flexibility and openness from the Ministry of Health and Sports; and the important role of ethnic health organizations to deliver care in non-government controlled areas has been recognized. We must build upon these opportunities and strengthen collaboration between all actors.

This report has five main sections, providing specific detail on 3MDG’s work in 2018 as well as the entire lifetime of the Fund. The first section, ‘Evolution of our Approach’ details how 3MDG evolved over the years – from its design in 2010, set-up in 2012, first year of programming in 2013, extension in 2017, and end in 2018. The ‘Yearly Snapshot’ gives an overview of the Fund’s activities, achievements and key results from 2013 to 2017. What follows is a more detailed annual reporting from 2018, with a sub-section dedicated to each state and region where 3MDG partners worked in 2018, and a sub-section for nationwide programmes and thematic areas. The ‘Results over the Fund’ section considers 3MDG results by geography and by thematic area over the entire lifetime of the Fund, including challenges and achievements. The final chapter documents ten key lessons that we have learned through the implementation of this programme.

None of the achievements and lessons in this report would have been possible without the tireless work of many individuals and organizations: the Ministry of Health and Sports, fellow donors, implementing partners, including ethnic and community-based health organizations, national and international non-government organizations, and civil society organizations; other health and development actors, with whom we have coordinated, and all the people working at community level in grassroots health structures, such as village health committees. Last but not least, I’d like to thank the Fund Management Office team for their commitment and engagement in making 3MDG a success story for all stakeholders involved.

The Ministry of Health and Sports is ready to meet the health needs of much of the population — but stubborn challenges remain in the health system. It is here that Access to Health Fund will target its efforts: reaching for those left behind, and aiming for the furthest behind first. This means working in support of ethnic health organizations in non-government controlled areas, it means seeking out the most vulnerable groups, such as people with disabilities, prisoners and people who use drugs, and making sure they can access the care they need, and it means finding ways to continue delivering care even when conflict threatens to disrupt the health system. It means understanding that health can bring people together, and good health is central to social cohesion and peace.

As the country moves towards universal health coverage, the Access to Health Fund is committed to working with the Ministry of Health and Sports, Ethnic Health Organizations and other partners to meet the needs of the entire population, and ensure no one is left behind. Together, we can meet this challenge.
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The Executive Summary provides an introduction, followed by a summary of the five sections of the report: Evolution of our Approach, Yearly Snapshot, 2018 Results, Results over the Fund, and Lessons Learned.
INTRODUCTION

Good Progress amid Real Challenges
Throughout the lifetime of the 3MDG Fund, Myanmar has undergone change, reform, and transition. When the 3MDG Fund was designed in 2010, Myanmar was politically isolated and investment in the health sector was among the lowest in the world. Access to health care was limited, especially for those living in conflict-affected areas. Decades of armed conflict and neglect had negatively impacted the health system and the mental and physical health of communities. High out-of-pocket payments created financial barriers to access, which, coupled with poor quality roads and transport to impede access to services. The health system itself was poor quality, with infrastructure gaps, an unreliable supply chain and limited human resources for health. Trust in the system and health-seeking behaviour were low, especially in non-government controlled areas.

The right to health is proclaimed in Myanmar’s Constitution, as well as multiple international instruments to which the country is a signatory. The country has committed to achieving universal health coverage by 2030. Investing in health helps enable people to fulfill their potential, reduces the burden of preventable disease, and increases life expectancy. Global evidence shows that investments in health stimulate productivity and economic growth. However, significant inequalities remain in Myanmar’s health system. Advancements in health indicators have not necessarily reached all groups in all places. 3MDG was designed to address these challenges with a focus on maternal, newborn and child health, HIV, tuberculosis and malaria, and health systems strengthening. The Fund was set up in mid-2012 and began implementation in January 2013. It was originally scheduled to end in 2017 but was extended until the end of 2018.

As one of the largest contributors of external assistance for health in the country, 3MDG delivered around USD 308 million (preliminary figure) in the period 2012-2018. By bringing key donors together in a single fund, 3MDG increased aid effectiveness, achieved scale, pooled risks and provided coordinated support to government priorities. Four bilateral donors, Sweden, Switzerland, the United Kingdom and the United States, are also maintaining funding to the Access to Health Fund to continue pooling resources for the Myanmar health sector, sustain the gains and support Myanmar’s path to universal health coverage.

Working with All Actors
At the start of the 3MDG Fund, it was difficult to work closely with the government, but this began to change as the country opened up. In 2014, a strategic review reflected this development by recommending a closer relationship between 3MDG and the Ministry of Health and Sports. Shortly after, the Ministry was permanently added to the 3MDG Fund Board, encouraging greater alignment to Ministry priorities, national ownership and collaboration. This was reflected throughout 3MDG programming, from working together with the Ministry to select maternal, newborn and child health townships, reinforcing sector strategies in HIV, TB and malaria, and efforts to strengthen the entire system.

However, in Myanmar, there are many parts of the country beyond the reach of the government, where government health staff are not able to provide care. Ethnic and community-based health organizations are often the sole health service provider, and their ability to deliver quality care is crucial to meeting the health needs of communities living there. However, they often have limited resources and face significant challenges related to security, geography and funding. 3MDG has been working with ethic and community-based health organizations since 2015, filling critical gaps in conflict-affected and non-government controlled areas. With this approach, supporting both the Ministry and non-government service providers, 3MDG had the opportunity to have a transformational impact on the provision of health care across the entire country, and support Myanmar’s path to universal health coverage.

Solid Results In Changing Times
This report covers the entire lifetime of the Fund, from the start of implementation in 2013 to closure in 2018. The report has a particular focus on activities and results from 2018, the extension-year of the Fund, where the Fund performed well despite contextual challenges. In some areas, such as Kachin, the resumption of restricted access for health staff and threatened their security. Access to services in Rakhine continued to deteriorate and gaining approval to enter certain areas was difficult and unpredictable. In the southeast, floods in the latter half of the year affected many townships and hampered the delivery of health services. In spite of this, most of 3MDG’s indicators met or exceeded targets or objectives, due in large part to the flexibility and resourcefulness of partners’ responses to difficult situations. The 3MDG risk management framework allowed the Fund and partners to identify early risks and challenges, and implement mitigation strategies to overcome them.

At the end of 2017, maternal, newborn and child health projects in Ayeyarwady and Magway ended and activities were transitioned to the Ministry of Health and Sports, except for the emergency referral intervention, which continued with 3MDG funding. To facilitate the transition of emergency referrals in 2018, the programme was altered to lower costs by reducing the eligible costs for reimbursement and minimizing the number of staff needed. Project closure in these nine townships affected the overall numbers and percentages of 3MDG results, as the nine townships in Ayeyarwady and Magway townships were both high performing and high population. However, the extension year was a chance for the Fund to move towards the Access to Health Fund design, which is almost exclusively targeted on vulnerable people living in conflict-affected and non-government controlled areas. These nine townships, with their strong results and stable context, no longer required the same level of external support and were de-prioritized in favour of more needy places.

That meant that in 2018, 3MDG covered 33 townships with maternal, newborn and child health services, and nine more with only referral services. In supported areas, generally speaking, women have better quality care and easier access to the services they need for safe and healthy pregnancy, childbirth and infancy. Skilled health personnel, such as doctors, midwives and nurses, helped deliver nearly 44,000 babies during the year, more than the country with 3MDG support. About 20,000 women got to hospitals in critical situations, even from remote and conflict-affected areas with cross-border referrals and clearance of travel restrictions.

Declining malaria prevalence and deaths represent one of the Myanmar health system’s great successes. The result of collaborative work from many partners is that much of the country is now heading towards malaria elimination. In 2018, 3MDG partners did 533,000 rapid diagnostic tests for malaria and met malaria treatment targets. However, in some townships, and amongst some populations such as migrants, malaria rates remain a problem that requires continued emphasis especially at the community level.

3MDG Harm Reduction programme partners worked tirelessly to reach vulnerable people who use drugs and reduce community resistance to their services. In 2018, 3MDG partners reached 40,422 people who inject drugs through drop-in centres and outreach, which is 4% of the national estimated number of people who inject drugs. 18.6 million sterile needles and syringes were distributed to facilitate safe injecting in 2018, 73% of the national target.

In 2018, seven mobile teams, facilitated by the National TB Programme worked in all states and regions; two mobile teams facilitated by Asian Harm Reduction Network worked in ethnic health organization areas of Northern Shan and Kachin. Together with community health volunteers, they examined 205,000 cases of TB that were referred for further testing and treatment. To fortify Myanmar’s efforts to reach universal health coverage by 2030, 3MDG invested to help finalize the National Health Plan second year Annual Operational Plan (2018-2019) and Monitoring and Evaluation framework (2017-2021). Important inputs for the Community-based Health Worker national policy development are also in the process of finalization. The Fund also worked closely with ethnic health organizations in service delivery and organization of social services for ethnic people.

To reach highly vulnerable people in prisons and labour camps, 3MDG began construction and renovation of health facilities in four prisons in 2017, three were completed and handed over in 2018. The final centre will be completed in 2019. The Standard Operating Procedures for Prison Health were also launched in 2018. 3MDG partner Jhpiego supported the introduction of an accreditation system for Basic Medical Education, midwifery and nursing pre-service education with the finalization and dissemination of the Accreditation Standards.

3MDG has been committed to mainstreaming four principles in all of its work – accountability and responsiveness, social inclusion, gender equity and conflict sensitivity. The Fund has done so through customized training,ited and clear guidelines and standards for implementing partners. In 2018, this included training sessions on community feedback, disability and gender: a total of 3,405 health workers and implementing partner staff (2,261 female and 1,144 male) were trained in these concepts.

Partnerships between local community-based and civil society organizations and implementing partners were also fostered to overcome barriers to care at the community level. For example, in Shan State, local organizations were able to help build trust by acting as an intermediary with the community and helped facilitated training local people to overcome language barriers.
The Fund’s Evolving Approach: The Need For Flexibility

Within a challenging context – including start-up challenges, the resurgence in conflict in some areas, natural disasters, and community resistance to some services – called for flexibility. The Fund demonstrated a willingness to respond to all different types of situations. For example, slow township selection and difficulties in programme design for a ‘township-wide’ approach meant that funding that was originally planned for maternal, newborn and child health services had to be re-programmed for infrastructure projects and communicable disease activities. In 2017, a need to work more closely at the state and regional level triggered a restructure of the Fund Management Office to be better at responding to contextual challenges, coordinating implementing partners, and working with the state health departments.

The 3MDG Fund is built on the principles of working in partnership, value for money, building work on evidence, alignment to the Ministry of Health and Sports and sector priorities, and accountability, equity, and inclusion, including gender equality (later known as ‘Health for All’).

Partnerships

3MDG fostered strong partnerships with key stakeholders, including the Ministry of Health and Sports, Ethnic Health Organizations, United Nations agencies, non-government organizations, beneficiaries, affected populations and communities. The Myanmar Ministry of Health and Sports was central to planning and implementation across all aspects of the 3MDG Fund, with Ministry staff at national, regional, state and township levels regarded as key stakeholders. This was strengthened after 2015 when the Ministry was added permanently to the Fund Board.

Value for Money

Value for money has been a 3MDG principle from the very beginning, reflected in the design of the Fund. By pooling the contributions of several bilateral donors, 3MDG promoted the efficient and effective use of development funds. 3MDG was managed by UNOPS, resulting in increased efficiency and economies of scale through shared services with other UNOPS Funds and entities in procurement, human resources, finance and other services.

Each year, 3MDG reviewed costs – both of itself and implementing partners – and analyzed where efficiency gains were possible. The findings of a benchmarking study commissioned by the 3MDG Fund Board in early 2017 concluded that UNOPS management of the Fund was competitive and presented good value for money.

Building on Evidence

The Fund promoted an evidence-based approach to health care. Basing health decisions on evidence connects the needs and priorities on the ground with interventions at all levels. To establish a sound evidence base, reliable data is essential. 3MDG used data from the national health information system, additional systems established by its implementing partners, and financed large surveys.

Health for All

3MDG set an overarching goal to contribute to national progress towards the health Millennium Development Goals through a rights-based approach. This meant ensuring equal access to health services, empowering women, engaging communities in decision-making, and ensuring the voices of minorities and other vulnerable communities were being heard.

3MDG’s rights-based approach was underpinned from inception by the principles of responsibility, fairness, inclusion and ‘do no harm.’ The four principles formed the basis of the 3MDG Accountability, Equity and Inclusion Strategic Framework, and were streamlined in 2015 under the banner ‘Health for All.’ The principles were also reflected in the Fund’s financing decisions, which targeted resources to those who could not otherwise access services or afford health care, including women and children, people living with HIV, and those in conflict-affected areas. The Collective Voices initiative was also launched in 2015 and aimed to uncover barriers to health care and devise solutions to overcome these barriers.

Conflict Sensitivity

Issues related to ethnicity and conflict severely affect access to and delivery of health services, exacerbate health challenges and highlight the limited resources of non-government health providers. 3MDG financed health care in conflict-affected areas and Special Regions and supported ethnic and community-based health organizations to address the health needs of under-served populations. In consultation with the Ministry of Health and Sports and other stakeholders, implementing partners worked with the township health departments, ethnic health organizations and civil society groups that had access to areas not accessible to basic health staff. This work was guided by a conflict sensitivity strategy that adheres to international best practices related to ‘do no harm,’ including conflict sensitivity principles.

In 2017 and 2018, 3MDG carefully expanded beyond ‘do no harm’ to maximize opportunities where the Fund and its partners could contribute to peace-building and cooperation across conflict lines. This expansion included building capacity and knowledge across the Fund, providing technical support and contingency budgeting to partners, and deepening support to non-government providers in recognition that they are critical health service delivery partners and often have access where government health staff do not.

The peace process did allow for increased cooperation and communication between the Ministry of Health and Sports, local authorities and ethnic health organizations, and the willingness of the Ministry to engage and recognize these organizations has provided hope for future effective and context-appropriate health care arrangements. Health also has the potential to bring actors together around specific, result-oriented discussions. This will continue in the Access to Health Fund, which focuses almost exclusively on working in conflict-affected areas in recognition of the vulnerability of people living there.

Risk Management

Being conflict-affected, prone to natural disaster, and rapidly changing means that in Myanmar risk management is an integral element of programme management. UNOPS endeavours to manage risks effectively to avoid or minimize the impact of adverse effects from threats and enable opportunities. The 3MDG Fund had a number of approaches to risk identification and management, outlined below.

Broadly speaking, the flexibility and responsiveness of the Fund were the most effective tools in managing risk as they allowed the Fund to shift programming in view of the context and challenges. Risks that were identified at the beginning of the programme were sometimes not significant throughout the life of the fund however, some emerging risks led to significant changes in the overall portfolio. An example of this was the slow start-up of the maternal, newborn and child health programme which presented a substantial risk to overall delivery. The response was to channel more resources into other areas of work, based on evidence and need. Conflict and natural disaster which occurred unexpectedly in parts of the country also called upon the Fund to respond to meet evolving needs.

The 3MDG Risk Matrix was reviewed and updated regularly by the Fund Management Office to reflect current risks and mitigating actions in place. The Board’s regular review of the risk matrix and protest was a standing item on the Board’s agenda. Risks were identified through close work with implementing partners, such as at performance monitoring and review meetings, and field monitoring. Regular coordination meetings at township, state and regional, and national level were also an opportunity to take stock of threats and challenges that may present, along with close relationships with other development actors, technical experts, and conflict specialists.

Key risks were identified during 3MDG operations. For example, increased armed conflict and instability had the potential to affect service-delivery in areas covered by 3MDG. Mitigation approaches included context analysis and the use of context monitoring tools, technical assistance for capacity building and sharing best practices, and the use of contingency budgeting to respond to natural or man-made disasters. Support to Rakhine State introduces the risk in relation to local perceptions of favouritism from aid agencies, this was mitigated by emphasis on visible support to all communities, building strong relationships with key health actors in the state, such as the State Health Department, the maintenance of flexibility to adjust the programme to respond to a changing situation, and regular monitoring and communication with partners as to the local situation.

Identified risks were categorized according to the Copenhagen Circles Framework for risk management in conflict settings: contextual risk, programmatic risk, and institutional risk. The Fund Management Office determined the impact of the risk, the likelihood of the risk, and the proximity of the risk. Mitigating actions were re-assessed to ascertain their continuing appropriateness and effectiveness.
EXECUTIVE SUMMARY

2013:
- 2013 was the first year of implementation for the 3MDG Fund, with three focus areas identified in line with the Millennium Development Goals from which the Fund took its name: maternal, newborn and child health, HIV/AIDS, tuberculosis and malaria, and health systems strengthening. In this first year, 33,000 children were vaccinated against measles. Just over half a million people were tested for malaria, with nearly 80,000 treated, and there were also projects for finding, testing and treating tuberculosis (TB), and HIV Harm Reduction.

2014:
- More projects were added in 2014 in all focus areas of the Fund. In particular, the Fund significantly scaled-up access to maternal, newborn and child health services, particularly in conflict-affected areas. There were 8,000 emergency maternal referrals in 2014.
- Harm Reduction services were available in 36 townships and reached nearly 27,000 people who injected drugs. The multi-drug resistant TB programme, which had been declared a priority in the previous year, began and reached 372 patients with treatment and treatment adherence activities.
- Nearly half a million people were tested for malaria, with more than 29,000 treated according to national guidelines – already the incidence significantly dropping from the previous year.

2015:
- The entire programme was running at full speed in 2015. Maternal, newborn and child health services covered 44 townships, and more than 50,000 women received antenatal care four or more times. There was a serious flood in 2015 that affected large parts of the country. 3MDG partners quickly adjusted programming in areas where communities were affected.
- The prevalence of malaria continued to decline, the incidence significantly dropping from the previous year. TB infrastructure, including an outpatient department and a caretaker quarters, were also completed.
- A report was compiled and launched in August 2016 from the Collective Voices project, revealing barriers to health services. Women were more likely to access care when it was needed.

2016:
- The National Health Plan 2017–2021, which was financially and technically supported by 3MDG, was launched in 2016, and the government reaffirmed its commitment to universal health coverage.
- 3MDG maternal, newborn and child health services were more targeted to areas that are remote or affected by conflict. The contraceptive prevalence rate continued on its upward trend, rising to 66% in 2016 from 63% in 2015.
- In the emergency referral programme, 19% of pregnant women in 3MDG townships were referred to a secondary care centre when it was needed.
- Harm Reduction services were available in 36 townships and reached nearly 27,000 people who injected drugs. The multi-drug resistant TB programme, which had been declared a priority in the previous year, began and reached 372 patients with treatment and treatment adherence activities.

2017:
- 3MDG’s HIV Harm Reduction programme performed well across all its indicators and contributed significantly to national targets. Partners expanded services to previously unreached areas and nearby townships, and continuing advocacy has increased uptake of services and reduced community resistance. As a result, 3MDG was able to reach nearly 43,000 people who inject drugs—52% of the estimated number of people who inject drugs in Myanmar according to the Integrated Biological and Behavioral Surveillance Report (IBBS 2014).
- 3MDG’s approach in 2017 was 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, which was financially and technically supported by 3MDG. The programme was designed to respond to and deliver on the key principles of the national Health Plan.

YEARLY SNAPSHOT

Photos: In maternal, newborn and child health, 3MDG began working in non-government controlled and conflict-affected areas in 2015, guided by a conflict-sensitive approach. These photos are from early trips to set up programming in Shan, Kayah and Kayin states.
Activities and highlights from 2018 are presented geographically for states and regions where maternal, newborn and child health interventions were covered. Summaries of results and activities in sexual and reproductive health and rights, tuberculosis, malaria, drug use and its health consequences/harm reduction, health systems strengthening, and health for all, are also summarized here. ‘At a Glance: 2018 Results’ shows that most indicators met or exceeded targets and partners and projects were running well. Nevertheless, there were geographic disparities, particularly as a result of increased conflict in some states and regions. The start-up performance of new projects in sexual and reproductive health and rights was impressive considering the short time period.

STATES AND REGIONS: MATERNAL, NEWBORN AND CHILD HEALTH

Primary results shown here are from the maternal, newborn and child health interventions, but some top level results from other components are also included.

CHIN:
Chin State is one of the hardest-to-reach parts of the country, with the poorest health outcomes. In 2018, 3MDG partners continued to stimulate Village Health Funds, which remove financial barriers to access. Through advocacy and health education, the contraceptive prevalence rate continued to improve. High prevalence of malaria in Pakhaw and surroundings was clear. 16,093 tests taken in just one township, and 3,997 malaria cases treated in only 100 villages. More work is needed to get this epidemic under control.

KACHIN:
 Armed conflict re-intensified in Kachin State in 2018 - particularly the first half of the year - resulting in the displacement of more than 14,000 people. Humanitarian needs were high, and drug use and migration remain significant contributors to high rates of HIV transmission. In 2018, 3MDG partners expanded outreach to reach hidden populations in more locations with services including HIV testing, hepatitis screening and vaccination. In total, 17,317 people who inject drugs were reached with prevention programmes, and 9.5 million needles and syringes were distributed. Community health workers provided integrated health services including tuberculosis and malaria. 68,000 malaria tests were taken and read, with 323 cases treated, and 16,500 cases of suspected TB examined, with 789 cases of tuberculosis (all forms) detected and notified.

KAYIN:
Conflict in Kayah interrupted health activities in 2018, but regular coordination meetings meant that access could be restored quickly. Nearly 5,000 women attended ante-natal care at least four times during their pregnancy, and 36,500 malaria tests were taken and read. 18.6 million needles and syringes distributed to people who inject drugs.

2018 IN REVIEW

Flood Response
The floods in southeastern Myanmar in the last week of July 2018 caused severe disruption to basic services, with many in the state unable to meet their nutrition, sanitation and health needs. Community Partners International coordinated the response together with ethnic health organizations, and were able to provide food and hygiene items and health services to 21 villages in Kayin and five villages in Taninthary.

MYANMAR HEALTH ASSISTANT ASSOCIATION conducted a rapid needs assessment in flooded areas, advocated to state and township level administrative and health departments for response, and built latrines. Community Driven Development and Capacity Enhancement Team distributed purified water, soap, and antiseptic, and funded environmental sanitation for 21 village health committees.

See more results in Annex II: Results Matrix.
TUBERCULOSIS

Tuberculosis (TB) is a major public health problem in Myanmar, and, despite preliminary results of the Prevalence Survey (2017-2018) demonstrating a decreasing prevalence trend, TB is limited by poverty, gender inequity, lack of service availability and social taboos. Contraceptive use is low, especially in rural areas; health knowledge is limited; and adolescent fertility is high. Before 2018, services under the umbrella of sexual and reproductive health and rights supported by 3MDG were limited primarily to family planning and contraceptives. In 2018, this was scaled-up to reach more young people with more health education and services, implementation of post-abortion care guidelines and Standard Operating Procedures at hospitals, cervical cancer prevention and treatment, procurement of syphilis test kits to strengthen syphilis testing among pregnant women, and awareness raising activities, such as the celebration of World Contraception Day.

The need for sexual and reproductive health and rights for young people in Yangon is especially high, and hence a new project was launched in 2018. Project activities only started in March 2018, but because of a huge effort from the Myanmar Medical Association (MMA) team, everything that was planned could be implemented. Youth from the targeted townships, including rural and ethnic minority youth, could access information through MMA's FM radio programme and community-awareness raising activities, and a number of peer educators were trained from a mix of genders. In 2018, in total there were 274 (152 female, 122 male) Groups of Protection delivered by 3MDG partners in 2018. There were 42,295 young people (15,372 men, 26,923 women) reached with sexual and reproductive health and rights education during the year.

NUTRITION

Nutrition is a major public health problem in Myanmar. An enabling environment for these groups and their health care is not yet realized in Myanmar, despite the National Strategic Plan on HIV and AIDS (2016-2020) promoting a human rights-based approach. In 2018, UNAIDS and UNODC, alongside government partners, made significant advances in their work in creating an enabling environment, including the Standard Operating Procedures on health care in prisons, and conducting training with key groups on the importance of Harm Reduction services.

The 3MDG Harm Reduction programme was extremely high achieving, with partners working tirelessly to reach vulnerable people who use drugs and reduce community resistance to their services. In 2018, 3MDG partners reached 40,422 people who inject drugs through drop-in centres, community based outreach and mobile activities, which is 43% of the national estimated number of people who inject drugs. Of these, the vast majority are men (39,843), with 579 women who inject drugs reached with prevention services.

These low rates of women reached are a reflection of epidemiology, but they also highlight the difficulty in reaching this highly stigmatized and hidden population. 3MDG partners introduced measures to ensure women felt safe and included at drop-in centres, such as female-only centres and spaces, and more female staff at centres and for outreach. More work is needed in the Access to Health Fund to expand access to women and other vulnerable groups, such as people who use drugs who have disabilities and spouses of people who use drugs, who may also be at risk for HIV. The integration of more services with Harm Reduction care, such as sexual and reproductive health services may also help to attract more women and other groups to services. The benefits of this continuum of care model are manifold: groups are drawn to the expanded services, and all populations have a better chance of having all of their health needs met.

In 2018, 18.6 million sterile needles and syringes were distributed to facilitate safe injecting in 2018, 73% of the national target. Acceptance of Harm Reduction interventions at community level has also significantly increased.

In 2018, the Multi-sectoral National Plan of Action on Nutrition (MS-NAP) was finalized and launched. Community-level activities were bolstered with the integration of more nutrition-focused interventions under maternal, newborn and child health grants.

2018 saw the first ever coordination of a nationwide nutrition promotion campaign in August. 3MDG also working with the NNC to bring together different stakeholders for a schedule of events. The focus was on community engagement, especially in areas with the poorest nutrition outcomes.

HEALTH SYSTEMS STRENGTHENING

Initiatives to strengthen the health system continued at central, state and regional and township level in 2018. Most notably, 3MDG worked with the National Health Plan Implementation Monitoring Unit (NIMU) to finalize the services available under the Basic Essential Package of Health Services (EPSH), which will be available to the entire population by 2020/2021 under the plan towards universal health coverage.

Since 2015, 3MDG has financed the construction of 82 health facilities in Myanmar, built by the UNOPS Infrastructure Unit. In 2018, 3MDG allocated additional fund to build 11 centres mostly in conflict affected areas of central Rakhine. Three capacity building trainings were conducted in 2018 for Ministry and Health and Sports staff on infrastructure project management, quality assurance and quality control, health, safety and environmental management, contract administration, and procurement.

HEALTH FOR ALL

Through customized trainings to implementing partners, providing clear and feasible guidelines and minimum standards, 3MDG affected the most vulnerable populations. The accountability, social inclusion, gender equity and conflict sensitivity in its work. In 2018, 3MDG provided two batches of refresher training to improve understanding on “social accountability and community feedback mechanism” and “gender and social inclusion” to senior field staff of all implementing partners.

The Collective Voices initiative was better linked to the rest of the programme in 2018, by addressing social barriers to access which affect the most vulnerable populations. The project also worked to enhance accessibility of service providers, and equity of access, as well as include the participation of local civil society and community based organizations in township-level participatory planning, budgeting and coordination.
RESULTS OVER THE LIFETIME OF THE FUND

EXECUTIVE SUMMARY | 3MDG Annual Report 2018 and End of Fund Report

INTRODUCTION

Despite many outstanding achievements, challenges and opportunities over the 3MDG Fund period impacted partners’ ability to deliver health care and meet targets. However, partners were responsive and tried to capitalize on opportunities, such as the chance to work more closely with government and to draw closer government and non-government health providers, and overcome barriers, such as limited access, to maintain service delivery.

Progress often wasn’t consistent, with places and health areas where rapid gains were made, and other situations were gains were more limited. In malaria and Harm Reduction programming, 3MDG results met and even surpassed expectations. Solid results were also recorded in TB, and in many aspects of the maternal, newborn and child health programme - though it was uneven between states and regions.

Even where progress was more difficult, important developments were still recorded. In Chin State, though the contraceptive prevalence rate was unmoved for years, there was a significant up-tick in 2017 and 2018 thanks to tireless advocacy from partners.

The ‘Results over the Fund’ section outlines in detail the trends, progress and challenges in the major areas of health where 3MDG worked: maternal, newborn and child health, HIV Harm Reduction, tuberculosis, malaria, and health systems strengthening.

There is also a section on sexual and reproductive health and rights, which was expanded in 2018 to include adolescent sexual and reproductive health and rights and post-abortion care, though elements such as family planning and contraceptive distribution were incorporated from the start of the 3MDG programme.

Photos: 3MDG supports mothers and babies with improved ante and post-natal care, referrals, and the capacity development of skilled birth attendants, for a better chance for a healthy pregnancy and childbirth.

AT A GLANCE Cumulative, nationwide results

MATERNAL, NEWBORN AND CHILD HEALTH

- 280,683 women received ante-natal care (four visits per woman)
- 379,260 infants were vaccinated against measles
- 265,583 births were attended by a skilled health personnel
- 87,882 life-saving referrals for pregnant women
- 316,134 women received post-natal and newborn care within three days
- 70,926 life-saving referrals for children under five
- 385,655 infants were vaccinated with DPT/Penta3
- 972,256 Couple Years of Protection achieved (Family Planning/ SRHR)

DRUG USE AND HEALTH CONSEQUENCES

- 42,977 people who inject drugs reached by prevention programmes
- 15,632 people who inject drugs given HIV testing and voluntary counselling
- 71,565,135 needles and syringes distributed

TUBERCULOSIS

- 196,349 referrals for TB testing by community health workers and volunteers
- 68,953 notified TB cases (all forms)

MALARIA

- 2,821,746 malaria rapid diagnostic tests taken and read
- 151,090 confirmed cases of malaria treated

HEALTH SYSTEMS STRENGTHENING

- 82 rural and sub-rural health centres constructed and handed over to the MoHS
- 14,705 number of staff from MoHS, implementing partners, community based organizations (at central, regional and township level), trained in Accountability, Equity, Inclusion and Conflict Sensitivity
Maternal, newborn and child health

3MDG was set-up to address unacceptable levels of maternal, newborn and under-five mortality in Myanmar, particularly the wide disparities between urban and rural areas, and between and within states and regions. Available data was used to select the states, regions and townships with the worst health outcomes in order to target services to the poorest and most vulnerable people in the country, insofar that this was possible.

Across the country, key indicators increased from 2013 to 2018. This was true even though the high performing states of Ayeyarwady and Magway were removed from the results in 2018, and Rakhine - a state with poor health coverage and high population - was added in 2017. For example, the percentage of pregnant women who had a skilled birth attendant increased from 56% to 60% from 2013 to 2018, and post-natal and newborn care coverage increased from 58% to 76% during the same period. These are incremental but important improvements, and mean that women living in towns that 3MDG supports are more likely to have safe, healthy pregnancies. Developments are more pronounced at state and regional level, which is detailed in ‘Results over the years’ section and summarized on the next pages of the report.

As noted in the preliminary findings of the 3MDG Final Evaluation, although ambitious targets were set and outcome performance was lower than planned, it was still impressive. Access to maternal, newborn and child health services increased for between 15-20% of the township population in 34 townships in Myanmar. There is still a long way to go, with the evaluation report also estimating that 15% of people still lack many basic services. Many of these people are the most vulnerable in their communities, those who are poor, or live remotely. The Access to Health Fund, the successor fund to 3MDG, will need to explicitly target and measure these populations to ensure that the furthest behind are reached and can access the health services they need.

MATERNAL, NEWBORN AND CHILD HEALTH COVERAGE OVER THE YEARS OF THE FUND

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline 2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017**</th>
<th>2018**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and percentage of women attended at least four times during pregnancy by skilled health personnel</td>
<td>64% 65% 67% 68% 71% 68% 65%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number and percentage of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)</td>
<td>56% 56% 65% 67% 68% 64% 60%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number and percentage of mothers and newborns who received postnatal care visit within three days of childbirth</td>
<td>69% 58% 75% 83% 82% 78% 76%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunization coverage for Penta 3 in 3MDG supported townships</td>
<td>85% 83% 97% 91% 95% 89% 91%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunization coverage for measles in 3MDG supported townships</td>
<td>82% 83% 96% 84% 96% 82% 92%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Baselines are taken from 3MDG LF VI.
** Implementation started in Rakhine in 2017.
*** High performing Delta and Magway township phased out in 2018.

RESULTS OVER THE YEARS OF THE FUND IN AYEYARWADY

IN BRIEF:

- **Context:** Ayeyarwady Region had poor health outcomes, as demonstrated by the 2015 Census. The region was devastated by Cyclone Nargis in 2008, which destroyed health and other basic services, depriving access for many living in the region. 3MDG work started in 2013 based on the urgent need to restore access. Prioritized townships was based on existing support provided by the previous fund, JIMNCH.

- **Maternal, newborn and child health:** Key indicators increased from 2013 to 2018. The percentage of pregnant women who received ante-natal care four times or more improved from 65% of the coverage population in 2013 to 86% in 2017. Skilled birth attendance increased from 56% to 73%, and post-natal and newborn care coverage increased from 58% to 87%. The use of contraceptives, indicated by the contraceptive prevalence rate, increased from just 51% of the coverage population in 2013 to 80% in 2017.

- **Emergency referrals:** In 2018, following strong results from the region, only referrals were continued using a pilot model with minimum partner staff. The model, which was designed by the Ministry of Health and Sports with assistance from 3MDG, had slightly altered referral criteria, and total expenses reimbursed was calculated differently to make it more affordable, and thus, potentially more sustainable. There were 5,362 maternal referrals, and 3,881 child referrals in 2018. This was in line with 3MDG targets, and represents 22% of pregnancies (a reduction from 28% due to improvement of the referral pathway), and 3% for child referrals.

EXECUTIVE SUMMARY | 3MDG Annual Report 2018 and End of Fund Report
EXECUTIVE SUMMARY | 3MDG Annual Report 2018 and End of Fund Report

RESULTS OVER THE LIFETIME OF THE FUND: MATERNAL, NEWBORN AND CHILD HEALTH

CHIN STATE

RESULTS OVER THE YEARS OF THE FUND IN CHIN

<table>
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<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and percentage of women attended at least four times during pregnancy by skilled health personnel for reasons related to the pregnancy</td>
<td>63%*</td>
<td>64%</td>
<td>63%</td>
<td>61%</td>
<td>72%</td>
<td>&lt;2%</td>
</tr>
<tr>
<td>Number and percentage of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)</td>
<td>57%*</td>
<td>57%</td>
<td>57%</td>
<td>62%</td>
<td>66%</td>
<td>66%</td>
</tr>
<tr>
<td>Number and percentage of mothers and newborns who received postnatal care visit within three days of childbirth</td>
<td>76%*</td>
<td>84%</td>
<td>82%</td>
<td>79%</td>
<td>83%</td>
<td>83%</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>25%*</td>
<td>27%</td>
<td>33%</td>
<td>32%</td>
<td>32%</td>
<td>32%</td>
</tr>
<tr>
<td>Immunization for (i) Penta and (ii) Measles</td>
<td>(i) 96%*</td>
<td>(i) 91%</td>
<td>(i) 95%</td>
<td>(i) 96%</td>
<td>(i) 96%</td>
<td>(i) 96%</td>
</tr>
<tr>
<td>Number and percentage of appropriate maternal (EmOC) referrals</td>
<td>0.1%*</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Number and percentage of appropriate child (ECC) referrals</td>
<td>80%*</td>
<td>173</td>
<td>2319</td>
<td>2503</td>
<td>3413</td>
<td>1247</td>
</tr>
</tbody>
</table>

IN BRIEF:

- **Context:** Chin State is isolated and poor, leading to poor health outcomes - especially in maternal, newborn and child health. Cultural and religious beliefs mean that contraceptive prevalence and family planning in the state is low.
- **Maternal, newborn and child health:** Improvements in coverage of these services in Chin were notable, but were not as large as other states and regions. For example, newborn care coverage only increased from 76% to 83%. The state also started from a lower point, such as skilled birth attendance at only 59% (improving to 66%). For contraceptive prevalence, it took a long time for any gains to be made, but due to work from partners to reduce community resistance through advocacy, some improvements were noted in the final years of the Fund.
- **Malaria:** The impact of conflict in one township, Paletwa, impacted the delivery of health services, and also contributed to an outbreak of malaria in the area. Community level programmes were utilized to address the outbreak by maximizing the skills of local health workers, however, high levels of malaria continue.
- **Approach and system strengthening:** Vacant health staff in the state is a persistent issue, but addressing it can have substantial positive impacts. When new midwives were recruited in 2018, there was a dramatic increase in coverage. Integrated activities in the particularly hard-to-reach parts of Chin meant that even services are limited, community health needs can be met as long as there is adequate training and supervision.

KAYAH STATE

RESULTS OVER THE YEARS OF THE FUND IN KAYAH

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Number and percentage of women attended at least four times during pregnancy by skilled health personnel for reasons related to the pregnancy</td>
<td>76%*</td>
<td>67%</td>
<td>71%</td>
<td>72%</td>
<td>76%</td>
<td>76%</td>
</tr>
<tr>
<td>Number and percentage of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)</td>
<td>75%*</td>
<td>74%</td>
<td>76%</td>
<td>80%</td>
<td>82%</td>
<td>82%</td>
</tr>
<tr>
<td>Number and percentage of mothers and newborns who received postnatal care visit within three days of childbirth</td>
<td>64%*</td>
<td>85%</td>
<td>87%</td>
<td>52%</td>
<td>93%</td>
<td>53%</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>52%*</td>
<td>48%</td>
<td>58%</td>
<td>59%</td>
<td>65%</td>
<td>55%</td>
</tr>
<tr>
<td>Immunization for (i) Penta and (ii) Measles</td>
<td>(i) 100%</td>
<td>(i) 94%</td>
<td>(i) 97%</td>
<td>(i) 98%</td>
<td>(i) 99%</td>
<td>(i) 99%</td>
</tr>
<tr>
<td>Number and percentage of appropriate maternal (EmOC) referrals</td>
<td>N/A**</td>
<td>N/A**</td>
<td>N/A**</td>
<td>N/A**</td>
<td>N/A**</td>
<td>N/A**</td>
</tr>
<tr>
<td>Number and percentage of appropriate child (ECC) referrals</td>
<td>N/A**</td>
<td>3438</td>
<td>985</td>
<td>971</td>
<td>790</td>
<td>4184</td>
</tr>
</tbody>
</table>

IN BRIEF:

- **Context:** Kayah State has been conflict-affected, but some recent stability in some places mean that it has lower human resource challenges than other conflict areas. That meant that there could be steady increases in coverage for maternal, newborn and child health indicators over the years of the Fund.
- **Maternal, newborn and child health:** Despite overall good results, there were township level disparities. Lower results were evident in townships covered largely by ethnic health organizations, and with migrant populations. Immunization coverage was extremely high by the final year of the Fund, which is an outstanding result made possible by outreach activities by health staff in hard-to-reach areas.
- **Emergency referrals:** Percentage of maternal referrals, hovering at 13%, were near the WHO recommended standard. However, child referrals actually reduced in percentage. This might be because more child cases could be treated at community level and did not require hospital treatment.
- **Ethnic health organizations (EHOs) make up a small, but important element of service coverage in Kayah. For skilled birth attendance, 322 pregnant women received services from EHOs and 5,305 women from township health departments (THD). For referrals, EHOs supported 260 maternal and 357 child referrals, and THDs supported 907 maternal referrals and 790 child referrals. This may show that in emergencies, community members prefer to seek care from trusted local organizations, rather than government providers. It may also reflect ethnic health organization presence in the most hard-to-reach areas.

* 5 out of 9 townships in Chin started implementation in semester 2 of 2014
** During 2014 inception period, there was no referral support
*** Target (15% of total expected pregnant women (EPW)) is based on the globally accepted number of women (WHO) who will require emergency obstetric services during pregnancy and childbirth
**RESULTS OVER THE LIFETIME OF THE FUND: MATERNAL, NEWBORN AND CHILD HEALTH**

### MAGWAY REGION

#### RESULTS OVER THE YEARS OF THE FUND IN MAGWAY

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Number and percentage of women attended at least four times during pregnancy by skilled health personnel for reasons related to the pregnancy</td>
<td>62%</td>
<td>58%</td>
<td>65%</td>
<td>76%</td>
<td>NA*</td>
<td>78%</td>
</tr>
<tr>
<td>Number and percentage of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)</td>
<td>86%</td>
<td>79%</td>
<td>82%</td>
<td>88%</td>
<td>NA*</td>
<td>89%</td>
</tr>
<tr>
<td>Number and percentage of mothers and newborns who received postnatal care visit within three days of childbirth</td>
<td>86%</td>
<td>94%</td>
<td>97%</td>
<td>98%</td>
<td>NA*</td>
<td>98%</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>55%</td>
<td>83%</td>
<td>84%</td>
<td>71%</td>
<td>NA*</td>
<td>71%</td>
</tr>
<tr>
<td>Immunization for (i) Penta and (ii) Measles</td>
<td>0 (i) 97%</td>
<td>94%</td>
<td>96%</td>
<td>100%</td>
<td>96%</td>
<td>(i) 96%</td>
</tr>
<tr>
<td>Number and percentage of births attended by skilled health personnel</td>
<td>76% 79% 82% 88%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>(i) 86%</td>
</tr>
<tr>
<td>Number and percentage of appropriate maternal (EmOC) referrals</td>
<td>495 (10% of EPW)</td>
<td>3,205 (4% of EPW)</td>
<td>2,967 (2% of EPW)</td>
<td>3,439 (4% of EPW)</td>
<td>3,525 (5% of EPW)</td>
<td>13,595 (26% of EPW)</td>
</tr>
<tr>
<td>Number and percentage of appropriate child (ECC) referrals</td>
<td>482</td>
<td>3,243</td>
<td>7,51</td>
<td>3,647</td>
<td>3,143</td>
<td>13,666</td>
</tr>
</tbody>
</table>

* The full package of CTHP activities started in 2014-2017 with Save the Children and Marie Stopes International (MSI). But, in 2018, there was only emergency referral support by MSI for all 5 townships in Magway.

** Target (15% of total expected pregnant women (EPW)) is based on the globally accepted number of women (WHO) who will require emergency obstetric services during pregnancy and childbirth.

** IN BRIEF: **

- **Context:** With a large population, many living in rural and remote places, uptake of health services was low when the 3MDG Fund began work in Magway in 2013. Health outcomes were poor, and health seeking behaviour needed to improve.

- **Maternal, newborn and child health:** There was improvement across all maternal, newborn and child health indicators, including skilled birth attendance and ante-natal care. For example, the percentage of pregnant women who received ante-natal care four times or more improved from 62% of the coverage population in 2013 to 76% in 2017. Skilled birth attendance increased from 76% to 88%, and post-natal and newborn care coverage increased from 86% to 98% during the same period. The use of contraceptives, indicated by the contraceptive prevalence rate, increased from just 55% of the coverage population in 2013 to 71% in 2017. Impressive results in Magway led to the downsizing of the programme in the 2018 extension year.

- **Emergency referrals:** Use of services and facility-based delivery in some parts of the region are still too low. The continued use of the emergency referral programme, alongside health education and awareness of services, remains critically important to improving these numbers. Village Health Committees and civil society organizations also have an important role to play in the sustainability of emergency referrals, as they can encourage more reluctant community members to make use of them, and provide sustainable financing through Village Health Funds.

### RAKHINE STATE

#### RESULTS OVER THE YEARS OF THE FUND IN RAKHINE

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Number and percentage of women attended at least four times during pregnancy by skilled health personnel for reasons related to the pregnancy</td>
<td>N/A</td>
<td>55%</td>
<td>59%</td>
<td>59%</td>
</tr>
<tr>
<td>Number and percentage of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)</td>
<td>N/A</td>
<td>57%</td>
<td>54%</td>
<td>54%</td>
</tr>
<tr>
<td>Number and percentage of mothers and newborns who received postnatal care visit within three days of childbirth</td>
<td>N/A</td>
<td>64%</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Immunization for (i) Penta and (ii) Measles</td>
<td>N/A</td>
<td>0 (i) 77%</td>
<td>0 (i) 87%</td>
<td>0 (i) 87%</td>
</tr>
<tr>
<td>Number and percentage of appropriate maternal (EmOC) referrals</td>
<td>194</td>
<td>4,161 (94%)</td>
<td>5,822 (99%)</td>
<td>10,177</td>
</tr>
<tr>
<td>Number and percentage of appropriate child (ECC) referrals</td>
<td>523</td>
<td>2,623</td>
<td>4,838</td>
<td>7,114</td>
</tr>
</tbody>
</table>

** Target (15% of total expected pregnant women (EPW)) is based on the globally accepted number of women (WHO) who will require emergency obstetric services during pregnancy and childbirth.

** IN BRIEF: **

- **Context:** The outbreak of violence in August 2017 exacerbated the already significant health challenges faced in Rakhine State, which is the poorest state in Myanmar with amongst the worst health outcomes.

- **Maternal, newborn and child health:** When 3MDG projects started in full in 2017, achievements were low - to be expected considering the contextual challenges, existing poor health outcomes and knowledge, and affect of the conflict. Results continue to be lower than other states, primarily due to access challenges and low health seeking behaviour. Percentage of births with skilled attendance was only 54% at the end of 2018, the lowest of any 3MDG-supported state.

- **Emergency referrals:** Referrals rose from just 9% of pregnant women in 2017, to 14% in 2018 - closer to the 15% of pregnant women who may require emergency treatment during pregnancy, as established by the World Health Organization and set as a 3MDG emergency referral target. Partners showed flexibility and ingenuity in designing cross-township referrals to overcome geographic and access challenges. More is needed to enhance access further in future.

- **Approach and system strengthening:** During implementation, township health departments in Rakhine began to feel more ownership over the plans and activities, contributing to greater potential for sustainable programming and better informed interventions based on contextual needs and priorities. Access, vacant posts and security remain significant impediments to the realization of the right to health for all communities, especially Muslim populations.
RESULTS OVER THE LIFETIME OF THE FUND: MATERNAL, NEWBORN AND CHILD HEALTH

SHAN STATE
RESULTS OVER THE YEARS OF THE FUND IN SHAN

<table>
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</thead>
<tbody>
<tr>
<td>Number and percentage of women attended at least four times during pregnancy by skilled health personnel for reasons related to the pregnancy</td>
<td>NA*</td>
<td>61%</td>
<td>63%</td>
<td>63%</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>Number and percentage of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)</td>
<td>NA*</td>
<td>58%</td>
<td>54%</td>
<td>55%</td>
<td>59%</td>
<td>59%</td>
</tr>
<tr>
<td>Number and percentage of mothers and newborns who received postnatal care visit within three days of childbirth</td>
<td>NA*</td>
<td>69%</td>
<td>67%</td>
<td>73%</td>
<td>77%</td>
<td>77%</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>NA*</td>
<td>47%</td>
<td>59%</td>
<td>64%</td>
<td>64%</td>
<td>64%</td>
</tr>
<tr>
<td>Immunization for (i) Penta and (ii) Measles</td>
<td>NA*</td>
<td>67%</td>
<td>66%</td>
<td>66%</td>
<td>66%</td>
<td>66%</td>
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<tr>
<td>Number and percentage of appropriate maternal (EmOC) referrals</td>
<td>15</td>
<td>65%</td>
<td>65%</td>
<td>64%</td>
<td>64%</td>
<td>64%</td>
</tr>
<tr>
<td>Number and percentage of appropriate child (ECC) referrals</td>
<td>16</td>
<td>58%</td>
<td>57%</td>
<td>55%</td>
<td>55%</td>
<td>55%</td>
</tr>
</tbody>
</table>

* Three townships (Hsinhseng, Mawka and Lahka) supported by Relief international started their inception phase in Q4 of 2014. Therefore the EmOC and ECC figures are reported only for those townships.

** Target 15% of total expected pregnant women (EPW)) is based on the globally accepted number of women (WHO) who will require the EmOC and ECC figures are reported only for those townships.

IN BRIEF:
- **Context:** Progress was slow in Shan State at the start of implementation, with only incremental improvements for many indicators for the first couple of years. This was due to the difficulty of working in severely conflict-affected areas, and the subsequent challenges in attracting health staff and their ability to remain safely at their posts. In a state as diverse as Shan, language barriers present a challenge for health education activities, as well as for delivery of health services. Partners found that the optimal solution was to employ more local staff, but when this was not possible, they translated health education materials, and used puppets and cartoons to minimize the number of words needed.

- **Maternal, newborn and child health:** Reduction in tensions in 2018 had predictable results - more outreach and less vacant health posts meant maternal, newborn and child health results improved significantly in that year.

- **Ethnic health organizations (EHOs)** were supported in townships in Shan State. Their limited resources meant that start-up was low, achievements are low in numbers, and challenges remain to be addressed in the Access to Health Fund. However, this collaboration is an important platform for ensuring equitable health access in non-government parts of the state. Constant engagement with health staff at these organizations, through meetings and inclusion in activities, helped to build relationships, trust and capacity.

- **EHOs** had poor data management systems when the 3MDG Fund began working in Shan State in 2014/2015. This has been improved through trainings, supervision and support to setting up better systems - however, more work is needed to ensure the areas know what their problems are, can set targets for improvement, and can track their progress.

HIV, TB and malaria

Significant strides were made in communicable diseases, especially in malaria, where Myanmar has reduced prevalence and death rate by enormous amounts over the lifetime of the Fund. In tuberculosis, it has been more mixed. The prevalence of the disease has only slightly reduced, though health providers have improved in finding and treating cases. More effort is needed to find hidden cases, and the Ministry of Health and Sports has showed commitment to this through guidelines for private and public health providers related to mandatory case notification, and continual efforts by mobile teams in reaching the most hard-to-reach populations.

For HIV, generally speaking the country has seen improvement in this area, with rates dropping for the general population. However, this has not been the case for the most at-risk populations, such as people who use drugs. The HIV prevalence rate has increased from 18% to nearly 35%, which is a worrying trend. This increase has come despite the significant efforts and good results of partners working in Harm Reduction, including prevention programmes and dissemination of clean needles. This may indicate that without these interventions, the trend could have been much worse. Another contributing factor to higher recorded prevalence could be the more widespread availability of anti-retroviral therapy in Myanmar. This means that the lives of HIV patients is extended, including those people who inject drugs – and thus the recorded prevalence rate may increase. Nevertheless, significantly more resourcing and commitment is required to halt this epidemic and extend Harm Reduction services.

HIV, TB AND MALARIA IMPACT INDICATORS

<table>
<thead>
<tr>
<th>Year</th>
<th>HIV Prevalence</th>
<th>TB</th>
<th>Malaria</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>18%</td>
<td>85%</td>
<td>2014: 53</td>
</tr>
<tr>
<td>2017</td>
<td>34.9%</td>
<td>91%</td>
<td>National TB (all forms) mortality per 100,000 population per year</td>
</tr>
<tr>
<td>2012: 403</td>
<td>2017: 30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013: 36%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Number and percentage of confirmed malaria cases treated in accordance with national malaria treatment guidelines

HIV, TB AND MALARIA 3MDG OUTCOME INDICATORS

<table>
<thead>
<tr>
<th>Year</th>
<th>HIV Harm Reduction</th>
<th>Tuberculosis</th>
<th>Multi-Drug Resistant TB</th>
<th>Malaria</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>82.3%</td>
<td>(18,934/ 23,000 people who use drugs in programme area)</td>
<td>85%</td>
<td>96%</td>
</tr>
<tr>
<td>2018</td>
<td>97%</td>
<td>(40,422/ 413,500 people who use drugs in programme area)</td>
<td>95%</td>
<td>71%</td>
</tr>
<tr>
<td>2017: 51</td>
<td>2017: 51</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012: 80%</td>
<td>2013: 36%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Global average – 55%
The National TB Prevalence Survey conducted in 2017-2018 notification for private sector, non-government controlled more needs to be done, especially in mandatory case the gap between the notified and the missing cases, but Active case finding activities have done a great deal to close implementing partners.

there are gaps in reach and service quality, which will be the their life span and increasing prevalence rates. Nevertheless, (IBBS). This would be significantly worse without the to the Integrated Biological and Behavioural Surveillance amongst people who inject drugs: from 18% in 2012 Health transmission of HIV, prevalence has actually increased In spite of the expansion of activities designed to prevent Law on Rights of People with HIV. discriminatory. This included the writing of a new law, the Law on Rights of People with HIV.

In spite of the expansion of activities designed to prevent the transmission of HIV, prevalence has actually increased amongst people who inject drugs: from 18% in 2012 Health Systems Strengthening Survey, to 34.9% in 2017, according to the Integrated Biological and Behavioural Surveillance (IBBS). The annually worsen without the contribution of 3MDG partners, and may also reflect growing numbers of people on anti-retroviral therapy, thus improving their life span and increasing prevalence rates. Nevertheless, there are gaps in reach and service quality, which will be the focus of programming in the Access to Health Fund with grants continuing to the national programme and implementing partners.

MALARIA

During the 3MDG Fund’s lifetime, and as a result of multiple coordinated interventions by government and non-government actors, there was a 98% reduction in malaria deaths, and declining prevalence in Myanmar in recent years. The malaria test positivity rate decreased from 28.76 in 2013 to 3.47 in 2017.

This required restrategizing towards elimination and rethinking how malaria volunteers were to be utilized when their skills were limited to just malaria interventions. In some cases, volunteers were retrained to deliver more health services under a model called ‘Integrated Community Malaria Volunteer’ (ICMV). Re-training volunteers to provide more services, and integrating service delivery, meant that even as prevalence declined, system efficiencies could be maintained and communities could access even more health care.

For malaria interventions, 3MDG focused on areas where government health providers, supported by the Global Fund, may have had more limited access, such as non-government or ethnic health areas. In these areas, health seeking behaviour was low because of language, literacy, and trust barriers. National treatment guidelines were better adhered to because partner organizations trained volunteers in migrant sites and expanded testing for mobile and migrant populations. This was demonstrated by yearly increases from 2013 to 2017 in the outcome indicator for this area of work, the ‘proportion of cases treated within 24 hours of the onset of fever.’

Paletwa, in Chin State, remains a significant trouble spot for malaria in Myanmar, contributing nearly half of all 3MDG-treated cases and a large number of deaths from the disease. 3MDG partners provided testing and treatment but the challenge remained in this township and work will continue in the Access to Health Fund.

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Since the start of the Fund, 3MDG funded Population Services International and Marie Stopes International to provide family planning services, via outreach and clinics, and distribute contraceptives through several channels. In total, nearly one million ‘Couple Years of Protection’ were achieved by 3MDG-financed activities. This means that families are choosing how, and when, to have children, and women have more control over their reproductive health.

However, the improvement in contraceptive prevalence rate was uneven, nationwide. In Ayeyarwady, for example, it increased significantly – from 51% in 2013 to 80% in 2017 (when support ended). Similarly impressive improvement was seen in Magway. However, in Chin State – which started from the lowest base, and also had the least improvement – success was more muted, but not insignificant. Despite increasing from just 25% to 32% over the five years of operation, the fact that it changed at all was a testament to the significant work of implementing partners working together with community leaders and communities to reduce the serious resistance to family planning in the state.

In 2018, the sexual and reproductive health and rights programme was scaled-up to include reaching young people with more health education and services, called ‘adolescent sexual and reproductive health and rights’ (ASRHR). Interventions in 2018 also included the implementation of post-abortion care guidelines and standard operating procedures at hospitals, cervical cancer prevention and treatment, procurement of syphilis test kit to strengthen syphilis testing among pregnant women, and awareness raising activities, such as the celebration of World Contraception Day. The two major initiatives: ASRHR, implemented by Myanmar Medical Association and Marie Stopes, and post-abortion care, implemented by Ipas and Marie Stopes, were both able to achieve a lot in a very short amount of time, despite their work being in sensitive areas.

Myanmar Medical Association, who worked on adolescent sexual health, along with Marie Stopes International, trained 904 youth peer educator volunteers and disseminated adolescent sexual and reproductive health messages to 42,295 young people at their communities. Ipas provided Post Abortion Care training to 50 doctors and infection control training to 43 hospital nurses. Marie Stopes International trained 25 doctors in post abortion care, and 28 nurses in infection prevention.

HEALTH SYSTEMS STRENGTHENING

A responsive, resilient and people-centred health system is critical for everyone’s health needs to be met, and for gains made in service delivery quality and reach to be sustainable. In Myanmar, however, there are gaps in the health system and some parts are stronger than others.

To help build a more efficient and responsive system, health systems strengthening efforts at national, state and region and township levels were a priority. 3MDG assisted the development of the National Health Plan 2017-2021 through an inclusive process, and also to the National Health Plan Implementation Monitoring Unit (NMHU) as they move towards UHC 2030.

Improving human resources for health, through Jhpiego’s work with the Ministry of Health and Sports, was a focus area due to the significant challenges faced. Notable results include the training of upgrading of skills labs in all midwifery schools, strengthened accreditation, and better trained faculty members for stronger, more confident midwifery staff.

A supply chain improvement project had great results: by 2018, 290 out of 330 towns in the country had functional cold chain equipment and adequate storage space for effective vaccine management.

Despite improvements, substantial challenges in health systems strengthening remain. Human resource retention and deployment still face significant issues, with gaps in hard-to-reach areas and low remuneration making jobs away from government service more attractive. Fragmentation of different parts of the health system, seeking to complement each other, has been an ongoing learning process. More is needed in Access to Health to ensure investments have the most significant, sustainable impact.
LESSONS LEARNED

ACCESS: ONE-OFF SOLUTIONS CAN HELP, BUT PARTNERS NEED TO ADVOCATE FOR SPACE FOR HEALTH SERVICES

Limited access for health staff and implementing partners is one of the most pressing issues facing health in Myanmar. It is often addressed by local actors coming together, despite their own politics, to find creative and cooperative solutions to meeting the needs of their communities. This shows the potential for health to create positive dialogue between groups with difficult histories and the importance of working at the grassroots to facilitate access. Access to care may also be impacted by poor health knowledge, limited health seeking behaviour, or barriers such as language, distance and cost. 3MDG partners, in particular the Collective Voices initiative, worked to overcome these barriers at the local level. For example, emergency referrals supported by village health funds could overcome cost barriers, and employing local people as health workers could help mitigate language barriers.

However, despite these efforts, there are still places where access challenges are insurmountable for local organizations and implementing partners, such as Rakhine. More efforts is needed at higher levels to guarantee access and ensure equitable delivery of health services. Development and humanitarian partners, including the Access to Health Fund, must do more to advocate for increased space and access for health care.

3MDG PARTNERS WERE POSITIONED WELL FOR EMERGENCY RESPONSE, BUT NEED MORE TRAINING IN PREPAREDNESS

Myanmar is conflict-affected, and amongst the most prone in the world to natural disasters, especially floods and storms. The ability to respond in an emergency is thus important for health service continuity. 3MDG partners were well-positioned to respond as they already had established relationships with the community and administrators, but they did not always have the right skills or financing for emergency response or preparedness activities. More training, delivered in a partnership with HARP-F, a UK Department for International Development (DFID)-funded humanitarian relief organization, and access to more contingency budgeting was introduced late in 3MDG. Partners could develop emergency preparedness plans and take stock of where they may be able to contribute during an emergency. For example, 3MDG partners who had received training from HARP-F were able to contribute to relief efforts in the southeast of Myanmar when it was affected by floods in 2018. Emergency preparedness activities will continue in Access to Health.

WITH THE RIGHT SUPPORT, THE MINISTRY OF HEALTH AND SPORTS CAN FIND SOLUTIONS TO TOUGH CHALLENGES

During the 3MDG years, challenges related to conflict and system weaknesses persisted for health, but Myanmar underwent positive changes, including increases in the health budget accompanied by Ministry of Health and Sports commitments to universal health coverage and leaving no-one behind. In this context, 3MDG and other development partners worked to build a trusting, open relationship with the Ministry of Health and Sports. This groundwork, alongside the Ministry’s recent maturation and willingness to change, has meant that new innovative initiatives could be trialed and the envelope pushed. Policies and plans being developed are now formulated in a more inclusive way, with more focus on important cross-cutting themes, and the Ministry is more willing to include new concepts and ideas in their work. Large bureaucracies can take time to change, but the Ministry is demonstrating that with the right approach and the right support, they are ready and willing to make necessary changes.

INTEGRATING SERVICES ENABLES A CONTINUUM OF CARE TO BE DELIVERED

In Myanmar, fragmentation of the health system has resulted in health workers and volunteers who only offer a limited set of services, delivered in a non-comprehensive way. This can also result from donor and development partner priorities driving activities, especially if they are focused on specific diseases or are not well-aligned to the Ministry of Health and Sports. However, challenges in Myanmar around access and financing mean that it is important to maximize the amount of health care that can be delivered – per project, per health care worker, per volunteer, per dollar. A better integrated approach, which addresses the ‘continuum of care’, may be able to result from donor and development partner priorities driving activities, especially if they are focused on specific diseases or are not well-aligned to the Ministry of Health and Sports. However, challenges in Myanmar around access and financing mean that it is important to maximize the amount of health care that can be delivered – per project, per health care worker, per volunteer, per dollar. A better integrated approach, which addresses the ‘continuum of care’, may be able to result from donor and development partner priorities driving activities, especially if they are focused on specific diseases or are not well-aligned to the Ministry of Health and Sports.

FLEXIBILITY IS NECESSARY TO ADJUST TO A CHANGING COUNTRY AND NEW ROLE

Myanmar is a country that has recently opened to the outside world, and is in the midst of a transition from military dictatorship to democracy. The number of donors has increased and public spending on health has grown. Within this rapidly changing context, having the flexibility to respond helps an organization maintain its relevance. For 3MDG, the biggest change was its shifting role within Myanmar’s health system. 3MDG went from supporting a substantial part of the health budget, to just accounting for a small fraction of it. This, combined with the Ministry’s growing ability to take more responsibility for health service delivery in areas they could access, meant 3MDG had to transition into an organization that filled gaps, piloted new approaches, and worked in areas outside of government control. For example, in Yangon and in ethnic health organization areas, partners piloted strategic purchasing projects that trialled new approaches to paying for health services, in line with increasing centralization of operational research and piloting new approaches for the Fund. The Fund also began to work more extensively, from 2015 onwards, in conflict-affected and non-government controlled areas such as the Special Regions. This was in recognition that they are inaccessible to government health providers and remain a serious gap due to the limited capacity of health providers responsible for these areas. Without this ability to adapt, 3MDG would have stood in the way of the Ministry taking responsibility for the health of the people of Myanmar.

TO PROVIDE SERVICES TO PEOPLE WHO USE DRUGS, ACTIVITIES TO OVERCOME BARRIERS ARE NEEDED AT ALL LEVELS

Providing care to people who use drugs is enormously challenging, and access to services is limited by community resistance, stigma and discrimination, limited resources in public settings, and fear of the police by people who use drugs. The response from 3MDG to these multi-faceted challenges was focused on expanding access, and reducing stigma and resistance to services. This work, which has been long-term, has made clear that drug use and its health consequences cannot be tackled at only one level or with only one group. There are many changes needed from policy reform in Nay Pyi Taw to working with communities and community leaders to help them understand Harm Reduction services, drug dependency, and rights-based approaches. This work needs to escalate as the drug use problem in Myanmar continues to worsen, and must include prevention work with young people and expansion of services to include all groups and meet all client health needs.

REACHING THE MOST VULNERABLE REQUIRES THE RIGHT DATA, CLEAR DEFINITIONS AND CONCERTED EFFORT

When the 3MDG Fund was designed and set-up, Myanmar suffered from poor health outcome. Findings from the 2010 Census demonstrated and confirmed a lack of health equity across the country. The 3MDG Fund was designed with the intention to restore health equity by addressing disparities and targeting health services towards poor and vulnerable people. However, the Fund’s ability to do this was uneven across the programme. There were challenges at each step of the process – which was to first clearly define vulnerability, identify who was vulnerable, target services towards these populations, and finally measure who had been reached – often related to limited funding to carry out the level required to target and measure service reach.

The 3MDG Fund learned that without clear definitions and adequate data, health services will more often reach those who are relatively less vulnerable. Some barriers to healthcare can be overcome through project design and community engagement, but without the ability to explicitly identify and target vulnerable people, the ability of any fund to impact overall health equity is unclear. This was also noted in the Final Evaluation of the 3MDG Fund, which is a preliminary document that was being finalized as of July 2019.

This does not undercut the achievements of the 3MDG Fund. Services often reached people who did not have access, in many cases, the work of partners was lifesaving. It does mean, however, that the Access to Health Fund needs to do more work to target, identify and measure health services reaching vulnerable people. That work has already begun, and is crucial to ensure services are targeted to the most vulnerable and health equity can become a reality in Myanmar.
LESSONS LEARNED

PARTNERS NEED MORE THAN CONFLICT SENSITIVITY TO MAINTAIN SERVICES WHEN CONFLICT ERUPTS

Large parts of Myanmar continue to be affected by active or latent conflict, and the outbreak of conflict can severely hamper the delivery of health services. The safety of health personnel cannot be guaranteed, access may be restricted and health seeking behaviour may diminish. 3MDG partners, and the Fund Management Office, often did not have the experience or expertise to know how to respond. Working under a conflict sensitivity strategy is a good first step, but it needs to be sufficiently mainstreamed and translated into practical, specific actions at the ground level. To meet partner needs, technical support was provided by Community Development Association and RAFT in the later years of the Fund. They were able to suggest activities and approaches to overcome challenging situations. In Kachin for example, a number of coping strategies were discussed when conflict worsened: working closely with local organizations who had already established trust with the community and using contingency budgeting to distribute food and non-food items in internally displaced person camps. Similar support and solutions that are funded, practical, implementable and solution-based will continue in the Access to Health Fund.

BOLDER STEPS ARE NEEDED TO IMPROVE HUMAN RESOURCES

Human resource issues are among the most significant that face the health sector in Myanmar. There are too many vacant posts, attrition of community-based health workers is high, and retention of basic health staff in rural areas is poor. Without the right people in the right places, health disparities in health will persist and Myanmar cannot achieve universal health coverage. 3MDG and other partners have worked to improve the quality of the health workforce, for example, Jhpiego has worked with the Ministry of Health and Sports to improve education, accreditation and standardization of midwifery, nursing and medical education, and human resources for health management systems. However, challenges remain and bolder, more sweeping changes are needed. The Ministry of Health and Sports is committed to changing, as evident by their development of a standardized policy for village health workers and the formation of a dedicated Ministry department for human resources for health. This should be used as a starting point for all future initiatives – but partners need to do more to advocate beyond the Ministry of Health and Sports to facilitate the needed reforms in remuneration and deployment of government workers.

ENGAGING THE COMMUNITY IS CRUCIAL TO REDUCING RESISTANCE TO SERVICES

The impact that pressure from the community has on the delivery of health services has reinforced for 3MDG the importance of engaging the community in all health interventions. This pressure may come in a variety of ways, from resistance to services, such as family planning or Harm Reduction, to cultural norms undermining a woman’s ability to make decisions about her own care in a patriarchal society. In recognition that the community’s involvement and inclusion in health education and planning is vital to grow their understanding and facilitate access, demand generation and high quality care, community engagement and health education have been a longstanding part of 3MDG programming. Work with communities on improving their health literacy can also reduce stigma and resistance towards particular health conditions and services. This includes family planning, where uptake of contraceptives has increased in every state and region where 3MDG works, including Chin State, which faced particular challenges and where regular advocacy and educational models were not proving effective. In efforts to overcome barriers and ensure health-related messages are disseminated widely and heard by all, it is also important to involve community leaders and other influential persons in community engagement activities.

Fighting TB in Yangon

Hlaing Hlaing was scared when she was first diagnosed with TB - but with the support of her family and the National TB Programme, she could get through the treatment.

Hlaing Hlaing Htet, 18-years-old lives with her parents and eight siblings. She dropped out of school a few years ago and spends her time helping out at the family’s grocery store. But, last June, something changed. Hlaing Hlaing Htet started losing weight and incessant coughing and sweating would keep her up at night. Her father suspected that she might have tuberculosis (TB) and took her to see a TB mobile team.

“I started coughing and sweating a lot at night. I was always ill during the evening. After two months with symptoms, my parents thought it could be TB but we didn’t think we had enough money to go to the hospital.”

“One day, my father told me about the mobile TB clinic and we decided to go. He said it was free! Doctors checked my X-ray and said I had TB. Everyone there was very kind and supportive, and they explained to me about TB, but I only wanted to cry.”

The team, co-ordinated by the National TB Programme and supported by 3MDG, was making its way through town. They tested Hlaing Hlaing Htet and diagnosed her with TB.

“I started the treatment right away. I never experienced bad symptoms, but everyone was scared of contracting TB when being around me. I used to cry a lot. I felt weak and ashamed.”

“But finally, when I went to the hospital six months later, the nurse said I was cured. My family and I were so happy, we danced.”

“When I was cured, we were so happy we danced!”

Photo: John Rae/UNOPS
THE WAY FORWARD

With continuing challenges in Myanmar’s health system, the United Kingdom, Sweden, United States and Switzerland committed more than 215 million US dollars to improving the health of Myanmar’s most vulnerable people living in conflict-affected areas through the UNOPS-managed Access to Health Fund. This pooled fund is the follow-on mechanism to the 3MDG and will build on the lessons learned from 3MDG. It will operate from 2019 to 2023.

The Access to Health Fund focuses on areas and approach aim to tackle the stark health inequities that persist in Myanmar, particularly in conflict-affected areas of the country. People living in conflict-affected areas are likely to experience poorer health outcomes than those who do not, for example, with infant and under-five mortality rates double to triple the national averages. People who live far from health services, in remote or hard-to-reach places, are more likely to suffer due to lack of transportation or the high costs of accessing care, or because health facilities are not available at all. Access to Health Fund partners will focus efforts towards areas affected by conflict, under a conflict-sensitive approach that aims to first ‘do no harm’, and then foster social cohesion by bringing actors together around health. An integrated approach, aiming to bring ‘more health for dollars’ by expanding the services currently provided, is well-suited to these areas where services may be more limited, and access and security pose challenges. Support will be provided directly to non-government health providers, such as ethnic and community-based organizations, who provide essential care where there the government cannot reach. Improving the capacity of these organizations, as well as their coordination with the Ministry of Health and Sports, is a priority.

Health inequities may also result from ethnicity, gender, sexuality or ability, and thus, Access to Health Fund will focus on the most under-served and vulnerable populations, under a human rights-based approach. Reaching those who are furthest behind, across the thematic areas of the Fund – maternal, newborn and child health, sexual and reproductive health and rights, nutrition, HIV and drug use, tuberculosis and malaria – will require significant investment with a multi-pronged approach. Partners will be supported to provide more inclusive services that overcome barriers to care, for example, by focusing on reducing language barriers for ethnic minorities by training local health staff. Services will be targeted towards those most in need, such as care provided to prisoners, or mobile TB visits and outreach to the most remote areas. Prevention and response to drug use will expand to include other services, including sexual and reproductive health and rights, and female-friendly centres, in recognition that stigma can often prevent people who inject drugs accessing other health services.

Access to Health will also continue work in health system strengthening, sustaining and building on the gains achieved by the 3MDG Fund. These efforts will also consider how the system can be strengthened to target, account for, and meet the needs of the most vulnerable people in the country. The Access to Health Fund is aligned with national health goals and priorities, especially the achievement of Universal Health Coverage by 2030 as laid out in Myanmar’s National Health Plan 2017-2021. The Access to Health Fund will be supporting the Myanmar response to communicable diseases (malnutrition, HIV, and tuberculosis), maternal, newborn and child health, sexual and reproductive health and rights, and nutrition and will also dedicate resources to Myanmar’s health system through investments in human capacity, infrastructure, and management systems.

Maternal, newborn and child health programming for the Access to Health Fund will follow an integrated approach focused in conflict-affected areas. Integration means that people who may only have limited contact with the healthcare systems are able to have more of their health needs met. Integration follows the continuum of care model of health care delivery as laid out in the National Health Plan 2017 - 2021, which focuses on the delivery of the Basic Essential Package of Health Services to everyone in Myanmar, before expanding the items available in that package.

For sexual and reproductive health services, the focus for health education will be on adolescents – especially those who are vulnerable because they are out-of-school, working or disabled. Services, such as family planning, contraceptives, cervical cancer testing and treatment, and post-abortion care, will be provided.

Access to Health Harm Reduction partners are expanding the service package to include sexual and reproductive health, tuberculosis, malaria and mental health in recognition of the importance of a comprehensive approach for people who use drugs and their families. Access to Health partners will also expand services to include mental health assessments and treatment due to the risk of mental and psychiatric disorders from drug use.

Ending TB by 2030 is a target of the United Nations Sustainable Development Goals. The next five years will be critical for the country to ensure that the momentum is translated into an accelerated End TB response. Based on the preliminary findings of the TB prevalence survey in 2018, the TB national prevalence declined compared to the previous prevalence survey result, but huge variations in prevalence in different geographic areas remain. It is thus important to have specific recommendations on active case finding and to accelerate TB case finding in TB high burden townships and in inaccessible areas.

3MDG contributed significantly to TB case finding in Myanmar, and Access to Health will maintain this momentum through community-based TB case finding, case finding in clinical groups (patients with diabetes and pregnant mothers), case finding in groups of people in settings (prisoners and miners), and TB cases finding through Integrated Community Malaria Volunteers approach. TB services will be integrated into almost all of maternal, newborn and child health implementing partner activities to accelerate TB control activities.

Malaria elimination is targeted in all states and regions by 2030. This requires strengthening of the case surveillance system, improving access to diagnosis and treatment and improving preventive interventions to prevent parasite transmission. A significant change from 3MDG is the prioritization of more comprehensive services, will also see malaria diagnosis and treatment offered alongside harm reduction and other services.

Health system strengthening services for Access to Health will be targeted towards ‘leaving no-one behind’ in line with the National Health Plan and universal health coverage. The coordination and monitoring of the National Health Plan 2017-2021 at central, regional and township level will continue through the National Health Plan Implementation Monitoring Unit (NIMHU). Access to Health will also support the development of the newly introduced State Health Plans and Inclusive Township Health Plans (ITHP) and capacity building of State and Township Health Working Groups to improve health planning. The Fund will also – for the first time – give grants directly to state health departments for health system strengthening.

Improvements in supply chain management, through defined essential medicine and equipment list and health facility assessments, will continue. Strategic purchasing pilots will provide evidence to health financing models – furthermore, the new health financing strategy will be rolled out and its implementation supported. Efforts to improve health information systems will continue. Finally, Access to Health Fund will also seek potential areas to invest in innovations and digital communications for health that can scale, providing breakthrough solutions to respond to unmet health needs of vulnerable populations and improve health outcomes.
From the design phase of the Fund, until its closure in 2018, Myanmar underwent many changes. Opportunities to work with government increased, but conflict and natural disaster continued to affect programming.
INTRODUCTION

When the 3MDG Fund was designed in 2010, Myanmar was politically isolated and economic management was poor. Investment in the health sector in 2009 was the lowest in the world. Access to health care was limited, especially for those living in conflict-affected areas, where decades of armed conflict and neglect negatively impacted the health system and the mental and physical health of communities. High out-of-pocket payments created financial barriers to access that exacerbated other barriers, including remoteness, poor quality roads and transport. The supply chain for equipment and medicines was unreliable, and human resources for health were limited in many areas.

3MDG was designed to tackle these challenges with a focus on maternal, newborn and child health and HIV, tuberculosis (TB) and malaria. The Fund was set up in mid-2012 and implementation began in January 2013. Originally scheduled to end in 2017, 3MDG was extended until the end of 2018 before being reconfigured as the Access to Health Fund (2019-2023).

Over the years from the design of the 3MDG Fund till its close, sweeping changes across Myanmar both created opportunities and presented challenges to the Fund’s operations. At the start, the opportunity to work closely with the government was limited. This changed as the country opened up: a strategic review of the 3MDG Fund in 2014 deemed that the time was right for a closer relationship with the Ministry of Health and Sports. Shortly after in early 2015, the Ministry was permanently added to the 3MDG Fund Board, encouraging greater alignment to Ministry priorities and fostering national ownership of the programme.

Alignment to the Ministry of Health and Sports’ priorities was supplemented by increasing the support given to health providers who deliver health care in places and contexts where government reach is limited and places where the government may have no access at all, including ethnic and community-based health organizations. This dual, close, sweeping changes across Myanmar both created opportunities and presented challenges to the Fund's opportunities to work with the government of Myanmar, and the need for expanded access to health services was urgent. Hence, the Ministry of Health and Sports was not originally a member of the Fund Board. Following the process of transition from military dictatorship towards democracy since the 2015 election of the National League for Democracy, there have been more opportunities to work more closely, including the Ministry of Health and Sports. 3MDG’s governance arrangements responded in 2015 by including the Ministry of Health and Sports as a permanent board member, where representatives could provide guidance and feedback, share priorities, ensure alignment and request support. This helped strengthen governance and stewardship of the health sector and helped support the delivery of the 3MDG Fund.

More financing allocated to support service delivery at township level and below, for example, was an opportunity to have a transformational impact on the provision of health care across the entire country, and support Myanmar’s path to universal health coverage.

Growing space for health

3MDG was established amidst increases in government spending on health, in line with the government’s commitment to achieving universal health coverage as part of its 2030 vision. In 2012/2013, the health budget was only 94 million USD, this grew more than ninefold to over 850 million USD in 2016/2017. This level of change was a positive sign, but it must be recognized that the base budget level was extremely low (the lowest in the world, at one point) and thus the impact on out-of-pocket expenditure for the population was limited, according to the World Bank Myanmar Health Financing System Assessment Report* from 2018. Significant challenges also remain in the execution of the available budget, and areas of the country that the government is unable to reach due to conflict, or because they are outside of government control.

However, the increased budget did signify a growing commitment to health, particularly to help finance the delivery of health services and expand existing coverage. This helped provide a concerted space for the 3MDG Fund to operate, and helped facilitate the government’s efforts to meet the health needs of more people, in more places. More financing allocated to support service delivery at township level and below, for example, was an opportunity for the 3MDG Fund to align with and complement the Ministry of Health and Sports to support township health departments. This work began in earnest in 2014 for maternal, newborn and child health services. These changes were accompanied by an increase in the number of donors in the health sector, which required greater coordination, but also afforded the opportunity for synergies and pooled resources.

GOVERNANCE, ALIGNMENT AND PARTNERSHIP

Governing the Fund

The initial governance arrangements for 3MDG were built on the lessons learned from the two preceding funds: The Three Diseases Fund (2007-2012) – working on HIV, tuberculosis (TB) and malaria – and the Joint Initiative for Maternal, Newborn and Child Health (JIMNCH) (2010-2012). The governance arrangements took into account the Fund’s expanded scope as well as contextual changes in Myanmar.

As the Fund Management Office, UNOPS was responsible for the effective, transparent and efficient management of the Fund on behalf of the Fund Board. UNOPS had delegated authority for the management of the 3MDG Fund in accordance with the policies and priorities established by the Fund Board. The Fund Board was originally made up of representatives from each of the donors and three independent experts. In addition, there was a parallel Senior Consultation Group that was chaired by the Ministry of Health and Sports and included key representatives from the Ministry of Health and Sports, United Nations, and international and local non-government organizations.

During the design stages of the Fund, there were fewer opportunities to work with the government of Myanmar, and the need for expanded access to health services was urgent. Hence, the Ministry of Health and Sports was not originally a member of the Fund Board. Following the process of transition from military dictatorship towards democracy since the 2015 election of the National League for Democracy, there have been more opportunities to work more closely, including the Ministry of Health and Sports. 3MDG’s governance arrangements responded in 2015 by including the Ministry of Health and Sports as a permanent board member, where representatives could provide guidance and feedback, share priorities, ensure alignment and request support. This helped strengthen governance and stewardship of the health sector and helped support the delivery of the 3MDG Fund.

A subsequent review found 3MDG’s governance arrangements “fit for purpose.” The Fund was better aligned to health sector priorities and better able to support the Ministry of Health and Sports move towards universal health coverage. The Ministry’s close participation continued until the end of the Fund in 2018.

The Ministry was also consulted on a number of occasions during the design and contracting phases of the Access to Health Fund. This practice will continue throughout the lifetime of the Access to Health Fund.

*Teo, Hui Sin; Cain, Jewelwayne Salcedo. 2018. Myanmar Health Financing System Assessment Report*
Restructuring the Fund Management Office

In 2017, five years after being established, the Fund Management Office underwent significant restructuring to better support integrated programming, reduce vertical silos, and increase the proportion of national staff in the office. Previously, programme teams were structured in “components,” divided by disease area:

- Component 1 was maternal, newborn and child health
- Component 2 was the three diseases - HIV, tuberculosis and malaria
- Component 3 was health systems strengthening.

In late 2017, the teams were restructured to be organized by state and region to support integrated programming, collaborate with the state and regional level of the Ministry of Health and Sports, and deepen engagement with ethnic health organizations. As a result, teams could effectively and rapidly respond to state-level contextual changes. For example, when floods affected the southeast of Myanmar, the relevant geographical team could coordinate with existing actors in the affected states to tap into contingency funding and available capacity to effectively respond with those who already deeply understood the context.

In the restructure, Programme Teams were organized based on four geographical regions:

- Rakhine
- Chin
- Kayin, Kayah and Shan;
- Kayin, Kayah and ethnic health organization areas; and Yangon.

These teams were supported in a matrix approach by a Strategy Team, made up of three sub-tasks:
- Health Systems Strengthening, Health, and Accountability
- Equity and Inclusion, and by Monitoring and Evaluation, Procurement and Directors’ Office and Communications.

This matrix structure will continue into the Access to Health Fund, allowing greater focus on contextual differences at state level, closer relationships with state-level actors, and better integration of health services.

These changes were also accompanied by the nationalization of the office, which saw full-time international positions reduced from 12 in 2016 to three at the end of 2018. See more in the Lessons Learned chapter, page 190.

Working in Partnership

3MDG fostered strong partnerships with key stakeholders, including the Ministry of Health and Sports, United Nations agencies, non-governmental organizations, beneficiaries, affected populations and communities. The Myanmar Ministry of Health and Sports was central to planning and implementation across all aspects of the 3MDG Fund, with Ministry staff at national, regional, state and township levels regarded as key stakeholders. The Ministry was also a direct beneficiary of the Fund’s capacity building and systems strengthening works. Financing was aligned to the Ministry’s sector strategies, with technical interventions based on the specific interventions endorsed.

EQUITY AND PROGRAMME DESIGN

Introduction

The Constitution of Myanmar says that every citizen shall have the “right to health care.” This fundamental right must be upheld no matter where they are born, their gender or ethnicity, or how much money they have. This can only be guaranteed through health equity, which is only realized when each individual has a fair opportunity to enjoy a healthy life. A focus on health equity helps concentrate efforts on those who are most vulnerable, most isolated, distant and most hidden.

3MDG had a unique role to play in building health equity, aligned to the priorities of the Ministry of Health and Sports and the National Health Plan. Populations beyond the reach of the government are often most in need. 3MDG was able to complement Ministry efforts by filling challenging gaps in health service delivery and helping to make the health system truly universal. This meant working on some of the most complex issues in Myanmar’s health response: extending access to health services in remote areas; working with vulnerable, criminalized and stigmatized population groups; and working in areas affected by conflict.

Maternal, newborn and child health services were targeted to areas that are remote or affected by conflict. Tuberculosis (TB) active case detection activities prioritize prisons and those who live in urban slums, and malaria interventions target endemic areas. 3MDG’s HIV Harm Reduction programme brings services to people who inject drugs. They can be high-vulnerable and face criminalization and stigmatization.

Even when health services are in place, people can face barriers in reaching them. These include distance, cost, embedded beliefs about health services, lack of trust, stigma, discrimination and links to the Collective Voices initiative, 25 local civil society organizations uncovered the causes of limited access to health care, and all 3MDG partners incorporated the principles of accountability, equity, inclusion and conflict-sensitivity into their work, with the aim to overcome these barriers to care. 3MDG’s support to emergency referrals helps overcome barriers of distance, cost and lack of knowledge about available health services, by training health workers to detect and refer pregnant women and children under five who need emergency care.

3MDG’s approach centred collaboration and co-ordination, to build trust and facilitate enhanced dialogue between key stakeholders, including the Ministry of Health and Sports, ethnic health organisations, private providers, non-government organizations and civil society.

Designing the Maternal, Newborn and Child Health Service Delivery Component

Targeting services towards those in need

Maternal, newborn and child health interventions for 3MDG partners were focused on areas where existing services were weakest, due to conflict or remoteness, or based on the epidemiological context. Locations were chosen following extensive processes conducted together with the Ministry of Health and Sports.

In 2012, under the leadership of the Ministry of Health, the 3MDG Fund used survey data to compare health situations and better understand disparities across Myanmar’s states and regions. To ascertain which乡镇ships required priority support, the Fund Management Office staff consulted with state and regional health authorities and collected data and conducted baseline assessments at township level. Implementing partners also conducted comprehensive township assessments and stakeholder analyses. The Fund also coordinated with other partners to minimize gaps and avoid service overlaps and considered how important it was to maintain service continuity to ensure important gains that had already been made were not lost.

The first batch of townships that received 3MDG support was a continuation of the Joint Initiative on Maternal, Newborn and Child Health (JIMNCH) townships in the Ayeyarwady Region. Townships in Chin and Magway were added next, targeted regions needing to address the highest infant mortality rates, under-five mortality rates, and maternal mortality rates in the country. In 2014 and 2015, projects began in Kayah, Shan, Rakhine and Special Regions with a focus on conflict-affected and hard-to-reach areas, many of them beyond the control of the government and outside the reach of government health authorities, had poor health outcomes and limited access to care.

The difficulty of the start-up of the programme meant that some of the intended money for maternal, newborn and child health was re-directed towards other initiatives. There was originally US$ 200 million earmarked for maternal, newborn and child health in the Fund design, and the total amount ultimately spent was US$ 130 million. This was primarily due to slow start-up, time-consuming township selection, poor fund flow and difficulties in rolling out the programme in hard-to-reach and conflict-affected areas. Some implementing partners and township health departments had little experience in planning and delivering services using comprehensive township health planning processes. This later improved as coordination improved. The money was redirected to important initiatives in communicable diseases, and in health systems strengthening - particularly in infrastructure projects: the building of 82 rural health centres, and four TB facilities.
Working together in a township-wide approach

Partnership between the township health department and implementing partners was structured around a comprehensive township planning tool and associated service delivery in maternal, newborn and child health; immunization, nutrition; and health systems strengthening. Under the leadership of the township health department, implementing partners provided financial and technical assistance. 3MDG supported a wide range of activities at township level to improve coordination through meetings; capacity through training and supervision; quality of service delivery; health education and promotion; and outreach. As projects gathered speed in each location, oversight and leadership from the state and regional health departments – not an original focus of the Fund – became stronger through meetings and supervision. In the final year of 3MDG, connections were fostered between township-based activities and the National Health Plan Implementation Monitoring Unit’s (NHPIU) health system strengthening activities launched the year before. This was done by developing needs-based, context-specific state health plans in Chin and Kayah states.

Challenges with reaching vulnerable populations with maternal, newborn and child health services

The 3MDG Programme Description identified reaching vulnerable populations as a goal of the Fund. Identifying which populations were vulnerable in the area of maternal, newborn and child health was done by considering epidemiological data (eg. maternal, infant and under-five mortality rates) at a township level. However, with the data available at the time, it was not possible to identify vulnerable populations at more disaggregated levels, such as the village tract, village, or even at the individual level. Further, other aspects of vulnerability, such as poverty or disability, were also difficult to locate amongst the population due to limited data.

3MDG was also unable to ascertain when vulnerable populations were reached for most of its indicators due to the lack of nationwide mechanisms. For those that could be measured, such as emergency referrals (which indicated if the patient receiving the referral was hard-to-reach or non-hard-to-reach), it was clear support intended for the most hard-to-reach persons did not always reach them.

However, 3MDG partners and the Ministry of Health and Sports worked to reach vulnerable populations. Outreach and active case finding, including remote areas, were prioritized. Partners and basic health staff received yearly training on accessibility, equity and inclusion principles, which aimed to design and deliver services that overcome the barriers to health care that many people in Myanmar faced. This was bolstered in 2015 by the Collective Voices programme. Civil society and community-based organizations researched the barriers to health care and then conducted demand generation, community engagement and trust-building activities to overcome them. Village health funds were set up in many locations to overcome financial barriers to access.

However, more work is needed in the Access to Health Fund to explicitly define, identify, reach and measure vulnerable populations. As noted in lessons learned page 194, if vulnerable populations are not intentionally targeted, it is clear that it is the least vulnerable people who will reach the services on offer. This is still important: these are people in need of health care services, but if the Access to Health Fund is to live up to its mandate, more concerted effort is needed.

Working in conflict-affected areas

Working in conflict-affected areas requires good knowledge of the context, relationships with local actors, and flexibility and responsiveness to adjust to changing circumstances.

During the 3MDG lifetime, the intensity of the world’s longest-running civil war in Myanmar has fluctuated, with violence periodically increasing and decreasing in different areas. Issues related to ethnicity and conflict affected the delivery of health services. Certain health challenges may have worsened due to conflict, the health needs of displaced people are challenging to meet, and non-government providers have limited resources. However, the peace process allowed for increased cooperation and communication between the Ministry of Health and Sports, local authorities and ethnic health organizations. The willingness of the Ministry to engage and recognize these organizations has provided hope for future effective and context-appropriate health care arrangements.

3MDG financed health care in conflict-affected areas and Special Regions to address the health needs of underserved populations. For example, work in Kayah State began in July 2014, with the International Rescue Committee (IRC) receiving 3MDG support maternal, newborn and child health service provision across all seven townships in the state. In Special Regions, implementing partners were able to act as a bridge between the Ministry of Health and Sports and health authorities, to support integrated services for minorities and hard-to-reach populations.

3MDG-supported project implementation in conflict-affected areas has been guided by a conflict sensitivity strategy. The strategy adheres to international best practices related to ‘do no harm’, including conflict sensitivity principles and a clear strategy to engage in conflict-affected areas. In consultation with the Ministry of Health and Sports and other stakeholders, implementing partners worked with the township health departments, ethnic health organizations and civil society groups that had access to areas not accessible to basic health staff.

3MDG facilitated advocacy and dialogue to enhance cross-learning opportunities with a wide range of partners, governmental and non-state actors. This will continue in the Access to Health Fund, which focuses almost exclusively on working in conflict-affected areas in recognition of the vulnerability of people living there. Working together with these partners to ensure continued access to health services will be critical to building equity in health outcomes in Myanmar.
HIV, Tuberculosis and Malaria

3MDG prioritized three communicable diseases, HIV, tuberculosis (TB) and malaria major public health issues in Myanmar. Though they can affect anyone, these diseases are particularly debilitating for populations that are already vulnerable. These groups may have difficulty in accessing services because they are living in rural, remote or conflict-affected areas, engaged in criminalized or highly stigmatized activities, part of migrant or mobile populations, or facing incarceration in prisons or labour camps. To achieve health equity, 3MDG focused on reaching these groups.

Tuberculosis

Reaching those most-at-risk

Tuberculosis (TB) prevalence data suggests that late- or advanced cases are detected more often in remote, hard-to-reach, mobile or migrant populations and in urban slum areas compared to stable urban populations who have ready and easy access to health facilities (National TB Prevalence Survey, 2009). Hidden cases of the disease are common, as those who suffer from it may be reluctant to access services, or they may be financially, geographically, or socially out-of-reach. With 3MDG funding, nine ‘TB active case finding’ mobile teams operated strategically throughout Myanmar to improve access to diagnosis and early treatment. Their focus was finding the most vulnerable populations, including prisoners, people who use drugs, HIV co-infected patients, and migrant populations. They tested suspected cases, and referred them onwards for further confirmation testing and treatment where necessary. At community level, volunteers were trained to provide testing and treatment adherence support for TB and multi-drug resistant TB.

Malaria: Adjusting programming amongst changing context

Malaria was a significant health problem when the Fund began operations. However, the number of deaths has reduced by 39% over the course of 13 years, with 7,100 deaths in 2005, and only 12 deaths in 2018. The achievement is so significant that the government is now looking towards elimination by 2030. For this to be realized and for improvements to be sustained, investments in malaria testing and treatment remained a priority throughout the 3MDG lifetime.

There was particular emphasis on the containment of Artemisinin-resistant malaria and pre-elimination work. Health workers targeted conflict-affected populations in co-ordination with ethnic health organizations, as well as other hard-to-reach groups.

To respond to the changing epidemiology of the disease, programmes like ‘Integrated Community Malaria Volunteers’ were piloted. Volunteers were trained to identify, treat and refer other health conditions to make sure volunteers who had already been trained in malaria interventions could be utilized as prevalence dropped.

In Sagaing, where the pilot took place, malaria volunteers could tackle major causes of death for children under five, such as pneumonia and diarrhea. As the signs and symptoms of these diseases could be easily taught, community-based volunteers could make an enormous difference to health in these under-served locations and ultimately helping save many lives.

HIV: Expanding services for people who use drugs

Unsafe drug use – especially injecting drug use and associated risky behaviours, such as unprotected sex – is an efficient mode of transmission for sexually transmitted diseases. That increases the risk of HIV, and in fact more than a quarter of new HIV infections (28 percent) in Myanmar are among people who inject drugs. Higher levels of co-infection of sexually transmitted infections, HIV, Hepatitis C and TB are also prevalent for this group (National Strategic Plan on HIV and AIDS (2016-2020)). To exacerbate the risk, the group is criminalized, highly stigmatized, and incredibly vulnerable in the Myanmar context. In support to the National HIV and AIDS Strategy, 3MDG financed Harm Reduction services in Shan and Kachin states, and Mandalay, Sagaing and Yangon regions. Activities are prioritized in areas with large numbers of people who inject drugs, and include drop-in centres, needle and syringe exchange programmes, regular testing and treatment, prevention and advocacy.

Working in Nutrition

Nutrition is a significant public health challenge in Myanmar. Interventions at township level attempted to address this challenge from the start of the Fund, including indicators related to immediate breastfeeding initiation after childbirth and distribution of micro-nutrients. 3MDG’s work in nutrition greatly expanded in 2016 with concentrated support to the National Nutrition Centre in service delivery, as well as provide support to the Multi-sectoral National Plan of Action on Nutrition (MS-NPAN). This plan was developed with Ministry of Health and Sports’ leadership and involvement of other ministries such as Ministry of Agriculture, Livestock and Irrigation, Ministry of Social Welfare, Relief and Resettlement and Ministry of Education in recognition that nutrition is cross-cutting.

Collaboration with other nutrition actors, such as the Livelihoods and Food Security Fund (UFTF) and the Humanitarian Assistance and Resilience Programme Facility (HARP-F), further extended 3MDG’s reach and positively impacted the work of the Fund.

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To strengthen maternal, newborn and child health and to complement service delivery, support to the Ministry at central level included the roll-out of Community Case Management, Helping Babies Breathe and Basic Emergency Obstetric and Newborn Care training together with the Maternal and Reproductive Health and Child Health divisions. Multiple new initiatives in maternal and child health surveillance were also carried out with a variety of partners.

Together with the Ministry of Health and Sports, 3MDG initiated and technically supported policy work to standardize the different community-based health workers in Myanmar, who had previously had different levels and quality of training, a range of incentive schemes, and a variety of tasks to perform depending on their location and employer.

Continuum of Care: A More Integrated Approach

When 3MDG was established, HIV, TB and malaria programmes were designed vertically both for the Fund and the Ministry of Health and Sports, however, on recognition of the interlinkages between the diseases, this began to shift. Under the Basic Essential Package of Services that is a foundation of the National Health Plan 2017–2021, health service delivery follows a more comprehensive, continuum of care model.

3MDG partners began to provide integrated health care packages to beneficiaries rather than implementing vertical programmes. This was especially valuable for under-served, difficult-to-reach and remote communities in resource-limited settings. Methods of integration included the Integrated Community Malaria Volunteer (ICMV) programme, the addition of testing and treatment facilities for communicable diseases at other locations, such as maternal health and diabetes clinics, and the provision of other health services at drop-in centres and outreach under the Harm Reduction programme.

In the extension year of the Fund, in preparation for the Access to Health Fund and to better align to the framework of the National Health Plan 2017–2021, all partners, including maternal, newborn and child health partners, were asked to further integrate service delivery to provide services with comprehensive care. This transition was challenged in some cases, but ultimately led to more health services being available in resource-poor settings, with less financing and lower human resource requirements. This is further explored in lessons learned on page 187.

3MDG Annual Report 2018 and End of Fund Report
HEALTH FOR ALL: A RIGHTS-BASED APPROACH TO HEALTH

Myanmar has a largely rural population with a high degree of ethnic and linguistic diversity, alongside historical and ongoing insecurity and inter-ethnic conflict. There are significant levels of poverty, and women often experience limited decision-making power within families, a fact mirrored by lower levels of leadership and representation in public forums and institutions. Against this background, equitable access and people-centred health systems and services were crucial to the work of the Fund. This was reinforced by the Fund’s overall strategy to operate in conflict areas. It requires an in-depth understanding of the context of these operations to ensure health activities do not create or worsen conflict, and involves stakeholders at all stages, among other principles.

3MDG set an overarching goal to contribute to national progress towards the health Millennium Development Goals through a rights-based approach. This meant ensuring equal access to health services, empowering women, engaging communities in decision-making and implementation, ensuring the voices of minorities and other vulnerable communities are heard, and more.

3MDG partners removed barriers to health care through health education and demand generation activities, improving service quality and building trust through community engagement, removing financing barriers through emergency referrals, and working with communities and community leaders to reduce resistance to services like Harm Reduction and family planning. These activities, in particular community engagement and demand generation, have been implemented by specific civil society and community-based organizations, who are able to work closely with communities that they know and understand well. They have helped set up village health funds, and supported the capacity development of local health structures, such as village health committees. This work has also been integrated across the interventions of the Fund, with all partners having minimum requirements for their communication with communities through feedback and response mechanisms, meetings between service providers and community members, and representation for women on local structures such as village health committees.

3MDG’s rights-based approach was underpinned from inception by the principles of responsibility, fairness, inclusion and ‘do no harm’. The four principles formed the basis of the 3MDG Accountability, Equity and Inclusion Strategic Framework, and were streamlined in 2015 under the banner ‘Health for All’. The principles were also reflected in the Fund’s financing decisions, which targeted resources to those who could not otherwise access services or afford healthcare, including women and children, people living with HIV, and those in conflict-affected areas. The Health for All Strategy resulted in a simple, non-technical approach to communicating the Fund’s rights-based work and its four key principles to a range of audiences, including the Ministry of Health, non-government organizations, civil society organizations and communities. Through Health for All, 3MDG supported all stakeholders to adopt health policies and deliver health services in a more responsible, fair and inclusive way.

Accountability

3MDG supported training and resources to help implementing partners improve their approaches to participation and community feedback. This helped to create health accountability and responsibility amongst providers. See more in the Community Feedback Mechanisms box.

Fairness

To create more fairness in the health sector – ensuring that all people, no matter their gender or sexual identity, are able to access the health services they need – 3MDG supported activities that improved understanding of how needs may differ, increased access and provided essential services and enhanced women’s representation and voice. In 2018, the percentage of women in township health committees was 33 percent, and 42 percent of the members of village health committees were women.

Do No Harm

The principle ‘do no harm’ forms the basis of 3MDG’s strategy to operate in conflict areas. It requires an in-depth understanding of the context of these operations to ensure health activities do not create or worsen conflict, and involves stakeholders at all stages, among other principles.

3MDG financed health care in conflict-affected areas where the Ministry of Health and Sports had identified challenges to serve the population through the public health system. 3MDG partners act as an important bridge between ethnic health organizations, local authorities and the Ministry of Health and Sports, enabling greater coordination, communication and information sharing, thereby improving access to health services in areas that are not regularly accessible to government health staff.

Inclusion

3MDG supported services and interventions to ensure the inclusion of a wide range of population groups who were considered vulnerable. Partners received training on the inclusion of different groups, including women and young children, migrants, persons with disabilities, ethnic minorities, people living with HIV and those most at risk, such as people who inject drugs.

For example, inclusion of people with disabilities has been supported in a number of ways. This includes training for 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. For example, in 2016, Marie Stopes International worked with persons with disabilities to support their involvement in village health committees and health education sessions. Inclusion of disability was supported through yearly training and quarterly sharing sessions to implementing partners in delivering health services that are responsive and sensitive to the needs of disabled people, community-level awareness-raising and advocacy. In 3MDG’s project implementation, the needs of persons with disabilities were also prioritized with ramps, parking areas, wide (double) doorways and lifts.

3MDG also committed to ensuring people of all genders could equally benefit from interventions, as well as furthering gender equality through its 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 (see next page).

Listening to Voices

Hearing the community as they express their own health needs has been increasingly embraced by the Ministry of Health and Sports, with the elevation of community voices and feedback reflected in the National Health Plan 2017 – 2021. At the launch event for the formulation of the plan, the Minister of Health and Sports said: “I would like to hear the voices of those working at the ground level. We must include these voices and perspectives, we want a holistic perspective of what is happening in the country.”

3MDG was well-placed to support this through community feedback mechanisms, the Collective Listening to Voices initiative and participatory health planning. 3MDG encouraged implementing partners to listen to the voices of people living in the community, helping staff and organizations to understand the social factors that limit access to health care, be more accountable, increase awareness of how much people know about their project and correct minor mistakes and manage risks. This helps to increase local health and other authorities’ involvement and build trust between organizations and communities.

Community Feedback Mechanisms

Community Feedback Mechanisms within a rights-based approach are a key means of seeking out beneficiary views and addressing their concerns to improve service quality. The mechanisms provide a range of tools that promote transparency, accountability and the participation of communities to enhance impact. It encourages two-way discussions and exchanges of information between the partners who provide the services and the beneficiaries who use them. This allows local partners to engage communities in project planning and implementation as well as in monitoring and evaluation.

It had been shown that when more information about Fund activities was available, and objectives were understood, communities participated more actively. Over the lifetime of the Fund, 40,313 community responses were recorded, including requests for primary health care services, provision of additional health education sessions, adjustment in referral pathways, improvements to used needle and syringe re-collection in the community, and arrangement for female-friendly drop in centres. Of these, 32,758 were addressed, and project adjustments included changes to clinic opening hours, installation of water filters, and trust building activities. The percentage of feedback addressed increased year by year, from 75% in 2014 to 91% in 2018. However, topics submitted to the mechanism related to gender remain low, and the full potential of the Community Feedback Mechanism to reach beneficiaries living in remote or unstable areas has not been met.
GENDER EQUALITY

Gender equality is about equal rights, equal opportunities and equal access to the resources needed for a fulfilling life for all people. This includes alleviating the barriers faced in access to health. 3MDG made progress 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).

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 enhancing women’s participation in township and village-level decision-making;
- Feedback mechanisms that enhance women’s voices;
- Dismantling of barriers to health care, which may disproportionately affect women and girls;
- Provision of appropriate health care for women, including for pregnancy and childbirth when they are particularly vulnerable to health emergencies;
- Promotion of sexual and reproductive health and rights for all people, including family planning and birth spacing, safe sex and protection from violence;
- Engagement of men and Boys, and community leaders, in health and gender equality activities, acknowledging their role in promoting health seeking behaviour, challenging norms and power structures, and bringing about their own good health and that of their families.

A country’s progress towards gender equality can often be reflected in maternal and child mortality rates. In Myanmar, these rates are still far too high. To make sure that women are able to have healthy pregnancies and healthy babies, 3MDG supported 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 and boys in health care and caring roles can improve their health and the health of their families. Engrained gender roles can mean that engaging men in healthy decisions and participating in health care can be challenging but, their involvement is critical because they need knowledge about sexual and reproductive health, to be informed for family planning decisions, and because they are often responsible for decisions about health and nutrition for their families. Bringing families together to make collective decisions can also help promote more equal gender roles. 3MDG-supported activities which aimed to enhance the role of men and boys included:

- Training provided to implementing partners in topics ‘men’s engagement’ and ‘gender and positive masculinity’ in 2017 and 2018. Partners disseminated trainings to project field staff and community, especially focused on decision-making in health and family planning, and sexual health and reproductive rights knowledge
- Partners encouraged the participation of both men and women in cooking demonstration and nutrition activities, supporting families to cook more nutritious food for their household
- Sexual and reproductive health and rights projects targeted both 15-24 male and female youth, including persons with disabilities.
- In Chin in 2018, male involvement trainings were given to influential persons in the community to increase health seeking behaviours and increase knowledge of reduce resistance to sexual, reproductive and maternal health.

3MDG supported women and children with immunization, nutrition, pregnancy care and health education and promotion. Contraception and family planning services were provided, as well as expansive sexual and reproductive health services to people who use drugs as well as their partners. This is because though most people who use drugs are men, as their spouses, women may also be affected as people who use drugs, or because of exposure to sexually transmitted diseases, stigma, and marginalization.

The second step provided essential health services for women and-at-risk men in recognition that health conditions may impact people differently, and people may have different health needs. Through implementing partners, 3MDG supported women and children with immunization, nutrition, pregnancy care and health education and promotion.

Community feedback and response mechanisms in their villages.

3MDG Gender Sensitive Steps and Guidance

To support partners in their implementation of gender mainstreaming activities, 3MDG developed the ‘3MDG Gender Sensitive Steps’ and practical guidance material which outlined minimum requirements for project interventions. The four steps are outlined below:

**Improve understanding**

The first step improved understanding of how gender affects health in Myanmar to inform activities and build the capacity and knowledge of health staff. The Collective Voices project, for example, aimed to understand how gender impacts health-seeking behaviour. Partners were supported to better understand the principles of gender equality and inclusion with training and capacity development.

**Provide essential services**

The second step provided essential health services for women and-at-risk men in recognition that health conditions may impact people differently, and people may have different health needs. Through implementing partners, 3MDG supported women and children with immunization, nutrition, pregnancy care and health education and promotion. Contraception and family planning services were provided, as well as expansive sexual and reproductive health services to people who use drugs as well as their partners. This is because though most people who use drugs are men, as their spouses, women may also be affected as people who use drugs, or because of exposure to sexually transmitted diseases, stigma, and marginalization.

Men may also be at more risk for particularly diseases, such as tuberculosis and malaria, as well as men who have sex with men for HIV. 3MDG partners also targeted these groups for testing and care services.

**Increase access to health**

The third step increased access to health with financial support. 3MDG funded the cost of emergency referral services to hospitals for pregnant women who developed a complication during pregnancy or childbirth in 3MDG-supported townships. This programme is in the process of transitioning to government ownership. In 2017 and 2018, 3MDG also supported the establishment of revolving and community-managed village health funds in some project areas to help communities cover their own health costs in emergencies. Local civil society organizations were supported with a focus on community engagement to generate demand and improve health-seeking behaviour in communities. This included empowering women to make health decisions and participate in local health governance.

**Women’s representation and voice**

The fourth step strengthened women’s voice and representation. 3MDG worked 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 was reinforced with behaviour change initiatives for women and communities. More women participated in community health education sessions and village health committees in each year of the Fund. Communities often suggest changes that can improve projects using feedback mechanisms or after attending trainings in gender, accountability, equity, social inclusion and conflict sensitivity. For example, conducting health education and gender sensitization in local languages, or adjusting the opening hours of clinics to accommodate women’s childcare schedules, can be important interventions to support access to care and ultimately, gender equality.

**Voices: Encouraging women to participate**

“By forming village health committees in 19 villages in Namsan Township, we were able to encourage women to participate. Women’s participation in village committees is rare, and very conservative, and the nature of the lifestyle prevents it. After the formation of the committee, women’s voices have been heard, and the attitude of the community towards women has improved. Some women were selected as chairpersons of their committees.

“In Myanmar, women comprise more than half of the population, yet women’s participation in the development of the country is very low. We cannot achieve the goal of health for all in Myanmar without the participation of women. The participation of women on village health committees is a basic step that opens the channel for better health for all in Myanmar.” Jo Htoo Aung, Accountability, Equity, Inclusion and Conflict Sensitivity Officer, Cesvi

Photos: Women participate in activities designed to set up community feedback and response mechanisms in their villages.
VALUE FOR MONEY

Pooling Resources and Economies of Scale

Value for money was a principle which underpinned the design and implementation of the 3MDG Fund. By pooling resources, the contributions of several bilateral donors – first eight donors, moving to four by the end of the year in 2018 – 3MDG promoted the efficient and effective use of development funds. Management by UNOPS meant that 3MDG was able to realize efficiency achievements, due to economies of scale and shared services for human resources, procurement, finance, and other support services. UNOPS also manages other funding programmes, including UK Department for International Development (DFID)-funded bilateral and multi-lateral funds such as Livelihood and Food Security Trust Fund (LFTT), Joint Peace Fund (JPF) as well as the Global Fund (for which UNOPS is a Principal Recipient).

Collaborating for Efficiency

Collaboration with other health actors, such as the Global Fund, GAFL and World Bank, reduces the overlaps and redundancies that impede efficiency of development programmes, whilst also minimizing gaps and increasing service coverage. Aligning to national priorities, and working in support to the Ministry of Health and Sports promotes aid effectiveness and sustainability. Use of government systems demonstrates that the 3MDG approach intrinsically linked itself to the value for money of the national health system.

Reviewing Costs for Efficiency Gains

The financial proposal is one of the key considerations while selecting implementing partners. In addition, specific unit costs are reviewed in significant detail both during budget negotiations, and annual budget revisions - and analyzed where efficiency gains were possible. For implementing partners, and terminating some grants which did not have a high performance. Converting or terminating international staffing structures, reducing the proportion of international positions reduces costs, facilitates national steering and ownership over the programme, and builds local capacity.

The findings of a benchmarking study commissioned by the 3MDG Fund Board in early 2017 assessed various fund performance. Converting or terminating international staffing structures, reducing the proportion of international positions reduces costs, facilitates national steering and ownership over the programme, and builds local capacity.

HIV, TB and Malaria Interventions

3MDG also calculated ‘in-house’ costs per DALY averted for HIV, tuberculosis and malaria using the Population Services International’s impact calculator. The 3MDG HIV Harm Reduction programme continuously improved its cost effectiveness over the past four years. The increased distribution of needles and syringes among people who inject drugs, and lower grant management costs has led to the reduction of cost per DALY – from US$ 74 in 2014 to US$ 41 in 2017. For TB, cost per DALY averted has decreased from US$ 102 in 2014 to US$ 47 in 2017. However, reaching hidden and difficult populations in remote areas can be costly – reflected in the increased cost from 2016 to 2017.

For malaria, the cost per DALY was the lowest cost-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 when compared to other implementing partners. After a three-fold cost increase in 2015 due to significant drop in cases, costs have since reduced year by year as partners became more efficient. It is important to recognize, however, that costs do rise during disease elimination stages, but interventions may still be merited even when the cost per DALY is high.

BUILDING AN EVIDENCE BASE

The Fund supported and promoted an evidence-based approach to health care. Basing health policy on evidence connects the needs and priorities on the ground with interventions at all levels. This helps policymakers understand which intervention responds best to which problem, allowing for context-dependent implementation. This also supports the effective use of money, and ensures that 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 used data from both the national health information system and additional systems established by its implementing partners. For instance, 3MDG supported the District Health Information System (DHIS2) by providing overall support to 32 townships and HIV, tuberculosis (TB) and malaria support to all townships. This led to better collection of quality data and is now supplemented by the recent roll-out of the Volunteer Recording System.

3MDG has supported large scale surveys, including a nationwide malaria indicator survey in 2015. This survey provided information, such as malaria prevalence data, which was crucial for the programming of the Artemisinin resistant malaria containment programme and moving to pre-elimination of Plasmodium falciparum malaria. In early 2017, the Ministry of Health and Sports released findings from the Myanmar Demographic and Health Survey, which was implemented by the Ministry with funding from the United States Agency for International Development and 3MDG. The survey provided important input for the Ministry’s future planning, policies, strategies and guidelines, including at state level.

3MDG prioritised financing research and innovation. 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.

3MDG and partners have also financed implementation research through pilot programmes in a wide variety of areas, including expanded use of misoprostol to prevent post-partum haemorrhage; the role of village health volunteers; the transition of the emergency referral programme to government-ownership; strategic purchasing to test a new payment method for health care and to increase health seeking behaviour, and the implementation of health care in prisons via an implementing partner.

COST PER DALY AVERTED: HIV, TB AND MALARIA (USD*)

<table>
<thead>
<tr>
<th>Year</th>
<th>HIV</th>
<th>Tuberculosis</th>
<th>Malaria</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>74</td>
<td>102</td>
<td>824</td>
</tr>
<tr>
<td>2015</td>
<td>53</td>
<td>55</td>
<td>2,657</td>
</tr>
<tr>
<td>2016</td>
<td>50</td>
<td>44</td>
<td>2,557</td>
</tr>
<tr>
<td>2017</td>
<td>41</td>
<td>47</td>
<td>2,092</td>
</tr>
</tbody>
</table>

Average 2014-2017: HIV = 56 USD per life year saved, TB = 46 USD per life year saved, Malaria = 2,415 USD per life year saved.

*Costs per DALY were calculated on the assumption that DALYs averted were the result of a change in the probability of death, disability or disease with the life expectancy used as the unit of measurement. The DALYs are calculated using the standard measure of Disability-Adjusted Life Years (DALYs).

**Average is based on data for 2015-2017, as 2014 is not comparable to 2015-17 (National Malaria Control Programme was one of the main implementers).
3MDG OVER THE YEARS

From design work in 2010, to final closure in 2018 - and everything in between. Explore the years of the 3MDG Fund with a timeline and yearly snapshots from implementation years.
FUND TIMELINE

2010-2019

2010
- Design of the SWcC Fund

2012
- June: Start-up phase of the SWcC Fund

2013
- Strategic review of the Fund

2014
- First rural health centres constructed by ICW, financed by the Ministry of Health and Social Development. 80 more facilities were constructed during the SWcC Fund

2015
- Alignment of the accountability, equity and inclusivity principles under the banner “Health for All”

2016
- July: Significant increase in government spending on health, nearly 10 times larger than in 2010. Total health sector spending as percentage of GDP increased from 3.3% to 16%.

2017
- January: Behavioural year of the SWcC Fund
- Small and reproductive health and rights admission added to the SWcC programme

2018
- December: Consolidation of funding from three donors, Australia, Denmark, and European Union

2019
- January: Access to Health Fund implementation begins

December
- Grants signed for Access to Health Fund

FUND TIMELINE 2010-2019:

- Collection of resources, designed to better understand
  - access to health in the context of national and regional barriers to health access from the perspective of the community, led by ICW

- Ministry of Health and Social Development is added to the Fund Board

- 10,000th emergency referral given to a woman who needed urgent medical care during pregnancy

- 150,000 pregnant women accessed all five services for children

- Improvements made to the HIV/AIDS suppression programme, including prenatal care and ante-natal care

- Launch of the programme to reduce maternal mortality and improve maternal health

- Internal restructuring of the fund management office to increase integration and manage the programme rather than thematic areas

- Design work for Access to Health Fund begins

- Significant improvement in contraceptive prevalence rate in this state, given the efforts

- First prison health services clinic opened and handover in Wabba State, including expansion of outpatient departments and laboratory
First year of implementation

The 3MDG Fund was established in June 2012 to finance health initiatives in Myanmar that would accelerate national progress towards the three health-related Millennium Development Goals (MDGs): to reduce child mortality, to improve maternal health and to combat HIV/AIDS, malaria and other diseases. The set up phase of the Fund ran from June 2012 to December 2012 and implementation began in January 2013.

There were three priority areas for the Fund: maternal, newborn and child health, HIV/AIDS, tuberculosis and malaria; and health systems strengthening. They were identified to be in line with the three health-related Millennium Development Goals, and in response to Myanmar’s health challenges and epidemiological context, and a need to strengthen the health system for the long term.

The Fund was set up with the goal of working closely with the Ministry of Health (which became the Ministry of Health and Sports in 2015), as well as other health partners in Myanmar, to support the delivery of national health sector strategies, policies and plans.

MATERNAL, NEWBORN AND CHILD HEALTH

CONTEXT
Maternal, newborn and child health was a high priority of the 3MDG Fund due to Myanmar’s high rates of preventable maternal and child mortality and morbidity.

The first year of the maternal, newborn and child health programme focused on training basic health staff, particularly midwives, and volunteer health workers such as community health workers and auxiliary midwives, and supporting the provision of emergency obstetric and newborn care by the Ministry of Health. The procurement of drugs, equipment and commodities and the refurbishment of health facilities were also supported.

To address financial and transportation barriers to accessing health services, 3MDG introduced the emergency referral programme for pregnant mothers, newborns and children under five. Through the programme, the cost of transport to the hospital for the patient and an attendant, and medical and ancillary costs, were reimbursed via the implementing partner or village health funds. Making sure pregnant women and young children reach hospital when they need care is a potentially lifesaving intervention. This programme was also designed to improve the rates of institutional delivery, which was estimated births per year, to ensure continuity of service.

ACHIEVEMENTS
1. An initial 42 townships in Chin, Magway, Ayeikawaddy, Shan and Kayah were prioritized for the first phase.
2. Support to six townships in Ayeikawaddy was carried forward from the Joint Initiative for Maternal, Newborn and Child Health (JIMNCH), with a total of 31,000 estimated births per year, to ensure continuity of service.
3. 3MDG conducted township health assessments in 32 priority townships in Chin, Kayah and Shan States and the Magway Region.

IN NUMBERS

- 17,427 births attended by a skilled health personnel.
- 33,585 infants vaccinated against measles.
- 8,873 life-saving referrals for women and children.
- 353 basic health staff trained.

TUBERCULOSIS

CONTEXT
A 2009-2010 survey found that tuberculosis (TB) prevalence was three times higher than previously thought in Myanmar, with 613 cases per 100,000 people. The dangerous and deadly multi-drug resistant TB (MDR-TB) was estimated at 5% of new TB cases. High risk populations living in poor urban areas, hospitals, prisons, hard-to-reach areas and mines were prioritized in 3MDG partner interventions.

ACHIEVEMENTS
1. 3MDG signed a financing agreement with the World Health Organization to support ongoing efforts to combat MDR-TB together with the National TB Programme.
2. The Ministry of Health, 3MDG and the national AIDS, TB, and malaria programmes held discussions to increase engagement with the Prison Department of the Ministry of Home Affairs and other implementing partners working within the prison health system. This led to an agreement between the Ministries to form a Prison Health Advisory Committee to support a Rapid Assessment and Response of prison health facilities and services.

IN NUMBERS

- 2,930 million needles and syringes distributed to facilitate safe injecting.
- 5,700,000 people who use or inject drugs received Voluntary Counselling and Testing for HIV and other bloodborne diseases and STDs.
- 2,930

HIV

CONTEXT
In 2013, approximately half a percent of the general population were living with HIV, but prevalence was considerably higher in some groups: over 7% among female sex workers, 8.9% among men who have sex with men, and 18% among people who use and inject drugs. 3MDG’s HIV programme aimed to close gaps in the national response to HIV not readily funded by the Global Fund, with a specific emphasis on reducing harm for people who use and inject drugs. Priority areas were with injecting drug use and HIV prevalence to reach the vulnerable drug-using population.

ACHIEVEMENTS
1. 3MDG signed nearly US$ 6.7 million in grants with 11 partners, for services in a total of 33 townships in Shan, Kachin and Mon states, and Mandalay, Sagaing and Yangon regions for Harm Reduction.
2. 3MDG funded the delivery of HIV Harm Reduction services to almost 19,000 people who inject drugs across 24 townships in six states and regions, using drop-in centres, community outreach and mobile services. The availability of preventive measures was increased, through education programmes and distribution of clean needles and syringes (approx. 500 needles and syringes per client per year).

IN NUMBERS

- 1,161 MDR-TB patient supported in accessing treatment and care.
- 354 MDR-TB patients assisted with nutritional support.
- $261,500 amount of the grant signed for MDR-TB programme.

KEY RESULTS

- Result of HIV sentinel surveillance 2012 by Myanmar National AIDS Programme

2013
MALARIA

CONTEXT
Despite significant improvements, malaria remained a major cause of illness and mortality amongst children and adults in Myanmar in 2013. Over three-quarters of the population lived in malaria endemic areas.

Financing from 3MDG supported the Myanmar Artemisinin Resistance Containment (MARC) strategy and was predominantly targeted at addressing gaps in coverage, especially amongst mobile, migrant or remote populations, particularly in former conflict areas. In early 2013, MARC activities previously supported under the Three Diseases Fund (3DF) were transitioned into 3MDG to maintain uninterrupted coverage.

ACHIEVEMENTS
1. 3MDG signed nearly US$ 13.3 million in grants with 11 partners for services in 75 townships.
2. A malaria gap analysis was completed.
3. There was an overall decline in malaria prevalence across Myanmar, with 570,000 people suspected to have contracted malaria tested within the 21 Tier 1 townships in 2013. 80,000 confirmed cases of malaria received treatment in line with national guidelines.

KEY RESULTS
- 570,000 people tested for malaria.
- 2,966 total malaria volunteers trained by partners.
- 80,000 people treated for malaria.
- 34,000 people treated within 24 hour of onset fever.
- 800,000 long-lasting insecticide treated nets distributed.

HEALTH SYSTEMS STRENGTHENING

In Myanmar, challenges relating to health financing, human resources, infrastructure, essential drugs and supplies, health information, and stewardship have undermined the capacity of the public sector to deliver basic health care. The 3MDG health systems strengthening component aimed to address the challenges that undermine the provision of basic health care and to support the longer-term sustainability of its investment in maternal, newborn and child health and communicable disease interventions.

ACHIEVEMENTS
1. 3MDG awarded funds to the World Health Organization Asia-Pacific Observatory and the World Bank to provide direct support to the Ministry of Health in strengthening the health system.
2. 3MDG conducted an in-depth analysis of up-to-date evidence on Myanmar’s health system organization, coverage, performance and current reforms.
3. Technical support was provided to the Government of Myanmar in their efforts to develop and implement evidence-based health sector policies.

A young man’s father dies from malaria in Kayah State, just months before a malaria project is started in his township.

“One day when returning from collecting wood in the forest, my father began to feel sick. He had malaria. We tried to cure him with traditional medicines, but it didn’t work.

“He passed away.

“Not long after, my wife learned from our village leader that social malaria workers were being recruited in our village, in Hpruso Township in Kayah State.

“She was chosen to attend the training, organized by the Myanmar Health Assistant Association (MHAA), for our village.

“During the training period, she was taught how to use modern malaria drugs for positive cases, and how to conduct blood tests.

“She learned more about malaria and its complications and shared this knowledge with the villagers.

“I thought to myself, ‘my father would not have died if this project was started earlier in my village.’

A Needless death from malaria in Kayah

“My father would not have died if this project started earlier”
2014 Expansion of projects and programmes to reach more people

3MDG made progress in improving health outcomes and strengthening Myanmar’s health system in 2014. The Fund significantly scaled up access to maternal, newborn and child health services, particularly in conflict-affected areas in Myanmar.

Access to HIV/AIDS, tuberculosis and malaria prevention and treatment across the country was also expanded, and active tuberculosis case finding started in 75 townships to find hidden cases.

Key health system strengthening initiatives supported by the Fund during the year included improving public financial management as well as expanding training for midwives and auxiliary midwives across the country.

MATERNAL, NEWBORN AND CHILD HEALTH

CONTEXT
In 2014, maternal, newborn and child health services were extended to conflict-affected areas across Kayah State and within areas of Shan State. An innovative programme aimed to deliver health benefits to people living in Wa Special Region and Special Region 4, as it brought together the Ministry of Health and Special Region health authorities to scale-up maternal, newborn, child health and TB services for communities living in these areas.

ACHIEVEMENTS
1. Around 30,000 pregnant women, or 65% of all expected pregnancies within the defined coverage areas were able to access skilled care for childbirth delivery, almost doubling 2013 achievements.
2. Almost 47,000 children were vaccinated against measles.
3. There was an increase in institutional delivery of four points from 2013, and there was a sharp increase in newborn care provided within three days of birth by basic health staff from 58% to 75%.

KEY RESULTS
- 31,395 women received ante-natal care (four visits per woman).
- 30,276 births were attended by a skilled health personnel.
- 46,569 infants were vaccinated against measles.
- 13,541 life-saving referrals for women and children were financed by 3MDG and supported by implementing partners.
- 34,306 women received post-natal and newborn care within three days.

TUBERCULOSIS

CONTEXT
The major objectives for 3MDG support to the National TB Programme (NTP) were to find hidden or unidentified TB cases in the community by using active case finding strategies, and screening for multi-drug resistant tuberculosis (MDR-TB) among newly diagnosed cases. MDR-TB remains a major public health concern in Myanmar, and addressing the challenges posed by the disease requires a concerted effort by government, donors and communities.

ACHIEVEMENTS
1. Active TB case finding programme were designed and launched in 2014. Activities under this programme were being rolled out across 75 hard-to-reach townships across seven states and regions. 4,200 TB patients were identified and enrolled on treatment with a rapid acceleration of activities.

KEY RESULTS
- 50,764 people screened for TB.
- 372 MDR-TB patients supported.
- 9,912 referrals to TB Departments by Community Health Workers/Volunteers.
- 4,295 notified cases for TB treatment all forms.

HIV

CONTEXT
In 2014, the number of townships being financed for Harm Reduction services under 3MDG expanded to 36, following the addition of 12 townships. The programme continued to prioritize activities in areas with large numbers of people who inject drugs, such as Kachin and Shan states which are conflict-affected and have high physical and contextual vulnerabilities, including gold prospecting and jade mining sites.

ACHIEVEMENTS
1. 3MDG contributed to 44% of the national target for prevention activities for people who inject drugs in Myanmar. Implementing partners reached 26,661 people through drop-in-centres, community outreach and mobile activities. A ‘one-stop’ service model for drug treatment was also introduced in five townships, making services more accessible and more comprehensive.
2. The number of sterile needles and syringes distributed to people who inject drugs increased from 5.7 million in 2013 to 6.9 million in 2014, equaling 35% of the national target.
3. A review of legal barriers was conducted, with the aim to remove some of the major obstacles to Harm Reduction interventions.
4. An in-service training curriculum on drug use and HIV was developed to strengthen the critical role of law enforcement in public health. A local organization conducted training for police and staff from the General Administration Department at state and regional levels.

KEY RESULTS
- 6.956 million needles and syringes distributed to facilitate safe injecting.
- 5,950 people who inject drugs had Voluntary Counselling and Testing.
- 26,661 people who inject drugs reached by prevention programmes.
2014
More projects and programmes added to the portfolio

MALARIA

CONTEXT
3MDG’s malaria response went through a transition period in 2014, with the phasing out of the previous 3DF-supported Myanmar Artemisinin Resistance Containment (MARC) response, and the beginning of the 3MDG-supported national MARC response. The focus shifted towards the early diagnosis of malaria cases and helping confirmed people with malaria to get effective and rapid Artemisinin-based Combination Therapy (ACT) treatment. This was done by expanding the areas served by the trained volunteer network and health care providers at the community level. The malaria test positivity rate among tested cases was 6% in 2014, declining from 14% in 2013.

ACHIEVEMENTS
1. Almost 500,000 people suspected of having malaria received testing, which brought the number tested since 3MDG began to almost one million. Almost 30,000 new cases of malaria were treated, which brought the total number of malaria patients treated through 3MDG support to almost 100,000.
2. 2,899 volunteers were trained by partners, and equipped with malaria Rapid Diagnostic Tests (RDTs) and Artemisinin-based Combination Therapy (ACT) kits. Around 300 volunteers were trained to reach migrant populations, including peer migrant workers who volunteered their time to provide malaria diagnoses and treatment services for their community.
3. Evidence to guide policy and planning towards elimination was incomplete, so 3MDG financed studies to model best options for containment/elimination, studies to optimize use of therapies as well as a nationwide survey to measure prevalence. This included an agreement in 2014 to jointly fund the planned nationwide malaria indicator survey with USAID-President’s Malara Initiative.

HEALTH SYSTEMS STRENGTHENING

CONTEXT
The health sector in Myanmar continued in 2014 to evolve rapidly. The Government committed to achieve universal health coverage as part of its Vision 2030, defined as “the provision of optimal quality of health care to everyone in the country that is accessible, efficient, equitably distributed, adequately funded, fairly financed, and appropriately used by an informed and empowered public.” 3MDG programmes aimed to improve capacity for evidence-based policy making, strengthen midwifery schools and have better coordinated supply chains in Myanmar.

ACHIEVEMENTS
1. The first Myanmar national supply chain baseline assessment completed, and a supply chain strengthening agreement prepared for Magway, Bago, and Ayeyarwady regions.
2. A US$ 15 million agreement to strengthen health facility infrastructure across Myanmar was signed.
3. A US$ 20.7 million agreement to support the Joint UN Programme (UNICEF, UNFPA, UNAIDS) on health systems strengthening was signed.
4. A US$ 10 million contract with Jhpiego signed and activities commenced to support midwifery schools.

KEY RESULTS
- 469,714 people tested for malaria.
- 29,530 people treated for malaria.
- 15,729 people treated within 24 hours of the onset of fever.

Beneficiary voices from 2014

“It made a huge difference to attend health education.”

Thanks to a health education session two years before, Saw Kyaw Htoo Win knew what to do when he got sick.

“I started using a lot of drugs without my family knowing.”

A person who uses drugs in Kachin talks about the difference it made to receive support from MANA.

“I started using a lot of drugs without my family knowing.

“When I used drugs, I stole a lot of goods without letting my family know about it. I started to face isolation by my family and my neighbourhood.

“With the help of Myanmar Anti-Narcotics Association, I started methadone maintenance therapy. Since then, my health has improved and my drug use has significantly reduced.

“Now I no longer need to worry about my health, and I can work properly and am not concerned with money. I am now accepted by my community and have regained their trust.”
2015

Programme running at full speed.

2015 was a significant year for the 3MDG Fund. The Fund was able to carry forward and expand health initiatives, as well as undertake a rapid emergency response to the massive floods that struck Myanmar in 2015.

FLOOD RESPONSE

Devastating rains in July 2015 caused massive flooding in twelve states and regions. More than 1.6 million people were severely affected, with about 240,000 households forced into temporary displacement. The vulnerability of affected communities increased, especially women and children.

Following discussion with the Ministry of Health when the scale of the disaster became apparent, 3MDG began a rapid and time-bound flood and landslide emergency response. 3MDG allocated US$ 500,000 for implementing partners to mobilize resources to support the immediate flood response in project areas, conduct needs assessments, and support township health departments to undertake contingency planning in areas that were not yet affected by floods. The response prioritized the needs of 148,000 people in 26 townships in six states and regions, primarily in those most-affected Magway, Chin and Sagaing, but also in Ayeyarwady, Rakhine and Bago.

MATERNAL, NEWBORN AND CHILD HEALTH

CONTEXT

In 2015, the 3MDG Fund continued its work to improve access to services for women, newborns and children under five in order to contribute to Myanmar’s goal of attaining Millennium Development Goals 4 and 5. The focus was on four different areas: scaling-up services in conflict-affected areas, supporting health care in Special Regions, strengthening service delivery in the public and private sector and support to Ministry of Health Human Resources for Health Strategy.

ACHIEVEMENTS

1. More than two-thirds of births (67%) were attended by a skilled birth attendant, an improvement over the previous year. Additionally, 83% of newborns received postnatal care within three days.
2. Improved health services reached to poor and vulnerable rural populations in remote areas within Magway and Ayeyarwady Regions, across seven conflict-affected townships within Shan State, and across all of Chin and Kayah states. This increased the number of townships supported by 3MDG where the essential package of maternal, newborn and child health were delivered compared to 2014.

TUBERCULOSIS

CONTEXT

Myanmar remained in 2015 one of the world’s 30 highest tuberculosis (TB) burden countries, with a TB prevalence rate three times higher than the global average and one of the highest in Asia. 3MDG supported the National TB Programme in the development of the Tuberculosis National Strategic Plan (2016-2020) in collaboration with all TB stakeholders in the country. 3MDG supported TB mobile team visits to prisons, and the construction of four major pieces of TB infrastructure and two mobile TB X-ray vans. 3MDG also provided technical support to the in-country consultation process for improving prison health facilities and services.

ACHIEVEMENTS

1. 3MDG successfully launched a new innovative cash transfer system for multi-drug resistant TB (MDR-TB) patients, using the Kanabawza Bank’s ATM system.
2. Conducted 149 mobile screening missions to remote, hard-to-reach populations, work sites and prisons.
3. Launch of nationwide mass and social media campaign, featuring Myanmar celebrity Sai Sai Kham Leng. The campaign shared the signs and symptoms of TB with a broad public, helping them to know where they could receive free treatment.

HIV

CONTEXT

In Myanmar, studies revealed HIV prevalence of almost 30% among people who inject drugs in 2015. 3MDG continued to support measures to address social, legal and structural barriers to HIV prevention, while funding partners offer Harm Reduction services such as providing sterile injecting equipment to reduce infection.

ACHIEVEMENTS

1. The programme was boosted with the launch of a new project with Médecins du Monde and Metta Development Foundation in Kachin, aiming to reduce stigma and discrimination against people who inject drugs, and increase community acceptance of services.
2. More than 30,000 people who inject drugs benefited from HIV prevention and Harm Reduction services through drop-in-centres, community outreach and mobile activities - 104% of the target.
3. Over 10 million needles and syringes were distributed - 125% of the target.

KEY RESULTS

<table>
<thead>
<tr>
<th>Maternal, Newborn and Child Health</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ante-natal care (4 visits per woman)</td>
<td>50,960</td>
<td>50,307</td>
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<tr>
<td>Births attended by a skilled health personnel</td>
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<td>Children immunized with Penta 3</td>
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<td>Life-saving referrals for women and children</td>
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<tr>
<td>Post-natal and newborn care</td>
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<td>Diarrhea treated with oral rehydration therapy</td>
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<table>
<thead>
<tr>
<th>Tuberculosis</th>
<th>2014</th>
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<tr>
<td>Notified cases for TB</td>
<td>187,607</td>
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<td>MDR-TB patients supported</td>
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<td>Referrals to TB Departments by Community Health Workers/Volunteers</td>
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<td>New people screened for TB</td>
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<td>Million needles and syringes distributed to facilitate safe injecting</td>
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</tr>
<tr>
<td>People who inject drugs had Voluntary Counselling and Testing</td>
<td>8,272</td>
<td></td>
</tr>
<tr>
<td>People who inject drugs reached by prevention programmes</td>
<td>30,411</td>
<td></td>
</tr>
</tbody>
</table>
2015

Programme running at full speed.

MALARIA

CONTEXT
With approximately 28 million people living in malaria-endemic townships, malaria remained a leading cause of morbidity and a significant cause of mortality in 2015. Containment programmes remained vital as part of the effort to control the spread of Artemisinin-resistant malaria, and in 2015 a consensus emerged that resistance can only be addressed through malaria elimination strategies. This has required a concerted and massive effort at the national, regional and global level.

ACHIEVEMENTS
1. 3MDG supported the National Malaria Control Programme (NMCP) in the development of the Malaria National Strategic Plan (2016-2020) in collaboration with malaria stakeholders in the country.
2. Almost 440,000 people including asymptomatic malaria cases received testing, representing 17% of the national target, with around 12,000 confirmed cases receiving treatment. The total patients tested for malaria between 2013 and 2015 was over 1.5 million.

KEY RESULTS
- 439,192 people tested for malaria.
- 11,742 people treated for malaria.
- 5,923 people treated within 24 hours of the onset of fever.

HEALTH SYSTEMS STRENGTHENING

In 2015, the government reaffirmed its commitment to achieving universal health coverage by 2030. Increased investments and efforts in strengthening the service delivery systems for essential medicines and technologies, infrastructure, the health workforce and the financing system were needed to achieve this. 3MDG supported universal health coverage knowledge improvement, public financial management and strengthened technical capacity and health workforce in this year. A strategic re-visioning exercise jointly undertaken by the Ministry of Health and 3MDG in 2014, meant that by 2015, 3MDG’s support was better aligned with government priorities and the rapidly changing context.

ACHIEVEMENTS
1. UNOPS built 17 health centres in Magway, improving health care access for about 61,000 people, financed by 3MDG.
2. 3MDG financially supported the organization of the first Myanmar Health Forum in Nay Pyi Taw.
3. Important work was undertaken and significant financing provided to address the human resources for health shortage in Myanmar, with a focus on the midwifery workforce. Through Jhpiego, the Fund supported the Ministry of Health in transforming midwifery education to a competency-based training by improving teaching methods and upgrading skills labs. By the end of 2015, all midwifery school faculties were enhanced with skills labs upgraded in the following schools: Taunggyi, Magway, Monywa, Hpa-An, Piay, Loikaw, Mawlamyine, Sittwe, Myeikayin, and Pathein.
4. 3MDG supported the Ministry of Health’s scale-up plans for auxiliary midwives, financing the training of over 4,000 auxiliary midwives in 178 townships.
5. 3MDG supported scholarships for Ministry of Health and Sports staff at a reputable university to gain knowledge, skills and exposure in public health.
6. 3MDG also supported the development of standard operating procedures for health in prisons.
7. Important work began on the Regional Supply Chain Strengthening pilot project in Bago, Magway and Ayeyarwady. The aim of the project was to reduce stockouts to benefit a total population of almost 15 million people living in the three regions.

HEALTH FOR ALL

Accountability, Equity, Inclusion and Community Engagement

This area of work became a stronger focus in 2015, acknowledging that the principles of accountability, equity and inclusion make projects stronger, more responsive, and more equitable, and community engagement enables community views to be used to inform health policies, programmes, services and projects. 3MDG supported people in communities by providing them with increased information and the confidence to help them access health services, and health service organizations were encouraged to listen and respond to community voices. In 2015, the ‘Health for All’ team conducted trainings in these principles, set up community feedback mechanisms and established the Collective Voices initiative.

ACHIEVEMENTS
1. In 2015, the Fund launched the US$ 1.5 million ‘Collective Voices: Understanding Community Health Experiences’ initiative. Six new partner organizations received direct financing, and they partnered with a further 19 community-based organizations (CBOs). Partners in 2015 achieved the following results:
   - 500+ community consultations, producing a situational assessment of community needs.
   - Six qualitative reports, highlighting key social barriers experienced in accessing health services across areas of the country and target groups.
   - Assessments were followed by an implementation phase (to the end of 2018), testing approaches to address social determinants of health.
2. To know how to engage communities effectively, partners and other stakeholders need tools and resources, awareness, skills and confidence. In 2015, the Fund increased the capacity of partners through a range of initiatives, with additional attention given to strengthening the capacity of local organizations. This included: training related to accountability, equity, inclusion and conflict sensitivity, partner learning and sharing mechanisms, tailored organizational capacity development support through Pact Myanmar, and partner exchange visits in the field.
3. 3MDG encouraged partners to establish community feedback and response mechanisms, and provided guidance on how to do this effectively.
   - In 15 of the 34 townships where maternal, newborn and child health partners are implementing projects, partners had an operational community feedback mechanism (CFM). Partners received a total of 3,947 pieces of feedback and responded 54% of the time.
   - Amongst the HIV/TB/malaria partners, ten out of 14 had an operating CFM in 2015. These partners received feedback 1,896 times and responded to 70% of this feedback.
“These changes make me want to work harder”

Pyae Oo Khine, from South Okkalapa Township, in Yangon Region found out she had MDR-TB in 2015. The patient support she received, and kindness from loved ones, helped her through the difficult treatment process.

When Pyae Oo Khine started losing a lot of weight, she visited the hospital and found out that she had contacted multi-drug resistant tuberculosis (MDR-TB). With the patient support package from the 3MDG MDR-TB programme, her twice-daily dosage is administered by qualified nurses and volunteers. Pyae Oo Khine also receives an additional 30,000 Myanmar kyat (approx. 25 USD) to help with transportation fees for the journeys between her home and the hospital, and staple food items.

Now, she is halfway through her treatment period of 20 months. Although there are side effects from the treatment, the patient support and support from her family and friends have helped her through the difficult process. “I have friends and volunteers who care for me... it helps a lot,” she said.

“Women’s voices have been heard, and attitudes improved.”

Ja Htoi Aung, the Accountability, Equity and Inclusion Officer at Cesvi, worked in 2015 to engage women to participate in health projects.

Support that Hkaw Yaw, from Mading village, Waingmaw Township, in Kachin State received from Metta helped him reconcile with his family.

Hkaw Yaw was just 19 when he first turned to drugs for relief from the backbreaking work in the gold mines. “When I was gold mining, even though I earned a lot of money, I spent it all on drugs. I didn’t send any to my parents.” He became so dependent on the drugs that he started asking his parents for money too.

When a peer volunteer and staff member from Metta Harm Reduction Centre visited his house, offering counselling and health education, they also encouraged Hkaw Yaw to take a HIV test. When he found out he was HIV positive, he immediately received anti-retroviral therapy with the help of Metta staff.

After attending peer group meetings and receiving methadone treatment, his health status has significantly improved. “I have reconciled with my parents, and now we have a happy family life. I am so grateful to the Metta Harm Reduction Centre staff for the support they showed me.”

“Now I have a happy family life... I am so grateful to Metta.”

Providing immunization in hard-to-reach areas is an important Ministry of Health and Sports priority; if these communities are left out, children can be left unprotected against common diseases.

Language differences, limited transportation and lack of trust are barriers between staff of the Ministry of Health and Sports and the community. As a result, many children in hard-to-reach villages do not receive proper immunization. In Laikha in Shan State, with support from 3MDG, partners like Relief International conduct monthly vaccination visits, coordinating closely with the village leader. The village leader helps to explain the purpose and benefits of immunization, and encourages villagers to have their children immunized.

The midwife said that she has been able to reach more people and her relationship with villagers has improved because she has a translator and better co-ordination with the villages. “These changes make me more willing and happy working in the community, and makes me want to try harder to deliver these services to vulnerable people,” she added.
2016

**MATERNAL, NEWBORN AND CHILD HEALTH**

**CONTEXT**

The Myanmar Demographic and Health Survey released in 2016 showed that only 60% of women had their deliveries assisted by skilled attendants and only 37% of deliveries were in health facilities. This indicates a lack of skilled care around the labour and delivery period, which is where the largest number of maternal and child deaths take place. Women in rural, remote or conflict-affected areas are particularly disadvantaged, and often interventions are not adequate, available or affordable.

To build health equity, 3MDG maternal, newborn and child health interventions focused on areas where existing services were weakest, due to conflict or remoteness. 3MDG provided support to towns in delivery of health services as well as health system strengthening interventions that improve immunization services, the cold chain and midwifery skills. In areas where communities are out-of-reach of government services, ethnic health organizations and local authorities were supported to provide services.

**ACHIEVEMENTS**

1. There was good progress in the delivery of essential maternal, newborn and child health services in 2016, across 34 townships in Ayeyarwady, Magway, Chin, Shan and Kayah and Wa and Special Region 4.
2. The contraceptive prevalence rate continued on its upward trend, rising to 66% in 2016 from 63% in 2015.
3. 19% of all pregnant women in 3MDG townships were referred to a secondary care centre when it was needed.
4. In Ayeyarwady, immediate breastfeeding was initiated within one hour of birth for 85% of total live births, and 84% of mothers and newborns received post-natal care. Contraceptive coverage for the region was good, with use by 77% of married couples. These improvements led to the eventual phase-out of support for Ayeyarwady in 2018.
5. In 2016, 3MDG partners with a range of ethnic health organizations and local authorities in Special Regions. They are critical health providers for areas remote or conflict-affected by conflict.

**TUBERCULOSIS**

**CONTEXT**

Late or advanced cases of tuberculosis (TB) are detected more often in remote, hard-to-reach, mobile or migrant populations and in urban slum areas. National TB Programme active case detection activities were strengthened over 2016, with testing and referral becoming more routinely available within closed settings, such as prisons and labour camps, as well as within internally displaced person camps in Rakhine and Kachin. Nine mobile teams operated strategically throughout Myanmar to improve access to diagnosis and early treatment. Their focus is the most vulnerable populations.

**ACHIEVEMENTS**

1. In total, 227 visits to 131 townships across the country were conducted by the mobile teams.
2. The multi-drug resistant TB (MDR-TB) database was further developed in health facilities in Yangon, Mandalay and at the central level for the National TB Programme in Nay Pyi Taw.
3. New TB infrastructure with caregiver accommodation in Pathein Gi Hospital in Mandalay handed over to Ministry of Health and Sports.

**KEY RESULTS**

- **MDR-TB patients supported.** 158,300
- **referrals to TB Departments by Community Health Workers/Volunteers.** 66
- **notified cases for TB treatment (all forms).** 43,449
- **people screened for TB.** 4,117

**HIV**

**CONTEXT**

In Myanmar, HIV prevalence among people who inject drugs remains extremely high in 2016. 28.5 percent according to the 2014 Integrated Bio–Behavioural Surveillance (IBBS) Survey. Kachin suffers from HIV rate higher than the national average, and the high rate of drug use in the State is accompanied by frustration from communities, who have resorted at times to vigilante actions against people who use drugs. In 2016, a project was added to the Harm Reduction programme to help communities grow their understanding of the benefits of Harm Reduction work and advocate for the decriminalization of low level drug use in response.

**ACHIEVEMENTS**

1. Partners were able to reach 96 percent of the target population (people who inject drugs) with prevention measures, which included distribution of needles and condoms, education and testing.
2. The Myanmar Anti-Narcotic Association and the Asian Harm Reduction Network extended Harm Reduction service coverage to different parts of Sagaing Region.

**KEY RESULTS**

- **Million needles and syringes distributed to facilitate safe injecting.** 12.98
- **people who inject drugs given HIV testing and counselling.** 10,786
- **people who inject drugs reached by prevention programmes.** 40,033
**2016**

**Acceleration and increased reach.**

**MALARIA**

**CONTEXT**

Malaria incidence declined in the two to three years leading up to 2016. To sustain these improvements, investments in malaria testing and treatment remained a public health priority, targeted towards endemic areas and hard-to-reach groups, such as internally displaced persons and mine workers. 3MDG’s contribution was towards the containment of Artemisinin-resistant malaria and pre-elimination. Services include diagnostic facilities and standard treatment through a trained community volunteer network. Directly Observed Treatment (DOT) volunteers ensure that patients take their initial treatment immediately and explain how to complete the rest of the course to improve adherence.

**ACHIEVEMENTS**

1. 3MDG supported moves by the Ministry of Health and Sports towards the integration and multi-tasking of malaria volunteers. Integration of TB and malaria service provision could bring about significant reductions in cost; this was evidenced in a pilot programme in Sagaing where malaria workers were re-trained to also provide child health services.

**HEALTH SYSTEMS STRENGTHENING**

In Myanmar in 2016, the health system was not robust enough to deliver services to the people who need them most. At all levels of health system strengthening, 3MDG invested in people to strengthen the technical capacity of the Ministry, civil society, and other stakeholders, improved approaches to promote efficiency, and built an enabling environment for front-line staff by ensuring medicines, supplies and infrastructure were available.

**ACHIEVEMENTS**

1. 3MDG’s health system strengthening work in 2016 had tangible results, with important contributions to government process to launch National Health Plan 2017-2021.

2. Through a total grant value of USD 2.8 million provided to the World Bank, 3MDG supported a two-year effort to design and cost the Essential Package of Health Services (OOPES) went down when they sought health care or family planning from these clinics.

3. 37 rural and sub-rural health centres were handed over to the Ministry of Health and Sports (see more right).

**KEY RESULTS**

- 444,482 people tested for malaria.
- 8,194 people treated for malaria.
- 5,312 people treated within 24 hours of the onset of fever.

**Building health infrastructure**

Since 2015, 3MDG has been financing the construction of health facilities across the country. By the completion of the project in early 2018, 82 new rural and sub-rural health centres were serving community health needs. In 2016, 44 of the health centres were completed, bringing the total completed since the project began to 61. These 44 centres can provide care for about 270,000 people. During the year, 32 of the centres were formally handed over to the Ministry of Health and Sports, with the remaining 12 handed over in the beginning of 2017.

By building the centres, 3MDG aims to increase access to care for some of the hardest-to-reach people in the country. Locations were chosen based on lack of existing facilities, accessibility and population coverage. Services focus on maternal, newborn and child health, because of disparities between rural and urban settings in health indicators related to maternal and child mortality. However, they serve all community health needs and can treat up to 50 patients per day. The centres include delivery, emergency and waiting rooms, solar panels, examination rooms, water tanks, incinerator and placenta pit, on-site accommodation for staff, and drug storage facilities. The construction of the centres was managed by the UNOPS Infrastructure Unit.

**INNOVATION IN HEALTH CARE PAYMENTS**

The private sector plays a significant role in the provision of health care in Myanmar, where out-of-pocket spending on health is over 70%. In 2016, Population Services International (PSI) Myanmar began piloting a government-supported project to demonstrate the capacity of private general practitioners to offer a basic package of primary care services.

PSI contracted five private Sun Quality Health clinics to provide a defined primary health package to low-income households. Instead of fee-for-service payments, this pilot implemented capitation payments and a pay-for-performance bonus.

In 2016, PSI completed the project design - including defining the package of health services covered and modelling the anticipated disease burden in target areas - identified providers and began mapping out low-income households.

Beginning in the first quarter of 2017, approximately 2,000 low-income households in two townships in Yangon region were screened and issued with a health card. This entitles household members to a defined benefit package. The research aimed to evaluate whether out-of-pocket expenditure (OOPES) went down when they sought health care or family planning from these clinics.

This pilot is one of a series of pilots testing whether providers outside of the public sector can be contracted to deliver a package of essential health services, in order to inform the National Health Plan 2017-2021.

**KEY RESULTS**

- 1,985 Doctors, nurses and midwives who participated in at least one mother, newborn and child health training.
- 80% 3MDG-supported townships with functional cold chain equipment and adequate storage space.
HEALTH FOR ALL
Accountability, Equity, Inclusion and Community Engagement

Engagement with communities is important to understanding problems and needs, as well as drive project improvements. 3MDG interventions in this area helped to make township health systems more responsive, holistic and inclusive. 3MDG financed community governance structures such as village health committees and funds. Village health committees were trained to work alongside health staff to support referrals, and mobilize health seeking practices.

ACHIEVEMENTS
1. 3MDG supported health education and promotion, delivered through basic health staff and community health workforce, as well as volunteers through the Collective Voices initiative.
2. A report was compiled and launched in August 2016 from the Collective Voices project, revealing barriers to health access. At its launch event, government and civil society representatives discussed how community voices can be used to inform health policy-making and programming at every level.
3. 3MDG’s ‘Health for All’ strategy aligned to the guiding principles of the Ministry of Health and Sports, reflected in the Myanmar National Health Plan 2017–2021. These include equity, inclusiveness, accountability, efficiency, sustainability and quality.
4. Trainings and workshops organized throughout the year, both by Pact Myanmar and by 3MDG. In total in 2016, there were 470 attendees from implementing partners at the sessions. Topics included information-sharing, universal health coverage, the social determinants of health, ethnic diversity, sexual and reproductive rights and men’s engagement.

HEALTH IN PRISONS
A high proportion of the national prison population, (anywhere between 20% and 70% in some prisons in Kachin State) are imprisoned for drug-related crimes. This is a result of long mandatory prison sentences for people with drug dependence convicted for possession of illicit drugs. Low investment in public health facilities and services, leads to severe overcrowding, limited health facilities and services, under-deployment of health staff and lack of infection control. This creates conditions that are harmful to the health of people in these closed settings - prisoners and staff.

In partnership with United Nations organizations, international non-government organizations, the Ministries of Health and Sports, and the Home Affairs/Prison Department, 3MDG assessed priority actions to strengthen health facilities and services for people in closed settings. This includes the construction of new health facilities, standard operating procedures governing health service provision, and training of health staff.

Stories from the field in 2016

“I hope I can be a volunteer for a long time.”

Moh Moh Darli, 21, is a volunteer at Social Care Volunteer Group (SCVG). She raises awareness on gender and health issues in her community.

Social Care Volunteer Group was one of the 25 local organizations supported by 3MDG as part of the Collective Voices Initiative. Moh Moh Darli joined as a volunteer to raise awareness on gender and health issues in her village, especially tuberculosis (TB). “Once, I gave a session to 15 women in a neighbouring village from mine. Women from rural areas may not understand their rights and are subjected to their husbands’ decisions in health. After the training, the participants were empowered and many changed their situation at home. “This job is so rewarding, I hope I can be a volunteer for a long time.”

“Attitudes have started to change following advocacy.”

Sut Nau, Programme Coordinator, from Metta in Kachin State has witnessed first hand the devastating consequences of drug addiction.

Having witnessed family members and friends dying of HIV and AIDS, Sut Nau was determined to work in Harm Reduction-related activities at the community level. After joining Metta in 2006, he has worked on improving the conditions of people dependent on drugs, helping them to avoid HIV and enabling their reintegration into their communities. “Working with the communities can be tricky sometimes. At the beginning, they did not accept Harm Reduction, particularly methadone treatment and needle and syringe exchange programme. They thought that would encourage people to use more drugs. Attitudes have started to change following advocacy meetings, trainings and workshops in the communities.”
2017

Reaching for ‘Health for All.’

3MDG’s approach in 2017 was underpinned by key principles, aligned to the activities and priorities of the Ministry of Health and Sports, in particular those articulated through the National Health Plan 2017–2021. In 2017, the 3MDG Fund Annual Report focused 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.

MATERNAL, NEWBORN AND CHILD HEALTH

CONTEXT

In 2017, 3MDG-supported projects under the maternal, newborn and child health programme focused on:

- Supporting the delivery of services by township health departments and ethnic health organizations 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 micro-nutrients and nutrition education about the first 1,000 days.

Maternal, newborn and child health indicators were stronger across the country in 2017, except for in Rakhine State and Chin State. Swollen rivers during rainy season can make access difficult, but referrals and outreach are making life easier.

ACHIEVEMENTS

1. The contraceptive prevalence rate in 3MDG-supported township health departments and ethnic health organizations increased in 2017.
2. Maternal, newborn and child health services, including in remote, hard-to-reach and conflict-affected areas.

TUBERCULOSIS

CONTEXT

In Myanmar in 2017, tuberculosis (TB) continued to particularly affect urban poor and migrant populations. To address the epidemic within these groups, the Ministry of Health and Sports, supported by 3MDG and partners, sent mobile teams out to find cases of TB amongst hard-to-reach populations in prisons, work sites and urban slums. These active case finding activities continued in 2017 with nine mobile teams making more than 230 visits to nearly 160 townships and 43 prisons and work sites.

ACHIEVEMENTS

1. 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.
2. Better collaboration for more testing in more places - mobile teams expanded the reach of tuberculosis testing capabilities to more vulnerable populations in prisons and work sites, the urban poor, and hard-to-reach areas.

HIV

CONTEXT

In 2017, 3MDG’s HIV Harm Reduction programme performed well across all indicators and contributed significantly to national targets. It was mainly delivered in Kayin and Shan states, as well as in Yangon and Mandalay regions. Partners expanded services to previously un-reached areas and nearby townships, and continuing advocacy increased uptake of services and reduced community resistance. People who use drugs are a mobile population to reach these groups, 3MDG used a combination of facility-based services and trained peer outreach workers to provide services. Needle and syringe exchange, prevention programmes and Methadone Maintenance therapy were provided through drop in centres and outreach.

ACHIEVEMENTS

1. The distribution of needles and syringes—17 million in 2017—represents 52% of the national achievement. This represented an average of 400 needles and syringes per person who injects drugs in 3MDG–supported areas.
2. 3MDG was able to reach nearly 43,000 people who inject drugs—52% of the estimated number of people who inject drugs in Myanmar according to the IBBS 2014 (83,000) and 90% of people who inject drugs in the coverage area.
MALARIA

CONTEXT
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 were 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 treated cases for 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. ACHIEVEMENTS
1. 120 volunteers have been trained to provide integrated services under the Integrated Community Malaria Volunteer (ICMV) model.
2. In 2017, 3MDG supported 366,002 rapid diagnostic tests (RDT) for malaria; the tests showed increased positivity (through better targeting) and an over-achievement 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 towards elimination of the disease, to which Myanmar has committed by 2030.

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-centred health care at national and sub-national levels.

ACHIEVEMENTS
1. Supported the implementation of the National Health Plan 2017–2021 and the establishment of the National Health Plan Implementation Monitoring Unit (NIIMU).
2. Logistics management systems were rolled out in 79 townships and trainings in six states and regions
3. 3MDG financed the development of the Strategic Action Plan for Strengthening Health Information 2017–2021
4. All but one rural health centre financed by 3MDG had been handed over to the Ministry of Health and Sports. Construction of infrastructure key to the fight against

KEY RESULTS
366,002 number of malaria tests taken and read.
10,821 confirmed malaria cases treated.
20 Health centres built, 8 in Shan, 3 in Chin, 3 in Kayah, 3 in Yangon, 2 in Ayeyarwady and 1 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 (42% of total eligible basic health staff).
3,700 Health facilities have implemented Logistic Management Information System (LMIS) paper-based forms.

multi-drug resistant tuberculosis, including part of a National Reference Laboratory was completed.
6. 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 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.

HEALTH FOR ALL

Accountability, Equity, Inclusion and Community Engagement

CONTEXT
Myanmar continued in 2017 to have disparities in health status indicators. Access to health was impacted by location, gender, disability and language. 3MDG was 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 in 2017 was 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.

ACHIEVEMENTS
1. The Collective Voices project covered 169 villages and 58 ethnic health organizations are important because they reach the hardest-to-reach places and people. In 2017, partners worked to strengthen the capacity of village health committees, which connects communities with service providers. More women were included as committee members (15,636 out of 36,687 members or 43 percent) and knowledge on gender equity increased, the result of training and information sharing sessions.
2. As a result of continued advocacy, the ‘Heath for All principles (accountability, equity, inclusion, gender and conflict sensitivity) were included in the National Health Plan 2017–2021. The Plan also highlighted the importance of community engagement in health and formalized this with the introduction of ‘Township Health Working Group’ including civil society organizations.
3. In 2017, implementing partners received 14,648 pieces of feedback from communities. This indicates widespread usage and responsiveness at the township level. 92 percent (13,534 in number) of the feedback was used to adjust programming.
4. 3MDG maternal, newborn and child health implementing partners worked to strengthen the capacity of village health committees, which connects communities with service providers. More women were included as committee members (15,636 out of 36,687 members or 43 percent) and knowledge on gender equity increased, the result of training and information sharing sessions.
5. Ethnic health organizations and local civil society organizations are important because they reach the hardest-to-reach places and people. In 2017, organizational capacity development support was provided to them by Pact Myanmar through training sessions, forums, technical assistance and coaching.

Members of township health committees are women (193 out of 3,700), exceeding target of 20 percent.
Members of village health committees are women (15,636 out of 36,687).
People trained in accountability, equity, inclusion and conflict sensitivity, including 2,765 staff members from the MOHS.

Pieces of feedback received by implementing partners from community members, 13,534 (82 percent) pieces of this feedback have already been addressed, a significant improvement on the 2016 result (60%).

2017 Reaching for ‘Health for All.’
Health in Prisons

Context
Prisons in Myanmar are overcrowded, with more than 90,000 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 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.

In 2017, 3MDG strengthened 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 provided primary health care, HIV and TB testing and care, Hepatitis B screening and vaccination in close collaboration with local National Aids Programme team.

Achievements
1. Development of Standard Operating Procedures (SOPs) for Health Care in Prisons.

Nutrition
Rates of under-nutrition in Myanmar are among the highest in the region. 3MDG supported partners active in maternal, newborn and child health to provide health education and supplies for good nutrition in the community in 2017. These were 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 services for young children, pregnant women and distribution of micro-nutrients.

In 2017, 3MDG planned to increase its nutrition activities with a specific emphasis on capacity development of the National Nutrition Centre in 2018. 3MDG also worked 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.

KEY RESULTS
- 3 health facilities were improved in four prisons, Insein, Myitkyina and Lashio.
- 1,245 prisoners and prison staff vaccinated against Hepatitis B.
- 210 people received HIV care.
- 246 prisoners screened for TB, seven receiving TB treatment.

Voices for gender equality from 2017

“Gender equality is about equal opportunities.”
Dr. Aye Muyar Kyaw is the Township Medical Officer in Yangon. She fights for gender equality in everything she does.

“Now we have women parliamentarians in Chin - that’s progress!”
Daw Om Kyaw Ti is the Deputy Director of K’Cho Land Development Association. She is pushing for gender equality in Chin State.

“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 stay at home to help out in the house. That is not gender equality.”

“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.”

“Women in Chin State 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. “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 going to school. There are more opportunities for women to participate and raise their voices in rural development projects, community meetings and in politics. “Now we also have women parliamentarians in Chin State Parliament – that’s real progress!”

Reaching for ‘Health for All’
2018 was an extension year for the 3MDG Fund. The focus on sexual and reproductive health increased, and more activities were integrated to deliver comprehensive care in a more cost-effective way.
AT A GLANCE
2018 Results

AREAS OF WORK

- Maternal, Newborn and Child Health
- Tuberculosis
- Malaria
- Drug Use and its Health Consequences
- Nutrition
- Infrastructure
- Sexual and Reproductive Health and Rights
- Prison health
- Health systems strengthening

33 townships supported by maternal, newborn and child health services, including people in remote and conflict-affected areas. 8 extra townships were supported with only referral services.

13,113 pieces of feedback received by implementing partners from community members, 91% has been responded to, with actions taken.

18.6 million needles and syringes distributed to people who inject drugs.

43,908 births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)

13,382 cases of tuberculosis (all forms) detected and notified.

66,153 children under one immunized with DPT3/Penta 3

20,111 emergency maternal referrals

47,852 women received ante-natal care at least four times before delivery

53,339 referrals for TB testing by community health workers and volunteers

13,113 referrals for TB testing by community health workers and volunteers

40,422 people who inject drugs who were reached by HIV prevention programmes

1,905 doctors, nurses and midwives who participated in at least one mother, newborn and child health training

13,113 people who inject drugs who were reached by HIV prevention programmes

Measuring performance against target (% of target achieved)

- Above 90%
- 60% - 90%
- 30% - 59%
- Below 30%

See more results in Annex II: Results Matrix.
2018 ACTIVITIES

MATERNAL, NEWBORN AND CHILD HEALTH
- REFERRALS: Support to the provision of maternal and child referrals, in a sustainable way.
- OUTREACH: Outreach activities for Extended Programme of Immunization and maternal health services, including ante-natal and post-natal care, growth monitoring, nutrition promotion, newborn & under five children care and health literacy promotion.
- CAPACITY BUILDING: Trainings and other activities designed to build technical and broader capacity of basic health staff, and volunteers.
- SUPERVISION: Supportive supervision visits by state and township health departments, and rural health centres.
- DEMAND: Demand generation support for maternal health services, immunization, health education, emergency referral and basic health care services.
- NUTRITION: Support to nutrition activities, such as cooking demonstrations, mother-to-mother support groups, events during Nutrition Promotion Month, and micro-nutrient powder distribution.
- INTEGRATED MATERNAL, NEWBORN AND CHILD HEALTH: Integrated maternal, newborn and child health activities with disease control programmes.
- SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: Training of peer educators, dissemination of messages through hot-lines, Facebook, events and radio; edutainment programmes; sexuality education for young people; training to general practitioners to provide youth-friendly sexual and reproductive health and rights services; advocacy to parents and gatekeepers.
- FAMILY PLANNING: Provision of modern family planning methods and cervical cancer prevention services; community awareness raising activities; procurement and distribution of family planning commodities through social marketing; provision of sexual and reproductive health and rights services and information, including cervical cancer screening and treatment, clinical response to sexual and gender-based violence through clinic and outreach.
- MALARIA: Integrated case management activities, including prevention, diagnosis, treatment and referral for malaria, and health education and referral of sexually transmitted infections, and diseases such as leprosy, lymphatic filariasis and dengue.
- COMMUNITY-LED HEALTH: Support to the capacity development and reach of the village health committee, who conduct health promotion, reduce financial barriers for access, generate demand for health services, and engage the community.
- HEALTH FINANCING: Strategic purchasing pilot activities to improve access to health by reducing financial barriers.

2018 ACHIEVEMENTS

Removing Financial Barriers with Village Health Funds
During the five years of the 3MDG Fund operations in Chin State, village health committees were established and strengthened. These bodies are a key connection between community members, and health services. They are able to facilitate access to care through management of village health funds that can support villagers with financing when they need it, as well as conduct demand generation activities and health promotion. Financial and book-keeping trainings were supported in 2018, which helps the village health committee with those lending practices. Village health funds are established with a small amount of seed funding fees by villagers, and then small amounts of interest on loans to keep them ‘topped-up’.

Expanding Mobile TB Team Active Case Finding Activities
Before 2018, mobile tuberculosis (TB) activities in Chin were covered by mobile teams from Sagaing and Magway. This year, the National TB Programme established more extensive case finding activities in Chin State with the support of 3MDG, and 1,968 potential TB cases were examined during the mobile visits, with 30 cases were diagnosed and notified.

Local Language Education Materials for Expanded Opportunities for Learning
Health education materials are often only available in Burmese language, limiting their usefulness for those who cannot read Burmese language or are not literate. In 2018, local language and graphic malaria health education materials were distributed to all villages covered under the ‘Integrated Community Management Volunteer’ programme in Tonzang and Thantlang townships. This was done by Save the Children in coordination with the Ministry of Health and Sports Health Literacy Promotion Unit.

Nutrition Activities Targeted at Community Level
Demonstrations how to cook nutritious foods were held at village level. In some cases, such as Paletwa, they were organized and conducted by the Village Health Committee themselves, with financing from their own Village Health Fund. Other nutrition activities in Chin State included Integrated Management of Acute Malnutrition (IMAM) training, distribution of hygiene kits, a media and social campaign to promote exclusive breastfeeding for the first six months, and distribution of micro-nutrient powders.

Photos: Grandparents and community members play an important role in child health in Chin State, and in Myanmar 3MDG partners work with wider family members in health education activities, particularly nutrition and family planning.

2018 CHIN RESULTS

9,556
Number of women attended at least four times during pregnancy by skilled health personnel (72% of all deliveries).

8,747
Number and percentage of births attended by skilled health personnel (66% of all deliveries).

12,491
Number of children immunized against measles (97% of all under one year); 12,289 children immunized with Penta3 (96% of under one year).

5,631
Number of referrals for pregnant women and children under five years to reach hospital in an emergency (at or above target for both groups) (15% for women, 5% for under five years).

20,620
Malaria rapid diagnostic test taken and read.

2,209
Number of cases of suspected TB examined.
Armed conflict re-intensified in Kachin State in 2018 - particularly the first half of the year - resulting in the displacement of more than 14,000 people. Calm in most parts of the state was restored with the Tatmadaw’s declaration of a four-month unilateral ceasefire in December 2018. Nevertheless, humanitarian needs are unlikely to lessen in the short term, and drug use and migration in Kachin State remain significant contributors to high rates of HIV transmission. The maturity of the Fund’s implementing partners in providing health services in conflict settings has grown, albeit with technical and operational capacity limitations.

PARTNERS
- Asian Harm Reduction Network (AHRN)
- Community Partners International (CPI)
- Health Poverty Action (HPA)
- Médecins du Monde (MdM)
- Medical Action Myanmar (MAM)
- Metta Development Foundation
- National Tuberculosis Programme (NTP)
- Population Services International (PSI)
- Substance Abuse Research Association (SARA)

ACTIVITIES

MATERNAL, NEWBORN AND CHILD HEALTH
- REFERRALS: Support to provision of maternal and child referrals including patients from the internally displaced person camps, in a sustainable way.
- OUTREACH: Outreach activities for Extended Programme of Immunization and maternal health services, including ante-natal and post-natal care in hard-to-reach areas and ethnic areas.
- SUPERVISION: Supportive supervision visits conducted to ethnic health organization staff and volunteers.
- DEMAND: Demand generation support for maternal health services, immunization, health education and emergency referral.
- INTEGRATED MATERNAL, NEWBORN AND CHILD HEALTH: Integrated maternal, newborn and child health activities with disease control programmes.

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS:
- Youth-focused comprehensive sexuality education.

HIV/HARM REDUCTION:
- Integrated and comprehensive harm reduction services for people who use drugs and their families, including testing and treatment for HIV, TB and malaria, hepatitis and sexually transmitted infections, prevention services, opioid substitution therapy, and community-led harm reduction activities.

TUBERCULOSIS:
- Community based TB care, including capacity building of volunteers, case finding and referral, treatment adherence; acceleration of TB case finding in hard-to-reach and ethnic minority areas with mobile digital chest X-ray, and appropriate referral for treatment (NTP).

MALARIA:
- Engaging non-formal private sector providers in malaria elimination (Artemisinin Monotherapy Replacement AMTR project).

INTEGRATED COMMUNITY CASE MANAGEMENT:
- Integrated community case management activities, including prevention, diagnosis, treatment and referral for malaria, and TB volunteer capacity building, case finding and care.

SUPPORT TO EHOs:
- Capacity building and performance based incentives for ethnic health organization (EHO) workers, support to organizational capacity development activities for EHOs.

PRISON HEALTH:
- Provision of integrated basic health services in Bhamo Prison (HIV/TB, primary health care, viral hepatitis, health education).

INFRASTRUCTURE IN PRISONS:
- Health infrastructure support in Myitkyina Prison: one male clinic and one female clinic.

KEY ACHIEVEMENTS

Growing Acceptance of Harm Reduction Services
- Reports about local anti-drug movements and crackdowns decreased in 2018. This is tangible progress from efforts of 3MDG partners to build community support toward Harm Reduction. Local committees were able to mobilize communities, and a hotline campaign for collection of discarded needles at public places and the availability of PEP (post-exposure prophylaxis) services helped ease community concerns and tension. Art therapy followed by an exhibition of the art created, and promoting handicrafts made by people who inject drugs also demonstrated their capacity to contribute to the community.

Community Health Workers and Integrated Services
- Community health workers who can provide integrated health services can improve access to health and reduce health disparities for people living in conflict-affected and hard-to-reach areas. Tuberculosis (TB) and malaria were previously delivered vertically in Kayah State, but have been successfully integrated as ‘Integrated Community Case Management’ (ICCM) projects. One volunteer is trained to provide services from early diagnosis and prompt treatment of malaria, TB referrals and Directly Observed Treatment (DOT) provision, referral of maternal, newborn and child emergency cases, to health literacy promotion.

Reaching More People Who Use Drugs With Prevention
- Increasing HIV testing rates among people who inject drugs was a priority of the National AIDS Programme, but access to facility-based testing and prevention services for this underserved population is challenging, especially when police crackdowns escalate. Expanded outreach was used in 2018 to reach hidden populations in more locations with services including HIV testing, hepatitis screening and vaccination.

Coordination Between Ministry Of Health and Sports and Ethnic And Community-Based Health Organizations
- Activities to strengthen coordination between the Ministry of Health and Sports, specifically the State Public Health Department and township health departments, and ethnic health and community-based health organizations (ECBHOs) included helping to align to national guidelines and protocols through capacity development, training auxiliary midwives and community health workers in providing services in hard-to-reach areas, facilitating micro-planning for immunization, and gradually improving reporting and data collection to township and state-level health departments.

Photos: An Internally Displaced Persons camp in Myitkyina, Kachin State where 3MDG partner, Medical Action Myanmar trains and supports health volunteers. Ongoing conflict in Kachin has led to thousands of displaced persons who need quality health care.
**PARTNERS**

- Community Partners International (CPI)
- International Rescue Committee (IRC)
- Jhpiego
- Medical Action Myanmar (MAM)

**CONTEXT**

Conflict between the Tatmadaw and an ethnic armed group in Kayah State, the Karenni National Progressive Party (KNPP), interrupted health activities in 2018. Immunization activities in eight villages in Shawdaw Township could not be completed by the Township Health Department in June 2018. However, regular coordination meetings including representatives from the KNPP meant the issue could be resolved quickly, agreement to resume immunization activities was reached in July 2018.

The International Rescue Committee (IRC) partnered with ethnic health organizations, Civil, Health and Development Network (CHDN) to strengthen the coordination, mobilization, management and use of resources to improve the effectiveness and efficiency of the health system focused on maternal, newborn and child health. A key facet of the programme is supporting the development of the Comprehensive Township Health Plans (CTHPs), which takes work to ensure it is inclusive and relevant for all stakeholders in Kayah.

For tuberculosis (TB) active case finding and integrated community case management activities, Community Partners International (CPI) and Medical Action Myanmar (MAM) worked with CHDN in Kayah.

**ACTIVITIES**

**MATERNAL, NEWBORN AND CHILD HEALTH**

- **REFERRALS:** Support to provision of maternal and child referrals, in a sustainable way.
- **OUTREACH:** Outreach activities for Extended Programme of Immunization and maternal health services, including antenatal and postnatal care, growth monitoring, nutrition promotion, newborn & under five children care and health literacy promotion.
- **NUTRITION:** Support to nutrition activities, such as cooking demonstrations, mother support groups, and events during Nutrition Promotion Month.
- **CAPACITY BUILDING:** Trainings and other activities designed to build technical and broader capacity of basic health staff, ethnic health organization staff and volunteers.
- **PACKAGE TOUR:** Support to the provision of the ‘package tour,’ including crash immunization activities and open mobile clinics in hard-to-reach areas.
- **SUPERVISION:** Supportive supervision visits by state and township health departments and rural health centres.
- **FAMILY PLANNING:** Family planning training and commodities supply to the volunteers.
- **TUBERCULOSIS:** Community-based TB care, including capacity building of volunteers, case finding and referral, treatment adherence, acceleration of TB case finding in hard-to-reach and ethnic minority areas with mobile digital chest X-ray, and referral for treatment by National TB Programme mobile team.

**INTEGRATED COMMUNITY MALARIA VOLUNTEER**

Integrated case management activities, including prevention, diagnosis, treatment and referral for malaria, and health education and referral of sexually transmitted infections, and diseases such as leprosy, lymphatic filariasis and dengue.

**COMMUNITY-LED HEALTH**

Support to the capacity development and reach of the village health committee, who conduct health promotion, reduce financial barriers for access, generate demand for health services, and engage the community.

**HEALTH SYSTEMS STRENGTHENING**

Planning and coordination meetings for stakeholders at state and township level, biannual and annual Health Management Information Systems (HMIS) review meetings.

**MIDWIFERY**

Strengthening pre-service education for midwives, including the establishment of a preceptorship system (internship) to improve competency and skills, establish skills labs at midwifery schools, with simulators and equipment, helping midwifery faculty to improve their teaching, assessment and leadership skills.

**ACCREDITATION**

Roll out of new accreditation system for medical education institutions, including support to quality assurance team to enable self-assessment on the criteria.

**KEY ACHIEVEMENTS**

**Better Quality Services Result From Cross-Learning Between Government and Non-Government Health Staff**

Exchange visits between the State Health Department and township health departments and ethnic health organization staff were a great opportunity for learning. Joint mobile visits maximize resources and ensure that more populations, in more locations, can be reached with health services.

These were arranged with numerous coordination meetings during the project period. Health staff at all levels are able to gain a lot from these cross visits, to better understand the health system, contextual challenges, and the curriculum of health training material. This improves the quality and standardization of health services.

**Better Access Means Better Health For All**

Without access to areas where people need health services, health staff who want to help may be unable to provide care. Access in Kayah State has improved so that basic health staff from township health departments are able to move more freely to deliver ‘package tour’ services. This can include maternal, newborn and child health services, nutrition, health education and immunization. In 2018, despite clashes between armed groups and the Tatmadaw, health providers were able to quickly regroup and coordinate, so that access could be restored. Rates of immunization in the state have increased as a result of this improved access.

**More Services Available for the People of Kayah State**

Coordination with the National Tuberculosis (TB) Programme mobile teams also made visits to ethnic health organization (EHO)-areas possible in 2018, and community mobilization and referral made sure the right people accessed services. EHO volunteers were able to help TB patients adhere to their treatment. Medical Action Myanmar (MAM) expanded the services they supported in 2018. On top of community-based care, which has been delivered for a number of years, in 2018 they added integrated community case management for malaria and tuberculosis, basic health care and emergency referral support. This was because of a new partnership between MAM and CHDN for EHO-areas, where MAM helped with training to EHO volunteers and conducted joint supervision visits to CHDN sites.
Planning a Family in Kayah State

After seeing how hard her mother works to take care of her and her 12 siblings, Julia Htoo knew she wanted a different life for herself. The midwife supported her with health education and family planning methods.

Julia Htoo, 25, is the eldest daughter of a large family. She is a kindergarten teacher in Demoso Township. Even though Julia knew she wanted children when she got married at 23, she wanted to wait. She had seen how difficult it was for her parents growing up: with 12 siblings; there wasn’t always enough food.

Daw Nae Ray Phaw, a midwife at Loi Nan Pha Rural Health Centre in Demoso says that Kayah women are reluctant to use birth spacing methods due to traditional beliefs and limited awareness. “Most of the rural women don’t have enough health education. They prefer home delivery – they are reluctant to come to the clinic,” she said.

Julia is now seven months pregnant and has been regularly visiting the rural health centre to receive antenatal care. She has been eagerly learning from the health staff. “I told her about birth spacing, which has positive effects for the mother,” Daw Nae Ray Phaw says.

Julia and her husband decided to follow the family planning methods they had been taught to ensure their family’s well-being. “I only want three children. Then, I can take care of them and raise them as happy and healthy children,” Julia says.

“I told her about birth spacing, which has positive effects for the mother”

Avoiding Catastrophic Health Expenditure

With the knowledge that health spending is one of the biggest causes of poverty, CPI have been implementing a health financing project which tackles health challenges and poverty, whilst empowering local health structures, in ethnic health areas.

Each year in Myanmar, around 1.7 million people are pushed into poverty by health spending. Many people delay or avoid seeking health care, leading to worse health outcomes and lost productivity and income for the whole household. Myanmar has committed to providing universal health coverage (UHC) by 2030, but crucial to this is knowing how to reach ethnic minorities living in the border areas of Myanmar affected by the civil war.

Money is not the only barrier ethnic minorities face when seeking care. They may also be held back by barriers of distance, language, trust, and cost. A recent survey estimated only 8.3% of people had been to a government clinic in the previous year while 70% had accessed ethnic health organization (EHO) services.

Community Partners International (CPI) have been working with the Karen Ethnic Health Organization Consortium (KEHOC) on a new approach to providing health in these under-served areas. A pilot funded by 3MDG, CPI and KEHOC aims to develop a payment system where EHOs receive stable funding, while maintaining autonomy to provide health for communities un-reached by government clinics. This represents a change from the more traditional funding that EHOs have received, which has focused on targeting specific diseases, and shaping EHOs to those disease priorities.

Strategic Purchasing allows local organizations to determine the best way to satisfy the needs of their populations, while covering certain key areas, strengthening local institutions and giving a role for people living in ethnic health organization areas in their own care.

There is potential for this model to be scalable: using the existing network of ethnic health organizations can allow Myanmar to rapidly expand towards UHC. This will bring down poverty rates and ill health for some of Myanmar’s most vulnerable communities.

This project is a new way of working in Myanmar to improve health and eradicate poverty, promote dignity and leadership among ethnic minorities, while also informing national policy direction and effectively using resources for health.

1. Qualitative Study of Out of Pocket Expenditure (OOPEx) on Health: Further Expanding the Knowledge and Evidence Base of Health Financing in Myanmar FINAL REPORT 30th June 2017 https://www.3mdg.org/sites/3mdg.org/files/publication_docs/final_oope_st...
2. NHP 2017-2021 http://themimu.info/sites/themimu.info/files/assessment_file_attachments...

Bringing health services at affordable prices to people in non-government areas

Access to care can be challenging in some areas. CPI is piloting Strategic Purchasing Pilot Activities in four EHO clinics. 90% of the targeted population (9,258 out of 10,304) were registered, and as of October 2018, 27% of the registered population had utilized services. Photo: Community Partners International
Activities

Sexual and Reproductive Health and Rights: Youth-focused comprehensive sexuality education, training to general practitioners to provide youth-friendly sexual and reproductive health and rights services.

Post Abortion Care: Post Abortion Care (PAC) training to Medical doctors in all seven townships of Kayin State, and doctors from Taung Nor hospital (EHO area) and continuous monitoring and ‘manual vacuum aspiration’ (MVA) equipment supply provision.

Tuberculosis: Community-based TB care, including capacity building of volunteers, case finding and referral, treatment adherence; acceleration of TB case finding in hard-to-reach and ethnic minority areas with mobile digital chest X-ray, and appropriate referral for treatment by National TB Programme mobile team.

Malaria: Engaging non-formal private sector providers in malaria elimination (Artemisinin Monotherapy Replacement ATM project).

Integrated Community Malaria Volunteer: Integrated case management activities, including prevention, diagnosis, treatment and referral for malaria, and health education and referral of sexually transmitted infections, and diseases such as leprosy, lymphatic filariasis and dengue.

Community-Led Health: Support to the capacity development and reach of the village health committee, who conduct health promotion, reduce financial barriers for access, generate demand for health services, and engage the community, through Collective Voices.

Demand: Demand generation support for maternal health services and immunization, health education, emergency referral and basic health care services.

Civil Society: Provide support to the Myanmar Civil Society Network (CSO) to raise awareness about Universal Health Coverage, through CSO health forums and election of CSO representatives to participate in state/regional and township health working groups, a critical element of the National Health Plan.

Midwifery: Strengthening pre-service education for midwives, including the establishment of a preceptorship system (internship) to improve competency and skills; establish skills labs at midwifery schools, with simulation and equipment; helping midwifery faculty to improve their teaching, assessment and leadership skills.

Health Financing: Strategic purchasing pilot activities in ethnic health organization areas, to improve access to health by reducing financial barriers, with potential for scale-up dependent on results.

Key Achievements

Health Service Availability Readiness for Universal Health Coverage (UHC) in Non-Government Areas: Community Partners International (CPI) conducted a situation analysis of six ethnic and community based organizations. It aimed to understand service availability and health provider readiness for implementation of universal health coverage in alignment with the National Health Plan 2017-2021, and to inform development of an Annual Operational Plan for each organization. CPI also piloted ‘strategic purchasing’ activities at four ethnic health organization clinics, and 90% of the targeted population (9,258 out of 10,304) are registered.

Supporting Communities to Play a Role in Their Own Health: Collective Voices partner, Community Driven Development and Capacity Enhancement Team (CDDCET), worked with community-based organizations and village health committees in Kayin State. In total, three community based organizations and 21 village health committees were supported to increase women’s representation, and organize community events. Two new village health funds were established. Community feedback mechanisms were a key tool to constructive conversations between health staff and community members, exchange information, and build trust and mutual understanding. Health service accountability and responsiveness was built via discussions about the barriers to health services and ways to overcome them.

Improving Post-Abortion Care to Enhance Women’s Safety: There was a significant uptake in use of technology recommended by World Health Organization for the ‘uterine evacuation’ process needed post-abortion or miscarriage, thanks to the advocacy and interventions of 3MDG partner Ipas. They were able to raise awareness about abortion in Myanmar to government partners, and conducted three trainings covering Kayin and Bago East Region (14 total townships). On-the-job training showed doctors how to use manual vacuum aspiration and the correct practice was taken up quickly (56% in Kayin State in just months).

The Last Mile: Reaching Migrant and Mobile Populations with Malaria Services: Migrants can experience health challenges and limited access to care. They may have language challenges, or may not understand the health sector where they are. Their work may also make them more at risk of certain conditions. Medical Action Myanmar (MAM) trained integrated case malaria volunteers (ICMV) to reach these groups, including construction and rubber plantation workers, with health services. MAM mobile teams actively looked for migrant populations, and arranged clinics for malaria and tuberculosis case finding and referral, health education, and emergency referrals.
Flood Response in Southeast Myanmar

3MDG partners respond to the floods in south-eastern Myanmar with health services and more.

The floods in south-eastern Myanmar in the last week of July 2018 caused severe disruption to basic services, with many in the state unable to meet their nutrition, sanitation and health needs. The most affected villages were within areas where Myanmar Health Assistant Association (MHAA), Community Driven Development and Capacity Enhancement Team (CDDCET) and Community Partners International (CPI) were financed by 3MDG to provide basic essential services.

In the first week of August, the 3MDG Fund and the three partners met to coordinate response and secure financing, together with United Kingdom Department for International Development (DFID)-funded HARP technical experts. CPI coordinated the response together with ethnic health organizations, and were able to provide food and hygiene items and health services to 21 villages in Kayin and five villages in Tanintharyi.

MHAA conducted a rapid needs assessment in flooded areas, and advocated to state and township level administrative and health departments for response. Together with basic health staff and community members, they built latrines. CDDCET distributed purified water, soap, and antiseptic, and funded environmental sanitation for 21 village health committees.

Flood response activities (clockwise): The Township Medical Officer visits a flood-affected area in Hlaing Bwe; testing out the newly constructed latrines; construction of latrines to promote personal hygiene and avoid disease. Photo: Myanmar Health Assistant Association

WORKING IN MANDALAY

More than 6,000 people who inject drugs reached with HIV prevention programmes in Mandalay Region.

The consequences of drug use, including HIV transmission, are a significant issue in Mandalay. Myanmar Anti-Narcotic Association (MANA) is implementing Harm Reduction services to tackle this challenge, reaching out to people who use or inject drugs and their families, with outreach services and drop-in centres.

In Mandalay, in three townships - Aungmyaythazan, Pyigyitagon and Mogoke - 6,237 people who inject drugs were reached with HIV prevention programmes. This was 39% of the total reached by MANA, who also work in Sagaing and Shan. In these three states and regions, in total MANA reached 15,865 people who inject drugs, and 9,430 people who use drugs.

The amount of sterile injecting equipment distributed to people who inject drugs in Mandalay was 2,632,337. The return rate is at 83%, however, this could still be improved by encouraging those who are more reluctant to return needles and syringes to do so. Some needles and syringes are not returned because they are destroyed by burning.

HARM REDUCTION: Integrated and comprehensive harm reduction services for people who use drugs and their families, including testing and treatment for HIV, TB and malaria, hepatitis and sexually transmitted infections; prevention services; opioid substitution therapy; and community-led harm reduction activities.

ACTIVITIES

More than 6,000 people who inject drugs reached with HIV prevention programmes in Mandalay Region.

26 villages supported with flood response activities.

PARTNERS

- Myanmar Anti-Narcotics Association (MANA)
- National TB Programme (NTP)

Activities in Mandalay Region (clockwise): A doctor screens a patient for HIV and Hepatitis B and C; targeted health education activities using video; working together with the National TB Programme for early diagnoses and treatment using the mobile TB vans with X-ray machines. (Myanmar Anti-Narcotic Association)
ACTIVITIES

MATERNAL, NEWBORN AND CHILD HEALTH
• REFERRALS: Support to provision of maternal and child referrals, in a sustainable way.
• OUTREACH: Outreach activities for Extended Programme of Immunization and maternal health services, including ante-natal and post-natal care, growth monitoring, nutrition promotion, newborn & under five children care and health literacy promotion.
• DEMAND: Demand generation support for maternal health services, immunization, health education, emergency referral and basic health care services.
• SUPERVISION: Supportive supervision visits conducted by state, township health departments, and rural health centres.
• CAPACITY BUILDING: Trainings and other activities designed to build technical and broader capacity of basic health staff, and volunteers.
• REVIEW: Support to maternal and child death review and response activities.

MALARIA: Integrated case management activities, including prevention, diagnosis, treatment and referral for malaria, and health education and referral of sexually transmitted infections, and diseases such as leprosy, lymphatic filariasis and dengue.

HEALTH SYSTEMS STRENGTHENING: Planning and coordination meetings for stakeholders at state and township level.

PATNERS

• International Rescue Committee (IRC)
• International Organization for Migration (IOM)
• Myanmar Health Assistant Association (MHAA)
• Relief International (RI)
• UNICEF

KEY ACHIEVEMENTS

Strengthening The Referral Network in Pauktaw
The involvement of the community and village leaders in Pauktaw Township has strengthened the facilitation of the referral network. Involvement of the ‘Funeral Services’ team as well as village leaders through the ‘hotline system’ has meant that pregnant women and children in need of hospital care are more easily referred.

Coordination Leading To Positive Outcomes In Mrauk U
In Mrauk U, the Township Health Department, civil society organizations and Relief International have been able to work together closely for a number of positive outcomes in an extremely difficult context. For example, on the International Day for Persons with Disabilities, the community was brought together with interesting activities, performances and games, as well as a sharing session which brought to light the challenges faced by persons with disabilities in the community. The three partners also came together to strengthen referral with the use of ambulances.

However, limitations remained in reaching communities with services because of the repercussions of conflict and tensions. In 2018, health staff were able to somewhat overcome these challenges by offering a package tour of services, including immunization. Basic health staff were also made aware of maternal and child death surveillance and response systems, meaning that key issues are identified and managed.

Unicef Support To Strengthen Health System
Unicef provided support to the Rakhine State Health Department to improve the collection of routine health information and ensuring the use of data in decision-making. By the end of 2018, the reporting rate was 98% from all 17 townships of Rakhine (compiled in DHIS2 platform). Significant improvement was also demonstrated in timeliness and validity of monthly DHIS2 reporting which showed 60% timeliness and 94% validated by January 2019. This has been achieved through direct supportive supervision visits by State Health Department with standardized checklist for DHIS2, and improving on the job capacity development of DHIS2 focal points from respective townships. In addition, the commitment of township health departments and timely submission of basic health staff on monthly basis played a critical role to higher reporting rates.

RESULTS

2018 RAKHINE

23,867 Number of women attended at least four times during pregnancy by skilled health personnel (59% of all deliveries).

21,762 Number and percentage of births attended by skilled health personnel (54% of all deliveries).

34,211 Number of children immunized against measles (86% of all under one year); 34,760 children immunized with Penta3 (87% of under one year).

10,190 Number of referrals for pregnant women and children under five years to reach hospital in an emergency (near targets for both) (34% for women, 2% for under five years).

31,812 Malaria rapid diagnostic test taken and read.

5,137 Number of cases of suspected TB examined.

CONTEXT

The consequences of the conflict in August 2017 continue to reverberate in Rakhine State. Project activities could not be implemented as planned, though some activities such as outreach, referral, and coordination meetings were supported with the guidance of the State Health Department and township health departments.

Despite challenges in reaching Muslim communities in camps and villages, referral support was able to be delivered for all communities. An integrated package of services and mobile clinic system was made available through close work with the township health departments. Services included immunization to socially and geographically hard-to-reach people, as well as other maternal, newborn and child health services.

In the beginning of November 2018, armed clashes intensified between the Tatmadaw and Arakan Army in areas of southern Chin State and northern Rakhine State. In December 2018, a mine exploded in Buthidaung and Mrauk U townships. This was followed by a series of attacks between the Myanmar Army and Arakan Army in the areas around Buthidaung, Maungdaw and Rathedaung in northern and central Rakhine. As a result, routine outreach visits could not be conducted in December 2018.
Regions next to Kachin State are affected by the consequences of illicit drug use, including health consequences. In Sagaing Region, the HIV transmission is the second highest in Myanmar. As people who use drugs are the main driver of high HIV prevalence, 3MDG implementing partners provided comprehensive harm reduction services in seven townships.

A particularly high risk population is people who use drugs in detention centres, highly susceptible to limited essential health services, stigmatization, discrimination, and punitive action. Asia Harm Reduction Network and Myanmar Anti-Narcotic Association expanded outreach services in detention centres, prisons, and labour camps.

The burden of tuberculosis is significant in Sagaing, due to high population density. 3MDG funded the National TB Programme to promote active case finding with mobile teams across Sagaing Region, complemented by Myanmar Health Assistance Association implementation of a 3MDG-funded community based TB care programme in ten townships. In total, 29,070 cases of suspected TB were examined in 2018.

8,845 people who inject drugs reached with prevention programmes.

3,328,247 needles and syringes distributed to facilitate safe injecting.

5,624 number of prisoners, people who use drugs and people who inject drugs who received an HIV test and know the result.

29,070 number of cases of suspected TB examined.

“Increasing Access in Chin State”

Dr Zaw Hein works for Myanmar Red Cross Society in Chin State. He is proud to support health care services in a place where they can be difficult to access.

“There are not enough health service providers who want to work in hard-to-reach areas like Chin State. But it is here where health care services are needed most.

“Post-partum haemorrhage is a leading cause of maternal mortality for pregnant women in Chin State. Last year, two women who lived in a township on the border died from post-partum haemorrhage on their way to hospital. Transportation is such a challenge, especially during rainy season.

“Infrastructure, emergency health funds, human resources and transport arrangements are linked to each other. We need to try to improve in each sector – this is the most effective way to reduce maternal mortality.

“Last year, I completed a training course in Hakha, and then went on to teach basic health staff how to manage and provide emergency care during post-partum haemorrhage cases. This will be very beneficial for mothers and newborns. I believe this is one of the best things I’ve ever done in my life.

“I am really proud of my work because we save lives. Helping others gives me strength and motivation to move forward.”

Dr Zaw Hein is the Programme Manager of the Maternal and Child Health Project at Myanmar Red Cross Society in Mindat. They support the Township Health Department in providing health services, and support emergency referrals for pregnant women and young children.

“Providing training is the best thing I can do to save lives.”

SAGAING REGION

Sagaing Region is seriously affected by the consequences of drug use, including high levels of HIV transmission.

Regions next to Kachin State are affected by the consequences of illicit drug use, including health consequences. In Sagaing Region, the HIV transmission is the second highest in Myanmar. As people who use drugs are the main driver of high HIV prevalence, 3MDG implementing partners provided comprehensive harm reduction services in seven townships.

A particularly high risk population is people who use drugs in detention centres, highly susceptible to limited essential health services, stigmatization, discrimination, and punitive action. Asia Harm Reduction Network and Myanmar Anti-Narcotic Association expanded outreach services in detention centres, prisons, and labour camps.

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**SHAN STATE**

**CONTEXT**
Parts of Shan State have been affected by conflict for many years, in some areas fighting continues. This has serious consequences for the health status of the state’s residents. Throughout 2018, the security situation in the Northern Shan townships remained a significant concern as armed conflict between the Tatmadaw and ethnic armed groups, and inter-ethnic armed conflict flared-up. These clashes meant that some areas where 3MDG implementing partners worked were not regularly accessible. Despite these constraints, implementing partners have been able to deliver essential services especially life-saving maternal and child emergency referrals in the State.

Across the 3MDG Fund, the focus for 2018 was integration, but this proved challenging in Shan State, where instead partners concentrated on maintaining and scaling-up services in areas characterized by insecurity, human resource gaps and retention challenges, and remoteness.

**PARTNERS**
- Asian Harm Reduction Network (AHRN)
- Cooperazione e Sviluppo (CESVI)
- Health Poverty Action (HPA)
- Myanmar Medical Association
- Myanmar Anti-Narcotic Association (MANA)
- National TB Programme (NTP)
- Relief International (RI)
- Save the Children International (SCI)
- UNAIDS/UNODC/WHO (nationwide policy reform for HIV/Harm Reduction)
- UNODC/WHO (nationwide for all prisons)

**ACTIVITIES**

### MATERNAL, NEWBORN AND CHILD HEALTH
- Integrated maternal, neonatal and child health activities with disease control programmes, referrals, supervision, outreach activities for Extended Programme of Immunization and maternal health services, including antenatal and postnatal care, growth monitoring, nutrition promotion, newborn & under five children care, health promotion.

### NUTRITION
- Cooking demonstrations, mother support groups, events during Nutrition Promotion Month, micronutrient powders distribution.

### PACKAGE TOUR
- Support to the provision of the ‘package tour’, including crash immunization activities and open mobile clinics in hard-to-reach areas.

### SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS
- Youth-focused comprehensive sexuality education, training to general practitioners to provide youth-friendly services.

### FAMILY PLANNING
- Family planning training and commodities supply to the volunteer.

### HIV/HARM REDUCTION
- Integrated and comprehensive harm reduction services for people who use drugs and their families, including testing and treatment for HIV, TB and malaria, hepatitis and sexually transmitted infections, prevention services, opioid substitution therapy, and community-led harm reduction activities.

### 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.

### TUBERCULOSIS
- Community-based TB care, including capacity building of volunteers, case finding and referral, treatment adherence, acceleration of TB case finding in hard-to-reach and ethnic minority areas, referral.

### MALARIA
- Engaging non-formal private sector providers in malaria immunization (Artemisinin Monotherapy Programme).

### INTEGRATED COMMUNITY MALARIA VOLUNTEER
- Supporting community health workers to provide essential integrated services, including early diagnosis and prompt treatment of malaria cases, TB active case finding.

### COMMUNITY-LED HEALTH
- Support capacity development and reach of the village health committee, who conduct health promotion, reduce financial barriers for access, generate demand for health services, engage the community.

### CIVIL SOCIETY
- Support to the Karen Civil Society Network (CSO) to raise awareness about Universal Health Coverage, through CSO health forums and CSO representatives in health working groups.

### INFRASTRUCTURE IN PRISONS
- Health infrastructure support in Lashio Prison: one men’s and one women’s clinic.

### SUPPORT TO EHOs
- Capacity building and performance based incentives for ethnic health organization (EHO) workers, support to organizational capacity development activities for EHOs.

**KEY ACHIEVEMENTS**

**TB Active Case Finding in Non-Government Areas**
A project was started to extend tuberculosis (TB) active case finding activities in recognition of limited health care services in non-government areas. In Northern Shan, despite the late arrival of the portable x-ray machine and difficult recruitment in remote areas, Asian Harm Reduction Network (AHRN) were still able to conduct 22 mobile visits in the two Special Regions: 3,918 potential TB cases were examined, with 169 receiving treatment. HIV testing and counselling was also provided for 95% of TB cases. In Southern Shan, PSI worked with Shan State Development Foundation (SSDF) to train 47 ethnic health organization staff and volunteers for screening and referral of TB cases. 623 potential TB cases were examined, with 10 cases confirmed and notified.

### Young People Taking Charge of their Sexual Health!
Myanmar Medical Association (MMA) engaged young people in sexual and reproductive health and life skills trainings in 2018. They helped youth combine knowledge about healthy behaviours with good decision-making skills. After the training, some participants became volunteers so they could share what they had learned with others. General practitioners are also a key gatekeeper, and received training on how to offer services that are youth-friendly.

### Working with Ethnic and Community-Based Health Organizations For Better Health Outcomes
With limited resources and capacity, ethnic and community-based organizations (ECBHO) may be unable to meet the needs of their communities, even though they may be the only health provider. 3MDG partners worked to address that. Health Poverty Action worked in Wa Special Region and Special Region 4 to facilitate coordination, train ECBHOs in national standards in basic obstetric care and cold chain, and improve immunization planning. In Mawlamyine and Lashio, Relief International and ECBHOs integrated school-based WASH activities, nutrition feeding, health promotion, and maternal, newborn and child health services based on a needs assessment. In Northern Shan, escalating conflict threatened access to harm reduction services and people who use drugs were at risk of recruitment and ‘forced-rehabilitation.’ Shan State Youth Capacity Building Centre (SSYCBC), who have relationships with local armed groups, received technical support from Myanmar Anti-Narcotic Association (MANA) to advocate for harm reduction activities. MANA were then able to provide services in previously inaccessible areas.

**PHOTOS:** In Hsipaw in Shan State, Myanmar Anti-Narcotic Association brings Harm Reduction services to people who inject drugs in the community via a drop-in centre. It is a safe place where people who use drugs can spend time together in a judgement-free zone.

**2018 SHAN RESULTS**

- **9,563** number of women attended at least four times during pregnancy by skilled health personnel (70% of all deliveries).
- **13,414** number of children immunized against measles (97% of all under one year); 12,648 children with Penta3 (91% of under one year).
- **4,467** number of referrals for pregnant women and children under five years to reach hospital in an emergency.
- **106,668** malaria rapid diagnostic test taken and read.
- **38,323** number of cases of suspected TB examined.
- **8,023** people who inject drugs reached with prevention programmes.
- **3,089,496** needles and syringes distributed for safe injecting.

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In Lon Htan Local Health Authority clinic in Mong Mao Township in Wa Special Region 2, at only 22 years old, Ms. Yae Blup has already delivered over 40 babies.

In Wa Special Region, with limited Ministry of Health and Sports infrastructure, local Health Authorities are responsible for providing most health services. 3MDG works together with partner Health Poverty Action (HPA) to build the capacity of local Health Authorities through actions such as supporting the training of health staff.

Ms. Yae Blup was born in Lon Htan village and lives with her parents and siblings. She works at her Local Health Authority Clinic in maternal, newborn and child health. “At first, I was assigned to this clinic and I felt like it was a duty. But later, I grew to love my profession and now I serve the community with passion,” she says.

Yae Blup says she is particularly delighted when she sees the baby’s face for the first time during deliveries. As well as this, two moments, in particular, stand out as high points for her: when she treated a child with a high fever, and when she was able to help a pregnant woman who was having a difficult labour due to a big baby.

“They were saved by my hands! When their lives are spared, I feel the value of life.”

But there are low points too. As a woman herself, Yae Blup finds it difficult to see women’s pain during delivery. “We are women and can feel their troubles and pain during pregnancy. We want to console them from their sufferings,” she says.

The worst moment for her was during the second year of her internship at the clinic when she provided antenatal care to a woman when she was on duty travel for outreach activities. When she got back, she found that the patient was in labour. However, there was no fetal heartbeat and the delivery was a stillbirth.

Although Yae Blup was trained in maternal and child health care and basic health services, she is looking forward to receiving more training and being able to do more for her community in the future.

“I have a dream that people can have easier access to health care services and all are healthy without emergency life-threatening conditions.”

With an enormous effort, the team from Myanmar Medical Association was able to make a big difference in a short time for young people and their sexual health.

Myanmar Medical Association (MMA) works with young people in eight townships across the country in sexual and reproductive health and rights - Hlaing Thar Yar, Yangon Region; Pyapone and Yayako, Ayeyarwady Region; Mandalay, Mandalay Region; Mudon, Mon State; Hpa’an; Kayin State; Taunggyi, Shan State; and Myitkyina, Kachin State.

Project activities only started in March 2018, but thanks to a huge effort from the MMA team, everything that was planned could be implemented. Youth from the targeted townships, but also from other places, could access ‘sexual and reproductive health and rights’ information through Pandammyar FM radio programme and community awareness raising activities. This included rural and ethnic minority youth. In total, 42,295 young people - 15,372 men and 26,923 women were reached with sexual and reproductive health and rights education. A number of trainings were also conducted for peer educators, and in total 904 youth were trained.

There were, of course, challenges. In townships outside of Yangon, there were limited focal staff. Further, there are limited supply of local language education materials. These challenges will be addressed by MMA in their 2019 programming through the Access to Health Fund. This will include further reach to young people in areas outside of Yangon, and translation of education materials.

Local Health Authority Clinic worker Ms. Yae Blup. In 2018, 3MDG supported Health Poverty Action (HPA) project activities in Wa Special Region 2 and Special Region 4 in Shan State will continue. These include the strengthening of local health systems and better linking with government health systems with planning, technical support, medical supply provision and health information integration.
Despite recent political reforms and increased health spending, reproductive health outcomes in Myanmar remain poor. Use of any modern methods of contraception is 60.2%, and while the unmet need of currently married women is the lowest in Myanmar (11.9%), numbers vary from township to township and a great deal of people still do not have realization of their sexual health and reproductive rights. Peri-urban townships in Yangon are characterized by poor infrastructure, slum conditions, and a highly mobile population. The youth population in these areas has increased, particularly mobile youth ages 15-24 years. This only increases the need for sexual and reproductive health and rights (SRHR) services.

In Yangon, the burden of tuberculosis (TB) and multi-drug resistant tuberculosis (MDR-TB) is also high. Nationwide in 2018, 2,802 MDR-TB cases received treatment under the guidance of National TB Programme. This is up from 2,666 in 2017, 2,539 in 2016 and 2,207 in 2015. More than half the cases are from Yangon (1,315 out of 2,666 in 2017). There may be many more hidden cases. Basic health staff face many challenges in ensuring daily DOT is given to enrolled MDR-TB patients. Some patients may also refuse treatment due to lack of health knowledge and socioeconomic problem. This makes the disease even more difficult to manage in crowded peri-urban areas.

### ACTIVITIES

**SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS:**
Training of peer educators, dissemination of messages through hot-lines, Facebook, events and radio, education programmes; sexuality education for young people; training to general practitioners to provide youth-friendly sexual health services; advocacy to parents and gatekeepers.

**FAMILY PLANNING:**
Provision of modern family planning methods and cervical cancer prevention services; community awareness raising activities, procurement and distribution of family planning commodities through social marketing, provision of sexual and reproductive health and rights services and information, including cervical cancer screening and treatment, clinical response to sexual and gender-based violence through clinic and outreach.

**TUBERCULOSIS:**
Train TB community volunteers for active case finding; provide patient support, Directly Observed Treatment (DOT) and treatment adherence; health literacy promotion and infection control.

**MULTI-DRUG RESISTANT TUBERCULOSIS:**
Train community volunteers to provide evening DOT and side effect monitoring; infection control, counseling; World TB Day activities; community awareness raising and school health.

**HEALTH FINANCING:**
Strategic purchasing pilot activities; community awareness raising and school health.

### CONTEXT

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### PARTNERS

- Marie Stopes International (MSI)
- Myanmar Health Assistant Association (MHAA)
- Myanmar Medical Association (MMA)
- Population Services International (PSI)

**Photo.** The PSI strategic purchasing project in Shwe Pyi Thar improves health access for poor families. Here, family who is supported by the project.

### Key Achievements

**Self-Help Groups Improve Treatment Adherence for TB**
TB treatment can be a long and difficult process, and having patients adhere correctly to treatment can present a challenge for health providers. However, support from peers and community members, as well as health providers and volunteers, has shown to be effective in raising treatment adherence rates. In 2018, Myanmar Health Assistant Association set up seven self-help groups in Hlaing Thar Yar Township - part of Yangon that is particularly disadvantaged and vulnerable, and where TB is prevalent. The three new groups were on top of four already existing self-help groups, and this community-based model of care has proven effective for the patients who have joined in. There were 30 sharing sessions in total, and afterwards patients reported feeling more motivated to continue their treatment, and more trusting of health staff and the treatment process. In total, 686 presumptive TB patients were referred by self-help group volunteers and 343 patients are on treatment in Hlaing Thar Yar.

**First Ever World Contraceptive Day Celebrations!**
The first ever Myanmar government-led celebration for World Contraceptive Day was held in 2018 with 3MDG support. The celebration event was held in Hlaing Thar Yar, due to the high number of maternal mortality due to abortion - the highest in the country, and indicative of an unmet need for family planning. The Maternal and Reproductive Health Division from the Ministry of Health and Sport and 3MDG conducted the event jointly with the Regional Health Department and other stakeholders. More than 16 organizations, including Population Services International, participated in the booth exhibitions. In total, more than 5,000 women, mostly migrant women from garment factories, visited the event.

**Inclusive Delivery Of Health Education To Persons With Disabilities**
Increasing focus on people with disabilities for the final year of the 3MDG Fund, continuing into the Access to Health Fund, was reflected in health education activities in Yangon through the year. Peer education sessions for young people with disabilities were facilitated by Myanmar Medical Association, and to make sure everyone could participate, ‘feel-to-see methods’ were utilized for participants with impaired vision, and sign language interpreters supported hearing impaired participants.

**Cervical Cancer Screening Provided**
In both Yangon and Mandalay, one stop cervical cancer screening was offered at Targeted Outreach Programme (TOP) centres for female sex workers. It was free-of-charge, starting in 2018.
WORKING IN NON-GOVERNMENT AREAS

CONTEXT

Many parts of Myanmar are outside of government control; in those areas, it is ethnic and community-based health organizations (ECBHOS) who provide health services. They can often have limited resources and capacity, and standardization and coordination between the systems can be lacking. 3MDG has supported ethnic and community-based health organizations working in these areas to improve coordination, reach and quality of care.

In 2018, United Kingdom Department for International Development (DFID) handed over projects in Ka'chin Special Region I, Ka'chin Special Region II, and Kokang Special Region, to 3MDG. There was active conflict in the second quarter of 2018 in Ka'chin, which affected project implementation.

In Kayah in 2018, there were some areas where access was highly restricted - Hpapawn, Hpruso and Demoso - meaning that the local community was unable to receive immunization. 3MDG implementing partner International Rescue Committee were able to work together with the State Health Department and ethnic health organizations to ensure that immunization services could reach these areas.

PARTNERS

• Community Partners International (CPI)
• Health Poverty Action (HPA)
• International Rescue Committee (IRC)
• Medical Action Myanmar (MAM)
• Relief International (RI)

Ethnic and Community-Based Health Organizations:

• Back Pack Health Worker Team (BP-HWT)
• Burma Medical Association (BMA)
• Civil Health & Development Network (CHDN)
• Ka'chin Baptist Convention (KaBIC)
• Ka'chin Special Region 2 Health Department
• Karen Department of Health and Welfare (KDHW)
• Karen Baptist Convention (KBC)
• Pa-Oh Health Working Committee (PHWC)
• Mon National Health Committee (MNHC)
• Shan State Development Foundation (SSDF)
• SR4 Special Region Health Department
• Wa Special Region Health Department

ACTIVITIES

MATERNAL, NEWBORN AND CHILD HEALTH

• OUTREACH: Outreach activities for EPI (immunization) and maternal health, including ante-natal and post-natal care, growth monitoring, nutrition promotion, newborn & under five children care and health literacy promotion. Support to the provision of the ‘package tour’, including crash immunization activities and open mobile clinics in hard-to-reach areas.
• SUPERVISION: Supportive supervision and monitoring to ethnic health organization (EHO) staff and volunteers including joint training, supervision and exchange
• CAPACITY BUILDING: Trainings and activities to build technical and broader capacity of EHO staff and volunteers, performance-based incentives.
• DEMAND: Demand generation support for maternal health services and immunization, health education, emergency referral and basic health care services.

TUBERCULOSIS: Community-based TB care, including capacity building of volunteers, case finding and referral, treatment adherence, acceleration of TB case finding in hard-to-reach and ethnic minority areas with mobile digital chest x-ray, and referral for treatment by National TB Programme mobile team.

COMMUNITY-LED HEALTH: Support to the capacity development of the village health committee, who conduct health promotion, reduce financial barriers for access, generate demand, and engage the community.

CIVIL SOCIETY: Support Myanmar Civil Society Network to raise awareness about Universal Health Coverage, through civil society organization (CSO) health forums and CSO representatives in health working groups.

HEALTH SYSTEMS STRENGTHENING: Planning and coordination meetings for stakeholders at state and EHOs.

HEALTH FINANCING: Strategic purchasing pilot in EHO areas, to improve health access by reducing financial barriers.

ORGANIZATIONAL CAPACITY DEVELOPMENT: Support to organizational development activities of EHOs by annual operational plan development, assessment on service availability and readiness to ECHOs.

RESEARCH: Operational research to assess time-use by village health workers in EHO areas.

SITUATION ANALYSIS: Conducted by Community Partners International (CPI) for six ECHOs using a system approach to planning, financing and health service provision. It aimed to define the service availability and ECHO readiness for implementation of Universal Health Coverage in alignment with the National Health Plan 2017-2021, and to inform the subsequent development Annual Operational Plan for each ECHO. Based on the findings, strategic objectives, the operational plan, the Monitoring and Evaluation Plan and risk management were developed for each ECHO.

Supporting Pregnant Women in Special Region 4

Health staff conducting outreach in a remote village in Special Region 4 come across a woman about to give birth.

It was raining heavily when health staff from Se Le Hospital in Mongla, Special Region 4, headed out to a remote village tract, Mu Jian. They were going to provide vaccination to children under two years of age and pregnant women – but they didn’t get very far before they had to turn back. They had to return to the clinic to pick up a motorbike, because a truck had become stuck in the mud and was blocking the path, and only a motorbike could get through. After two hours riding in the rain, they arrived to Mu Jian, wet from head to toe.

While the village head began to call all the families to the clinic, the two health staff – A Xiang and Yu Er Meng – prepared the vaccinations, registration book and other essential medicines and materials. When they went through the kitchen to wash their hands, they saw a pregnant woman lying on the ground by the fire in pain. When they went to check, they saw she was in labour.

The baby was born. Both mother and baby were doing well. A Xiang washed her hands and quickly examined the woman, and Yu Er Meng went to inform the villagers what was happening. They told the mother and baby several days later. Yu Xiangyu smiled, while she listened to her husband.

“We have so many challenges that we encounter during outreach, and we are so exhausted when the day ends – but seeing a patient recovered and doing well is the best reward for our hard work.”

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NUTRITION

CONTEXT

Nutrition is a major public health problem in Myanmar. The recent Myanmar Micronutrient and Food Consumption Survey reveals that 26.7% of children aged between 6-59 months suffered stunting (also called chronic malnutrition). Of the same children, 6.7% are wasted (acutely malnourished). There are also staggering levels of anaemia: 40% of pregnant mothers and 35.6% of children (aged between 6-59 months) exhibiting that they are anaemic.

Improving nutritional outcomes in the country will be bolstered with high level commitment from the State Counsellor upon the development of the Multi-sectoral National Plan of Action on Nutrition (MS-NPAN). Four key ministries - the Ministry of Health and Sports, Ministry of Social Welfare, Ministry of Education and Ministry of Agriculture and Livelihoods, worked together to launch the document in 2018. 3MDG also significantly increased its support to nutrition from the start of 2018, particularly in central level coordination, education and capacity development activities via the National Nutrition Centre. Community-level activities were also bolstered with the integration of more nutrition-focused interventions under maternal, newborn and child health grants.

In August 2016, Population Services International with the National Nutrition Centre and UNICEF, developed a micronutrient powder brand for children called “Happy Kid”. Two million sachets of micronutrient powder were distributed freely to children under 5 years of age through community health service providers, Win Win agents and Sun doctors.

ACTIVITIES

PLAN OF ACTION: Together with other agencies, support the development of Multi-sectoral National Plan of Action on Nutrition (MS-NPAN)

QUALITY: Ensure quality implementation through supportive supervision and monitoring.

TRAINING: Roll out the Infant and Young Child Feeding (IYCF) training and its implementation; roll out the Integrated Management of Acute Malnutrition (IMAM) training and its implementation.

MICRONUTRIENTS: Procurement and distribution of Micronutrient Powder and Ready to Use Supplementary Food (RUSF).

COMMUNITY LEVEL: Strengthen the Growth Monitoring and Promotion (GMP) practices at community level.

SUPPORT NETWORKS: Establish and strengthen mother support groups.

AWARENESS RAISING: Community awareness raising on nutrition, Nationwide Nutrition Promotion Campaign.

2018

IN NUMBERS

2 million sachets of micronutrient powder distributed by Populations Services International.

USD 250,000 worth of nutritional goods purchased for the National Nutrition Centre.

USD 75,399

2018 Expenditure for nutrition.

PARTNERS

- Cooperazione e Sviluppo (CESVI)
- Danish Red Cross (DRC)
- International Organization for Migration (IOM)
- International Rescue Committee (IRC)
- International Organization for Migration (IOM)
- Myanmar Health Assistant Association (MHAA)
- National Nutrition Centre (NNC)
- Relief International (RI)
- Save the Children (SCI)

KEY ACHIEVEMENTS

Nutrition Promotion Month in Myanmar

2018 saw the first ever coordination of a nationwide nutrition promotion campaign in August. 3MDG supported the NNC to bring together different stakeholders, and focus on community engagement - especially in areas with the poorest nutrition outcomes.

More Nutrition Under Existing 3MDG Grants

In 2018, more nutrition activities were added to existing maternal, newborn and child health grants, following an integration model. This meant that health staff who already have knowledge and skills were able to increase the number of services they offered, and nutrition activities could be included without additional administrative cost.

Working At National Level With National Nutrition Centre

The new grant with the National Nutrition Centre, starting in 2018, gave 3MDG the opportunity to strengthen national capacity on nutrition, bring together different actors, and ultimately improve the status of nutrition in Myanmar.

Celebrating Nutrition Promotion Month!

The 2018 Nutrition Promotion Month with the theme of ‘The first 1,000 days for a brighter future’ aimed to draw attention to the importance of good nutrition for a happy and healthy life.

More than 30 partners held activities across the country under the leadership of Ministry of Health and Sports in collaboration with Unicef and 3MDG. There were weekly themes: breastfeeding, under five and school children nutrition, pregnant and lactating mother nutrition and Iodine Deficiency Disorders elimination.

The first 1,000 days are critical to give children the best start in life. Consequences of malnutrition during this time can be largely irreversible, and making good nutrition choices can determine a child’s growth potential and future. Malnutrition rates in Myanmar, however, are among the highest in the region. About one third of children in Myanmar are stunted, which can be a consequence of poverty, lack of access to services, good nutrition, inadequate hygiene and sanitation, or limited knowledge of healthy behaviours.

This year, partners shared the message of ‘food diversity’—eating different types of food from all food groups, or ‘eating the rainbow’. To encourage a diverse diet, young people on social media participated in quizzes, and shared pictures of their meals with prizes for the healthiest plate.

Pyae Phyo Aung, Health Team Leader from 3MDG, who attended the event in North Dagon, said: “It was great to see people learning about health in a new and different way. We know that when people have fun when they are learning, those messages are more likely to stick.”

Photo: A mother and her baby attend the Nutrition Promotion Month launch event in Yangon.

IN NUMBERS

2 million sachets of micronutrient powder distributed by Populations Services International.

USD 250,000 worth of nutritional goods purchased for the National Nutrition Centre.

USD 75,399

2018 Expenditure for nutrition.

PARTNERS

- Cooperazione e Sviluppo (CESVI)
- Danish Red Cross (DRC)
- International Organization for Migration (IOM)
- International Rescue Committee (IRC)
- International Organization for Migration (IOM)
- Myanmar Health Assistant Association (MHAA)
- National Nutrition Centre (NNC)
- Relief International (RI)
- Save the Children (SCI)

KEY ACHIEVEMENTS

Nutrition Promotion Month in Myanmar

2018 saw the first ever coordination of a nationwide nutrition promotion campaign in August. 3MDG supported the NNC to bring together different stakeholders, and focus on community engagement - especially in areas with the poorest nutrition outcomes.

More Nutrition Under Existing 3MDG Grants

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Photo: A mother and her baby attend the Nutrition Promotion Month launch event in Yangon.

2. Save the Children [https://myanmar.savethechildren.net/what-we-do/nutrition]
SEASONAL AND REPRODUCTIVE HEALTH AND RIGHTS

CONTEXT

Realization of sexual and reproductive health and rights is critical to allowing girls and women to achieve their full potential. Girls can avoid early marriage and stay in school, and women can pursue an income and have children if and when they are ready. In turn, they lift themselves, their families and communities out of poverty.

Sexual and reproductive health and rights access in Myanmar is limited by poverty, gender equality, service availability and social taboos. Contraceptive use is low, especially in rural areas; health knowledge is limited; and adolescent fertility is high. One in five deaths among adolescent girls in Myanmar is the result of pregnancy complications. Taboos can make the topic difficult to discuss, meaning young people are left in the dark about puberty, contraception and sexually transmitted diseases.

3MDG’s support to sexual and reproductive health and rights focuses on reaching young people with more health education and services. Interventions also include the implementation of post-abortion care guidelines and standard operating procedures at hospitals, cervical cancer prevention and treatment, and procurement of syphilis test kit to strengthen syphilis testing among pregnant women.

With the support of 3MDG, Marie Stopes International was able to serve women in Myanmar at highest risk of maternal mortality. Many of these areas present enormous challenges for service delivery. Chin State, for example, has difficult terrain, road conditions and frequent landslides, alongside resistance to family planning for religious reasons, limited health education or gender and social norms. However, MSI were able to work closely with religious groups, women and community leaders to overcome these barriers, which resulted in higher uptake of contraceptive use.

PARTNERS

- Ipsos
- Myanmar Medical Association (MMA)
- Marie Stopes International Myanmar (MSI)
- Population Services International (PSI)

ACTIVITIES

FAMILY PLANNING: Family planning services provided with clinics and outreach. Integrated with counselling, management of reproductive tract and sexually transmitted infections, cervical cancer screening and treatment of precancerous lesions through cryotherapy, clinical response to sexual and gender based violence.

POST ABORTION CARE: Post abortion care training for service providers, and provision of equipment in Kayin State and Bago (east).

COMMODOITIES: Procurement and distribution of family planning commodities (contraception).

PEER EDUCATION: Trained youth peer educators shared health information with peers in the community.

CAPACITY BUILDING: Skill development training for young people in basic life skills, communication and presentation, and leadership development.

HEALTH EDUCATION: Dissemination of sexual and reproductive health messages through hot-lines, radio programmes, Facebook and youth events, education programmes in schools and universities, World Contraception Day, social media; provision of sexual and reproductive health and rights information and services through clinics and outreach.

TRAINING: Trainings for health workers in clinical and counselling skills, rights-based approaches, training of general practitioners to provide youth friendly quality sexual and reproductive health services.

COMMUNITY ENGAGEMENT: Community engagement and demand generation with Collective Voices partners, community awareness-raising.

KEY ACHIEVEMENTS

Cervical Cancer Prevention, Awareness And Screening

In 2018, cervical cancer prevention activities were carried out by Marie Stopes International (MSI) in Magway, Sagaing, Mandalay, Bago, Mon, Ayeyarwady and Yangon. A total of 13,188 men and women attended cervical cancer awareness raising sessions, and 6,700 eligible women received cervical cancer screening services. There were 150 women who had positive screening results referred for treatment to the five MSI clinics that can provide cryotherapy for patients; 122 clients were treated.

At 48 Sun Clinic Providers supported by Population Services International (PSI), a total of 2,734 women received cervical cancer screening services in 38 townships. One stop cervical cancer screening was available to female sex workers, free-of-charge, by the addition of the service at two Sun Clinics and two Targeted Outreach Programme (TOP) centres. From this screening, 65 women were identified as needing cervical prevention (cryotherapy) service, which they received at the centre. The ability to provide cryotherapy at centre reduce high drop out rates that had occurred previously, as well as long gaps between diagnosis and treatment.

Guiding Strategy with the Ministry Of Health And Sports

A Short Programme Review of Reproductive, Maternal, Newborn, Child Health Development, and Adolescent Health Programmes (RMNCAH), conducted by MSI and supported by 3MDG, will inform the development of integrated RMNCAH Strategic Plan in 2019.

2018 EXPENDITURE

<table>
<thead>
<tr>
<th>Grant/Implementing Partner</th>
<th>Project Timeline</th>
<th>Actual Expenditure (USD) (2018)</th>
<th>Total Expenditure (USD)</th>
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<tr>
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<td>Marie Stopes International</td>
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<td>Ipsos</td>
<td>23 Feb 2018 to 31 Dec 2018</td>
<td>254,929</td>
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</tbody>
</table>

1. World Health Statistics http://www.searo.who.int/entity/maternal_reproductive_health/documents/mmr-fp.pdf?ua=1 (page 5). This is well below the SE Asia average of 54, but much lower than many places.

2018 IN NUMBERS

274,752
Couples Years of Protection delivered by 3MDG partners.

42,295
young people reached with sexual and reproductive health and rights education, 15,372 men and 26,923 women and trained 904 youth peer educators.

32,933
women received family planning services and sexual and reproductive health and rights information.

821
women received post-abortion care services in 2018. 75 doctors and 71 nurses received training in post abortion care and infection control, respectively.

JMDG and partners celebrate World Contraception Day in Yangon. This was the first time the day was publicly supported in Myanmar.
HIV is a concentrated epidemic among people who inject drugs, men who have sex with men and female sex workers. Despite the trend overall decreasing since a peak in 2000, prevalence is still at 34.9% for this group and has risen in recent years. The HIV epidemic varies from region to region, and in Yangon, Kachin, Northern Shan and Sagaing, HIV prevalence is also not declining. This is due to the large numbers of people who inject drugs in these areas, particularly in Kachin and Northern Shan. In total, there are 93,000 people who inject drugs in Myanmar. HIV prevalence among female sex workers is 14.6% and that of among men with sex with men is 11.6% (IBBS 2015). 3MDG financed comprehensive Harm Reduction services in 31 townships to those who inject drugs, and their partners and families in remote and conflict-affected areas.

Though the National Strategic Plan on HIV and AIDS (2016-2020) includes improving the integration of community and health system and promoting a human rights-based approach, an enabling environment to support these groups and their health care is not yet realized in Myanmar. In 2015, the Suspension of the Prostitution Act was amended by the previous government without consultation with stakeholders. It resulted in a hardening of penalties against sex workers, leading to decreasing access to health, social and legal elements. Punitive approaches are still common among key populations, and stigma, discrimination, confidentiality and informed consent in delivering services are still concerns of people living with HIV. United Nations partners took the initiative to work towards policy reform through advocacy, but despite some successes, there were also crackdowns against people who use drugs leading them to be more scattered and hidden in 2018.

For 3MDG, this area of work was a combination of different grants, working at different levels:

- Creating an enabling environment: Addressing policy, legal and social barriers in order to expand and implement standard operating procedures on health care in prisons jointly with the Prisons Department.
- Advancing and training: Advocate to key government stakeholders, capacity building, orientation session on prison SOP, skill building to all medical and health staff in prisons for MDR TB and Infection Control.
- Infrastructure: Upgrading health infrastructures in three selected prisons of Myitkyina, Lashio and Insein with the support of the infrastructure unit of UNOPS.

**KEY ACHIEVEMENTS**

**High Achieving Harm Reduction Programme**

The 3MDG Harm Reduction programme was high achieving, with partners working tirelessly to reach vulnerable people who use drugs, reduce community resistance to their services, and continually innovate and learn to reach more populations. In 2018, 3MDG partners reached 40,422 people who inject drugs through drop-in-centres, community based outreach and mobile activities: 43% of the national estimates of people who inject drugs. 18.6 million sterile needles and syringes were distributed to facilitate safe injecting in 2018, 73% of the national target.

**Law And Policy Reform For Enabling Environment**

United Nations Programme on HIV/AIDS (UNAIDS) and United Nations Office on Drugs and Crime (UNODC) alongside government partners, made significant advances in their work in creating an enabling environment. This included the Standard Operating Procedures on health care in prisons (see overleaf). They were also able to support amendment of the 1993 drug law to remove compulsory registration and find alternative ways from imprisonment of drug users, such as treatment, rehabilitation, community services. The new national drug control policy recognizes the importance of drug treatment in prisons and recommends investment in prison reform to address prison management and improve access of prisoners to health services, including drug treatment service in prisons.

**Growing Acceptance Of Harm Reduction Service**

Acceptance of harm reduction interventions at community level has significantly increased, including the Pat Ja San, who have been a group showing active resistance for some time. With advocacy and coordinated efforts of Metta, community members were encouraged to see people who use drugs as human beings, and positively portrayed drug dependency treatment and a rehabilitation approach.

**PARTNERS**

- Asian Harm Reduction Network (AHRN)
- Metta Development Association (Metta)
- Myanmar Anti Narcotic Association (MANA)
- Substance Abuse Research Association (SARA)
- United Nations Programme on HIV/AIDS (UNAIDS)
- United Nations Office on Drugs and Crime (UNODC)
- World Health Organization (WHO)

**PHOTOS**

- Photos: (clockwise) An outreach centre for sex workers to receive health care in Tamwe; The launch of the Prison Health SOP; Launch of the strategic plan for HIV/AIDS (2); Harm Reduction conference attendee.
PRISON HEALTH

A new commitment to better quality prison and labour camp health standards in Myanmar with the release of standard operating procedures.

Myanmar’s prisoners are among the country’s most vulnerable and marginalized people, with limited access to prevention and health services. Prisons and labour camps are overcrowded, which can turn them into hotspots for communicable diseases and infections such as tuberculosis, HIV, hepatitis and cholera.

To improve this, in collaboration with UNAIDS and WHO, 3MDG funded UNODC to support the development of the first Standard Operating Procedures (SOPs) to strengthen prison and labour camp health facilities and services. The Ministry of Health and Sports led this process in consultation with the Ministry of Home Affairs.

The primary objective of the SOPs is to provide guiding principles for the provision of health services in prisons. Prison health activities have also been integrated into Myanmar’s National Health Plan. Core focus areas are HIV, TB, maternal and child health, mental health, chronic, non-communicable diseases, infection control procedures, and the set-up of referral mechanisms and guidelines for their use for prison health staff.

Implementation of the SOPs is in process, including needed improvements in quality standards in health facilities and services for closed settings. Skills building activities organized by UNODC and financed by 3MDG build the capacity of prison medical staff, other prison staff and peers.

3MDG has also supported improved infrastructure in four selected prisons: Insein, Myitkyina and Lashio in 2017, and Mandalay in 2018. These were identified as a priority areas.

The Minister for Health and Sports attends the launching event for the Standard Operating Procedures for Health Care in Prisons in Nay Pyi Taw.

The Superhero Academy in Pathein

Standard operating procedures improve health care in prisons.

Pathein Midwifery School is using new teaching methods, including a more hands-on approach, to educate the next generation of community superheroes.

The aspiring midwives line up for the daily 7:45 am roll call at Pathein Midwifery School. The students are ready for a new day of learning life-saving knowledge and skills that they will bring with them when they are deployed by the Ministry of Health and Sports after graduation. A few years ago, the early-morning roll call was followed by a day of listening to the tutor speak about the theory of midwifery. These days, school is more fun.

“Before, the teaching focused on the teacher, who spoke a lot. Now we focus on the students, which make the teaching more efficient. In addition to the information you can read in textbooks, we share our own experience with the students,” says Dr. The Mon, Principal (Academic) at Pathein Midwifery School.

3MDG partner Jhpiego has been supporting Pathein Midwifery School (and 22 other midwifery schools nationwide) to strengthen their two-year midwifery education programme.

“I've decided to help communities in villages and I will take care of people's health as much as I can. As a midwife, I believe I can help reduce the mortality rate in villages”, says Yoon Ei, a second-year midwifery student.

Making sure midwives are trained to think on their feet and employ the skills they have learned in school to real-life situations is essential for Myanmar to make progress towards the goal of universal health coverage. New equipment in the skills lab and a practical approach to learning means that the students from Pathein Midwifery School can practise the skills they need to be a midwife.

“Previously, we couldn’t fully demonstrate childbirth to the students, but with the new equipment we can show the whole process. This means the students can practise and we can correct mistakes they make on the dolls. Then we repeat the whole process to help the students get better”, says Daw Khaing Thazin, Tutor Sister at Pathein Midwifery School.

Two young midwives-to-be excited to start the day of training at the superhero academy.
HEALTH SYSTEMS STRENGTHENING

CONTEXT

Myanmar is undergoing a major democratic transition and rapid economic development. In recent years, the country has increased public spending on health and education from a low base, which has led to some improvements in outcomes. Between 2011/12 and 2017/18, Myanmar increased spending on health from 0.19% to 0.80% of Gross Domestic Product (GDP).

Initiatives to strengthen the health system continue at central, state and 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 Health Plan 2017–2021 aims to pave the way towards central, state and regional and township level. The National Initiatives to strengthen the health system continue at increased spending on health from a low base, which has led to some improvements in rapid economic development. In recent years, the country Myanmar is undergoing a major democratic transition and has increased public spending on health and education.

PARTNERS

- Jhpiego
- National Health Plan Implementation Monitoring Unit (NIMU)
- World Bank

2018 EXPENDITURE

<table>
<thead>
<tr>
<th>Grant/Implementing Partner</th>
<th>Total Expenditure (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Health Plan Implementation Monitoring Unit</td>
<td>506,313</td>
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<tr>
<td>Jhpiego – Human Resources for Health (Comp. A)</td>
<td>1,16,784</td>
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<tr>
<td>Jhpiego – Human Resources for Health (Comp. B)</td>
<td>1,210,132</td>
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<tr>
<td>World Bank</td>
<td>522,629</td>
</tr>
<tr>
<td>Grand total (USD)</td>
<td>3,355,858</td>
</tr>
</tbody>
</table>

ACTIVITIES

GOVERNANCE: Coordination and monitoring of National Health Plan 2017–2021 implementation at central, regional and township level, supporting the development of policies and costed implementation plans.

HUMAN RESOURCES FOR HEALTH: Roll-out of the new accreditation system for pre-service training institutions and strengthening Myanmar Medical Council (MMC) and Myanmar Nurse and Midwifery Council (MNMC) for accreditation decision making processes, capacity building of the faculty members for effective implementation of new curricula, development of preceptorship system and skill labs in midwifery schools to strengthen midwifery pre-service education.

HEALTH FINANCING: Training in public financial management, electronic budget recording and reporting system trainings for central, state/region, and township level Ministry of Health and Sports staff, coordination and implementation of strategic purchasing pilots and analyses to support health financing strategy.

HEALTH MANAGEMENT INFORMATION SYSTEMS: Training on Health Management Information System (HMIS) and District Health Information System (DHIS2) at State and Township level, Health facility assessment in Kayah State as part of the nationwide health facility assessment to understand the supply side readiness.

MEDICAL PRODUCTS, VACCINES AND TECHNOLOGIES: Development, dissemination and revision of Standard Operating Procedures (SOPs) to deliver the Basic Essential Package of Health Service (BEPHS) package, define essential medicine and equipment list for health facilities in townships and below, constructions of health facilities.

KEY ACHIEVEMENTS

From Policies to Action

With support from 3MDG, the National Health Plan 2017-2021 (NHP) second year Annual Operational Plan (2018-2019) and Monitoring and Evaluation Framework (2017-2021) were finalized in 2018. The Situational Analysis and Consultations of Community-based Health Workers (CBHW) is also being finalized with 3MDG funding and technical support to form part of CBHW national policy development. 3MDG also supported the development of National Sexual and Reproductive Health and Rights Policy, the National Drug Control Policy was launched during February 2018 and sub-national plans for HIV for Kachin, Sagaing and Northern Shan.

Lessons Learned from Effective Coordination

Early and continuous collaboration between the Ministry of Health and Sports and all relevant stakeholders is important to successfully implement the NHP. Equally important is to translate the NHP into concrete activities with timelines and assigned responsibilities. Focal points were assigned to prepare a more detailed activity matrix for the second year’s AGP using the template provided. This matrix indicated how each activity would be carried out (i.e., which tasks it would involve), and provided a timeline, budget estimate with the funding source(s), and whether technical assistance is required. Achievements of the first year were reviewed and revised by focal departments, not solely by NIMU.

Accreditation Systems for Health Education Institutions

Accreditation represents a key quality assurance framework for educational institutions. 3MDG partner Jhpiego supported the introduction of an accreditation system for Basic Medical Education, midwifery and nursing pre-service education with the finalization and dissemination of the Accreditation Standards. These standards were used as the primary reference documents for all the accreditation processes; self-evaluation, on-site assessment, and decision making, including trainings organized in May 2018. The standards were disseminated to a wider audience in December 2018.

Building and renovating infrastructure

Myanmar’s inadequate primary health care infrastructure constrains the population’s access to health care services. Since 2015, 3MDG has financed the construction of 82 health facilities in Myanmar, built by the UNOPS Infrastructure Unit. In 2018, 3MDG allocated additional fund to build 11 centres mostly in conflict-affected areas of Myanmar. Three capacity building trainings were conducted in 2018 for Ministry and Health and Sports staff on infrastructure project management, quality assurance and quality control, health, safety and environmental management, contract administration, and procurement.

IN NUMBERS

5 number of policies and strategies developed and endorsed, with 3MDG financial or technical support.

6 number of pieces of research, situational assessments and studies conducted.

23 number of nursing, midwifery and Lady Health Visitor school supported to strengthen pre-service education.

Photos: Improving midwifery education was a key focus for 3MDG, through implementing partner Jhpiego. Here, we see midwives at Pathein Midwifery School, building skills and confidence before the graduate and head out into the community.
HEALTH FOR ALL

CONTEXT

Myanmar has a number of disparities in health status indicators, and access to care may be made more challenging because of distance, gender, disability, language, trust or stigma. 3MDG’s ‘Health for All’ programme has worked since 2015 to increase equity in health and improve access to affordable, quality health care, especially in rural and hard-to-reach areas and among poor and vulnerable groups. This work is done through enhanced health services accountability and responsiveness through capacity development of target communities, civil society organisations, and the public sector, and by increasing civil society engagement.

There were significant changes to the Collective Voices project in the 2018 extension year of the 3MDG Fund. The ambition was to better align the project with the rest of the 3MDG programme by creating linkages between communities and users, and the service delivery grants that 3MDG supports. By addressing social barriers to access which affect the most vulnerable populations, Collective Voices partners intended to increase demand for services. The project also worked to enhance accountability of service providers, and equity of access, as well as increase the participation of local civil society and community-based organizations in township-level participatory planning, budgeting and coordination.

ACTIVITIES

Mainstreaming Accountability, Equity, Inclusion, and Conflict Sensitivity

3MDG strengthened implementing partners’ capacity through training, workshops, sharing and learning sessions, coaching, and technical consultancy service based on needs. Key learnings were focused on themes including gender and social inclusion and the project cycle, conflict sensitivity, men’s engagement, disability, feedback and response mechanism, social accountability, first aid training, behaviour change communications, and universal health coverage and social determinants of health.

3MDG’s technical support on conflict sensitivity, RAFT, developed a tailor-made capacity building program for partners working in conflict-affected areas. Training was given to 238 staff from 29 organizations, working in seven states and two regions. RAFT also provided an overview of key conflict-related risks and opportunities, alongside practical recommendations.

Support to the Local Civil Society Health Network

In 2018, 3MDG supported the Local Civil Society Health Network through partners Pyi Pyi Khin and Community Partners International (CPI). Four health forums were organized in Kayin, Chin, Sagaing, and Nay Pyi Taw. The network effectively advocated for the Universal Health Coverage (UHC) law making process, issued a statement on “gender and social inclusion” to senior field staff of all implementing partners. This latter training included modules on inclusion of people with disabilities, sexual and gender minorities and people from different language and ethnic backgrounds. In 2018 alone, a total of 3,405 health workers and implementing partner staff (2,261 female and 1,144 male) were trained in these concepts.

Community Engagement Approach at Ministry Level

3MDG supported the Ministry of Health and Sports to develop a community engagement approach manual, and conducting a training of trainers at national and state and regional levels. In 2018, 3MDG supported the modification of the manual to be more in line with the Myanmar National Health Plan and changing context. It was re-launched in December.

KEY ACHIEVEMENTS

Mainstreaming a Rights-Based Approach

3MDG has been committed to mainstreaming four principles in all of its work - accountability and responsiveness, social inclusion, gender equity and conflict sensitivity. The Fund has done so through customized trainings to implementing partners, providing clear and feasible guidelines and minimum standards. In 2018, 3MDG provided two batches of refresher training to improve understanding on “social accountability and community feedback mechanism” and “gender and social inclusion” to senior field staff of all implementing partners. This latter training included modules on inclusion of people with disabilities, sexual and gender minorities and people from different language and ethnic backgrounds. In 2018 alone, a total of 3,405 health workers and implementing partner staff (2,261 female and 1,144 male) were trained in these concepts.

Maximizing The Collaborative Working Relationship To Greatly Improve Access

The partnership between harm reduction partner Myanmar Anti-Narcotic Association, and Collective Voices community based organization, Shan State Youth Capacity Building Centre (SSYCBC), increased access for health staff in previously inaccessible areas in Northern Shan State. Due to their close community ties, SSYCBC were also able to facilitate the training of 811 volunteers from 40 villages in drug use and health consequences, gender, family planning and male involvement, and sexual and reproductive health and rights, and help translate health education materials into Shan language, and develop a Shan language volunteer handbook. The end result was that more services were available to the community, and 1,728 community members received awareness sessions on health topics, including hygiene.

Save the Children also worked closely with civil society and community based organizations in Kachin, Palaung and Shan - ensuring to inform and involve ethnic literature and cultural groups on project activities, and challenges (including language, permission, safety and security). Together they brainstormed ways to overcome them. Basic health staff and Save the Children were able to provide more services, and formed one village tract health committee and six village health committees in non-government controlled areas.

IN NUMBERS

2018

3,405 staff from Ministry of Health and Sports, partners, community based organizations at all levels, trained in accountability, equity, inclusion and conflict sensitivity.

13,113 pieces of feedback received by implementing partners via the community feedback mechanism.

33% percentage of women representatives on the township health committees.

42% percentage of women representatives on the village and village tract health committees.

3,000 meetings held with participation and engagement between health providers and communities.

Photos: Getting the community involved is crucial to a project that is responsive to their needs, and can be flexible to extend access to even the most hard-to-reach populations. In 2018, 3MDG partners facilitated about 3,000 meetings between health providers and communities.

Photos: In 2017 and 2018, 3MDG held trainings and forums in disability inclusive health and social accountability for implementing partners and Fund Management Office staff members.

IN NUMBERS

2018

3,405 staff from Ministry of Health and Sports, partners, community based organizations at all levels, trained in accountability, equity, inclusion and conflict sensitivity.

13,113 pieces of feedback received by implementing partners via the community feedback mechanism.

33% percentage of women representatives on the township health committees.

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2018 EXPENDITURE FOR ‘HEALTH FOR ALL’

<table>
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<tr>
<th>Grant/ IP</th>
<th>Project timeline</th>
<th>Actual Expenditure (USD) (2018)</th>
<th>Total Expenditure (USD)</th>
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<td><strong>Total Collective Voices</strong></td>
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Past: Organizational capacity development and technical assistance to 3MDG’s partners on Accountability, Equity and Inclusion mainstreaming.

**2018 EXPENDITURE FOR ‘HEALTH FOR ALL’**

- **Grant with Charity Oriented Myanmar** was terminated before the end of 2018 as a result of serious misconduct and lack of appropriate response.

**COLLECTIVE VOICES PARTNERS**

<table>
<thead>
<tr>
<th>Lead CSOs</th>
<th>Partner CBs</th>
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**Collective Voices: Overcoming Barriers To Health**

“Health messages in Hakha dialect is very useful for us.”

Language barriers can affect access to health information. Providing health materials and training in local languages means that more people can acquire important health education.

In Chin State, many people have limited access to health education, information and health related materials due to language barriers. Health awareness trainings are often given by health service providers who may not be able to communicate in local languages. It is important that information, education and communication materials are published in local and Myanmar languages so that they can be better understood by the majority of people in local communities.

As one activity of the Collective Voices project, the Community Agency for Rural Development (CAD) with two partner community based organizations; Love in Action and Sumthawng Development Organization, conducted health awareness trainings to women in their local dialects. The training aimed to support women to make personal and health decisions and to increase health seeking behaviour in the community.

In February 2018, CAD also compiled key health messages from the training handouts and published community health education handbooks for its women health promoters. The handbooks were distributed to 225 women health promoters from the targeted project areas in 45 villages in Hakha and Thantlang Townships.

One of the women health promoters, Ma Hlaaw Zing from Tiphul Village, Hakha Township, said:

“I used to have difficulties in following and understanding the trainings. I had to read the handout again at home before sharing the health message with others. Now CAD has published a community health education handbook in both Chin (Hakha dialect) and Burmese languages. This is very useful for us and I would like to thank CAD and 3MDG for meeting our needs.”

**ABOUT COLLECTIVE VOICES**

The 3MDG Collective Voices project with a local partnership consortium model was developed to raise communities’ voices about their health needs, access to health services, and their right to equitable and responsive health services. To achieve this, Collective Voices aimed to understand social factors influencing health-seeking behaviours adversely affecting health outcomes and to support community responses to these barriers. Collective Voices was implemented in three stages including demand generation with a focus on community engagement and complementary to service delivery grants.

Stage 1, which started in 2015, centered on understanding community health experiences to uncover barriers to health care access. The second stage in 2016-and 2017 was about facilitating community action to respond to the findings from the first stage. In 2018, the third stage began, which focused on complementary to other 3MDG-supported health services, service alignment and area alignment.

Collective Voices quarterly forums have been conducted between the Fund Management Office and local civil society and community based organizations since November 2015. This discussion platform was a place to share learnings, challenges and solutions, and served as an opportunity to recommit to project goals.

**COLLECTIVE VOICES PARTNERS**

- Ar Yone Oo Social Development Association (AYO)
- Bright Future (BF)
- Community Agency for Rural Development (CAD)
- Community Driven Development & Capacity Enhancement Team (CDDCET)
- Charity Oriented- Myanmar (COM)*
- Phan Tee Eain (PTE)

*Grant with Charity Oriented Myanmar was terminated before the end of 2018 as a result of serious misconduct and lack of appropriate response.
## PROCUREMENT

### CONTEXT

In 2018, there was a restructuring of the UNOPS-wide procurement set-up in order to streamline activities, rather than having procurement units for each programme. This was initially difficult for 3MDG staff, who had periods of uncertainty about the roles and structure, and had to work with limited resources when two roles were moved away from 3MDG procurement unit during the final round of requisitions.

This was a particularly large round, including procurement of items for an external client, ad-hoc procurement support for nutrition items and syphilis test kits, and the procurement of prepositioning supplies to begin Access to Health activities at the very start of 2019. Due to low quantity of items and the short lead time, this prepositioning was only 58% successful.

### ACTIVITIES

- **REQUISITION:** Requisition of 354 items for 2018 (normal requisitions).
- **PRE-POSITIONING:** Prepositioning of stocks, 101 items.
- **PHARMACEUTICALS:** Procuring pharmaceuticals for Community Partners International as an external client.
- **PROCUREMENT:** Ad-hoc procurement for National Nutrition Centre.
- **PROCUREMENT:** Ad-hoc procurement for Sexual and Reproductive Health and Rights (syphilis test kits).

### EXPENDITURE:

- **USD 2,019,849** health supplies (pharmaceuticals, diagnostics, materials/consumables).
- **USD 16,740** supply chain management.
- **USD 85,717** warehousing/logistics (in-country transport/ customs clearance/insurance).
- **Total: USD 2,122,306**

### KEY ACHIEVEMENTS

**Procuring Nutritional Items for National Nutrition Centre (NNC) and Delivering to Townships**

The National Nutrition Centre (NNC) requested the procurement and in-country transport of two nutritional items, Micronutrient Powders (MNP) and Ready-to-Use Supplementary Food (RUSF). The procurement team completed the task with a short timeline, even though the amount to deliver was substantial. 3MDG Procurement team successfully delivered MNP to ten regions and RUSF to forty townships within the time frame. The total value of the goods delivered was about USD 250,000.

MNP is used to tackle micronutrient deficiency amongst children aged six to 23 months, and the 51.8 million sachets complemented government supplies for all states and regions, and was also held as emergency stock for the NNC for emergency response. To provide treatment for moderate to acute malnourished children under five, sachets of RUSF were distributed as part of the ‘Integrated management of Acute Malnutrition (IMAM)’ programme rolled out in 39 townships in 2018. There were 450,000 sachets in total, with some number also held in emergency stock.

**Procuring Syphilis Tests for Ministry of Health and Sports, Reproductive Health Division**

The Ministry of Health and Sports, National AIDS Programme requested 3MDG support as they anticipated a shortage of syphilis test kits for pregnant women in 2018. This test is critical for the elimination of congenital syphilis during the ante-natal stage. The timeline was short, and there were some internal difficulties in procuring branded items according to UNOPS procurement rules – however, the procurement team still managed to procure USD 215,000 worth of syphilis tests by the end of 2018.

**Project Closure and Final Distributions**

Project closure and final distributions ran concurrently, which was a high workload for staff – compounded by staff turnover, restructuring and contract change (requiring leave to be taken and limited staff in the office). Nevertheless, procurement team was able to carry out 118 final distributions in December, and close 40 procurement contracts.

## COMMUNICATIONS

### CONTEXT

2018 was a busy year for communications at the 3MDG Fund, as the team managed the refreshed branding and launch events of the Access to Health Fund. Two major events - the official signing, and the end of 3MDG and launch of ACCESS event will held in the second half of the year.

The communications unit also supported activities for World TB Day, and Nutrition Promotion Month - working in support to the Ministry of Health and Sports National TB Programme and National Nutrition Centre. 3MDG also participated in Save the Children’s exclusive breastfeeding campaign.

### Launch of the Access to Health Fund - and Goodbye to 3MDG!

Against the backdrop of the beautiful Inya Lake, donors, partners and everyone at 3MDG came together one last time on the evening of 11 December 2018 to celebrate the incredible achievements of 3MDG through the six years of partnership, as a new chapter awaits with Access to Health Fund. The UNOPS-managed Access to Health Fund, beginning in 2019, is the combination of the commitments of the United Kingdom, Sweden, United States and Switzerland of more than 215 million US dollars (MMK 342.69 billion) to improving the health of Myanmar’s most vulnerable people.

At the event, guests wandered through the photo exhibition which showcased the achievements by 3MDG and its partners over the last five years.
Monitoring and Evaluation Strategy

The Monitoring and Evaluation (M&E) Strategy of the 3MDG Fund was developed at its inception in 2013. Due to considerable changes both in Myanmar’s context and in the Fund’s operations in the following years, and in recognition of the need to improve the role of M&E in achieving the Fund’s objectives and knowledge generation, 3MDG conducted a review of the M&E Strategy in 2016. This review provided strategic guidance to monitoring 3MDG programmes in the following focus areas: monitoring the activities of implementing partners; supporting the strengthening of the M&E systems of the Ministry of Health; knowledge generation and translation; advocacy and training for M&E; information management; and participation in health sector coordination fora. Part of this guidance was used to inform 3MDG’s work in 2017-2018. Some of the guidance points will be used to guide M&E efforts of Access to Health.

Assessing and Verifying Grantee Performance

Grant agreements between UNOPS and implementing partners were prepared on a yearly basis, and included workplans, budgets and logframes with outcome, output and process indicators and targets. Performance review meetings were conducted twice a year, upon submission and review of six-monthly and annual reports. The multi-disciplinary team from the Fund Management Office, and the implementing partner reviewed performance and discussed any issues. Risks on programme delivery for the next reporting period were integrated into discussions, as well as any potential additional programming opportunities to improve performance and/or delivery.

Field monitoring visits were also regularly conducted, normally once per year per implementing partner per township – but more frequently if needed. The purpose of the monitoring visits was to assess service delivery, data quality and systems. Assessment results and recommendations are shared with implementing partners. In 2018, the Fund Management Office conducted 33 monitoring missions including 18 routine data quality assessments. These missions covered 25 organizations in 8 states and regions. The number of missions was lower than in 2017 and slightly under the target due to prioritization of work on design and set-up of the Access to Health Fund and the 3MDG Final evaluation.

An internal Fund Management Office process also assessed implementing partner risk for service delivery and performance; unit costs, budget spending rates are compared and contrasted among different townships. This process was formally conducted bi-annually after the six-monthly data and financial reports are submitted and has been integrated into grant management since 2015. Additionally, maternal, newborn and child health, and HIV, tuberculosis (TB) and malaria teams prepare inputs on the performance for state/regional meetings, and overall implementing partner performance at national level meetings (respectively).

Final Evaluation

The Final Evaluation of the 3MDG Fund started in August 2018. It is currently in the process of being finalized, at the end of July 2019. The findings summarized here can be considered preliminary. The objectives of the Final Evaluation were to:

1. Evaluate performance, value for money and to the extent feasible, impact;
2. Identify lessons learned and forward-looking recommendations to guide improvements in operations of the Fund Management Office and implementing partners of the successor fund, the Access to Health Fund;
3. Assess accountability for targeted use of resources;
4. Document learning for enriching the global body of knowledge

The framing questions of this evaluation were:

• “What lessons of future value can this evaluation generate?”
• “How can the final evaluation provide new evidence that would be useful to inform the work of a Successor Fund?”

The Final Evaluation covered eight thematic areas (as follows) with specific evaluation questions under each area. 3MDG Development Story; Target populations; Design principles; Key interventions; Impact; Value for Money (VfM); Access to Health Fund; and Knowledge Generation.

This evaluation used a combination of secondary data analysis and limited primary data collection sought to validate the trends identified in the secondary data. One of the limitations for assessing impact was that the 3MDG Fund had not been able to secure Ministry of Health and Sports permission to conduct the baseline study proposed in the Description of Action, providing insight into the poor and vulnerable target populations and their needs at township level. Therefore quantitative analysis had to rely predominantly on routinely-collected data from the national Health Management Information system and Implementing Partner systems. The Final Evaluation also was informed by township health assessments conducted at the inception of the 3MDG Fund.

The Final Evaluation report is being finalized in July 2019. Preliminary findings from the evaluation show that 3MDG had developed strong relationships with the Ministry of Health and Sports, and non-government actors in conflict affected areas. The evaluation noted that the Fund had spent less than half of the original amount planned for maternal, newborn and child health services, due to slow start-up, limited execution of fund in some areas due to township planning challenges, vacant health posts and supply chain issues, and challenges related to conflict, remoteness and geography. This money was re-programmed and utilized in HIV, TB and malaria interventions and health systems strengthening, particularly infrastructure.

The Fund also incorporated principles of conflict-sensitivity, community engagement, gender-sensitivity and human rights, in line with the equity approach outlined in design documents. However, due to difficulties related to defining vulnerability in Myanmar, and limited data to identify, target and measure those who are vulnerable, the ability to target the most vulnerable and to demonstrate the extent of the impact of the Fund’s interventions on the most vulnerable in the maternal, newborn and child health component was curtailed. However, the report did note that “3MDG focused its contributions to national HIV, TB and malaria programmes on locations and populations with high levels of disease. There were innovative approaches to working with vulnerable populations, such as prisoners and people who inject drugs.”

The evaluation report noted some of the successes of the Fund, such as the contributions to building the capacity of basic health staff, the development of an effective and transitional emergency referral programme, and support to delivery of basic maternal, newborn and child health interventions. 3MDG also contributed to the development and implementation of the National Efferents (3MDG 2021), and the report described contributions to active case finding and treatment of multi-drug resistant TB as “valuable, particularly within the context of 3MDG’s human rights approach.” The Fund had a well-considered approach to gender sensitivity, which showed a commitment to gender principles, and the evaluation team found that the Fund had “good respect for human rights.” An example given was in the HIV programme, where 3MDG partners worked with high risk groups for HIV, as well as the emergency referral programme with demand-side financing support.

The report also made a number of recommendations for the Access to Health Fund, with particular focus on the importance of targeting and reaching the most vulnerable people, and measuring results of these efforts. Furthermore, recommendations encourage continuing systematic collaboration with the Ministry of Health and Sports, ethnic and community based health organizations and other partners to remove blockages to access for remote and conflict-affected populations. Support to national organizations should be developed further to maximize contribution to Myanmar’s health economy. Some of the recommendations are already in the process of being adopted and operationalized by the Access to Health Fund.

Preventing Child Deaths Across Myanmar

Myanmar has struggled to reduce under-five mortality, because in Myanmar, and other countries with less established health systems, many children die due to causes that are easily preventable – often due to delays in seeking or accessing health care or inadequacies at health care facilities when they are reached.

To tackle this problem, it is vital to firstly know the circumstances that led to death so that actions can be taken to prevent similar deaths.

Accordingly, the Ministry of Health and Sports developed the Child Death Surveillance and Response system (CDSR) to investigate and report child deaths. This scheme was implemented in all townships in Myanmar in early 2017, with technical and operational support provided by 3MDG in partnership with UNICEF and other partners in 3MDG townships, and through government funding in the rest.

After one year of operation, an assessment of this modality was conducted in three regions/states – Shan, Magway, and Ayeyarwady. The assessment, released in July 2017, found that communities are now more aware of the need to notify a child death. Additionally, there is a better understanding around causes of death and better collaboration between clinical services and public health programmes.

However, still only approximately one third of all estimated child deaths were notified. It was agreed that training in CDSR methodology needs to be intensified, and advocacy, dissemination and public awareness need to grow. In specific situations where external support is being reduced, the Ministry of Health and Sports will need to develop solutions to fill emergent gaps, with a focus kept on working towards long term sustainability of the scheme.
Explore results over the years of the 3MDG Fund, including trends in coverage and outcomes, contextual challenges, and project adjustments to address them.
RESULTS OVER THE YEARS OF THE FUND

3MDG worked in a period of great transition in Myanmar. There were challenges and opportunities as the country was swept by dramatic social, political and economic changes with movement towards democratization, peace and reconciliation. 3MDG attempted to capitalize on these opportunities, such as the chance to work more closely with government and to draw government and non-government health providers closer together. In the face of challenges, which could impact access and the ability to deliver, 3MDG partners worked innovatively to attempt to maintain service delivery. For example, later in the Fund, working more closely with community-based and civil society organizations who had relationships with communities and armed groups proved a successful way of continuing to provide health care even in unstable situations. In Rakhine, however, limited access for health staff in particular areas was difficult to overcome and resulted in continuing poor health in the state as health care remains unavailable in large areas.

Overall, these challenges meant that progress wasn’t consistent, with periods and places where areas of rapid gain have been made, and other situations that were more challenging. In some areas, such as malaria and Harm Reduction, 3MDG results could meet and even surpass expectations. In other areas progress was more difficult, but nevertheless, important gains were made within a rapidly changing country. In Chin State, for example, the contraceptive prevalence rate stagnated for years - reflecting resistance to family planning services in the state. In 2017 and 2018, however, there was a significant jump as a result of tireless advocacy by 3MDG partners and other development actors.

This section of the report outlines the trends, progress and challenges in the major areas of health where 3MDG worked: maternal, newborn and child health, HIV Harm Reduction, tuberculosis, malaria, and health systems strengthening. There is also a section on sexual and reproductive health and rights, which was included from the start of the Fund and enhanced in later years. The maternal, newborn and child health section, which opens the chapter, is divided by the states and regions where 3MDG support was concentrated. These pages demonstrate the wide disparities, differing contexts, and unique challenges that each state and region faces.

Maternal, newborn and child health

INTRODUCTION

3MDG was set-up to address unacceptable levels of maternal, newborn and under-five mortality in Myanmar. There were wide disparities between urban and rural areas, and for some states and regions. When the Fund was designed, the aim was to make basic health care more accessible to the poorest and most vulnerable people in the country in order to address these disparities.

Selection processes for areas of work was thus important, however, in the face of limited data, only state-level and township-level choices could be made based on epidemiology. First, census data was used to identify those states with the highest maternal and under-five mortality ratios, such as Chin State and Magway Region. Next, specific townships were chosen on the basis of health outcomes, the level of existing services (and importantly, avoiding overlap with other external donors), and availability of health services due to distance, remoteness, or conflict.

However, this approach was not able to identify the most vulnerable people within any given township to ensure they received services. Instead, the approach aimed to improve the entire system for all populations, rather than targeting specific vulnerable individuals or groups. Strengthening the entire system is the preferred method for maternal, newborn and child health interventions because need for services is widespread, long-term, unpredictable and requires different parts of the system to all function well.

Nevertheless, some groups could be targeted, such as migrant women, who are vulnerable due to their mobility and limited health education. As the Fund matured, partners’ ability to overcome specific barriers to health, such as language and trust, improved. Outreach trips were targeted to needy and remote areas, and ethnic health organizations were supported to ensure women from ethnic minorities affected by conflict are also able to receive quality services.

More can be done, however, and in the Access to Health Fund, concerted effort is being directed towards defining, identifying and measuring the delivery of services towards the most vulnerable members of society. In this way, the maternal, newborn and child health work will more closely resemble the 3MDG HIV, TB and malaria programmes, which targeted vulnerable groups, such as prisoners and the urban poor, for its duration. See more in lessons learned on page 194-196.

ACTIVITIES

In each state and region where 3MDG partners worked in maternal, newborn and child health, partners:

• Helped establish and provide community-based referral services for pregnant women and children under five years and other lifesaving interventions, together with the township medical officer and township health team.
• Helped identify, select, train and support community health workers and auxiliary midwives, together with the township medical officer and township health team.
• Supported outreach services for hard-to-reach and non-hard-to-reach areas, for immunization and other services.
• Supported delivery of behaviour change communication interventions, including for nutrition, often through community-based approaches.
• Supported relevant maternal, newborn and child health training (Basic Emergency Obstetric Care, Infant and Young Child Feeding) for basic health staff in line with Ministry of Health and Sports priorities and needs.
• Provided refresher training of volunteer health workers (auxiliary midwives and community health workers).
• Helped understand and overcome barriers to health, including those related to gender, ethnicity, trust or poverty, fostered equity and inclusion from project design, supported health service planning, implementation and delivery.
• Provided operational support to the township health department in terms of financial management, supply chain management, reporting of health information and more, depending on specific context of the township.
• Identified, trained and supported Integrated Community Malaria Volunteers to conduct case detection activities in coordination with township health departments.
• Established community-based referral systems to identify suspected tuberculosis (TB) and malaria cases.

WAY FORWARD

Maternal, newborn and child health programming for the Access to Health Fund will follow an integrated approach targeted towards the most vulnerable people living in conflict-affected areas. Integration means that people living in remote, conflict-affected or hard-to-reach areas, who may only have limited contact with the health care systems, are able to have more of their health needs met by less health staff and less supporting organizations. Ideally, this approach will deliver ‘more health per dollar.’ Integration supports the continuum of care model of health care delivery as laid out in the National Health Plan 2017-2021, which focuses on the delivery of the Basic Essential Package of Health Services to everyone in Myanmar, before expanding the items available in that package.
INTRODUCTION

In May 2008, Cyclone Nargis hit the coastal parts of Myanmar, killing almost 140,000 people and leaving hundreds of thousands homeless. It was the worst natural disaster in the country's history. Nargis had far-reaching and long-term impacts on Ayeyarwady Region, with the destruction deteriorating access to health services for many people, particularly in remote parts of the delta only accessible by boat. Restoring access has been the priority ever since, and 3MDG work started there in 2013.

3MDG supported six townships in Ayeyarwady from 2013 to the end of 2018. Projects were implemented by the International Organization for Migration, Save the Children, Relief International and Médecins du Monde (MdM). Focus was maternal, newborn and child health activities and health system strengthening, with an overall objective to reduce severe maternal and child mortality rates. This was done through support to township health departments to develop a Comprehensive Township Health Plan (CTHP) annually, and implement activities.

In 2018, following strong results from the region, only referral support was continued using a pilot model with minimum partner staff. The model, which was designed by the Ministry of Health and Sports with support from 3MDG, had slightly altered referral criteria, and total expenses reimbursed were calculated differently to make it more affordable, and thus, potentially more sustainable. The model uses less partner staff, so more posts were filled. The use of contraceptives, indicated by the contraceptive prevalence rate, increased from just 51% of the coverage population in 2013 to 80% in 2017. This is a substantial improvement. Basic health staff and volunteers provided a continuous supply of family commodities to families who need them, supported by Marie Stopes International. Immunization rates by the end of 2017 were 97% coverage for Penta 3, and 89% for measles (the dip in 2017 was due to the Japanese Encephalitis campaign taking precedence).

PARTNERS, TOWNSHIPS AND TIMELINES

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RESULTS OVERVIEW

In general, key indicators increased from 2013 to 2017. For example, the percentage of pregnant women who received ante-natal care four times or more improved from 65% of the coverage population in 2013 to 86% in 2017. Skilled birth attendance increased from 56% to 73%, and post-natal and newborn care coverage increased from 58% to 87% during the same period. These are significant improvements, and mean that women living in townships that 3MDG supported in Ayeyarwady are more likely to have safe, healthy pregnancies. 3MDG supported outreach sessions, meaning midwives could reach more people in more difficult areas, and training in different topics made sure they have the skills they need. 3MDG also supported efforts to deploy and retain more staff, so more posts were filled.

Emergency Referral Programme in Ayeyarwady

Emergency maternal and child referrals were an important intervention in Ayeyarwady, characterized by difficult transport, geography and limited health-seeking behaviour. By 2017, the referral rate – at 28% - was in fact well above the target, which is based on the global average of women who will require emergency care during pregnancy (15%) This was so substantially over the targeted percentage due for a few reasons: an anomaly in how the township health departments calculated the number of expected pregnancies; potential double-counting in referral mechanisms in non-emergency cases; or cases being referred from different townships (thus not being accounted for in expected pregnancies figures which are the denominator of this indicator).

At the start of the 3MDG Fund, there were no standard referral criteria or guidelines for emergency referrals. When implementing partners developed their own guidelines, there were inconsistencies amongst partners in the same regions. The standardization of the guidelines was done through a consultative process with implementing partners and township health departments, and the final product was presented at central level for endorsement. The Emergency Referral Guideline was launched in 2015. Communication about what was in the guidelines and how to meet them was also improved; however, numbers in Ayeyarwady still remained above the targeted figure. Though enabling facility-based delivery is a positive end result in its own right, more work was needed to ensure referrals were only used in line with the criteria.

In 2018, a new pilot model – with stricter guidelines – was introduced. The result of this work was a more accurate figure of 22% referrals from expected pregnancies, dropping significantly from the 2017. This was also affected by a drop in the number of townships supported by 3MDG in this extension year, which also saw the overall number of referrals reduced.

Despite these project design and guideline improvements, challenges remained during implementation of the emergency referral programme. Cross-referrals could lead to double-counting of cases and problems in figuring out financial reimbursement due to differing internal compliance procedures of different implementing partners. It was thus decided that the referral would be recorded at the attending Township Hospital, based on a recommendation from the Regional Health Department. A standard cost was introduced, based on average transport costs, to reduce financial reimbursement challenges. This package has
proven a useful tool for the Township Health Department beyond 3MDG, it will be utilized while the ‘Stepwise Emergency Referral Mechanism’ is considered by Ministry of Health and Sports.

Lessons learned from the emergency referral programme in Ayeyarwady, Magway and more broadly in 3MDG townships, were shared with the relevant stakeholders, and carried forward into the Access to Health Fund. Identifying the hardest-to-reach populations, and encouraging them to make use of formalized health providers, remains a significant challenge. Nevertheless, efforts in Ayeyarwady – in particular, the hard work of implementing partners, basic health staff, and volunteers in raising awareness about referrals – increased trust in referral mechanisms and health seeking behaviour.

Implementing the Volunteer Recording System

Volunteers make up an important part of the health system in Myanmar, but there can often be difficulties in standardizing and collecting data about their work. An attempt to improve this was the ‘Volunteer Recording System’ (VRS) introduced in 2016. The VRS went further than previous efforts at data recording, as it included disease trends and essential health services up to village level. The data can be used in the Health Management Information System (HMIS).

Implementing partners were responsible for distributing health commodities and reporting forms to volunteers, and basic health staff monitored their activities and collected the completed forms. They were collated and analyzed during the township health department monthly meetings. Support to the VRS continued into the 2018 extension year, through the recruitment of a database assistant for data entry tasks. However, as implementing partners were only supporting emergency referral activities, and were no longer providing support for drug replenishment or to basic health staff to supervise volunteers, the reporting rate reduced in 2018. However, the townships that will continue under the Access to Health Fund will use the VRS to improve sustainability of the programme. The Fund will also continue to support the development of a policy for Village Based Health Workers, work which began during 3MDG. Lessons learned from the high attrition rate of volunteers in Ayeyarwady, such as the importance of proper selection, appropriate incentives, and career opportunities, will be incorporated into the policy.

THE WAY FORWARD

Due to high performance, and because it is not conflict-affected, support to Ayeyarwady will not continue in Access to Health. The transition to the Ministry of Health and Sports of all programming, including emergency referrals, is a positive sign for the Region.

RESULTS OVER THE YEARS OF THE FUND

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<tr>
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<td>66%</td>
<td>70%</td>
<td>77%</td>
<td>80%</td>
<td>85%</td>
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<tr>
<td>Contraceptive prevalence rate</td>
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<td>(i) 96% (i) 102%</td>
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<tr>
<td>Number and percentage of appropriate maternal (EmOC) referrals</td>
<td>(i) 38% (ii) 43%</td>
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<tr>
<td>Number and percentage of appropriate child (ECC) referrals</td>
<td>4,185</td>
<td>5,145</td>
<td>6,101</td>
<td>4,185</td>
<td>6,101</td>
<td>4,185</td>
<td>3,881</td>
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* Full implementation started in 2013 to 2017 but IPs provided only emergency referral support in 2018 (except for Relief International, who conducted only closure activities in 2018 from January to March. ** Target (5% of total expected pregnant women (EPW)) is based on the globally accepted number of women (WHO) who will require emergency obstetric services during pregnancy and childbirth.
LESSONS AND CHALLENGES

Community Case Management In Chin State

The community-based health workforce, such as auxiliary midwives and community health workers, were given the training, equipment and supplies they needed to meet community needs in Chin State. Under a community case management approach, their skills were expanded beyond single health areas in the final years of the fund, in line with recommendations gleaned from the process to develop a Community-Based Health Workforce. Trainings included Community Case Management, newborn care, tuberculosis, malaria, and reporting. Volunteers were able to provide a ‘continuum of care’ for pregnant mothers and newborns, and diagnose, treat and refer under five children for pneumonia and diarrhoea.

Community case management approaches, and the up-skilling of volunteer health workers, is a great way to ensure health services reach even the most remote people. However, without adequate training or supervision, volunteers may make errors that introduce serious risks for the community and broader society. In Chin State, a significant overuse of antibiotic prescription (and over diagnosis or incorrect diagnosis of pneumonia) was noted in 2017. This can be the result of limited training, as well as community pressure to provide the drugs, even when they are not appropriate, and can introduce a long term risk of anti-microbial resistance. This requires a comprehensive solution: implementing partners conducted refresher trainings in community case management for volunteers, as well as awareness-raising activities in the community to make them more aware of the dangers of over-prescribing and reduce pressures on health staff. Volunteer supervision by basic health staff was also improved. This saw results: in 2018, pneumonia diagnosis and treatment had reduced to acceptable levels.

Strengthening the Emergency Referral System

Emergency referral support, which improved continuously in Chin State, is critical to getting pregnant women and children to hospital when they need care. In hard-to-reach areas of Chin State and Magway Region, the importance of cross-township referral support was clear. For instance, referral cases from Matupi in Chin may more easily be able to access services in Halka, in Northern Chin or Gangaw, in Magway. To manage this, implementing partners in Chin and Magway held a coordination meeting and made a decision that patients could receive care from the most easily accessible township. This minimized gaps and contributed to the rise in women and children making use of the service in 2018: 13 maternal, and 11 child referrals were cross-refereed from other townships and supported by Marie Stopes International in Gangaw in Magway.

Context: Chin State is isolated and poor, leading to poor health outcomes - especially in maternal, newborn and child health. Cultural and religious beliefs mean that contraceptive prevalence and family planning in the state is low.

Maternal, newborn and child health: Improvements in coverage of these services in Chin were notable, but were not as large as other states and regions. For example, newborn care coverage only increased from 75% to 83%. The state also started from a lower point, such as skilled birth attendance at only 59% (improving to 66%). For contraceptive prevalence, it took a long time for any gains to be made, but due to work from partners to reduce community resistance through advocacy, some improvements were noted in the final year of the Fund.

Malaria: The impact of conflict in one township, Paletwa, impacted the delivery of health services, and also contributed to an outbreak of malaria in the area. Community level programmes were utilized to address the impact by maximizing the skills of local health workers, however, high levels of malaria continue.

Approach and system strengthening: Vacant health staff in the state is a persistent issue, but addressing it can have substantial positive impacts. When new midwives were recruited in 2018, there was a dramatic increase in coverage. Integrated activities in the particularly hard-to-reach parts of Chin meant that even services are limited, community health needs can be met as long as there is adequate training and supervision.
MATERNAL, NEWBORN AND CHILD HEALTH: CHIN

Challenges in Maternal Conditional Cash Transfer

It has been anecdotally reported that the introduction of the Maternal and Child Cash Transfer (MCCT) programme has resulted in an increase in the use of contraceptives. The abortion rate – often a sign of reduced use and acceptance of contraceptives – doubled after MCCT was introduced. This needs to be carefully monitored – on the one hand, if families are able to financially support their children’s good nutrition, this is a positive accomplishment, however, the dangers of poor birth spacing and high numbers of pregnancies (and abortions) for women must not be overlooked.

Supporting the Township Health Department In Comprehensive Planning Can Lead To Ownership

Health departments having a sense of ownership and demonstrating leadership can be a key indicator of the success of Comprehensive Township Health Planning. During the years of operation of the 3MDG Fund, the relationship between the State Health Department, township health departments, basic health staff and implementing partners has grown to be trusting, transparent and professional in Chin State. Regular coordination meetings between partners and government fostered joint decision making, and allowed lead implementing partners to coordinate activities together with these stakeholders. Joint supervision has become the norm, and basic health staff could spend more time in their duty stations to provide regular, lifesaving care.

Maintaining Accountability and Responsiveness Through Community Feedback and Response Mechanism

Through community feedback mechanisms set up by implementing partners at community level, beneficiaries could provide verbal and written feedback to project and health staff in Chin. This was then communicated to township health departments and basic health staff, and changes could be made based on the feedback. For example, when it was noted and reported that some villagers were expressing high rates of diarrhoea, water filters were purchased and installed. The end result was that community in those villages could use clean water and diarrhoea prevalence rate reduced.

Strengthening Health Information Systems

Health management information systems are noted weaknesses across most states and regions in Myanmar. Chin State is no different. To operationalize nationwide systems such as the District Health Information System (DHIS2), implementing partners supported basic health staff with office equipment, seconded staff for data entry, internet connection, on-the-job training, and technical support in data analysis, review and utilization. There was notable improvement: at the end of the 3MDG Fund, all township health departments in Chin State had adequate capacity to independently conduct DHIS2 data entry, though there is still room for improvement in data analysis and utilization.

THE WAY FORWARD

A significant difference between the 3MDG Fund and the Access to Health Fund is more emphasis on delivery of integrated services, to increase the comprehensiveness of the service package and align to the National Health Plan 2017-2021. In Chin State, the number of implementing partners has been reduced from four under 3MDG, to only two under Access to Health. Save the Children will implement integrated maternal, newborn and child health services in all nine townships, and Marie Stopes International will implement sexual and reproductive health and rights services in all nine townships in Chin State. Five static clinics will be established in five townships, and the other four townships will be served by mobile clinics.

Recognizing the high burden of malaria in specific parts of Chin, namely Paletwa Township, malaria interventions will continue in 2019 and throughout the Access to Health Fund. Support will be given to the ‘Integrated Community Malaria Volunteer’ approach. Tuberculosis interventions will also carry on through the nine mobile teams that travel around Myanmar to find and refer hidden cases, and treatment adherence support will continue at community level. As with the other Access to Health supported states, a direct grant will be provided to the State Health Department for health system strengthening activities.

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Stopping an Outbreak in its Tracks in Chin State

“When everyone needs to know how to prevent an outbreak”

When U Hlun Khis, community health worker, noticed an outbreak of fever in his village in Chin, he took all the steps to make sure it didn’t spread further. One day in 2017, U Hlun Khis noticed a high number of patients under five with fever and cough in his village - Thangaw village in Thantlang Township, Chin State. He quickly organized a meeting with villagers, health committee members and basic health staff. They knew they had insufficient medicines to treat everyone, and they didn’t want the illness to spread any further. So, they sought assistance from Save the Children and the Township Health Department who arrived the same evening to help. They had the medicines that were needed, and could help the village better understand what was wrong. All the children recovered with the treatment provided.

U Hlun Khis helped prevent an outbreak of acute respiratory infection in his village with his quick response, getting in touch with the right people to help solve the problem - and following the exact steps as he had been taught. He took it a step further, taking it on himself to make sure everyone in the village knew the most common causes of an outbreak of illness, and how to prevent it.

“Everyone needs to know 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,” he said.

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Isolation in Chin State can mean that health service providers have to make quick decisions, and know when to ask for help. U Hlun Khis did exactly the right thing when he noticed a spate of fever and coughs amongst under five children in his village. Photo: John Rae/UNDP
During 2014 inception period, there was no referral support. Distribution of family planning commodities by basic health centres showed a significant increase from relatively stable political context, and fewer human resource gaps and the quality of services in non-government and conflict-affected areas.

RESULTS OVERVIEW

Key indicators showed a general increasing trend of service coverage between 2015 and 2018 in Kayah. The percentage of pregnant women who received ante-natal care four times or more during pregnancy improved from 67% in 2015 to 75% in 2018. The percentage of births attended by a skilled person increased from 74% to 82% and post-natal and newborn care improved from 85% to 93% during the same period. These high and continually improving results were due to the relative stability political context, and fewer human resource vacancies compared to other conflict-affected states (though this is not the case for all towns). The increase in contraceptive prevalence rate (CPR) was significant – from 74% in 2015 to 65% in 2018. Contributing factors were distribution of family planning commodities by basic health staff and volunteers, training in the use of long-term methods, and availability of easy-to-use contraceptive methods via auxiliary midwives.

RESULTS OVER THE YEARS OF THE FUND

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<tr>
<td>Contraceptive prevalence rate</td>
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<tr>
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Hpaosalay, only 63% of deliveries had a skilled attendant, 77% newborn care coverage, 73% Penta 3 coverage, and 71% for measles. In Shadaw, only 67% of pregnancies received four ante-natal care visits, and 73% of deliveries had a skilled attendant. These figures were all below state-wide averages. There are a number of potential explanations for this. There are large migrator populations, especially in Hpaosalay, and in Shadaw, and active conflict may have limited access as well. Further, these towns are to a larger extent covered by ethnic health organizations than other areas, which are often under-resourced. These service gaps require additional coordination between different health systems to identify gaps and formulate solutions.

Ethnic Health Organizations Serving Their Communities

Despite their limited resources, ethnic health organizations were able to serve their populations between 2015 and 2018. For example, in 2018 alone, ethnic health organizations were able to provide ante-natal care visits at least four times for 372 pregnant women. Skilled birth attendants were present at 322 births, and 84 mothers and newborns received post-natal care. However, there is a significant gap between the level of post-natal care, and the skilled birth attendance - indicating that health staff are not aware of pregnancy early enough or do not have the resources to support childbirth.

Ethnic health organizations accounted for between 6% (skilled birth attendance) and 13% (newborn care) of the total. Kayah State service provision reported to 3MDG, indicating they are a small but vital part of the health system and continuing support to these groups may mean the difference between a healthy pregnancy and childbirth, and disastrous health risks for women in remote or conflict-affected areas. Improvement was noted in ethnic health organization referral systems, which increased from 41 maternal referrals and 42 child referrals in 2015, to 260 maternal referrals and 357 child referrals in 2018. Ethnic health organizations made up a much greater proportion of the total (27%) for maternal and child (31%) referrals indicating that in emergencies, community members are more likely to seek care from known and trusted local organizations, rather than government providers. This may also reflect ethnic health organization presence in the most hard-to-reach areas.

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MATERNAL, NEWBORN AND CHILD HEALTH: KAYAH

LESSONS AND CHALLENGES

Reaching The Unreached

Despite the notable improvements in service coverage in Kayah State, there are remaining challenges to fully reach the under-served and vulnerable. The ability to provide health care in these areas is heavily dependent on the armed conflict situation, the peace process, and human resource limitations when security is uncertain. About a quarter of the population live in areas controlled by ethnic armed groups.

In the first half of 2018, the ability of basic health staff to provide services in Shadaw was impacted by resurgence of armed conflict. In Hpasaung, Hpruso and Shadaw, access can be especially difficult in the rainy season. Human resource vacancies are common here because staff leave their posts for higher positions, for maternity leave, and due to geographical hardship or security concerns.

However, implementing partners and health providers worked tirelessly to overcome these challenges. They conducted coordination meetings between ethnic health organization representatives and township health department officials where service needs, gaps and future plans were discussed. Consequently ethnic health organizations were able to step in to geographical areas where government health staff were unable to access, and 3MDG implementing partners were able to support service provision efforts. This included through technical trainings, data analysis and sharing.

To address service gaps resulting from midwife vacancies, 3MDG financed an innovative approach to support relieving midwives in cases where the posted midwife was attending training or on maternity leave. This happened in 13 cases in 2014, 23 in 2015, 19 in 2016 and 2017, and nine in 2018. The result was that communities in these hard-to-reach areas with temporary midwife vacancies were able to receive essential health care services without a gap.

Willingness To Work Together

Improved coordination between health actors was a noticeable change in Kayah State during the project lifetime. Ethnic health organizations and the state and township health departments were able to work more closely together in a number of areas, including joint package tours activities, exchange visits, and immunization campaigns. This had both immediate impacts in improving service delivery and reach, but also helped build longer term relationships and facilitated information sharing. The end result was increased coverage of maternal, newborn and child health services. For example, an immunization campaign in Hpasaung and Shadaw was only possible because 29 ethnic health organization staff received training from the Ministry of Health and Sports, and went on to conduct vaccination activities in 40 villages. This was repeated during the Japanese Encephalitis campaign.

Strengthening the Volunteer System

In many parts of the country, volunteers are a critical part of the health system, bringing services, education and referral support to people who may have no other contact with health providers. Kayah State is no different, and 3MDG funded a number of activities to bolster the volunteer system. Basic recruitment trainings were conducted for 78 auxiliary midwives and 69 community health workers primarily from hard-to-reach areas, and regular refresher trainings, volunteer kits and regular drug refilling was also supported. Volunteers received necessary mentoring, supervision and capacity development from basic health staff. In 2015, only 31% of village health workers received quarterly supervision visits, but this rose to 86% in 2018. 147 village health workers were also trained in malaria and tuberculosis in 2018 in order to provide more comprehensive services to the community.

Data Management Systems of Ethnic Health Organizations

Organizations working in Kayah State had noted weaknesses in data recording and health information systems. For example, a misunderstanding of what was required meant that Civil Health Development Network (CHDN) incorrectly reported that ante-natal care visits in early years of the project met requirements even when they did not occur along the correct timeline. International Rescue Committee (IRC) and the Fund Management Office acted to rectify these weaknesses through workshops and routine data quality assessments and audits, and provided recommendations for improvements. These were taken on board, and over the project lifetime better alignment with national and global standards was evident. By 2017, CHDN were reporting ante-natal care correctly.

Routine data assessments also show that there has been a significant improvement in the overall quality of data recording and reporting of ethnic health information system throughout the project. However, gaps remain, with the need to improve vital statistics in non-government controlled areas, data sharing and verification between partners to avoid gaps and overlaps between health providers.

PARTNERS, TOWNSHIPS AND TIMELINES

<table>
<thead>
<tr>
<th>Township</th>
<th>July 2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>Dec 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bawlake</td>
<td>INTERNATIONAL RESCUE COMMITTEE*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demoso</td>
<td>INTERNATIONAL RESCUE COMMITTEE*</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Hpasaung</td>
<td>INTERNATIONAL RESCUE COMMITTEE*</td>
<td></td>
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<tr>
<td>Hpruso</td>
<td>INTERNATIONAL RESCUE COMMITTEE*</td>
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<tr>
<td>Lokiaw</td>
<td>INTERNATIONAL RESCUE COMMITTEE*</td>
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<tr>
<td>Mese</td>
<td>INTERNATIONAL RESCUE COMMITTEE*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shadaw</td>
<td>INTERNATIONAL RESCUE COMMITTEE*</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

* Consortium with CHDN (Civil Health and Development Network) and IOM (International Organization for Migration). IOM was the part of the consortium from the start to December 2017, before the structure was reformed in 2018

THE WAY FORWARD

A significant change from the 3MDG Fund maternal, newborn and child health programme is the introduction of integrated service delivery through volunteers to increase comprehensive services to the community, managed by a single organization. IRC, together with CHDN will implement malaria and tuberculosis activities in addition to existing maternal, newborn and child health support in Kayah State. This includes ‘Integrated Community Malaria Volunteer’ activities.

IRC will provide health system strengthening support to both township health departments and ethnic health organizations. In addition, Access to Health will provide a direct grant to the Kayah State Health Department which will focus on health system strengthening and improvement of service delivery, complementing implementing partner service delivery grants.
MAGWAY

INTRODUCTION

Magway, in central Myanmar, has typically had poor health infrastructure and services. Access to care for people living in hard-to-reach areas has been limited. 3MDG began supporting five townships in Magway in 2014 through Save the Children and Marie Stopes International. The goal was to reduce maternal, infant and under-five mortality rates through the development and implementation of the Comprehensive Township Health Plan. Activities included referrals, outreach (especially for immunization), ante-natal care, skilled birth attendance and facility-based delivery, post-natal care, alternative health care service provision by auxiliary midwives, especially in hard-to-reach areas, and supporting clean delivery kits and essential medicines. The programme was downsized in 2018 due to strong results: only emergency referral support and health facility renovation continued.

RERESULTS OVER THE YEARS OF THE FUND

<table>
<thead>
<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Number and percentage of women attended at least four times during pregnancy by skilled health personnel for reasons related to the pregnancy</td>
<td>52%</td>
<td>59%</td>
<td>65%</td>
<td>76%</td>
<td>83%</td>
<td>6%</td>
</tr>
<tr>
<td>Number and percentage of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)</td>
<td>71%</td>
<td>79%</td>
<td>82%</td>
<td>88%</td>
<td>NA*</td>
<td>88%</td>
</tr>
<tr>
<td>Number and percentage of mothers and newborns who received postnatal care visit within three days of childbirth</td>
<td>89%</td>
<td>94%</td>
<td>97%</td>
<td>98%</td>
<td>NA*</td>
<td>98%</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>34%</td>
<td>63%</td>
<td>64%</td>
<td>77%</td>
<td>NA*</td>
<td>77%</td>
</tr>
<tr>
<td>Immunization for (i) Penta and (ii) Measles</td>
<td>87% (85% of EPW)</td>
<td>100% (92% of EPW)</td>
<td>100% (92% of EPW)</td>
<td>100% (92% of EPW)</td>
<td>NA*</td>
<td>97% (92% of EPW)</td>
</tr>
<tr>
<td>Number and percentage of appropriate maternal (EmOC) referrals</td>
<td>42% (10.4% of EPW)</td>
<td>3.2% (1% of EPW)</td>
<td>2.6% (1% of EPW)</td>
<td>3.4% (1% of EPW)</td>
<td>3.5% (1% of EPW)</td>
<td>13.5%</td>
</tr>
<tr>
<td>Number and percentage of appropriate child (ECC) referrals</td>
<td>48%</td>
<td>92%</td>
<td>76%</td>
<td>100%</td>
<td>98%</td>
<td></td>
</tr>
</tbody>
</table>

* The full package of CTHP activities started in 2014 to 2017 with Save the Children and Marie Stopes International (MSI). But, in 2018, there was only emergency referral support by MSI for all 5 townships in Magway.

** Target (5% of total expected pregnant women (EPW)) is based on the globally accepted number of women (WHO) who require emergency obstetric services during pregnancy and childbirth.

Contraceptive prevalence rate increased from 55% in 2014 to 71% in 2017, due to efforts from Marie Stopes International to provide commodities and health education to increase demand. Achievements for Penta 3 and measles immunization were satisfactory, disregarding in 2017 when measles was deprived in favour of the Japanese Encephalitis campaign. The use of emergency referrals also increased throughout the Fund. By December 2018, 13,595 mothers and 13,666 under-five children with emergency conditions and danger signs were referred to quality care at township hospitals using the facility-based referral mechanism. This is the result of awareness-raising activities to community members about the importance of early referrals and preventable mother and child death.

LESSONS AND CHALLENGES

Activities in Magway have demonstrated the importance of quality health infrastructure and service readiness to encourage health seeking behaviour, especially for women giving birth. In a number of townships, there have been renovations (major and minor) to health facilities. Alongside friendly and supportive health staff, who welcomed women and provided them with baby clothes and other small gifts, the rate of facility-based delivery could significantly increase due to these infrastructure improvements. Outreach activities extended the reach of health staff, and increased community awareness and health seeking behaviour. Coverage rates for immunizations – both for children and pregnant mothers – were much higher than targeted, and these vaccination visits were also an opportunity to build trust with the community and share health information, bringing dual benefits.

Magway was also able to digitize Health Information Management System (HIMS) data, to improve the quality and completeness of submissions. This was supported by implementing partners, and data verification sessions were conducted monthly with good results. Achievements could be easily reviewed against targets, and gaps and areas for improvement could be identified. This made determining priority actions more straightforward.

Civil society organizations also had an important role to play in Magway, especially in supporting and promoting emergency referrals. Referrals were a key way that health staff were able to reach to the most difficult to access parts of the region. To support the referral mechanism, village health committees were set up within the townships. This is key to the sustainability of the mechanism, as these actors took a much larger role when the Fund ended in 2018.

THE WAY FORWARD

Due to high performance, and because it is not conflict-affected, support to Magway will not continue in Access to Health. Transitioning of programming to the Ministry of Health and Sports, including emergency referrals, is a positive sign.

Context: With a large population, many living in rural and remote places, uptake of health services was low when the 3MDG Fund began work in Magway in 2013. Health outcomes were poor, and health seeking behaviour needed to improve.

Maternal, newborn and child health: There was improvement across all maternal, newborn and child health indicators, including skilled birth attendance and ante-natal care. For example, the percentage of pregnant women who received ante-natal care four times or more improved from 62% of the coverage population in 2013 to 76% in 2017. Skilled birth attendance increased from 76% to 88%, and post-natal and newborn care coverage increased from 86% to 98% during the same period. The use of contraceptives, indicated by the contraceptive prevalence rate, increased from just 55% of the coverage population in 2013 to 71% in 2017. Impressive results in Magway led to the downsizing of the programme in the 2018 extension year.

Emergency referrals: Use of services and facility-based delivery in some parts of the region are still too low. The continued use of the emergency referral programme, alongside health education and awareness of services, re-mains critically important to improving these numbers. Village Health Committees and civil society organizations also have an important role to play in the sustainability of emergency referrals, as they can encourage more reluctant community members to make use of them, and provide sustainable financing through Village Health Funds.
INTRODUCTION

Over the last few years, Rakhine State has been characterized by a protracted crisis, long-standing communal tensions, chronic poverty, under-development and limited livelihood opportunities, especially in the northern townships. Since August 2017, this has escalated into a humanitarian crisis with the overwhelming response of the Myanmar military to attacks by a militant group on security targets. This caused the displacement of more than 600,000 Muslim people, who sought refuge in Bangladesh, and over 25,000 Rakhine people and people from ethnic minority groups. Access to health services was severely limited, and implementing partners have been unable to reach many areas due to restrictions. Health needs in the area are dire, and there is a severe lack of population data about health needs and access to available services, and health information.

Support to nine townships in Rakhine State began in the last quarter of 2016. An additional township was added in 2018. Building trust and gradually developing relationships with the State Health Department (SHD) has been fundamental for implementing programmes in a strategic and meaningful way in Rakhine. Implementing partners supported the comprehensive township health plan, with a key focus on special outreach and mobile clinics targeting very hard-to-reach areas and Muslim villages.

RESULTS OVER THE YEARS OF THE FUND

<table>
<thead>
<tr>
<th>Partners, Townships and Timelines</th>
<th>Oct 2016</th>
<th>2017</th>
<th>Dec 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sittwe</td>
<td>N/A</td>
<td>55%</td>
<td>59%</td>
</tr>
<tr>
<td>Minby</td>
<td>N/A</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td>Rathedaung</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Buthidaung</td>
<td>N/A</td>
<td>64%</td>
<td>70%</td>
</tr>
<tr>
<td>Pauktaw</td>
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<td>RELIEF INTERNATIONAL</td>
<td>RELIEF INTERNATIONAL</td>
</tr>
<tr>
<td>Mrauk U</td>
<td>MYANMAR HEALTH ASSISTANT ASSC.</td>
<td>MYANMAR HEALTH ASSISTANT ASSC.</td>
<td>MYANMAR HEALTH ASSISTANT ASSC.</td>
</tr>
<tr>
<td>Kyauk Phyu</td>
<td>INTERNATIONAL RESCUE COMMITTEE</td>
<td>INTERNATIONAL RESCUE COMMITTEE</td>
<td>INTERNATIONAL RESCUE COMMITTEE</td>
</tr>
<tr>
<td>Toungup</td>
<td>RELIEF INTERNATIONAL</td>
<td>RELIEF INTERNATIONAL</td>
<td>RELIEF INTERNATIONAL</td>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and percentage of women attended at least four times during pregnancy by skilled health personnel for reasons related to the pregnancy</td>
<td>N/A</td>
<td>5%</td>
<td>29%</td>
<td>59%</td>
</tr>
<tr>
<td>Number and percentage of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)</td>
<td>N/A</td>
<td>97%</td>
<td>54%</td>
<td>54%</td>
</tr>
<tr>
<td>Number and percentage of mothers and newborns who received postnatal care visit within three days of childbirth</td>
<td>N/A</td>
<td>84%</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Immunization for (i) Penta and (ii) Measles</td>
<td>N/A</td>
<td>(i) 77%</td>
<td>(i) 79%</td>
<td>(i) 84%</td>
</tr>
<tr>
<td>Number and percentage of appropriate maternal (EmOC) referrals</td>
<td>194</td>
<td>4,361</td>
<td>5,822</td>
<td>10,177</td>
</tr>
<tr>
<td>Number and percentage of appropriate child (ECC) referrals</td>
<td>123</td>
<td>2,623</td>
<td>4,386</td>
<td>7,314</td>
</tr>
</tbody>
</table>

** Target: 75% of total expected pregnant women (EPW). IQR is based on the globally accepted number of women (WHO) who will require emergency obstetric services during pregnancy and childbirth

RESULTS OVERVIEW

In 2016, when implementing partners started their operations, only referrals were supported in Rakhine townships. Full implementation of maternal, newborn and child health services began in 2017. At the start of 3MDG support in the state, indicators were significantly lower than other 3MDG-supported states and regions. This was to be expected, as Rakhine is one of the poorest states in the country with the worst health outcomes, and the start-up period of a programme usually has lower achievement.

The conflict in August 2017 exacerbated the serious challenges the state faced, as the mobility of basic health staff was more severely restricted, and many could not safely stay and work at their posts. The outbreak of violence also affected demand for services, as pregnant women and sick people could not easily travel to see the midwife or other basic health staff, and Muslim populations were unable to move freely. There was also a flood in some townships in southern Rakhine in 2017. Referral targets were not met in 2017.

Basic health staff numbers increased at township level in 2018, though persistent vacant posts affected the coverage of health services - still the lowest among all states and regions. However, broadly in 2018, when the conflict began to stabilize, health indicators improved because midwives and health staff could reach the community. Increased awareness of referral services and improved security saw the percentage of referrals increase for pregnant women from 9% in 2017 to 14% in 2018.

The breakdown of referral support shows that 413 maternal and 301 child referral cases came from Muslim communities in northern and central Rakhine townships. This is about 5-6% of the total referrals in these areas. Some referrals in these areas were supported using funding from other sources, such as United Nations Population Fund (UNFPA) and European Civil Protection and Humanitarian Aid Operations (ECHO), which explains to some extent this low percentage. Significant efforts are still needed to ensure access to referral services for Muslim populations; the use of cross-township referrals is explored further overleaf.

Tensions continued in northern and central Rakhine townships, and implementing partners still needed to submit approval documents for international non-government organizations to implement township-level activities. More work is necessary to ensure all populations in Rakhine State can access health services, this continues in the Access to Health Fund, amidst significant challenges in receiving necessary permissions to delivery services as well as safety concerns.

IN BRIEF

Context: The outbreak of violence in August 2017 exacerbated the already significant health challenges faced in Rakhine State, which is the poorest state in Myanmar with amongst the worst health outcomes.

Maternal, newborn and child health: When 3MDG projects started in full in 2017, achievements were low - to be expected considering the contextual challenges, existing poor health outcomes and knowledge, and affects of the conflict. Results continue to be lower than other states, primarily due to access challenges and low health seeking behaviour. Percentage of births with skilled attendance was only 54% at the end of 2018, the lowest of any 3MDG-supported state.

Emergency referrals: Referrals rose from just 9% of pregnant women in 2017 to 14% in 2018 - closer to the 15% of pregnant women who may require emergency treatment during pregnancy, as established by the World Health Organization and set as a 3MDG emergency referral target. Partners showed flexibility and ingenuity in designing cross-township referrals to overcome geographic and access challenges. More is needed to enhance access further in future.

Approach and system strengthening: During implementation, township health departments in Rakhine began to feel more ownership over the plans and activities, contributing to greater potential for sustainable programming and better informed interventions based on contextual demands and priorities. Access, vacant posts and security remain significant impediments to the realization of the right to health for all communities, especially Muslim populations.
LESSONS AND CHALLENGES

Changing Operational Modalities After August 2017 Violence to Continue to Meet Needs

The August 2017 armed clashes affected the security of northern and central townships and caused delays in delivery of health services to the community. Lack of safety meant that health staff could not stay at their posts. Implementing partners were forced to adjust their services to provide more outreach sessions, integrated service “package tours” and mobile clinics, to ensure health care services continued to reach those who needed it.

Even though implementing partners could not travel alone to some villages, especially in Buthidaung Township, they could be accompanied by basic health staff. Once there, they could work with the Township Medical Officer to conduct outreach, referral, trainings and coordination meetings. In Rathedaung Township, 3MDG supported one full mobile clinic team through International Rescue Committee to conduct more visits to Muslim communities and hard-to-reach villages.

Implementing partners provided timely reports to the 3MDG Fund Management Office about the number, trends and patterns of referrals, so that adjustments could be made to meet community needs. When accurate and timely information is available, partners can respond more quickly – they understand better where services are needed, and where to refer patients. The ability to adapt in this way increased reach to communities affected by conflict.

Improve Sense of Ownership from State and Township Health Departments

The concept of “comprehensive township support”, where funding supports a township’s health system as well as field activities, is new for Rakhine townships. In the early days of implementation, partners faced a lack of commitment from the township health departments because the ‘Comprehensive Township Health Plan’ was perceived as 3MDG’s plan, rather than the government’s plan.

Continuous advocacy was able to change this perception, and the sense of ownership for the township health department improved gradually. This resulted in increased participation of the township health departments in township level review meetings, more involvement in critical data analysis, and strengthened referral systems through basic health staff. The State Health Department also demonstrated increased commitment. This contributed to advancing implementation at the field level and efforts to ensure that health services reach every community, and creates more potential for services to be sustainable.

Continuing To Promote Emergency Referrals Despite Ongoing Conflict

The ability to link patients with different levels of the health system, especially in emergencies, underpins the implementation of the Comprehensive Township Health Plan. Implementing partners supported emergency referrals for mothers and under-five children to township hospitals or Sittwe hospital under the 3MDG programme, so that beneficiaries with life threatening conditions could reach health facilities without financial barriers. The delivery of this service was not always straightforward in Rakhine State, because of communal tensions, restricted access to health care for Muslim populations, and hard-to-reach areas. It was also imperative, due to ongoing perceptions of favouritism towards particular communities, to ensure both Rakhine and Muslim communities received referral support.

One way to overcome these barriers was the support of cross township referrals, where patients from one township could seek care in another township. For example, Muslim maternal referral patients from Minbya were able to receive treatment at Myaung Bwe hospital as they were not able to access care in Minbya. This type of cross-township referral is also useful where geographic challenges are faced, such as swollen rivers and difficult currents in one direction. These sort of initiatives have meant that despite ongoing tension and outbreaks of conflicts, emergency referral numbers have risen for both communities.

Working In Collaboration With Other Rakhine Partners

In Northern Rakhine, a large number of international non-government organizations work across sectors. Collaboration to minimize gaps, avoid overlaps, and overcome hurdles, is necessary. This is facilitated by health cluster and state level coordination meetings where all international non-government organizations participate and discuss their activities.

This is unique across the states and regions of Myanmar – organizations work closer together here because of the extremely challenging context and the need to maximize access opportunities whenever they eventuate. For example, Mercy Malaysia runs clinics in Internally Displaced Persons camps in Sittwe, and at the same time International Rescue Committee supports referrals and the ‘integrated package tour’ provided by basic health staff. Medecines San Frontiers runs clinics in internally displaced person camps in Paaktau, while International Organization for Migration supports referrals and emergency cases from hard-to-reach villages.

Technical Assistance To Local Organizations

Myanmar Health Assistant Association (MHAA) implemented the maternal, newborn and child health programme in three townships of southern Rakhine state. While MHAA has extensive experience in disease control, they had not managed a maternal, newborn and child health project before. However, being a local non-government organization allows them to operate with less access difficulties due to tension and animosity towards international organizations. To capitalize on this access, the Fund Management Office emphasized building the technical capacity of MHAA with extra funding and support from International Organization for Migration. Support focused on programme planning, budget management, monitoring and evaluation of indicators. Improving capacities of MHAA have supported the recent decision by the Access to Health Fund Board where MHAA was awarded a contract to implement activities in all southern Rakhine townships.

Improved Health Management Information System

In the first year of implementation in Rakhine State, reporting to the ‘District Health Information System’ (DHIS2) was poor. Timeliness was only 18%. 3MDG responded by including the health management information system (HMIS) trainings at the state level and townships level, DHIS2 trainings and data quality assessment visits, as part of the programme. By the end of 3MDG, the HMIS reporting rate through DHIS2 system was 98%, and timeliness increased to 60%.

THE WAY FORWARD

Under the Access to Health Fund, the Rakhine programme will expand to all 17 Rakhine townships. Focus will be on maternal, newborn and child health, as the Global Fund fully covers the state for malaria and tuberculosis services. This approach will contribute to Myanmar’s progress towards universal health coverage by supporting the State Health Department and township health departments to increase access, improve quality and stimulate demand for health care services, as well as to strengthen systems and capacity to sustain the achievements of the programme.

As with the other Access to Health supported states, a direct grant will be provided to the State Health Department for health system strengthening activities.

Nutrition support will also be provided, in reflection of distressing rates of malnutrition and undernutrition in the population, especially children. In addition, Ipas will work with state and township health departments to provide training in post-abortion care. Rakhine had the second highest abortion rate in Myanmar in 2016 according to Hospital Statistic Report (2014-16).

The primary intervention provided by Ipas is training medical doctors in the use of appropriate technology, in collaboration with Maternal and Reproductive Health Division (MRH). This will increase access for women and girls to high-quality post abortion care and contraceptive services. Stakeholders at all levels will be engaged in this sensitive issue, in a similar approach to that undertaken during the 3MDG Fund successful in Bago and Kayin. Public health facilities will be strengthened through better equipment and cascaded training to relevant staff members.
**SHAN STATE**

**INTRODUCTION**

Shan State is geographically Myanmar’s largest state, and one of the most diverse with many different ethnic groups and languages. Some parts of the state are affected by conflict, which escalates periodically. Health access in the state can vary markedly, due to distance to care, poor transport and many areas of non-government control. Drug use is quite significant, especially in Northern Shan, which consequently means that HIV prevalence is high.

3MDG supported seven townships in Shan State, all conflict-affected areas. Implementing partners supported township health departments in the planning and implementation of Coordinated Township Health Plan, and worked with ethnic health organizations to extend access and improve the quality of services in non-government and conflict-affected areas.

**RESULTS OVERVIEW**

Maternal, newborn and child health indicators in Shan State increased quite slowly at the beginning of the Fund, and then increased more quickly between 2017 and 2018. For example, the percentage of pregnant women who received ante-natal care four times or more during pregnancy improved from 67% in 2015, to 63% in 2017, and then to 70% in 2018. Newborn care coverage also showed significant increase from 68% in 2015 to 77% in 2018, with another substantial increase from 2017 to 2018. Less conflict allowed basic health staff to conduct more outreach trips and remain for longer periods at their respective health facilities, and also meant higher retention of staff and less vacant positions.

However, this was not the case for all indicators. There was actually a substantial decrease in skilled birth attendance from 2015 to 2016, due to lack of health staff at the health facility because of security conditions in Kutkai and Namhsan townships in that period. In 2017 and 2018, this did increase more rapidly again.

Reduction in conflict and subsequent improving staffing resulted in good immunization coverage - 91% for Penta 3 and 97% for measles in 2018. The sharp drop in measles immunization in 2017 was a result of postponed vaccinations due to Japanese Encephalitis Vaccination campaign that took precedence.

There was an increase in use of contraceptives across 3MDG-supported townships in Shan State, demonstrated by a growth in the contraceptive prevalence rate from 47% in 2015 to 65% in 2019. Increased distribution of family planning commodities through basic health staff and volunteers to the community, improved awareness of the benefits of family planning, and for some areas, distribution of ease-to-use contraceptives via auxiliary midwives contributed to this improvement. Nevertheless, ongoing conflict in some areas, such as Mawkmai Township, meant that overall coverage remains too low and improvement is still needed.

**RESULTS OVER THE YEARS OF THE FUND**

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</thead>
<tbody>
<tr>
<td>Number and percentage of women attended at least four times during pregnancy by skilled health personnel for reasons related to the pregnancy</td>
<td>NA*</td>
<td>67%</td>
<td>62%</td>
<td>63%</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>Number and percentage of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)</td>
<td>NA*</td>
<td>58%</td>
<td>54%</td>
<td>55%</td>
<td>59%</td>
<td>59%</td>
</tr>
<tr>
<td>Number and percentage of mothers and newborns who received postnatal care visit within three days of childbirth</td>
<td>NA*</td>
<td>68%</td>
<td>69%</td>
<td>72%</td>
<td>77%</td>
<td>77%</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>NA*</td>
<td>62%</td>
<td>59%</td>
<td>64%</td>
<td>67%</td>
<td>67%</td>
</tr>
<tr>
<td>Immunization for (i) Penta and (ii) Measles</td>
<td>NA*</td>
<td>30.7%</td>
<td>33.67%</td>
<td>38.85%</td>
<td>38.87%</td>
<td>41.9%</td>
</tr>
<tr>
<td>Number and percentage of appropriate maternal (EmOC) referrals</td>
<td>16</td>
<td>858</td>
<td>1491</td>
<td>2466</td>
<td>2777</td>
<td>8908</td>
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<tr>
<td>Number and percentage of appropriate child (ECC) referrals</td>
<td>10</td>
<td>534</td>
<td>1534</td>
<td>2177</td>
<td>2190</td>
<td>6423</td>
</tr>
</tbody>
</table>

* Three townships (Hsihseng, Mawkmai and Laikha) supported by Relief International started their inception phase in Q4 of 2014. Therefore the EmOC and ECC figures are reported only for those townships. 
** Target 75% of total expected pregnant women (EPW)** is based on the globally accepted number of women (WHO) who will require emergency obstetric services during pregnancy and childbirth.

When 3MDG support began in Shan, only 5% of expected pregnancies received emergency referral support. This left a gap to the target of 15%, which is based on the percentage of women globally estimated to have an obstetric emergency during pregnancy and childbirth. By 2018, this had increased to 15% because the community was more aware of the services thanks to the efforts of basic health staff, the village health committee, volunteers and implementing partner staff. The table shows a slight drop from 2017 to 2018, which was actually the result of a reduction in the number of ineligible referrals that were previously given in Laikha, due to increased knowledge of the requirements, and better reporting and staff capacity.

**Support By Ethnic Health Organizations**

Two ethnic health organizations worked with Relief International in Mawkmai and Laikha townships to provide health services to the areas not fully covered by government health facilities and providers. In 2017, when the project started, a number of coordination meetings between implementing partners and ethnic health organizations were held to build trust.

There were insufficient data management systems and reporting guidance right from the beginning of the project. To bring these up to standard, the implementing partner focused on strengthening the system for the long term, rather than quick fixes. They also concentrated on improving the volunteer network system right from the start, rather than waiting till the programme was more established meaning that the start-up period was particularly slow. In the end, though there were some improvements in data quality and loss persisted. This will continue to be addressed in the Access to Health Fund, in recognition that system changes of this nature take time.

Frequent attrition and turnover of staff and long vacances of emergency obstetric health workers and maternal, newborn and child health volunteers resulted in inability to provide continuous health services. However, though reported achievements were slow, these efforts reflected good collaboration between the township health department and ethnic health organizations, setting a platform on which to build.

**Support in Special Regions (WA and SR4)**

Health Poverty Action (HPA) worked with the Wa Health Department and Shan Special Region 4 Health Department from April 2015. HPA supported ethnic health organizations with service provision, including immunizations, and helped to strengthen their public health units. Seconded staff from ethnic health organizations worked with HPA to share skills in programme management and service delivery provision.
MATERNAL, NEWBORN AND CHILD HEALTH: SHAN

There were significant increases in service outputs. For example, the number of deliveries with skilled attendance increased from 818 in 2015 to 2,406 in 2018, and ante-natal care and newborn care nearly doubled during the same period. Numbers of children immunized with Penta 3 more than doubled (2.3 times), and increased more than one and a half times (1.6) for measles. Maternal and child referrals also increased significantly, due to increased awareness of the service. The reduction of referrals in 2018 is attributable to budget constraints.

In 2018, the UK Department for International Developments (DFI) project in Kokang Special Region was merged with Health Poverty Action’s (HPA) 3MDG programme. HPA worked with township health departments in Hsispaw and Laukkaing townships, and supported basic health staff in coordination meetings, trainings, outreach and improving the referral mechanism. Indicators for 2018 appear to be above targets, but it is likely that denominator figures such as live births and stillbirths were under-reported. This reflects ongoing data quality challenges in conflict-affected areas and Special Regions, and lack of standard procedures such as annual population surveys in these areas.

LESSONS AND CHALLENGES

Reaching The Unreached

Through meaningful engagement with ethnic health organizations, 3MDG supported the delivery of services to vulnerable and unreached populations in Shan State. Increased coverage of health services was the result of better training, better access, more involvement from local organizations, and improved coordination of health actors. On many occasions, it was simply a matter of getting ethnic health staff involved from including ethnic health organization volunteers in township trainings in 2016, to ethnic health organization staff joining the package tour and routine immunization outreach, health education and nutrition activities; these activities built relationships, improved coordination, and ultimately fostered trust between the parties.

In Mawkma, where ongoing security challenges presented significant access barriers, small interventions made a big difference. A recognition letter from the township health department to ethnic health organization staff could be shown to armed authorities to make sure staff could reach people in need of health services. In Hshih, with the involvement of a Seven Star Local Development Organization (SSLDO), a local organization, health staff in 40 villages were able to get closer to community members and build trust. SSLDO were able to convey health messages and facilitate emergency referrals.

Overcoming Language Barriers To Improve Health Literacy

With at least four local languages in Namtu, Namhsan and Manton, language barriers limit health education and promotion activities. As local staff are best placed to communicate with community members, implementing partners tried to recruit more local staff. However, local staff were not always available, so partners improvised with different tools and methods to increase local community understanding. For example, partners collaborated with the township health department and ethnic health organizations to develop and distribute materials and health education videos in three different languages and used hand puppets with local traditional dress as educational tools – thus limiting the need for language at all, and taking into account low literacy as well as language barriers.

Strengthening The Volunteer System

Finding volunteers who meet Ministry of Health and Sports’ eligibility requirements in non-government controlled areas is challenging. This is due to high dropout rates, outward migration of a significant proportion of the population, which means there are few or no people of working age at village level, low literacy rate and forced abduction to serve in armed groups. In collaboration with the township health department and local authorities, specific measures were implemented to reduce volunteer attrition. It was found that improved quarterly supervision by basic health staff and partner staff, regular commodity provision, and refresher training could make a difference. However, this still remains a significant issue and further solutions are needed.

Data Management Systems Of Ethnic Health Organizations

Ethnic health organizations did not have sufficient data management systems at the start of the project, meaning it was difficult to set target and track progress. Over the first two years of the project, implementing partners worked with ethnic health organizations to set up the data management system, developing Health Information System forms, giving capacity building training to ethnic health organizations staff, supervising health posts regularly for proper filling of record books, and providing regular feedback to staff. Through this effort, ethnic health organization data became available and quality gradually improved. This appeared to lower the achievement in 2018, but this was in fact because cases were being recorded more correctly. More improvement is needed through frequent supervision, data quality checking and data management trainings.

THE WAY FORWARD

Significant changes from the 3MDG Fund are the introduction of integrated service delivery and the expansion of the coverage area from only seven townships in Shan under 3MDG to 53 townships under Access to Health. Nine implementing partners will cover the whole Shan State: Myanmar Health Assistant Association, Save the Children, Relief International and Alliance, for integrated maternal, newborn and child health. In many cases, access is only possible through ethnic health and community-based organizations, who work with Relief International in a consortium approach.

Myanmar Anti-Narcotic Association and Asian Harm Reduction Network will implement harm reduction, tuberculosis, malaria and sexual and reproductive health and rights services, and some prison health activities. Health Poverty Action and UNICEF will cover the Special Regions. ‘Integrated Community Malana Volunteer’ activities, are also supported in Shan State. As with the other Access to Health supported states, a direct grant will be provided to the State Health Department for health system strengthening activities.

PARTNERS, TOWNSHIPS AND TIMELINESS

<table>
<thead>
<tr>
<th>Dec 2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>Dec 2018</th>
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<td>Hshih</td>
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<tr>
<td></td>
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<td>Lakha</td>
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<td></td>
<td>RELIEF INTERNATIONAL, with Shan State Dev. Foundation (SSDF)</td>
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<td>Mawkma</td>
<td></td>
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<tr>
<td></td>
<td>RELIEF INTERNATIONAL, with SSLDO and Pa O Health Working Committee</td>
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<td>Katak</td>
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<tr>
<td></td>
<td>SAVE THE CHILDREN, with Ta’ang Ethnic Cultural and Literature Group</td>
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<td></td>
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<td>Namhsan</td>
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<td></td>
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<td></td>
<td>HEALTH POVERTY ACTION, with Wa Health Department</td>
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<td>Special Region 4</td>
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<td>Kokang</td>
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<td></td>
<td>HEALTH POVERTY ACTION</td>
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</tbody>
</table>
**INTRODUCTION**

3MDG supported a set of sexual and reproductive health and rights activities from 2014 through partnership with Marie Stopes International (MSI) and Population Services International (PSI), primarily focused on family planning services and contraceptives. MSI delivered information and services through clinics and outreach services; family planning, sexually transmitted infection (STI) testing and treatment, cervical cancer screening and treatment, response to sexual and gender based violence, and referral services. Through community engagement and demand creation activities, information about the services available spread through the community, and use of services increased and resistance decreased. Involvement of male leaders in these areas of work reduced resistance to family planning services, and encouraged men to attend health information sessions and learn more about their own sexual and reproductive health and rights. PSI procured and distributed family planning commodities and provided family planning and cervical cancer prevention activities through Sun Quality Clinic providers.

The sexual and reproductive health component was significantly expanded in 2018 in response to growing needs in the country, with the addition of two new partners and projects. Myanmar Medical Association focused on adolescent sexual and reproductive health and rights through peer education programmes, dissemination of key messages through hotlines, radio, social media and events, capacity building of young people, and training of general practitioners to provide youth-friendly services. This was in recognition that young people often have no avenue for health information, particularly around sexual and reproductive health due to taboos and cultural sensitivities. Support is targeted for both young men and women, and includes people with disabilities.

Support to Ipas from 2018 was the result of shocking numbers of maternal deaths from abortions. Ipas provided post-abortion care training for doctors in Bago and Kayin to improve the quality of care. These two additional projects also pave the way for increased focus on sexual and reproductive health and rights in the Access to Health Fund. Awareness-raising activities also increased in 2018, with support to International Youth Day and World Contraception Day, and syphilis test kits were procured to strengthen syphilis testing among pregnant women.

**DEFINITIONS**

What is a ‘Couple Year of Protection’ (CYP)?

A CYP is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free-of-charge to clients during that period. For each method, the total quantity is multiplied by a ‘conversion factor’ which provides an estimate for how long the contraceptive will last. Then, all the distributed methods are added together for a total CYP.

What is a ‘Disability Adjusted Life Year’ (DALY)?

A DALY is the measure of overall disease burden, expressed as the cumulative number of years lost due to ill-health, disability or early death. DALY is calculated by adding the years of living with a disability to the years of life lost.

What is ‘Annual Impact’?

Annual impact provides a snapshot of the total impact that will happen in any given year - in this case, what impact will the services provided have on the clients who received them, including clients who received the services in a previous year but are estimated to still be using them. The impact is limited to one year.

What is ‘Service Lifespan Impact’?

Service lifespan impact provides a longer-term view of the impacts that will happen over future years, from services provided in a given year. This includes impacts from services provided in that year, over the lifespan of their use.

**RESULTS FOR 2018 NEW ACTIVITIES**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2018</th>
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<tbody>
<tr>
<td>Youth peer educator volunteers trained and supported in sexual and reproductive health and rights</td>
<td>144</td>
</tr>
<tr>
<td>Young people reached with sexual and reproductive health and rights education</td>
<td>42,295</td>
</tr>
<tr>
<td>Men and women (≥25 years) reached by sexual and reproductive health and rights awareness sessions</td>
<td>28,409</td>
</tr>
<tr>
<td>Women who received family planning services, with sexual and reproductive health and rights information</td>
<td>32,933</td>
</tr>
<tr>
<td>Post Abortion Care services</td>
<td>821</td>
</tr>
<tr>
<td>Health facilities providing Post Abortion Care services</td>
<td>71</td>
</tr>
<tr>
<td>Cervical screening services</td>
<td>9,434</td>
</tr>
<tr>
<td>Cryotherapy services</td>
<td>187</td>
</tr>
</tbody>
</table>

**RESULTS OVERVIEW**

**Family Planning and Commodity Distribution**

From 2014 to 2017, 3MDG supported family planning commodity distribution through PSI and MSI, from which Disability Adjusted Life Years (DALY) averted and Couple Years of Protection (CYP) achievements were reported. Results indicate that it was primarily the size of the contraceptive social marketing channel and number of commodities available which determined achievements. That is, in 2015 the achievements were highest because PSI procured commodities in 2014, and started major distribution in 2015. Disability and CYP achievements were lowest in 2017 because PSI only had remaining commodities to distribute, and MSI had already downsized its operation to just seven townships in Chin.

With the lowest Contraceptive Prevalence Rate (CPR) in the country, Chin State was a focus area for MSI. The State has low health literacy, strong drive towards population growth, and religious beliefs which prohibit contraception. All of this contributes to a low CPR, which was at only 25% in the first year of the Fund. In spite of efforts to improve it, CPR remained stagnant at about that level for a number of years. By 2018, however, thanks to substantial effort from partners in advocacy, service delivery and awareness raising, CPR grew to 32%. The significance of the achievement cannot be underestimated, though there is a long way to go. It demonstrates that behaviour and attitude change activities, and advocacy to reduce community resistance to family planning, is a long-term process but that it can foster change. It was important for service providers to build trust with the community, which takes time, and be able to communicate in local language.

MSI recruited local service providers, who were able to advocate and network with the community based on the trust they already had. Religious leaders were also educated and recruited to share information about family planning, as community leaders are willing to follow their teachings and guidance. Chin State remains a priority area for Access to Health Fund, as despite being largely unaffected by conflict, the state holds the lowest position in many health indicators particularly related to maternal, sexual and reproductive health, and as demonstrated by 3MDG’s experience in family planning, long term commitment is necessary to affect real change here.

MSI also implemented family planning and sexual and reproductive health services in Magway and Ayeyarwady until the end of 2016. This was scaled down in those two areas in 2017 due to substantial improvements, and a further 26 townships were picked up due to high unmet need for family planning services and high populations. These townships were in Yangon, Bago, Tanintharyi, Mandalay, Mon, Sagaing, Magway and Ayeyarwady.

**PARTNERS**

- **Marie Stopes International (MSI)**
- **Population Service International (PSI)**
- **Myanmar Medical Association (MMA)**
- **Ipas**
Sexual and reproductive health information for youth

Peer educators trained and supported by Myanmar Medical Association and MSI shared knowledge about sexual and reproductive health to young people. By 2018, MMA and MSI had trained 904 youth peer educator volunteers and had disseminated adolescent sexual and reproductive health messages to 42,295 young people at their communities.

Myanmar Medical Association also conducted Happy, Healthy and Melody Life for young people about gender based violence, teen pregnancy, HIV and sexually transmitted infections. Some youth also received life skills training, which helps young people to model positive behaviours, and learn more about risk analysis, problem solving, negotiation and decision-making. Some participants in the training went on to become peer educators themselves.

However, sexual education is still viewed as a sensitive topic in the community. Implementing partners worked with gatekeepers, such as state school headmasters, university rectors, peer educators and beneficiaries. Other community members were also included: leaders, local authorities, general practitioners, township medical officers and members of parliament. Focus group discussions allowed them to speak openly and share their views. These meetings were an opportunity share the importance of these trainings for young people, and ultimately, many became champions for the programme and recommend that it be continued. They also made suggestions for how to extend its reach.

Different targeted groups for adolescent sexual and reproductive health and rights education needed different approaches, depending on the context and their education level. For example, for university and school students, entertainment activities were used, but for industrial workers and out-of-school youth, peer educators were favoured. Young people with disabilities may also struggle to receive sexual and reproductive health information if it is not tailored for their needs. Partners used innovative methods (feel to see for vision impaired students, and sign language interpreters) and visited schools for children with disabilities. About 70% of youth with disabilities reported that they received satisfactory knowledge on adolescent health and sexual education.

Way Forward

In the Access to Health Fund, the Myanmar Medical Association project will be implemented nationwide, with sexual and reproductive health products and services to 37 Sun Quality Health providers and provision of youth-friendly family planning counseling and services especially in Yangon, Kachin, Kayin, Mon and Shan.

MSI will implement sexual and reproductive health and rights services in all nine townships in Chin State, six townships in Shan North and four townships in Kachin. PSI will implement sexual and reproductive health and rights services through 489 Sun Quality Health clinic providers in all states and regions (a total of 232 townships). Ipas will implement quality post-abortion care through training, supplies and supervision, as well as provide contraceptive services in all 62 townships across Rakhine, Kachin, Shan, South and Kayin.

The expansion of services is in recognition of the need for sexual and reproductive health and rights services, especially for young people and in conflict-affected areas.
INTRODUCTION

With 11,000 new infections each year, HIV/AIDS remains a major public health problem in Myanmar. More than a quarter of new infections (28%) are spread by contaminated needles used by people who inject drugs. The group are highly vulnerable to a number of infections and diseases, such as HIV, Hepatitis B and C, and tuberculosis (TB), and also to their co-burden. 3MDG supported interventions in a number of areas to limit the spread of HIV and other diseases amongst this group. This included policy and advocacy interventions implemented by Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Office for Drugs and Crime (UNODC) and World Health Organization (WHO); delivery of Harm Reduction services to people who use-drugs in 33 townships in Kachin, Shan, Sagaing, Mandalay and Yangon (reduced to 28 townships in 2018), and health service delivery to prisoners in Kachin and Sagaing.

RESULTS OVER THE YEARS OF THE FUND

Activities

- Needle and syringe programmes (NSPs)
- Opioid substitution therapy (OST) and other evidence-based drug dependence treatment
- HIV testing and counselling (HTC)
- Anti-retroviral therapy (ART)
- Prevention and treatment of sexually transmitted infections (STIs)
- Condom programmes for people who inject drugs and their sexual partners
- Targeted information, education and communication (IEC) for people who inject drugs and their sexual partners
- Prevention, vaccination, diagnosis and treatment for viral hepatitis
- Prevention, diagnosis and treatment of TB

RESULTS OVERVIEW

There are approximately 93,000 people who inject drugs in Myanmar. 3MDG partners were able to reach nearly 43% of people who inject drugs in 2018 as a result of integrated mobile HIV testing services in outreach visits in hard-to-reach areas. Needle and syringe programmes distributed an average of 347 needles per person who injects drugs per year, with an average between 260 and 460 per person. This is well above the WHO standard of at least 200 needles per person per year. In total, nearly 72 million needles and syringes were distributed under 3MDG. These programmes had to manage high levels of community concern due to health risks associated with discarded needles. Peer educators, often former drug users, collected used paraphernalia, and hot-lines were set up so community members could report places where used syringes had been left.

Methadone maintenance therapy is a method of opioid substitution, which allows people to manage their dependency on drugs. 5,817 clients were supported by 3MDG in 2018 for this method. In 2017, 15,994 were enrolled in total by the national programme, which only represents 17% of total people who inject drugs: WHO recommends that 40% of people who inject drugs are enrolled.

In spite of the expansion of activities designed to prevent the transmission of HIV, prevalence has actually increased from 28.5% in 2014, to 34.9% in 2017. Enormous gaps remain in reach and service quality. In late 2018, the National AIDS Programme led sub-national HIV operation planning and prevention workshops to better understand HIV prevalence and improve the efficiency and effectiveness of services, in an attempt to address remaining challenges to making a serious impact in HIV prevalence in this group.

Policy and Advocacy

- Joint United Nations Programme on HIV/AIDS (UNAIDS)
- UNODC
- World Health Organization (WHO)

HIV Interventions in Prisons

- AHRR
- MANA
- Health Poverty Action

1. National Strategic Plan on HIV and AIDS, Myanmar (2016-2020)

IN BRIEF

- Targets were met across all indicators.
- High number of needles and syringes distributed per injecting drug user, facilitating safe injecting.
- HIV testing rates increased from just 11% to 39%.
- Increase in number of clients receiving services at drop-in centres - a good result for the ‘demand generation’ activities, community acceptance and welcoming environment created there.
- Two laws which discriminated against people who use drugs reviewed and significantly amended as a result (in part) of 3MDG partner advocacy work, one Law on Rights of People with HIV was written.
- Despite these interventions, challenges remain in reducing prevalence amongst people who use drugs.
- Methadone Maintenance Therapy was used with good results, but take-up could be improved.

PARTNERS

Harm Reduction Interventions

- Asian Harm Reduction Network (AHRN)
- Myanmar Anti-Narcotic Association (MANA)
- Substance Abuse Research Association (SARA)
- United Nations Office for Drugs and Crime (UNODC)
- Population Services International
- Barret Institute
- Motta
- Medicines du Monde


**Drug Use and Health Consequences/HIV Harm Reduction**

**Innovation and Policy Making**

Building the right environment for people who inject drugs so they can receive needed services, as well as reduce stigma and increase community support, is difficult. Throughout the Fund, 3MDG financed a number of organizations in this work. Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Office for Drugs and Crime (UNODC), World Health Organization (WHO), Population Services International and Metta. They addressed the challenges in different ways, and at different levels. At the start of UNAIDS project “Creating an Enabling Environment,” UNAIDS conducted three situational assessments on key affected populations to identify programmatic gaps and priority actions. Two laws were reviewed and amended: The Bhamo Excise Act (1917) and Narcotic Drugs and Psychotropic Substances Law (1959), and development of a Law on the Rights of People Affected by HIV (2017). A number of pieces of research - 16 in total - were published, including situational analysis, legal framework review, best practices and qualitative analysis.

**HIV Harm Reduction in Prisons**

Together with the National AIDS Programme, 3MDG supported the expansion of health services in prisons, with HIV and tuberculosis (TB) screening and vaccination, primary health care and chronic disease management. Two partners, Asian Harm Reduction Network and Myanmar Anti-Narcotic Association (MANA), strengthened health services in prisons together with Ministry of Health and Sports and Ministry of Home Affairs. Standard Operating Procedures were developed and launched in 2018. 3MDG financed the UNOPS Infrastructure Unit to improve men’s and women’s clinics in four prisons in Myitkyina and Lashio prisons, Insein Prison in Yangon and Mandalay prison.

**Resistance to Harm Reduction Services and Approach**

Drug problems can cause frustration in the community due to the serious social consequences, and at times, community members have taken the law into their own hands. The most prevalent group involved in these activities is the Pat Ja San. Their activities can drive people who use drugs into hiding, increase stigma, and restrict access to services. Police crackdowns at hotspots usually end with people who use drugs in jail, without access to the care that they need.

In 2016, 3MDG initiated a community-based advocacy project delivered by Metta and Médecins du Monde. Through advocacy and community meetings, the project was successful in reducing resistance - even increasing the community’s participation in interventions that they now saw as important. Introducing TB and malaria services for people who use drugs and their families built community support as better disease control benefits everyone.

After a directive from the Presidential Office in 2018 in which a crackdown on drugs did not distinguish between low level dealers and users, and higher level operatives, resistance began to intensify again, however. Clients became more concerned about service accessibility, and the result was a 6% reduction in people who inject drugs reaching services in 2018. Commitment to community and stakeholder advocacy ensured this dip was not more severe. 3MDG partners were also able to provide access to more successful, rights-based approaches, instead of the ‘cold turkey’ methods that are employed by other groups, and supplemented by support services and health education provided by local AIDS committees – partners founded five and supported 18.

**Achievements in Services for People Who Inject Drugs (2013 - 2018)**

<table>
<thead>
<tr>
<th>Year</th>
<th>PWID reached by HIV prevention programmes</th>
<th>NS distributed per PWID</th>
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</thead>
<tbody>
<tr>
<td>Y2013</td>
<td>18,934</td>
<td>303</td>
</tr>
<tr>
<td>Y2014</td>
<td>26,681</td>
<td>22%</td>
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<tr>
<td>Y2015</td>
<td>30,411</td>
<td>33%</td>
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<tr>
<td>Y2016</td>
<td>40,033</td>
<td>27.2%</td>
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<tr>
<td>Y2017</td>
<td>42,977</td>
<td>38.9%</td>
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<tr>
<td>Y2018</td>
<td>40,422</td>
<td>35%</td>
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</table>

**A Drop-in Centre: What To Expect**

Visitors to drop-in centres are surprised by the relaxed, family-like atmosphere at the centre, where there is no judgement and everyone is welcome. Implementing partners have done more to ensure women also feel included.

People who use and inject drugs are often highly stigmatized, and can be reluctant to access services. Ensuring drop-in centres are safe, welcoming spaces – and outreach and clinic workers have been well-trained to provide non-judgmental services – is a critical piece of the puzzle. Kyaw Thein,* a 27-year-old person who used drugs loved visiting the centre, especially the counselling and health education that he received. “They care so much,” he said “Not just for the person who uses drugs, but also his family members.” He later became a peer educator, and helped around the office and with outreach services to his friends who use drugs. “With guidance from MANA, I can escape from the world of drugs,” he said.

Women who use drugs make up only a small number of overall drug users, but they may be more hidden, face extra stigma and have specific needs. Their health challenges may be compounded by guilt over their inability to perform the gender and social roles expected of them as women, and they may be further stigmatized for the same reason. The introduction of more women staff, women-only centres, and women-only spaces in existing centres encourage more women to attend the centres; safe, welcoming spaces without stigma. Comprehensive services were also available there, which is important as this group may be reluctant to seek care elsewhere for fear of judgement.

A doctor at a drop-in centre discovered that Ma Min Min,* a 47-year-old woman who used drugs had tuberculosis (TB). “I felt there was no hope and no future as I was struggling out on my addiction,” she said. “The worst thing was that I felt guilty about not caring for my children very well.”

“Right then and there, I made up my mind to begin methadone and stop using drugs. In the beginning, taking methadone can be hard - especially together with TB drugs. I had withdrawal symptoms, a bad temper, and poor appetite. But after two months, everything settled down. I could work every day and take care of my family again.”

*Not their real names

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**“I felt there was no hope, no future, because of my addiction”**

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**Photo:** Drop-in centres are a safe, judgement-free space for people who use drugs to go and spend time, and receive services. Clients often comment on how welcome they feel there. However, women may face extra stigma and desire their own space and female health workers - so partners had to do more to make sure they had the same experience.
LESSONS AND CHALLENGES

Lessons can - and must - be drawn from working within such a challenging context for provision of Harm Reduction services. For example, an intervention was trialled where shop owners provided needles and syringes for people who inject drugs. However, the return rate of needles and syringes was quite low, and the effectiveness of this approach in reducing HIV transmission was questionable, so the method was discontinued.

A ‘one-stop’ model for Harm Reduction services in public facilities was also trialled in the hospital complex at Kale and Tamu. However, due to limited space in the facilities and low political commitment to the initiative, 3MDG was asked to reduce their activities. This was an important reminder to build political capital before engaging on new initiatives, especially in this sensitive area of work.

Low dead space syringes were also distributed with support from Population Services International, as they lower the likelihood of transmission of blood-borne diseases when reusable. However, the use of this type of needle required specific funding, meaning it was not sustainable. More importantly, clients in fact preferred a different type of needle, so it was difficult to influence client behaviour to consistently use the low dead space needle. This approach was discontinued.

3MDG supported Harm Reduction work in large cities in Yangon and Mandalay because of the high HIV prevalence in these areas. However, there were difficulties in reaching people who inject drugs in cities like Yangon (estimated to be 1,625) because they remain hidden from services. There were some implementation hurdles in a highly politicized context. The local administrative department asked the partner not to operate a drop-in centre, and preferred they be consistent in using the low dead space needle. This approach was discontinued.

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Due to the success of methadone maintenance therapy (MMT) in Bangladesh, the low rates of uptake of the option amongst people who use drugs, Access to Health partners will provide more support to this programme. Services will be better coordinated, with less gaps and overlaps, under the guidance of the National AIDS Programme and Drug Dependence Research and Treatment Unit (DDTRU). A direct grant will also be provided to these two entities in order to support their efforts in reaching the most vulnerable populations and improving their systems.

In recognition of the importance of integrated service provision, under a comprehensive approach for people who use drugs and their families, Access to Health Harm Reduction partners are expanding the service package to include sexual and reproductive health, tuberculosis, malaria and mental health. Access to Health partners will also expand services to include mental health assessments and treatment due to the risk of mental and psychiatric disorders from drug use.

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A video highlighting one young man’s journey with addiction was launched on the 2018 International Day Against Drug Abuse and Illicit Trafficking to increase understanding of the vulnerability to using drugs, raise awareness of services and reduce stigma.

Sithu Min Than, a young man from Kachin State, began using heroin in college. After five unsuccessful attempts to quit, with the support of his family and methadone maintenance therapy, he is now managing his habit. These days, he supports other people who use drugs, letting them know about available services and how to reduce harm.

His story, told through a video created by 3MDG and local partner Metta, highlights how vulnerable people may be to using drugs, and raises understanding of drug use and drug dependency. It shows how people using drugs can remain responsible individuals, family and community members, with the right support. The video has been shared widely with community members, young people, people who use drugs and parliamentarians. It has also been shown at a number of film festivals, including at the International Harm Reduction Conference.

A critical part of managing drug use and drug dependency is community and family support. When Sithu’s father found out he was using drugs, he was devastated. But he knew he would help most by being patient. “I told him to know how much I love and care about him. I tried to persuade him to quit drugs.” U Maung Maung Tar said.

Sithu also received clean needles and syringes to reduce the risk of infection when he injected drugs, along with counselling and testing for bloodborne, sexually transmitted and communicable infections. Now, Sithu is receiving opioid substitution therapy.

Sithu also works as a peer educator at Metta Development Foundation, holding health education sessions and distributing and re-collecting needles and syringes. He wants to make sure others have the same chances as he had to lead a healthy life: “Now I want to help people, just like others helped me… I want to encourage others not to give up hope,” he said.
TUBERCULOSIS

INTRODUCTION

Tuberculosis (TB) is a major public health threat in Myanmar, and the country has been among the high burden countries for TB, TB/HIV co-burden and multi-drug resistant TB (MDR-TB) for a number of years, based on the 2018 Global TB Report.

3MDG-supported active case finding activities were instrumental for identifying people with TB who have difficulties accessing health facilities due to distance or cost, or because they are incarcerated at prisons and work sites. Active case finding was implemented through three modalities – mobile teams, community-based TB case finding and facility-based TB case-finding (for example, in maternal, newborn and child health and diabetes clinics). In total, over 68,000 TB cases were detected in 3MDG-supported programs in 271 townships in 14 states and regions.

Addressing the challenges posed by MDR-TB requires a concerted effort by government, donors and communities. In 2014, 3MDG supported a USD 19 million programme to address gaps in the national response and through a partnership with National TB Programme and four implementing partners, the programme was implemented in Yangon and Mandalay, where the prevalence of MDR-TB is most severe.

MULTI-DRUG RESISTANT TUBERCULOSIS (MDR-TB): The four components of the MDR-TB programme were the renovation and construction of MDR-TB facilities in Yangon and Mandalay; procurement of second-line TB drugs; provision of patient care (with standardized patient support package) and support and Directly Observed Treatment (DOT) with other implementing partners; and strengthening of data management in support of case management.

RESULTS OVER THE YEARS OF THE FUND

ACTIVITIES

TB CASE-FINDING BY MOBILE TEAMS: With 3MDG support, the National TB Programme (NTP) staffed nine mobile teams and equipped them with mobile digital X-ray machines. They operated in peri-urban, hard-to-reach sites, prisons and camps to find hidden cases.

TB CASE-FINDING AT DIABETES AND MATERNAL HEALTH CLINICS: There were also innovative approaches, including TB screening in maternal, newborn and child health clinics to reach more women, and diabetes clinics, as diabetes is a strong risk factor for TB. A survey conducted by the National TB Programme at Insein General Hospital showed TB prevalence for Diabetes Mellitus patients at more than two times that of the general population*.

COMMUNITY-BASED TB CASE-FINDING: National TB Programme and partners prioritized identifying more TB cases in hard-to-reach, ethnic health organization (EHO) and conflict-affected areas of Shan and Rakhine. 3MDG-supported case finding and control activities in ethnic health organization areas, and Wa and Special Region 4 areas in Shan State, as well as regular mobile team visits to camps for internally displaced persons in Rakhine. Mobile teams also covered camps for internally displaced persons (IDPs). Seven implementing partners worked for community-based TB care for active case findings and treatment support.

RESULTS OVERVIEW

3MDG partners gained momentum quickly for examination of TB cases, maintaining an average of 186,000 cases each year from 2015 to 2018 (with the starting year 2014 having 50,000 cases). Over the lifetime of the Fund, 3MDG contributed an average of 10% of the TB case notifications in Myanmar. 3MDG partners consistently examined TB suspects and there was a reduction in TB cases among examined cases as shown in the figure overleaf.

In 2013, there was only one implementing partner, Asian Harm Reduction Network that integrated TB case finding with HIV Harm Reduction interventions. This expanded to include Myanmar Anti-Narcotic Association from 2014, between the two partners, they found 2,567 cases of TB amongst people who use drugs from 2013 to 2018.

3MDG partners contributed to narrowing the gap between incidence and the TB notification rate during the early years of the Fund (2014-2016). The case notification rate of all forms of TB gradually decreased from 2014 because of declining TB prevalence, but also, unfortunately, because of missing cases from the urban poor, private sector, and conflict-affected areas. The notification gap to incidence increased again in 2017. The Ministry of Health and Sports took the step to instruct mandatory case notification in 2018. Cases for MDR-TB declined, but this could also due to shifting of some intervention sites to Global Fund in the extension year.

TB Interventions With Ethnic Health Organizations The TB prevalence survey from 2009-2010 reported a much higher burden of TB than earlier estimated, particularly in conflict-affected areas. The notification gap to incidence and the TB notification rate during the early years of the Fund (2014-2016). The case notification rate of all forms of TB gradually decreased from 2014 because of declining TB prevalence, but also, unfortunately, because of missing cases from the urban poor, private sector, and conflict-affected areas. The notification gap to incidence increased again in 2017. The Ministry of Health and Sports took the step to instruct mandatory case notification in 2018. Cases for MDR-TB declined, but this could also due to shifting of some intervention sites to Global Fund in the extension year.

IN BRIEF

• Tuberculosis (TB), and multi-drug resistant TB are serious public health problems in Myanmar, especially co-burden with other diseases, such as HIV and diabetes

• 3MDG partners began in 2013 and gathered momentum quickly - testing about 100,000 cases every year

• Active case finding activities have done a great deal to close the gap between the notified and the missing cases, but more needs to be done, especially in mandatory case notification for private sector, non-government controlled areas, and for high risk populations

• Incredible treatment success rates for MDR-TB - 80% compared to a global average of 55%

PARTNERS

Active case finding
• National TB Programme (NTP)

Community-based TB care
• Myanmar Medical Association (MMA)
• Myanmar Health Assistant Association (MHAA)
• Population Services International (PSI)
• The Union
• Medical Action Myanmar (MAM)
• Health Poverty Action (HPA)
• Community Partners International (CPI)

Multi-drug resistant TB
• MMA
• MHAA
• Pyi Gyi Khin
• The Union

TB case finding integrated with harm reduction
• Asian Harm Reduction Network (AHRN)
• Myanmar Anti-Narcotic Association (MANA)

Infrastructure
• UNOPS

*Myanmar Medical Journal, September 2018 - Vol. 60, No. 3

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<tbody>
<tr>
<td>National TB (all forms) mortality per 100,000 population</td>
<td>63</td>
<td>49</td>
<td>47</td>
<td>51</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of confirmed MDR TB cases successfully treated (disaggregated by sex and age)</td>
<td>-</td>
<td>-</td>
<td>80%*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Number of bacteriologically confirmed DR TB cases who began second line treatment</td>
<td>1,400</td>
<td>654</td>
<td>2,064</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Number of MDR-TB patients receiving allowance for transport for diagnosis and treatment</td>
<td>890</td>
<td>1,169</td>
<td>1,912</td>
<td>720</td>
<td>0</td>
<td>N/A</td>
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</tr>
<tr>
<td>People screened for TB</td>
<td>16,642</td>
<td>50,764</td>
<td>158,300</td>
<td>150,607</td>
<td>196,226</td>
<td>205,475</td>
<td>800,014</td>
</tr>
<tr>
<td>All forms of TB cases</td>
<td>2,896</td>
<td>4,295</td>
<td>16,934</td>
<td>18,376</td>
<td>15,780</td>
<td>13,382</td>
<td>68,953</td>
</tr>
<tr>
<td>Bacteriologically confirmed TB cases</td>
<td>1,555</td>
<td>2,881</td>
<td>4,161</td>
<td>3,488</td>
<td>3,028</td>
<td>17,492</td>
<td>75,685</td>
</tr>
</tbody>
</table>

2014: 17,467 (25%) 2018: 17,492 (26%)

TB cases from Diabetes and Maternal, Newborn and Child Health Clinic

TB cases from National TB Programme Mobile Activities

TB cases from Community-based TB Care

People screened for TB: 162,161
urban and non-government controlled areas. 3MDG emphasized active case finding of TB in the urban poor and ethnic areas together with ethnic health organizations (EHOs) in Shan (Wa, Special Region 4 and Shan State Development Foundation - SSDF), Kachin (Kachin Special Region 2), Kayah (Civil Health Development Network) Mon (Mon National Health Committee) and Kayin State (Burma Medical Association, Karen Department of Health and Welfare).

3MDG partners Health Poverty Action and Community Partners International made health service delivery a reality in areas with very little access for government health staff. Cases of TB that were diagnosed by National TB programme mobile teams were referred to EHOs. 3MDG supported community volunteers to ensure adherence to treatment. From 2015 to 2018, Health Poverty Action achieved 1,454 notifications for all forms of TB in 14 townships and Mongkeng and Monghla Regions in Shan State and Kachin Special Region 2 in Kachin State.

Technical capacities of EHOs were strengthened through training and supervision. Population Services International worked together with Shan State Development Foundation (SSDF) – an ethnic health organization - in two townships (Mongkeng and Kunhing) and in 2018, SSDF volunteers referred 638 presumptive TB cases and bacterially confirmed 10 TB patients.

MTR-TB interventions

3MDG supported the treatment of 2,054 MTR-TB patients with second-line treatment across all townships in Yangon and procured MTR-TB drugs in 13 townships in Mandalay. In 2015, the 3MDG’s contribution was 64% of the national achievement (1,460 MTR-TB cases out of 2,207 treated nationwide). In 2016, 654 cases out of 2,537 MTR-TB cases treated were supported by 3MDG, accounting for 26% of cases on treatment nationwide. Increasing numbers supported through the national programme is positive for the sustainability of the programme, increased capacity and reducing reliance on external support.

Among the patients enrolled via 3MDG in 2015, the MTR-TB treatment success rate (TSR) as of 2017 was 80%. This is a huge success, especially compared to the global average of MTR-TB TSR at 55%. This demonstrates the effectiveness of the comprehensive support that patients received, including food and financial support, as well as psychosocial and medical support. All enrolled MTR-TB patients received Directly Observed Treatment (DOT) from trained community volunteers with infection screening, side-effect monitoring and contact tracing.

TB Infrastructure And Equipment

3MDG supported four new pieces of TB infrastructure in TB care and control: a caregiver accommodation in Patheingyi Hospital in Mandalay, two outpatient departments in Yangon and Mandalay, and a Bio-Safety Level 3 National TB Reference Laboratory in Yangon. Two mobile X-ray vans, 10 mobile digital X-ray machines and seven cars for mobile teams, as well as three Gene Xpert machines were provided to NTP so they could expand ‘one-stop shops’ and improve the efficiency of case finding activities.

Support to the MTR-TB Data Management System

3MDG funded the development and roll-out of Open Medical Records System (OMRS), an open-source patient management information system for facility-based MTR-TB data management in 21 specialized health facilities in Yangon, Mandalay and Ayeyarwady. This system captures data on clinical check-ups and lab investigations, and aims at improving the quality of patient follow-up.

TRENDS OF TOTAL TB CASES NOTIFICATION (2013-2018)

- 1,642
- 50,764
- 158,300
- 187,607
- 196,226
- 205,475
- 150,000
- 200,000
- 250,000
- 100,000
- 50,000
- 0

- 2013
- 2014
- 2015
- 2016
- 2017
- 2018

1. WHO Global TB report 2016
2. WHO Global TB report 2017

People screened for TB
Bacteriologically confirmed TB cases
All forms of TB cases

Research and Policy Interventions

3MDG technically supported the development of the Tuberculosis National Strategic Plan (2016-2020). In line with the WHO End TB Strategy, the third strategic direction of the strategic plan is “to intensify research and innovation to enhance evidence-based programme monitoring and implementation and to strengthen the evidence base for future policy and practice through operations research.”

The Fund also supported major surveys which helped to build the evidence base for TB interventions: TB Prevalence survey (2018), Catastrophic cost survey: Patient Cost due to Tuberculosis in Myanmar, Assessment of Community-based MDR-TB Care in Yangon, Stochastic Assessments in Mandalay, Accelerated Case Finding of TB through Mobile Teams and Community Involvement, and Screening of TB Among Diabetes Patients. These surveys support evidence-based planning, the implementation of quality TB control activities, and help to track progress towards the goals of the National TB Programme. The catastrophic cost survey, for example, showed that 60% of TB-affected households in Myanmar were sent into poverty (or, further into poverty) because of the costs of TB. This knowledge was crucial to securing additional funding from the Global Fund for nationwide TB interventions.

TB Prevalence Survey

The National TB Prevalence Survey conducted in 2017-2018 found that TB prevalence declined from 113 per 100,000 populations in 2000 to 46 per 100,000 (Model 3, MI+IPW) in 2018. It also showed that men were more likely than women to have TB, and people living in regions rather than states also had higher prevalence. This is most likely due to service expansion and improvements in the last decade. The survey demonstrated that the efforts of the National TB Programme to remove smear-positive cases from the community, as there was a 50% reduction between 2009 and 2017/18 – from 502 cases in 2009 to 252 cases in 2017/18. This sort of information is useful for the National TB Programme, allowing them to revise epidemiological data, impact targets, and approaches to achieving End TB Strategy goals.

LESSONS AND CHALLENGES

In earlier years of implementation, targets set for the detection rate were revealed to be unrealistic for a number of reasons including: a lack of baseline data, the newness of the active case detection approach and lengthier than expected selection process of mobile team sites. 3MDG also had challenges with delayed operation of mobile teams related to new project start-up, in particular the time required to recruit new staff and to procure mobile X-ray units, equipment and vehicles for full functioning. To better understand and address these challenges, 3MDG had regular review of active case finding activities with the National TB Programme. In these meetings, programme implementation challenges were reviewed and solved, targets were reviewed, and plans were made to reach uncovered areas.

Although ethnic health organizations (EHO) provided health services to urban poor and ethnic areas, major challenges remained obstacles to TB prevention and control activities. There were no TB diagnosis and treatment facilities within EHO clinics, TB treatment was only available at the township health department. This was not always accessible for everyone. To increase service access, the National TB Programme provided sputum smear preparation training to EHOs towards the end of 2018. This means that EHOs can now do sputum smear side preparation in their clinic, and the slides can be sent to the nearest township hospital for TB diagnosis rather than patients travelling themselves.

THE WAY FORWARD

Ending TB by 2030 is a target of the United Nations Sustainable Development Goals. The next five years will be critical for Myanmar to ensure that the momentum gained recently is translated into an accelerated End TB response based on the preliminary findings of the TB prevalence survey in 2018, the TB national prevalence declined compared to the previous prevalence survey result, but huge variations in different geographic areas remain. It is thus important to have specific recommendations on active case finding and to accelerate TB case finding in high burden townships and in inaccessible areas.

3MDG contributed significantly to TB case finding in Myanmar, and Access to Health will maintain this through community-based TB case finding, case finding in clinical groups (patients with diabetes and pregnant mothers), case finding in groups of people in settings (prisoners and miners), and TB cases finding through Integrated Community Malaria Volunteers (ICMV) approach. The commitment to integrated service delivery is expanded under the Access to Health Fund, building on the approach developed and rolled out by implementing partners in 2018. For example, TB case finding is integrated into almost all of maternal, newborn and child health implementing partner activities to accelerate TB control activities. Further evaluation and adjustment to this programme will continue throughout Access to Health to ensure effectiveness.

The urban poor are a high risk population for TB, given the crowded living conditions and poor socio-economic status. Therefore, despite the focus on conflict-affected states, Access to Health Fund will still deliver support for TB and MDR-TB interventions where TB is highly prevalent – such as crowded urban areas in Yangon and Sagaing. The End TB strategy also includes mandatory TB notification, announced by the National TB Programme at state and district level notification from private care providers. Access to Health Fund will support this new development.

EHOs towards the end of 2018. This means that EHOs can now do sputum smear side preparation in their clinic, and the slides can be sent to the nearest township hospital for TB diagnosis rather than patients travelling themselves.
INTRODUCTION
In the last decade, Myanmar has made substantial improvements in malaria morbidity and mortality. The number of malaria deaths has reduced steadily year by year from 1,707 in 2005 to just 30 in 2017 (more than 98% reduction over 10 years). Malaria is now mainly concentrated in remote areas, and among migrants and displaced and conflict-affected persons.

3MDG provided funding to activities to prevent and control malaria, supplementary to the Myanmar government’s financing from the Global Fund. 3MDG’s malaria response went through a transition period in 2014, with the phasing out of the previous Three Diseases Fund (3DF)-supported Myanmar Artemisinin Resistance Containment (MARC) response, and the beginning of the 3MDG-supported national MARC response. The focus shifted towards the early diagnosis of malaria cases and helping confirmed malaria cases to get effective and rapid Artemisinin-based Combination Therapy (ACT) treatment. This was done by expanding the areas served by the trained volunteer network and health care providers at the community level.

ACTIVITIES
• Training of malaria volunteers
• Prevention and control of malaria, with distribution of long lasting insecticidal nets (LLINs) and health education and communication materials (IEC)
• Malaria testing with rapid diagnosis tests
• Treatment of Plasmodium falciparum and Plasmodium vivax cases according to national malaria guidelines
• Integrated Community Malaria Volunteer (ICMV) approach (introduced in some townships from 2018)

REDUCING MALARIA BURDEN IN MYANMAR

RESULTS OVER THE YEARS OF THE FUND

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<tbody>
<tr>
<td>Number and percentage of confirmed malaria cases treated in accordance with national malaria treatment guidelines (within 24hrs of onset of fever)</td>
<td>92% (34,462)</td>
<td>46% (19,729)</td>
<td>49% (5,023)</td>
<td>44% (5,312)</td>
<td>72% (8,002)</td>
<td>62% (7,499)</td>
<td>61% (5,867)</td>
</tr>
<tr>
<td>Number of people with confirmed malaria treated as per national treatment guidelines</td>
<td>79,952</td>
<td>29,530</td>
<td>11,742</td>
<td>11,194</td>
<td>10,582</td>
<td>10,851</td>
<td>10,681</td>
</tr>
<tr>
<td>Number of rapid diagnostic tests (RDTs) taken and read</td>
<td>57,8,462</td>
<td>469,714</td>
<td>4,39,052</td>
<td>4,44,482</td>
<td>88,002</td>
<td>533,094</td>
<td>2,321,746</td>
</tr>
<tr>
<td>Number of long lasting insecticide nets (LLINs) distributed (total) at migrant/mobile populations in high priority areas not readily covered by the Global Fund</td>
<td>799,276</td>
<td>312,776</td>
<td>70,736</td>
<td>2,013,938</td>
<td>-</td>
<td>2,065,665</td>
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RESULTS OVERVIEW
3MDG provided support to Myanmar’s national response, run by the National Malaria Control Programme (NMCP), to contain Artemisinin-resistant malaria and pre-elimination in priority areas located in the southeast of Myanmar. From 2013 to 2018, 17 implementing partners, including local organisations, participated in malaria control and intervention in selected villages of 130 townships in 11 states and regions. 3MDG focused on areas where government health providers, supported by the Global Fund, may have had more limited access, that is, non-government or ethnic health areas. Partners engaged with local health care providers and religious networks, to provide integrated interventions which reflected resource limitations. Interventions were sometimes conducted in conjunction with tuberculosis detection.

For 18 months starting in January 2013, the NMCP implemented malaria interventions with financing from 3MDG. The World Health Organization provided technical support. The grant was able to treat more than half (56%) of all cases of malaria treated with 3MDG funding, in just this short time period. On top of this, 3MDG partners contributed an average of 21% of the tests administered nationally, and 17% of the treatments undertaken, between 2013 and 2018.

National treatment guidelines were better adhered to because partner organizations trained volunteers in migrant sites and expanded testing for mobile and migrant populations. This was demonstrated by yearly increases from 2013 to 2017 in the outcome indicator for this area of work, the ‘proportion of cases treated within 24 hours of the onset of fever’. Achievement for this indicator dropped in 2018, because of disruption due to the extension year of the Fund. Some intervention sites shifted to the Global Fund, and the establishment of new sites meant a longer start-up period.

Decreasing Burden, But High Prevalence Remains In Pockets
The reducing burden of malaria cases and deaths in Myanmar is evident from data provided by the NMCP. The malaria test positivity rate decreased from 28.76 in 2013 to 3.47 in 2017. In 2013, there were 236 deaths from malaria, and in 2017 just 30. 3MDG saw similar trend, with reducing positivity from 14% in 2013 to 3% in 2017.

However, some high-burden areas remain, such as the hard-to-reach Paletwa in Chin State. With a high number of migrant workers, and the impacts of conflict in nearby Rakhine State, the prevalence of malaria was significant. In response, 3MDG began working in earnest in Paletwa in 2016, and by 2017 the township was contributing nearly half (47%) of all malaria cases detected and treated malaria cases (5,037 cases from Paletwa of 10,821 total cases). In 2018, positivity reduced to 23.6, but the township still contributed 37% of all cases found in 3MDG-supported areas.

IN BRIEF
• A 98% reduction in malaria deaths, and declining prevalence is great news for Myanmar - but requires re-strategizing towards elimination and how to make the most efficient use of trained health staff. Re-training volunteers to provide more services, and integrating service delivery, meant that even as prevalence declined, system efficiencies could be maintained and communities could access even more health care.
• 3MDG found that some government health providers, supported by the Global Fund, may have had more limited access, that is, non-government or ethnic health areas.
• Paletwa, in Chin State, remains a significant trouble spot for malaria in Myanmar; contributing nearly half of all 3MDG-treated cases and a large number of deaths from the disease.
• Access also remained challenging in other non-government areas, due to security, and language and trust also impacted health seeking behaviour.

PARTNERS
Malaria case finding and treatment:
• National Malaria Control Programme with World Health Organization
• Community Development Association (CDA)
• IOM
• MMA
• Phaung Daw Oo (PDO)

Malaria interventions by trained village health workers:
• Community Partners International (CPI)
• Medical Action Myanmar (MAM)
• Myanmar Health Assistant Association (MMAA)
• Population Services International (PSI)
• World Concern
• Burnet Institute

Malaria case finding integrated with Harm Reduction:
• Asian Harm Reduction Network (AHRN)
• Myanmar Anti-Narcotic Association (MANA)

Malaria case finding integrated with maternal, perinatal and child health:
• Save the Children
• International Organization for Migration (IOM)
Malaria Case Finding by Volunteers

Myanmar’s Malaria Control Programme relies on volunteer staff. Community-based malaria diagnosis and treatment services, for example, are primarily delivered by a network of around 15,000 village health volunteers (about 9,000 under the National Malaria Control Programme (NMCP) and the remaining under various local and international non-government organizations). 3MDG trained and supported malaria volunteers to find cases and provide treatment at the village level for a number of years. A total of 4,038 volunteers were trained by partners, and equipped with malaria Rapid Diagnostic Tests (RDTs) and Artemisinin Combination Therapy (ACT).

As malaria cases in Myanmar decreased, the NMCP recognized the need to sustain motivation among the large cadre of trained malaria volunteers, and make the most of their health care skills. They initiated a pilot to test a newly integrated community malaria volunteer (ICMV) approach which trained volunteers in the delivery of maternal, newborn and child health services, health promotion and education and referral services for TB, HIV, dengue haemorrhagic fever, lymphatic filariasis, and leprosy.

Voices: Working as a Malaria Volunteer

When Saw Aung stepped on a landmine and lost his right leg a few years ago, he thought he would no longer be able to help his community. But when Myanmar Health Assistant Association (MHAA) started the malaria project in his village – Myaung Myaung village, Hpapun Township in Kayin State - he was selected as a volunteer. He was selected by MHAA and by his villagers too, who knew he could do a great job and trusted him.

“When 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.”

Artemisinin Monotherapy Replacement Project

With Artemisinin resistance detected in-country and across the Greater Mekong Sub-region, the unprecedented drive to eliminate malaria from the entire region is in recognition of a public health emergency. 3MDG supported Population Services Internationals’ Artemisinin Monotherapy Replacement (PSI-AMTR) project. Non-formal providers are able to reach high-risk groups, including those who are mobile because they themselves have high mobility, and their closeness to these populations. Overall, 30% of rapid diagnostic tests and 15% of total cases treated in 2018 by 3MDG partners were contributed by the PSI-AMTR project.

Distribution of Long Lasting Insecticidal Nets

3MDG worked with implementing partners and the NMCP to provide key pharmaceuticals and long-lasting insecticidal nets. In total, 2,965,665 nets were distributed through community-based organizations and in collaboration with the Global Fund to mobile migrant populations and marginalized communities who live in high-risk and conflict-affected areas.

Research and Policy intervention

3MDG supported research to build understanding of the malaria epidemiology in Myanmar, and intervention models. In 2015, the Malaria Indicator Survey was launched - providing up-to-date baseline data on malaria intervention coverage, prevalence, population awareness and availability of services. The Myanmar Artemisinin Resistance Containment Modelling (MARCmod) Project, completed in 2015, provided practical recommendations on how to maximize impact from investment in insecticide-treated bed nets and early diagnosis and treatment through malaria community health workers. The icCM Pilot evaluation research assessed the feasibility of an Integrated Community Case Management (iCCM) intervention using malaria volunteers. By 2016 it was completed, and recommendations began to be implemented.

LESSONS AND CHALLENGES

Despite significant decreases in malaria prevalence in Myanmar, the context continued to present challenges. In non-government controlled areas, security, limited access, language barriers, low literacy and poor communication networks made it hard for volunteer health workers to record malaria data. Frequent military clashes made certain villages inaccessible. Access was also limited to some villages due to geographical factors and limited transport infrastructure, especially in the rainy season.

When malaria volunteers and health workers could reach people in difficult parts of the country, the nature of malaria treatment itself presented challenges. For example, for ‘Plasmodium Vivax malaria,’ an eight week course of Primaquine is the treatment standard – but despite health education and support, those who are only irregularly visited by health workers demonstrate poor completion rates. To address this issue, NMCP was in the progress of the revision of treatment guideline and strategy in 2018 and 2019.

There were also programmatic and reporting challenges. For example, without clear disease burden data - and in the context of rapidly dropping prevalence – it is difficult to set the right targets. In turn, this makes it difficult to measure programme efficiency and effectiveness.

Finally, despite all the positive benefits, the introduction of Integrated Community Malaria Volunteers (ICVM) was not without problems. Hard-to-reach villages, which were prioritized under the programme, can be more difficult already - for training, supervision and monitoring. The staff workforce numbers were limited, and their workload became higher – which for some volunteers was difficult to adjust to. More evaluations and review on the ICMV approaches are necessary to understand the challenges and effectiveness of the programme (see more in lessons learned chapter).

THE WAY FORWARD

Malaria elimination is targeted in all states and regions by 2030. This requires strengthening of the case surveillance system, improving access to diagnosis and treatment and improving preventive interventions to prevent parasite transmission.

The provision of integrated services under the ICMV model in all Access to Health Fund township – which is a significant change from 3MDG, and prioritizes the delivery of more comprehensive services – will also see malaria diagnosis and treatment offered alongside Harm-Reduction and other services. Out of 208 malaria elimination townships, 19 townships in six states and regions will be included as part of Access to Health Fund activities.

MALARIA CASES TESTED BY VOLUNTEERS

![Graph showing malaria cases tested by volunteers from 2013 to 2018](image-url)
HEALTH SYSTEMS STRENGTHENING

INTRODUCTION

A responsive, resilient and people-centred health system is critical for everyone’s health needs to be met, and for gains made in service delivery quality and reach to be sustainable. In Myanmar, however, there are gaps in the health system and some elements are stronger than others. To help support a more efficient and responsive system, 3MDG supported health systems strengthening efforts at national, state and region and township levels. The Fund aimed to increase the sustainability of investments in maternal and newborn health services and communicable disease control components, as well as to complement existing health systems strengthening initiatives.

HEALTH SYSTEM STRENGTHENING INTERVENTIONS SUPPORTED BY 3MDG

<table>
<thead>
<tr>
<th>Title</th>
<th>IP</th>
<th>State/ Region</th>
<th>Contract term</th>
<th>Total Exp. (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursable advisory services agreement for public financial management</td>
<td>World Bank</td>
<td>Nationwide – at central, state/regional, and township levels</td>
<td>May 2013-Nov 2017</td>
<td>3,144,731</td>
</tr>
<tr>
<td>Ministry of Health and Sports Capacity Building</td>
<td></td>
<td>Nationwide</td>
<td>Jan 2013-Dec 2016</td>
<td>500,000</td>
</tr>
<tr>
<td>National Supply Chain Study</td>
<td>Partnership for Supply Chain Management (PFSCM)</td>
<td>Nationwide</td>
<td>Mar 2014-Nov 2014</td>
<td>249,397</td>
</tr>
<tr>
<td>Improved Midwifery for Maternal, Newborn and Child Health Services</td>
<td>JHPIEGO</td>
<td>Nationwide – all midwifery schools</td>
<td>Jul 2014-Dec 2018</td>
<td>6,474,837</td>
</tr>
<tr>
<td>Rural Health Centre Infrastructure</td>
<td>JHPIEGO</td>
<td>Magway, Sagaing, Ayeyarwady, Yangon, Mandalay, Shan, Kayah, Chin</td>
<td>Jun 2014-Dec 2018</td>
<td>12,000,000</td>
</tr>
<tr>
<td>UN joint assistance to strengthen health systems in Myanmar</td>
<td>UNAIDS, UNICEF, UNFPA</td>
<td>Nationwide</td>
<td>Nov 2014-Dec 2017</td>
<td>2,981,610</td>
</tr>
<tr>
<td>Regional Supply Chain Strengthening</td>
<td>PFSCCM</td>
<td>Ayeyarwady, Magway, Yangon</td>
<td>Mar 2015-Dec 2017</td>
<td>4,200,000</td>
</tr>
<tr>
<td>Demographic Health Survey in Myanmar</td>
<td>ICF Macro Inc.</td>
<td>Nationwide</td>
<td>Oct 2015-Dec 2016</td>
<td>892,586</td>
</tr>
<tr>
<td>Evidence to policy design</td>
<td>International Health Policy Program</td>
<td>Nationwide</td>
<td>Dec 2015-Dec 2016</td>
<td>14,900</td>
</tr>
<tr>
<td>Health Systems Strengthening Support to the Rakhae State Health Department</td>
<td>UNICEF</td>
<td>Rakhae</td>
<td>Oct 2015-Dec 2016</td>
<td>862,002</td>
</tr>
<tr>
<td>Human resources in Health Management</td>
<td>JHPIEGO</td>
<td>Nationwide</td>
<td>Jan 2017-Dec 2018</td>
<td>1,993,432</td>
</tr>
<tr>
<td>Support to National Health Plan Implementation</td>
<td>National Health Plan Implementation Monitoring Unit (NIMU)</td>
<td>Nationwide</td>
<td>Apr 2017-Dec 2018</td>
<td>869,630</td>
</tr>
</tbody>
</table>

RESULTS OVERVIEW

GOVERNANCE

3MDG supported the Ministry of Health and Sports in their role in providing centralized oversight, co-ordination, regulation, strategic direction, and creating an environment conducive to health interventions. 3MDG provided technical assistance to improve the governance of the health system, helped to develop plans, policies and strategies based on evidence, and generated evidence relevant for policy, and helped to establish effective monitoring to assess progress.

>> Key Achievements

The National Health Plan (2017-2021) and annual operational plans (year one and two) preparation processes created strong partnership and ownership from different stakeholders. Key health sector policies, strategies and plans in the areas 3MDG supported were developed and delivered to the Ministry of Health and Sports (see below).

KEY POLICIES AND STRATEGIES

- The development and launch of the National Health Plan (NHP) (2017 – 2021) and the establishment of National Health Plan Implementation and Monitoring Unit (NIMU).
- Development of NHP first and second year annual operational plans.
- Development of Human Resources for Health Policy (2017-2026) and Human Resources for Health Strategic Plan (2018-2022).
- Situational analysis and consultations, as part of the national policy development on village-based health workers that was submitted for Ministry of Health and Sports review.
- Development of National Drug Control Policy.
- Development of National Sexual and Reproductive Health and Rights Policy.
- 3MDG contributed to the development of Multi-Sectoral National Plan of Action for Nutrition (MS-NPAN).
- Eleven national strategies and guidelines for guiding high quality pre-service education and in-service training developed and disseminated.

IN BRIEF

- 3MDG supported the development of the National Health Plan 2017-2021 through an inclusive process, and also the National Health Plan Implementation Monitoring Unit (NIMU) towards UHC 2030.
- Improving human resources for health, through Jhpiego’s support to the Ministry of Health and Sports, was a focus area due to the significant challenges faced. Notable results included establishment of the 3MDG’s health systems strengthening central monitoring and management mechanism, which ensured strong and consistent monitoring and management of all activities.
- A supply chain improvement project had great results: by 2018, 290 out of 330 townships in the country had functional cold chain equipment and adequate storage space for effective vaccine management.
- Despite improvements, substantial challenges in health systems strengthening remain.
- Human resource retention and deployment still face significant issues, with gaps in hard-to-reach areas and low remuneration making jobs away from government service more attractive.
- Fragmentation of different parts of the system, including supply chain and logistics management, as well as data and information technology, makes an efficient, effective system difficult to achieve.
- Patients still face high out-of-pocket expenditure, indicating more needs to be done on health financing.
- Budgets are often significantly underspent, revealing bottlenecks in public financial management and poor planning.
- Measuring the effectiveness and results of 3MDG’s health system strengthening grants, and ensuring they complement each other, has been an ongoing learning process. More is needed in Access to Health to ensure investments have the most significant, sustainable impact.
HEALTH SYSTEMS STRENGTHENING

Support to the National Health Plan Implementation Monitoring Unit (NHMI) and World Bank helped place Universal Health Coverage (UHC) at the centre of the agenda for the government, the Ministry of Health and Sports, civil society and ethnic health organizations, non-government organizations, and among members of Parliament and the National League for Democracy. This was done by raising awareness and urgency as well as increasing understanding of the various dimensions of UHC through capacity building and learning events. They ranged from Global and Asia Regional UHC Flagship Courses to Regional level learning and networking events, to in-country seminars and courses tailored to the Myanmar audience and context while solidly grounded on the global lessons learned and expertise. A total of six UHC Flagship Courses and 29 knowledge sharing and learning events at global, regional and national level were held.

HUMAN RESOURCES FOR HEALTH

Strengthening human resources for health is a key objective of the National Health Plan 2017 – 2021. Human resources are a building block of any health system, and with the right training, planning and monitoring, quality staff can be available where they are needed. In Myanmar, issues persist with management, planning, recruitment, retention and performance of health human resources, and a high proportion of sanctioned posts are unfilled. The Ministry of Health and Sports were supported through a multi-year grant totalling US$ 8.5 million to Jhpiego, an affiliate of Johns Hopkins University. The programme supports the Ministry of Health and Sports to improve the existing policy and regulatory framework, as well as providing high-quality pre-service education and in-service training.

**IN NUMBERS**

| **5** | number of policies and strategies developed and endorsed, with 3MDG financial or technical support. |
| **17** | number of pieces of research, situational assessments and studies conducted, including the Demographic and Health Survey in 2015-2016. |
| **23** | number of nursing, midwifery and Lady Health Visitor schools supported to strengthen pre-service education. |
| **290** | number of townships with functional cold chain equipment and adequate storage. |

In 2016, Jhpiego and the Ministry of Health and Sports developed the first strategy for nationwide refresher skills-based training of health workers on basic emergency obstetric and newborn care (BEmONC). By 2018, 113 master mentors had been trained to roll-out trainings for in-service midwives countrywide. Jhpiego supported the Ministry in overall human resource management, strengthening systems in planning, deployment, retention and support of quality professionals at all levels. This included the development of an integrated Human Resource Information System (HRIS), giving decision makers the information to efficiently plan for the recruitment, training and retention of the health workforce.

HEALTH INFORMATION

The demand for data and evidence increased with the development and launch of the National Health Plan 2017-2021, and its monitoring framework, the Myanmar Sustainable Development Plan 2018-2030 and international commitments such as the Sustainable Development Goals. An effective and reliable health information system is required for monitoring the implementation of the NHP, and measuring progress towards universal health coverage. It is crucial to knowing where the needs exist, what the priorities are, and what resources are required to meet them.

**HSS IN RAKHINE STATE**

Strengthening the health system at the subnational level in Rakhine has been instrumental to fulfill a number of priorities in the State Health Plan and other development agendas.

Better planning and coordination, health information management and supply chain activities, were supported by 3MDG partner activities. The medical equipment and drug storage system was improved by increasing capacity and improving storage conditions for medical products. Health management information systems trainings, including in the use of DHIS2, were provided in all townships with provision of computers and skill building for effective data management. As a result, DHIS2 has been successfully rolled-out in all townships and improvements for timeliness (35%) and regularity (92%) were seen.

Public Financial Management training was provided and followed-up by mentoring on budget planning, executing and reporting. At the end of 2018, all 17 townships were able to submit financial reports to central level within first week of every month.

**SUPPLY CHAIN MANAGEMENT**

Improving the supply chain ensures medicines and equipment are in the hands of health providers when they need them. It makes sure that the planning is right, so stock does not run out, and the cold chain is maintained for quality medicines and vaccines to work safely and effectively.

**Key Achievements**

3MDG supported the strengthening of the supply chain for essential medicines, and improving the cold chain to extend access to vaccines nationally. UNICEF, together with the Ministry of Health and Sports, implemented an effective vaccine management improvement plan and cold chain expansion plan. By 2018, 290 out of 330 townships in the country had functional cold chain equipment and adequate storage space. The cold chain inventory for all equipment had been updated in preparation for the Operational deployment plan for additional cold chain equipment support through the Gavi cold chain equipment optimization platform.

The Regional Supply Chain Strengthening (RSCS) project supported the Ministry of Health and Sports in strengthening supply chain management capacities under a three-year grant from 3MDG. The aim was to implement a Logistics Management Information System (LMIS) and related strengthening initiatives at the lowest health system level in three regions: Ayeyarwady, Bago, and Magway. These three regions, with 79 townships and 3,378 health care facilities, represent nearly 30% of Myanmar’s population.

An end-line study conducted in 2017 indicated improvements in four out of five areas: LMIS, human resources, and stock and management. The overall RSCS supply chain system score, which is the average of the five categories, improved from 47% to 68%. Implementation improved the most, moving from a poor rating to a good rating – which was the one area that did not improve - remained constant, however, with long-term implementation and continued improvement, the LMIS is expected to help alleviate this problem.

Other important achievements were the introduction of a consumption report tracking system for essential commodities at the health facility level, and the introduction of a pilot electronic data entry system at the township level with the goal of improving forecasting.
HEALTH FINANCING

Public financial management involves all of a country’s processes relating to financial management, from revenue capture and management, to budgeting and planning, reporting, audit and oversight. It is essential for good, sustainable governance and vital for the achievement of policy objectives. Without a robust public financial management system, service delivery is compromised. In Myanmar, there are roadblocks in the public financial management processes which can make the movement of money difficult, impeding planning, holding up service delivery and leading to underspend of budgets.

>> Key Achievements

A strong evidence base was put in place during the 3MDG lifetime, shedding light on the extent and impact of out-of-pocket expenditure (OOP) on households. The OOPE report and the two accompanying studies provided the first in-depth look at OOP spending from both quantitative and qualitative perspectives in Myanmar.

Population Services International (PSI) and Community Partners International (CPI) piloted two projects to demonstrate the capacity of private general practitioners to offer a basic package of primary care services. Instead of fee-for-service payments, this pilot implements capitation payments and a pay-for-performance bonus. The projects assessed whether increasing the range of services that 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.

The PSI project took place in Yangon (and will continue in Access to Health, as well as expanding to Chin). Services are delivered through the Sun Quality Health network. CPI is implementing their similar project in non-government controlled areas. This is a key study for the National Health Plan 2017-2021 and will inform the Government’s long-term universal health coverage plan, and health financing approaches, by testing a different strategic purchasing mechanism.

Efforts to improve public financial management were done by the World Bank and the National Health Plan Implementation Monitoring Unit (NIMU). The World Bank identified system bottlenecks and areas for improvement. The planning and budgeting process, electronic systems for timely data recording, better collaboration with other ministries and strengthening the standard operating systems. Training sessions were conducted and hands-on mentoring was provided to all states and regions and 50 townships in order to improve budget executing and tracking, public sector accounting, and understanding of the rules that affect health spending.

With awareness-raising and knowledge sharing activities, public financial management came to be recognized by important stakeholders in government and parliament as a core function of health systems, and a key challenge in Myanmar. Due to this work, the health financing portion of the National Health Plan was emphasized more strongly than before and in 2019 a Health Financing strategy will be launched.

The costing work on the basic Essential Package of Health Services (basic EPHS) and the National Health Plan 2017-21, financed under the World Bank grant, has provided the Ministry of Health and Sports with concrete data to plan future investments and to advocate with the government for increasing public spending in health.

In collaboration with University of Public Health, World Bank staff delivered a series of lectures for Masters of Public Health candidates at the University of Public Health since last academic year. The candidates are civil servants from the Ministry of Health and Sports, coming from different backgrounds - health assistants and medical officers, for example. Social media was also used to promote awareness of Universal Health Coverage (UHC) and dedicated channels such as Knowledge Leaders for UHC (Facebook/MKL-SUHC) offer distance learning opportunities and knowledge exchange.

LESSONS AND CHALLENGES

There have been immense challenges in Myanmar’s transition period, including those related to political transition as well as a humanitarian crisis escalating to an international human rights issue in August 2017 in Rakhine. It has been throughout this period that the Ministry of Health and Sports has embarked on health sector reforms, and thus the flexibility of the 3MDG Fund Management Office in adapting to changing context and needs during this period has been vital in maintaining relevance and value.

Ensuring central level buy-in and engagement is key to success in health systems strengthening. Introducing new approaches and establishing a new system at central ministerial level is challenging. Supporting learning visits and participation in international conferences was valuable and helped to overcome the challenges by sharing other countries experiences, enhancing their commitment and awareness for implementation. It also provides a more open environment to learn new things.

The Ministry of Health and Sports has spending units spread all over the country, and timely and accurate reporting from the frontline units to the union level on a regular basis has always been a challenge in a system solely reliant on paper. The end result is that budget execution is compiled with a six months lag, meaning it is too late to analyze expenses against budgets. The World Bank advocated to the Ministry of Health and Sports to introduce an electronic recording and reporting system. Design of the template was based on the government system. In 2018, trainings to introduce the templates were conducted over three months with key staff from all 330 townships and 17 states and regions from the Department of Public Health, Department of Medical Services and other departments. The training focused on the template, but also on basic Excel literacy and refresher on the government accounting, recording and reporting system. Assistance will continue in 2019.

The Ministry of Health and Sports has also launched a bid to begin the process of rolling out a Health Information System and DHIS2 and data quality improvements. The Ministry of Health and Sports will continue to support the development of the newly introduced State Health Plans and Inclusive Township Health Plans (ITHP) and capacity building of Working Groups to improve health planning. The Fund will also – for the first time – give grants directly to state health departments for health system strengthening.

In human resources for health, Access to Health will support the capacity development of the recently established Central Human Resources for Health Unit under the Ministry of Health and Sports. A forecasting model will be developed using the comprehensive Human Resources for Health Implementation and Planning System Accreditation systems that were developed under 3MDG will be rolled out under Access to Health. Capacity building of health staff and faculty will continue.

Service delivery support in terms of health systems strengthening will include the development, dissemination and revision of standard operating procedures to deliver the Basic Essential Package of Health Services which contains both public health and medical services. There will also be some infrastructure support in the construction of rural health centres, Sittwe General Hospital and health facilities at Mandalay Prison.

It is crucial that support to health information continues and is strengthened, as this is necessary for service prioritization, planning and resourcing. Access to Health will support evidence generation for the National Health Plan, including the development and implementation of health systems strengthening research agenda; development and implementation of human resource information system for priority health cadres (made available to the central and state and regional level to inform health workforce planning), trainings for Health Management Information System and DHIS2 and data quality improvements.

Support in supply chain management, through defined essential medicine and equipment list and health facility assessments, will continue. Strategic purchasing pilots will provide evidence to health financing models – and, the new health financing strategy will be rolled out and supported. Access to Health Fund will also seek potential areas to invest in innovations and digital communications for health that can scale, providing breakthrough solutions to respond to unmet health needs of vulnerable populations and improve health outcomes.

THE WAY FORWARD

Support to the coordination and monitoring of the National Health Plan 2017-2021 at central, regional and township level will continue through NIMU. Access to Health will also support the development of the newly introduced State Health Plans and Inclusive Township Health Plans (ITHP) and capacity building of Working Groups to improve health planning. The Fund will also – for the first time – give grants directly to state health departments for health system strengthening.

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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 Fund promotes 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 four funds are sharing facilities, procedures and standards. At the same time, increased knowledge, standardized procedures and greater transparency.

Access to Health Fund will contribute to improving equity and inclusiveness, aligned with and in support of the National Health Plan and the Ministry of Health and Sports.

The Fund has received USD 330.40 million in disbursements from contributing donors since its inception, including interest earned. 3MDG delivered around USD 308.43 million in the period 2012–2018, out of which US$ 276.34 million has been used for programme activities and US$ 32.09 million for programme management.

There are a number of areas of funding in the table below: maternal, newborn and child health, health systems strengthening, tuberculosis, malaria, HIV, integrated HIV, TB and malaria, and procurement for maternal, newborn and child health and HIV, TB and malaria for 2018. Activities to promote sexual and reproductive health and rights, such as family planning, adolescent health education and post-abortion care, are included under the maternal, newborn and child health component. The budget for these activities over the 3MDG Fund lifetime was about US$ 15.2 million.

Funding Breakdown by Component in Programme Implementation

US$ 276.4 million under the 3MDG Fund (2012 - 2018)

- Maternal, newborn and child health
- Health System Strengthening
- Tuberculosis
- Malaria
- HIV
- Integrated HIV, TB and Malaria
- Procurement MNCH & ATM 2018

DONOR CONTRIBUTION AS AT 31 DEC 2018

<table>
<thead>
<tr>
<th></th>
<th>Contributions Received</th>
<th>Million USD</th>
<th>% of total contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department for International Development (UK)</td>
<td>175.3</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>48.2</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>European Commission</td>
<td>31.4</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Sweden</td>
<td>37.8</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Denmark</td>
<td>9.2</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Swiss Agency for Development and Cooperation</td>
<td>13.2</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>USAID</td>
<td>8.6</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Three Diseases Fund (3DF) Rollover</td>
<td>2.1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Joint Initiative for Maternal, Newborn and Child Health (JIMNCH) Rollover</td>
<td>1.6</td>
<td>0.5%</td>
<td></td>
</tr>
<tr>
<td>Total donor’s contribution</td>
<td>327.5</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Interest &amp; Income earned</td>
<td>2.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>330.4</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

ANNUAL AUDIT FOR THE 2017 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. All Fund Management Office Audit reports are published on the UNOPS website and are accessible to the public.

An annual audit of expenditure for the 2017 financial year was conducted on the Fund Manager. The audit report for the Fund Management Office listed three medium priority audit recommendations on the functional areas of finance and human resources. A management action has been implemented already.

3MDG also conducts yearly audits on implementing partners. In 2017, the auditors identified 131 observations, of which 2 were high impact and 88 were considered as medium impact.

Only 8 medium impact recommendations remain from prior years 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 audit is to serve as an opportunity to build capacity of implementation partners and ensure continuous improvement.

In 2019, the final audit will be conducted on the Fund Management Office and implementing partners for the 2018 financial year.

DONOR CONTRIBUTION AS AT 31 DEC 2018 (PRELIMINARY)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Expenditures (Million USD)</th>
<th>% of total expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Programme Implementation</td>
<td>276.34</td>
<td>90%</td>
</tr>
<tr>
<td>1.1 Component 1 Maternal, newborn and child health (MNCH) (including sexual and reproductive health and rights)</td>
<td>113.89</td>
<td>37%</td>
</tr>
<tr>
<td>1.2 Component 2 HIV, TB and Malaria (ATM)</td>
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<tr>
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3MDG was a learning organization. The next pages document our top 10 lessons learned over the lifetime of the Fund. The Fund will build on these lessons as the Access to Health Fund is implemented.
ACCESS: ONE-OFF SOLUTIONS CAN HELP, BUT PARTNERS NEED TO ADVOCATE TO CREATE MORE SPACE FOR HEALTH SERVICES

Limited access to certain areas for health staff and implementing partners is one of the most pressing issues facing health in Myanmar. Access can be gained by local actors coming together, despite their own politics, to find creative and cooperative solutions to meeting the health needs of their communities. This shows the potential for health to create positive dialogue between groups with difficult histories and the importance of working at the grassroots to facilitate access. In Myanmar, however, this is not enough on its own. There are some hurdles that local actors cannot overcome. Development and humanitarian partners, including the Access to Health Fund, must do more to advocate for increased space and access for health care.

SITUATION

Myanmar has been ravaged by conflict for upwards of 60 years. Conflict can flare up at different times, and control of territory is fraught. Some parts of the country are under government control, while other parts are under control by ethnic armed groups. In some areas control is mixed, which can be confusing for the people who live there.

Government health staff can often not access non-government controlled areas. In their place, ethnic health organizations, Special Regions health authorities and social development organizations have emerged to provide care for the people who live beyond the reach of the government. These organizations often have limited resources, and coordination and collaboration with higher levels of the health system can be weak in some cases. Referral mechanisms are weak, trust between the government and non-government providers is low, and patients may be very reluctant to seek health care from the government, even in areas of mixed control. Security of staff is a huge issue, as is the safety of people travelling to and from health facilities. It is difficult for staff, medical supplies and equipment to reach places where there is active conflict. This can mean that health outcomes in these areas are worse than other parts of Myanmar.

While this broadly summarizes the challenges, at the ground level situations can differ from location to location. In Northern Shan State, frequent armed clashes between groups in some townships forced the reprogramming of activities due to restricted access. Health care was only available from local providers who may be unable to provide regular care, and lack proper equipment and medicines.

Access in Rakhaing state has worsened substantially since August 2017. The displacement of nearly one million Rohingya and other ethnic groups, violence perpetrated against all communities, and the inability for many Muslims to access healthcare in segregated facilities or within camps makes the achievement of good health outcomes almost impossible in the state.

Access can also be an issue outside of conflict situations. Areas that are extremely remote, or affected by natural disasters, such as parts of Chin or Ayearyawady, may also be hard for health workers to reach – requiring hours or even days of difficult travel.

RESPONSE

3MDG implementing partners have responded in different ways to these challenges at the ground level, examples are outlined below. Fragmentation of the health system means that access requires negotiation with multiple actors and rapid response to constantly changing contexts. However, these efforts must not stand alone. They must be supplemented by advocacy at the highest levels, continuing to push the message that access to health is a human right. Development and humanitarian partners must use their platform to expose the impact that limited access to health care has on the population in many parts of Myanmar.

Increasing Access Through Strengthening Partnerships At The Ground Level

In Hlaingbwe and Hpapun in Kayin, 3MDG implementing partner Myanmar Health Assistant Association (MHAA) saw that access to malaria testing and treatment was limited in non-government controlled areas. They began to call for regular coordination meetings and invited all stakeholders, including township health departments and health providers from non-government controlled areas. Holding regular coordination meetings may seem simple, and in many places they are. However, in some conflict-affected and non-government controlled areas, meetings did not previously take place at all, even though they are critical to widening access for health. In Hlaingbwe and Hpapun, malaria activities could not have continued without these meetings and indeed, as malaria moves towards elimination, this sort of access will be critical to reaching those under-served populations who are ‘the last mile.’

MHAA also worked with Community Partners International (CPI) to implement project activities. CPI have important experience in bringing together different health providers to ensure continued service delivery, even in the most complex contexts. They work in a non-political, judgement-free way that can foster collaboration between partners who may otherwise find it difficult to work together.

In Northern Shan State, trust in services was low, and it was already extremely difficult to get access and provide care. Escalating conflict worsened the situation, threatening access to vital Harm Reduction services provided by Myanmar Anti-Narcotic Association (MANA). People who used drugs went into hiding because they feared forced rehabilitation or recruitment into armed groups.

Ensuring Access at Community Level

Access is a two-way street: even when providers are able to work in certain areas, community access to services is not guaranteed. People may live remotely, transport may be expensive, or they lack trust in health providers or the system.

As part of the 3MDG Collective Voices initiative, barriers to health were explored with community members, in more than 500 ‘participatory learning and action’ meetings in villages across Myanmar. Demand-side barriers included lack of health awareness, migration and mobility, low education level, lack of trust and poor expectations, transportation, language, financial barriers, gender-related constraints, and cultural preferences including attitudes and social norms that limit knowledge sharing. Supply-side barriers including accessibility to service location, availability of health workers and volunteers, drugs and equipment, inability of cost sharing by service providers, staff motivation and poor interpersonal skills.

In the second stage of the project, from 2016-2017, 3MDG supported villages to overcome some of these barriers. Interventions included:

- Building up local health structures, including building organizational capacity of local organizations, and revitalizing village health committees and working groups
- Helping to establish community-managed village health funds to support the cost of care
- Health education and information activities, especially in local language
- Recruitment and capacity development of women health promoters
- Increasing women’s representation in health committees and peer and self-help groups
- Installing context-appropriate community feedback mechanisms to hear from the community, address their concerns, and where appropriate, make project adjustments
- Building trust between community members and health workers through joint information exchange meetings

In the third stage of the project, in 2018, projects that were complementary to 3MDG service delivery grants in Shan, Chin, Kayin, and Mon states aimed to improved linkages between health systems and communities.
MANA realized that they needed support from local organizations who could capitalize on their existing relationships, shared language and history, to improve access. They worked with Shan State Youth Capacity Building Centre (SSYCBC), who have relationships with local armed groups and could convince them of the importance of continuity of Harm Reduction services. MANA provided technical support to SSYCBC in their advocacy activities at the ground level, and was then able to regain access and provide services in previously inaccessible areas.

Supporting Those Who Do Have Access
3MDG and partners recognized that in areas where access challenges were intractable, the best solution was to work with those who already had access. These organizations, however, do not always have the resources or capacity to meet the health needs of the community. 3MDG partners worked to address that. For example, in Kayin State, when floods and security impacted access, an innovative solution was hatched. Buffer stocks were provided in advance for areas unreachable in the rainy season, and implementing partner staff made arrangements to meet with village health workers at so-called ‘kissing points’ – places that were accessible to both sides – to transfer medical supplies, data and provide other support.

Health Poverty Action worked in Wa Special Region and Special Region 4 to train health providers in national standards in basic obstetric care and cold chain and improve immunization planning. In Mawkmai and Laihka in Southern Shan State, Relief International supported ethnic health workers at so-called ‘kissing points’ – places that flood and security impacted access, an innovative solution worked to address that. For example, in Kayin State, when floods and security impacted access, an innovative solution was hatched. Buffer stocks were provided in advance for areas unreachable in the rainy season, and implementing partner staff made arrangements to meet with village health workers at so-called ‘kissing points’ – places that were accessible to both sides – to transfer medical supplies, data and provide other support.

Advocating For More Access
In some areas, partners were unable to find solutions, despite their best efforts. In Raikhine for example, access remains an enormous challenge that appears to be worsening. 3MDG and partner staff regularly discussed the access situation with the State and township health departments, and continued to file travel approval documentation regularly. To build relationships and increase the chance of access being granted, 3MDG and partners held meetings to explain 3MDG’s approach, and how the Fund can support the realization of health access for all populations. This established relationship with the State Health Department made it possible to advocate for cross-township referrals when it became clear that Muslim populations could only access health care in some townships. With the approval of this initiative, patients could be transferred to a location where they could access the treatment they needed.

Nevertheless, at the end of the 3MDG Fund and into the Access to Health Fund, the space to deliver health services in Raikhine State is still at an acceptably low levels. There are many townships which are completely closed to health providers, and places where Muslim populations are still unable to access the care they need. This demonstrates that though efforts on-the-ground can incrementally improve access, there are still places and populations that are unreachable, and the set of services provided is limited.

Access to healthcare is a human right which is currently unavailable to large parts of Myanmar’s population. This cannot stand. All development and humanitarian partners must leverage their influence to advocate for those people who live in areas where health workers cannot reach them. At the same time, important practical solutions on the ground must continue. Health service delivery has been shown to act as a bridge for partners and stakeholders to come together to find solutions and restore, maintain and increase access. Implementing partners are important intermediaries in this work.

SITUATION

Myanmar is conflict-affected, and amongst the most prone in the world to natural disaster, especially floods and storms. Organizations dedicated to emergency response are stretched thin considering the complex and widespread situations in which they are needed and limited resourcing they have. When there is a disaster, they respond rapidly but may also be able to stay very long.

In the provision of health care, as well as other community-based work, trust and relationship building is important, and humanitarian partners can be best supported by organizations who work in these communities long-term. 3MDG partners were in a position to provide this sort of support, but did not necessarily have the training or budget required. This is especially true for smaller, local partners.

RESPONSE

Recognizing the potential value but limited capacity of local health partners in emergency preparedness and response, 3MDG designed an initiative together with the Humanitarian Assistance and Resilience Programme Facility (HARP-F), a UK Department for International Development (DFID)-funded humanitarian relief organization, in 2017. HARP-F provided training to a selection of national organizations to improve their emergency preparedness and develop emergency preparedness plans. This training also registered organizations so they were eligible to apply for emergency rapid grants from HARP if and when needed. 3MDG partners could also apply to the Fund Management Office for contingency budgeting if they needed it in emergencies.

In July 2018, there was a flood in Kayin and Tanintharyi, that had a severe impact on people living in the area by inhibiting community access to basic services, such as food and sanitation. The flood affected villages covered by Community Partners International (CPI) with 3MDG financing. After discussion between the Fund Management Office, CPI, and other implementing partners, it was decided that Myanmar Health Assistant Association (MHAA) and Community Driven Development and Capacity Enhancement Team (CDDCET) would provide emergency response to affected villages. Partners were linked up with HARP-F who provided technical support. Funding was provided via 3MDG’s contingency budgeting allowance.

CPI, coordinated with ethnic health organizations to distribute food items, non-food items, micro-nutrient supplementation, hygiene items and health services to 21 villages in Hpa’an Township with Karen Baptist Convention and five villages in Tanintharyi Region with Karen Department of Health and Welfare. CDDCET, and their partner community-based organizations, also responded to the flood by distributing food and non-food items to the affected 1,255 households from 13 villages in Hpa’an and 1,658 households from 12 villages in Hlaingbye. The activities demonstrated the value of local organizations’ involvement. When the emergency response is over, they are able to seamlessly return to normal programming in the same areas, and ideally, this also means that more health services can be maintained throughout an emergency too.

Contingency funding will continue in the Access to Health Fund. It has been made clear to partners that these resources are available and should be used to respond in emergencies. Training in emergency preparedness will also continue via HARP-F. Due to the nature of its work in conflict-affected and disaster prone areas, Access to Health Fund must work to build community preparedness through shock proofing and improve the resilience of the health system more broadly.

3MDG PARTNERS WERE POSITIONED WELL FOR EMERGENCY RESPONSE, BUT NEED MORE TRAINING IN PREPAREDNESS
PARTNERS NEED MORE THAN ‘CONFLICT SENSITIVITY’ TO MAINTAIN SERVICES WHEN CONFLICT BREAKS OUT

Outbreak of conflict can severely hamper the delivery of health services. 3MDG partners, and the Fund Management Office, did not always have the experience or expertise to know how to respond. Having a conflict sensitivity strategy is a good first step, but it needs to be sufficiently mainstreamed and translated into practical, specific actions at the ground level. Technical support was provided by Community Development Association and RAFT in the later years of the Fund. Financing was made available by way of contingency budgeting. Similar support that is actually funded, practical, implementable and solution-based will continue in the Access to Health Fund.

SITUATION

Large parts of Myanmar continue to be affected by active or latent conflict. When active conflict breaks out, it is not easy to deliver care as the safety of health personnel cannot be guaranteed, access may be restricted, and health seeking behaviour may diminish as travel is avoided. During the lifetime of 3MDG, when conflict broke out or worsened it revealed that partners had varying experience and capacity in coping with conflict situations and continuing to deliver health services. For example, in Northern Shan in 2017, transport and restricted access meant that partners struggled to deliver the planned health care and community health needs were not met.

RESPONSE

The expansion of the Fund’s activities towards conflict-affected and non-government controlled areas, and growing pockets of instability meant that 3MDG and partners needed to improve their understanding of how to work in these sorts of situations. At the time within the Fund Management Office, conflict-sensitivity work was managed vertically, primarily within one team. This needed to change, and conflict-sensitivity needed to be more effectively mainstreamed so that all programme and monitoring and evaluation staff could monitor the implementation of conflict-sensitive activities. This could happen more effectively in 2017 after the Fund Management Office was restructured into state and regional teams. Team members could learn the general principles of conflict-sensitivity, and then apply them to the specific contexts in which they worked.

At implementation level, the conflict framework and approaches that governed partner activities were reviewed and realigned by technical agency called Community Development Association (CDA) in 2017. The framework was found to adhere to international best practices related to ‘do no harm’, including conflict-sensitivity principles. However, partners needed more support in what to do on-the-ground in different situations. Technical support was provided to rectify this situation.

For example, active conflict in 2018 in Kachin State caused transportation difficulties, security problems and displacement of people. Partners had not necessarily dealt with this situation before, so they reached out to the Fund Management Office and technical advisors for support. The group discussed coping strategies to ensure that the maximum amount of health care could still be provided through a mix of service continuity and specific emergency response. In Sumprabum, Community Partners International did specific emergency response activities together with the Kachin Baptist Convention (KBC). This included the distribution of food and non-food items for two camps in non-government controlled areas. KBC also provided medical commodities and facilitated hospital referrals.

Health Poverty Action, also in Kachin, had limited access due to poor transportation during the conflict. They adapted their approach through coordination with the State Health Department, township medical officers and health staff to provide more referral support, including from three internally displaced person camps to the hospital. Training support was provided to new auxiliary midwives, community health workers, and ethnic health ‘vaccinators’. Partners applied for funding from 3MDG, made available via contingency budgeting. This budget line will continue in the Access to Health Fund, and through more communication with partners about its availability, its use will ideally increase.

These experiences make clear that technical support was crucial for 3MDG partners working in conflict-affected areas. Strategies need to be translated into practical steps which aim to maintain access and as much health service delivery as possible. Availability of extra financing is also an important aspect of this work, helping partners to respond to needs on the ground.

WITH THE RIGHT SUPPORT, THE MINISTRY OF HEALTH AND SPORTS CAN FIND SOLUTIONS TO THEIR TOUGHEST CHALLENGES

For many years, 3MDG and other development partners have worked to build a trusting, open relationship with the Ministry of Health and Sports. This groundwork, alongside the Ministry’s recent maturation and willingness to change, has meant that new innovative initiatives can be trialed and the envelope can be pushed. Policies and plans being developed are formulated in a more inclusive way, with more focus on important cross-cutting themes, and the Ministry is more willing to include new concepts and ideas in their work. Large bureaucracies can take time to change, but the Ministry is demonstrating that with the right approach and the right support, they are ready and willing to make necessary changes.

SITUATION

During the lifetime of the 3MDG Fund, Myanmar underwent positive changes as the country began to transition away from a military dictatorship, and the peace process began. In the health sector, the country’s budget multiplied nearly nine times - although it was from a very low base. However, conflict continued to rage and the devastating deterioration in Rakhine State restricted access to basic services for many people in the State. Human resources for health, service delivery, information systems and supply chain remained weak, leaving healthcare out-of-reach for many.

RESPONSE

Despite challenges, the Ministry of Health and Sports provided cause to be optimistic about the future of Myanmar’s healthcare system - with commitments to achieving universal health coverage by 2030 now publicly announced, with an approach in the National Health Plan 2017 – 2021 that is explicitly pro-poor and pledges to leave no-one behind. Behind the scenes, the Ministry has reviewed and restructured to gain efficiency and to prioritize areas of weakness. They have been more willing to self-critique and look towards continual improvement, innovation and growth.

For example, in 2017 3MDG approached the Ministry with concerns about the poor standardization of community-based health workers. At that time, community-based health workers received different trainings and incentives, and were of vastly different capacity and quality. As the front-line of Myanmar’s health response, these failings to systematize and coordinate the volunteer workforce meant that community health needs were not being met. More significantly, as these workers are often in the most remote and difficult to access areas, their inability to meet community health needs threatens the achievement of universal health coverage and the eradication of non-communicable diseases.

In response, 3MDG took to the Ministry of Health and Sports an assessment of the situation and proposed that the Ministry develop a ‘Community-Based Health Worker Policy’ which would address problems faced by the workforce. After a nearly two-year process, led by the Ministry of Health and Sports and with support from 3MDG, a policy is being put in place to support health workers. This was due in part to the trust built between the Ministry and 3MDG, the inclusive and consultative process design from the 3MDG teams working on the project, and the Ministry’s openness to change and overall enthusiasm for growth. This exemplifies that with the right approach from partners, the Ministry is open to taking risks and pushing traditional boundaries in an effort to achieve better healthcare.

The Ministry’s maturation is also evident in the formulation of the National Health Plan, which in this renewed display includes direct reference to concepts like accountability, equity, and inclusion – thanks in part to 3MDG and other partners advocacy on these themes. The Ministry also launched for the first time a community engagement manual, with 3MDG support. These concepts were previously not prioritized, and as such their inclusion should be welcomed as a sign of a new, more inclusive and effective way to support health workers. This was due in part to the trust built between the Ministry and 3MDG, the inclusive and consultative process design from the 3MDG teams working on the project, and the Ministry’s openness to change and overall enthusiasm for growth. This exemplifies that with the right approach from partners, the Ministry is open to taking risks and pushing traditional boundaries in an effort to achieve better healthcare.

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TO PROVIDE SERVICES TO PEOPLE WHO USE DRUGS, ACTIVITIES TO OVERCOME BARRIERS ARE NEEDED AT ALL LEVELS

Providing care to people who use drugs is enormously challenging, and access to services is limited by community resistance, stigma and discrimination, limited resources in public settings, and fear of the police by people who use drugs. These challenges cannot be tackled at only one level – there are many changes needed: from policy reform in Nay Pyi Taw to working with communities and community leaders to help them understand Harm Reduction services, drug dependency, and rights-based approaches.

SITUATION

Providing services to people who use drugs is an area of work which faces monumental challenges in Myanmar. Community resistance to services is common, and can even extend to health workers. Some treatment facilities may use methods – such as ‘cold turkey’ or even imprisonment and beatings – which do not work and are detrimental to the realization of human rights. Vigilante groups, such as the Pat Ja San, have been known to threaten people who use drugs and care providers.

Limited resources limit the availability of treatment, rehabilitation and social reintegration programmes in the public sector. Linkages to effective treatments, such as methadone maintenance therapy (IMT) for drug dependency, and anti-retrovirals (ART) for HIV, are weak, or centres are too far away or don’t have enough staff.

People who use drugs – men or women – may fear discovery by the police who still treat them as criminals – more than 50% of people in prisons are incarcerated for reasons related to drugs. Health service availability in prisons is weak. The group may themselves be highly mobile and thus difficult to target and reach with services, and in particular, the number of women accessing services provided by 3MDG partners was low.

RESPONSE

The response from 3MDG to these multifaceted challenges has been focused on expanding access, and reducing stigma and resistance to services. This has happened at all levels.

Creating an Enabling Environment

UNAIDS in collaboration with United Nations Office on Drugs and Crime (UNODC) and World Health Organization (WHO), undertook a five-year advocacy project to address policy, legal and social barriers and expand and improve HIV prevention for people who inject drugs, people engaged in sex work, men who have sex with men, and transgender people in Myanmar. They worked with high-level officials from ministries, parliament and civil society for policy reform and creating an enabling environment for the delivery of health care for vulnerable groups. Certain sections of policies were removed or amended if they were particularly restrictive or damaging to the realization of rights for these groups, and for their access to care and support.

For example, in the 1993 Drug Law, the compulsory registration of people who use drugs was removed, and alternatives to imprisonment for people who use drugs was introduced, such as treatment, rehabilitation and community services. A set of Standard Operating Procedures on health care in prisons, and a new National Drug Control Policy were also jointly developed by the Ministry of Home Affairs and Ministry of Health and Sports, supported by UNODC.

Advocacy at Community Level

A community-level advocacy project was added in 2015 in recognition that the vigilante actions of groups like the Pat Ja San were severely impacting service delivery. It was implemented by Metta, with technical support from Medecines du Monde. As a result, acceptance and support for Harm Reduction interventions by local communities has improved. Even groups that were the most opposed to health care provided to people who use drugs, such as the Pat Ja San, were referring clients to 3MDG partner run drop-in centres and services by the end of the project in 2018.

Improving Existing Services

Community-based drug treatment camps do not usually adopt a Harm Reduction approach. Instead, they often force people who use drugs to go ‘cold turkey’ or use punishment as a deterrent. Patients are often enrolled against their wishes, the success rate is very low, and other basic health needs are rarely met. However, as the facilities appear to be here to stay for now, one partner decided to work with camp leaders to make changes and improvements.

First, the partner built a trusting relationship with camp leaders, and then introduced concepts around Harm Reduction and a rights-based approach to care. After months of advocacy work, the end result was that counselling and testing for HIV, Hepatitis B and C, vaccination, primary health care and referral services were provided. The surrounding community also better understood the importance of Harm Reduction services.

Despite immense challenges, 3MDG’s Harm Reduction programme could reach populations in need because it tackled barriers at all levels. Health staff and employees at drop-in centres and outreach worked with their surrounding communities to help them understand why the centres and services are important, and why Harm Reduction is the right approach. Building an enabling environment through policy reform creates the space and legal framework for health workers to provide care. Advocacy to government should be strengthened in the future, calling on the Ministry of Health and Sports to meet its responsibility in providing care to this group: there is the risk that services become solely provided through private providers.

Reaching People Who Use Drugs

Important interventions from partners that increased access to services at the community level:

Women: Gender-sensitive programming was added in response to figures which demonstrated that women who used drugs (and intimate partners of people who use drugs) were accessing services at a lower rate than men. One implementing partner has been providing women-focused prevention and care services through a women-only drop-in centre since 2014. Women outreach workers could provide prevention services for women clients who cannot access the drop-in centre.

Health services and income generation activities were offered to help women clients reintegrate into society.

Youth: The prevalence of using Amphetamine Type Stimulant among young people has increased in recent years – and with it, an increase in risky sexual practices. Adolescent-targeted activities have been included prevent drug use and HIV infection among youths. Myanmar Medical Association (MMA) were also funded by the 3MDG to train Harm Reduction implementing partners in adolescent sexual and reproductive health.

Integration: People who use drugs may be reluctant to visit standard health care services due to stigma, so services and commodities offered at drop-in centres were expanded – by Asian Harm Reduction Network (AHRN) since the start of 3MDG, and by all other Harm Reduction partners in 2018. The package of services on offer thus included comprehensive harm reduction services, as well as malaria screening and treatment, and condom programming. Innovative service delivery methods, such as mobile clinics for HIV testing, and community volunteers conducting HIV testing too, meant services were more accessible for this highly mobile population.

Peer Networks: Initially, former people who use drugs were only recruited for collecting needles – not for outreach. However, it was clear from representative groups for people who use and inject drugs that more meaningful participation of peers in the programme was necessary to reach the right people, as they already had trust and networks in the community.

In Mandalay, Myanmar Anti-Narcotic Association used peers to locate and approach mobile and hard-to-reach groups, and provide health education in a safe, welcoming manner. AHRN used peers in Kachin to facilitate outreach and to offer ‘buddy care’ to promote the use of referral and to encourage adherence to Methadone Maintenance Therapy. This was unique because it went beyond outreach into care and supportive services.
INTEGRATING SERVICES ENABLES A CONTINUUM OF CARE TO BE DELIVERED

When many people lack access to even the most basic care and health staff have difficulties in reaching all populations, it is important to maximize the amount of health care that can be delivered – per project, per health care worker, per volunteer, per dollar. An integrated approach, which addresses the ‘continuum of care’ is an approach that may be able to achieve this, however it is important not to stretch health workers beyond their capacity, especially in remote areas where limited support or supervision may be a challenge and health staff may not be able to live up to community expectations.

SITUATION

In Myanmar, fragmentation of the health system has resulted in health workers and volunteers who only offer a limited set of services. This can also result from donor and development partner priorities driving activities, especially if they are focused on specific diseases or are not well-aligned to the Ministry of Health and Sports. Fragmentation at all levels can also contribute to services that are not delivered in a comprehensive way, and thus do not meet the ‘continuum of care’ approach.

There is also a high reliance on volunteers in Myanmar’s health workforce, who may be unable to go beyond one set of interventions because their training is very limited. This may make them unable to meet community health needs, and people living in those communities then need to travel long distances for extra health services, pay extra costs for transport, or go without care.

Continuum of Care is a concept involving a system that guides and tracks patients over time through a comprehensive array of health services spanning all levels and intensity of care. The Continuum of Care covers the delivery of healthcare over a period of time, and may refer to care provided from birth to end of life. [Source: HIMSS]

At the same time, Myanmar has committed to achieving universal health coverage by 2030. To achieve this goal, in a manner that is equitable, resource-friendly and manageable, the plan outlined in the National Health Plan 2017-2021 is to first make available a Basic Package of Essential Services for the whole country. This set of services will then be gradually expanded as the financing available for health increases. However, the delivery of this package of services is challenged by system fragmentation, and a large part of the health system only delivering very limited interventions. A cost-effective approach dictates moving away from this vertical approach towards more comprehensive service delivery.

RESPONSE

Better integrating health services is vital to meeting the health needs of communities and delivering a ‘continuum of care’. 3MDG tried to improve the integration of health services in a number of ways.

An internal restructure of the Fund Management Office in 2017 removed the vertical disease-specific teams, and replaced them with geographic teams. This meant contextual challenges could be better accounted for, and health service delivery could move towards comprehensiveness according to local needs.

More health interventions being available from a single facility or health worker, as well as their ability to refer between the health system was also included in 3MDG programme design. This was most explicit in 2018, when integration as an approach was piloted across all the work of the Fund, but there were a number of integration efforts before this. For example, basic health services began to be included alongside Harm Reduction, in recognition that people who use drugs are stigmatized and unlikely to visit other health service providers. The co-burden of TB and diabetes lead to the availability of TB testing and referral at diabetes clinics.

Community Partners International (CPI) changed their approach under the Better Health Together initiative. At the start, only malaria testing and treatment were included. In 2017, TB referral and ‘Directly Observed Treatment’ (DOTS) were added, and then full integration followed in 2018. Activities included awareness-raising and health education around safe motherhood, family planning, and services for diarrhoea, acute respiratory infections, and hypertension.

Changing how community-based health workers operated was also targeted as they are one reason for non-integrated approaches being prevalent. Malaria volunteers have done a tremendous job at moving Myanmar closer to malaria elimination stage – but as prevalence of the disease began to drastically dip, their skills were underutilized and their pay reduced if they received incentives based on number of tests or positive cases. Many began to look for new work. By giving them new skills as part of the ‘Integrated Community Malaria Volunteer’ (ICMV) model, they could maintain motivation, a steady income, and provide extra services, such as treatment of pneumonia and diarrhoea amongst children. They learnt how to treat minor cases, and refer when necessary. They could maintain good motivation, as their skills expanded, they could earn an income and they could be useful for their communities. This approach also has the potential to reduce attrition rates of volunteers.

In Chin State, even though the integration approach had a delayed start due to Lack of Ministry approval and the chosen villages were very hard-to-reach, the achievements were impressive. Case finding and detection rates were satisfactory for the whole year, even though it only started in the second semester. The township health departments were also impressed with the programme due to smooth reporting to the state health department, comprehensive support for tuberculosis activities, and good coordination.

Though there are many positives, there are also challenges with an integrated approach for projects and for individual volunteers. For some partners, who struggle to meet targets in areas where implementation is difficult, being given more areas of responsibility has proven challenging. If services are too advanced for local organizations, and therefore can only be delivered by larger organizations who lack access, this removes rather than improves health access. Integration may also mean that if the delivery partner does not have access, the community has no health service provision at all (rather than having at least some interventions). Similarly, volunteers may feel overwhelmed by the addition of new responsibilities, and over-reliance on them may lead to poorer health outcomes. This highlights the importance of building the capacity of volunteers and local organizations to deliver as many integrated services as they can, without overwhelming their resources.

Integration will be carried forward into Access to Health as a better model to support the governments’ aim to deliver the Basic Essential Package of Health Services on the road to universal health coverage.
FLEXIBILITY IS NECESSARY TO ADJUST TO A CHANGING COUNTRY AND NEW ROLE

Within a rapidly changing context, having flexibility and responsiveness helps an organization maintain its relevance. For 3MDG, the biggest change was a shifting role within Myanmar’s health system. 3MDG went from supporting a substantial part of the health budget, to just accounting for a small fraction of it. This, combined with the Ministry’s growing ability to take more responsibility for health service delivery in areas they could access, meant 3MDG had to transition into an organization that filled gaps, piloted new approaches, and worked in areas outside of government control. Without this ability to adapt, 3MDG would have stood in the way of the Ministry taking responsibility for the health of the people of Myanmar.

SITUATION

Myanmar is a country that has recently opened to the outside world, and is in the midst of a transition from military dictatorship to democracy. The number of donors in the country has increased, the space for health interventions has grown, and opportunities to work with the government have now more evident. Funding available for health in the country – both from domestic sources and the international aid community – has increased during the years of the Fund. While this has created opportunities for the Ministry, it has also led 3MDG to shift its role from being a large contributor to the health budget to a relatively smaller actor.

RESPONSE

In the face of this changing context, with a Ministry that was more capable of addressing the health needs of many of its people, 3MDG needed to re-strategize. The role of the Fund became more targeted, and moved towards catalyzing important changes in the sector. The ‘added value’ of the Fund needed to be re-established whilst retaining alignment to broader government priorities.

First, a strategic review of the 3MDG Fund in 2014 suggested there was a greater role for the Ministry of Health and Sports to play in determining the direction of the Fund. They were added as an official board member in early 2015, cementing their role in providing guidance to the Fund, and ensuring alignment.

Next, more emphasis was given to sustainable approaches and transitioning activities where possible to the government. In 2017, for example, maternal, newborn and child health projects in Ayeyarwady and Magway were transitioned almost entirely to the government with limited implementing partner support following strong results over a number of years. Emergency referrals continued to be supported in both regions, but a new approach was trialled which could be more successfully transitioned to government due to its improved standardization and lower costs.

Operational research and piloting of new approaches also became more central to the Fund’s work. For example, in Yangon and in ethnic health organization areas, partners (Population Services International and Community Partners International) piloted strategic purchasing projects, which trialled new approaches to paying for health services. These projects were set-up to provide important inputs to the Ministry of Health and Sports Health Financing Strategy.

The Fund also began to work more extensively, from 2015 onwards, in conflict-affected and non-government controlled areas such as the Special Regions. This was in recognition that they are inaccessible to government health providers and remain a serious gap due to the limited capacity of health providers responsible for these areas.

Within this new space, 3MDG has a vital role to play in the coordination of health services and health service providers. 3MDG can bring together actors around health, through supporting forums such as the Shan State Health Forum, as well as regular coordination meetings between the Ministry of Health and Sports and ethnic health organizations, Ministry of Health and Sports and community, and Ministry of Health and Sports and private providers.

Carrying Forward Changes Into Access To Health

The Access to Health Fund was designed in recognition of the growing strength of the Ministry of Health and Sports. This is reflected in the increasing number of direct grants from Access to Health to central level departments. While 3MDG provided three direct grants, Access to Health will provide six direct grants to Ministry of Health and Sports: National Tuberculosis Programme, National Nutrition Centre, Child Health Division, Maternal and Reproductive Health Division, National Health Plan Implementation Monitoring Unit, National AIDS Programme/Drug Dependency Treatment and Research Unit. Direct grants are being provided to the state health departments for the first time.

However, continuing gaps in some areas and for some populations, including conflict-affected areas and non-government controlled areas, means that priority will be given to reaching these vulnerable, hard-to-reach populations. Access to Health Fund partners will help strengthen ethnic health organizations, improve linkages between different parts of the health system and foster standardization between government and non-government providers. The Ministry of Health and Sports to address its most significant weaknesses in human resources, health financing, and health information systems, ensuring that services reach those who are at risk of being left behind as the country moves towards universal health coverage.

The Fund can still play a greater role in innovative approaches in healthcare. A portion of the Access to Health Fund’s budget has been put aside to invest in innovations and digital communications for health that can scale breakthrough solutions to respond to unmet health needs of vulnerable populations and improve health outcomes.

Rapidly Developing Human Resources in Myanmar

Myanmar has significantly developed its human resources over the past ten years. More professionals are gaining experience in Myanmar and overseas in the area of public health but also more broadly across a range of professions: finance, communications, and management. This, combined with the increased capacity of the Ministry, and greater need to work closely with them, necessitated an increase in the number of nationals in high-level positions in the Fund Management Office.

National staff are able to work more effectively with the Ministry of Health and Sports and have a deeper understanding of context. The restructuring of the programme to work in state and regional teams, rather than technical health teams, meant closer work at the state and regional level, when better language skills and local knowledge is particularly valuable.

The Fund was thus restructured into four programme teams, divided geographically (Kachin, Shan, Rakhine, Southeast), and led by a Director of Programme. There were also three strategy, or specialist health teams (Health, Health For All/Accountability, Equity and Inclusion, Health Systems Strengthening), led by a Director of Strategy. These positions were all national positions. Only three full-time international personnel remained in the Fund Management Office – the Fund Director, Communications Officer, and Monitoring and Evaluation Officer. There were also international positions in the Programme Management Office, taking care of grants and finance functions. The roles that remained international were based on specific capacity gaps at the time, with the plan to transition as many of these roles as possible into national roles.

These changes build the capacity of national staff, supporting them to contribute their skills to the rebuilding of their country. They also facilitate more efficient processes with national partners, such as the Ministry of Health and Sports, and more effective programme design – in approaches, understanding of challenges, and areas like behaviour change communication and health education.
ENGAGING THE COMMUNITY IS CRUCIAL TO REDUCING RESISTANCE TO SERVICES

The impact that pressure from the community has on the delivery of health services has reinforced for 3MDG the importance of engaging the community in all health interventions. This pressure may come in a variety of ways; from resistance to services, such as family planning or Harm Reduction, to cultural norms undermining a woman’s ability to make decisions about her own care in a patriarchal society. In efforts to overcome barriers and ensure health-related messages are disseminated widely and heard by all, it is important to involve community leaders and other influential persons. Including the community more broadly enables greater understanding of the health services on offer, and why everyone’s ability to access care is crucial.

**SITUATION**

Community pressure can impact access to and delivery of health services in many ways. One form of pressure is the rejection of certain health interventions by community members, or religious and community leaders. In Chin State, for example, a traditional preference for large families and low levels of gender equality, has meant that women are often pressured into having more children. When family planning services were introduced, they were met with significant resistance.

In Kachin State, some community groups – such as Fat Ja San – put severe pressure on Harm Reduction services as they believe drug users should be punished and forced to attend community-based drug treatment camps which can resort to harsh, inhumane methods and dangerous cold turkey approaches. Evidence overwhelmingly suggests this does not work and can seriously impact the human rights of people who use drugs. Techniques like these drive people who use drugs into hiding and make them fearful to access services. It can also negatively affect the motivation and attitudes of health workers.

### Gender Norms And Access To Care

Women in Myanmar are often responsible for care and domestic work. This can include cooking and cleaning, caring for family members, volunteering in the community and attending health education sessions. Men, however, often have a higher status in the community and usually make the decisions for their family when it comes to income and health. Women’s access to care can be limited, and without control of financial resources, they may not be able to move freely and seek the care they need. They may also be pressured into childbearing.

Health education activities, especially those that include advocacy for gender equality, can have a positive impact on women’s ability to seek care. The main participants in these sessions, however, are often women. Engaging men is important to ensure men are well informed on health issues and can make better decisions on behalf of the family. This may further encourage men to support their partners’ health-seeking behaviour and relinquish some control over resources and decision-making. Women may also have the opportunity to apply the knowledge they have gained through their health seeking behaviour and purchasing decisions. To make this happen, men should be encouraged to get involved in these activities, to bring about better health for themselves and their whole families. Specific sessions and activities have been introduced for men, but in many cases participation is still low. More efforts in this direction are needed, such as adjusting session timing and content, and reaching out to male participants.

### RESPONSE

Community engagement and health education have been a long-standing part of 3MDG programming, in recognition that the community’s involvement and inclusion in health education and planning is vital for increased understanding, better access, demand generation and high quality care. These efforts intensified in 2015 with the start of the Collective Voices project, where health workers and educators aimed to generate demand for services, better understand community health needs and barriers that they faced, and build trust between health providers and communities.

Part of the work is about helping community members to have a better understanding of what the job of a ‘health provider’ entails. Often, health providers face challenges that community members do not understand, such as limited human or financial resources, medicines or equipment, and this can lead to confusion and poor expectation management.

The ‘community scorecard’ tool introduced in 2016 helped to facilitate dialogue between community members and providers to reduce this misunderstanding. This can help providers in their delivery of healthcare, as they can tailor their priorities towards concerns raised by the community. Health education activities have also been an important way that communities gain knowledge about the services that are available, and proper treatment of different conditions. This can help reduce the pressure on health workers.

Work with communities on improving their health literacy can also reduce stigma and resistance towards particular health conditions and services. This includes family planning, where uptake of contraceptives has increased in every state and region where 3MDG works, including Chin State, which faced particular challenges and where regular advocacy and educational models were not proving effective. Marie Stopes International undertook significant advocacy efforts with community and religious leaders, as they had the greatest resistance to family planning and the greatest ability to affect change. This required continuous efforts ‘on-the-ground’ to build trust and relationships, but slowly attitudes and acceptances began to adjust. As resistance from these groups reduced, the use of family planning and contraceptives increased amongst couples in the State.

Work to overcome community pressure for services for people who inject drugs and harm reduction involves advocacy at all levels. More on this can be found on page 185-186.

### Overuse of Antibiotics in Chin State

3MDG and implementing partner monitoring in Chin State revealed significant overprescription of antibiotics in some areas. Community members were found to be placing pressure on health staff – particularly volunteers – to issue them with antibiotics, even when they were not needed. Volunteers are close to the community and have limited training, so they may be more susceptible to this sort of pressure.

The solution is multi-faceted: volunteers must receive more training and supervision, and closer monitoring over their issuance of antibiotics; community members must have explained the impacts of overuse of antibiotics in simple and clear terms; and finally – and perhaps the most long-term – the status of volunteer health workers must be raised in the community so that they are trusted and their directives are followed more closely.

3MDG implementing partners made a significant impact in just the final year of the Fund, bringing down the overuse of antibiotics in Chin by more than half, through training, better supervision and supply chain monitoring, and community education. The development of the volunteer health worker policy – by the Ministry of Health and Sports supported by 3MDG – will also go some way to enhancing the status of volunteer health workers on the broader scale, but this must be transferred to the local level.
Human resource issues are among the most significant that face the health sector in Myanmar. There are too many vacant posts, attrition of community-based health workers is high, and retention of basic health staff in rural areas is poor. Despite many vacancies, many health staff wait years to be deployed after they complete their training. Remuneration is also low, so staff look for extra work to supplement their salary, and patients sometimes give ‘donations’ even when some services are meant to be free. This puts health care out-of-reach for Myanmar’s poorest people.

Community-based health workers - a critical provider of health services and education - are poorly standardized and retention is poor. Quality and length of their training, and how they are incentivized can differ. They may only be trained to deliver one ‘type’ of health intervention, meaning when disease burden shifts, they cannot meet community health needs.

RESPONSE

The Ministry of Health and Sports, with support from Jhpiego, has worked to improve education, accreditation and standardization of midwifery, nursing and medical education, and human resources for health management systems. Midwifery training has been improved through revising the curriculum, addressing skills gaps of faculty members, establishing skills labs to encourage hands-on learning, and successfully formalizing the preceptorship system for practice and preparation. Accreditation systems for Nursing, Midwifery, and Basic Medical Education were also introduced. A road map on human resources for health information system strengthening was built with commitments of all stakeholders, and systems were improved for better forecasting and deployment of health staff.

Joint efforts of the Ministry, 3MDG and partners were able to reduce high attrition rates amongst community-based health workers in some areas. To overcome language, culture and trust barriers, more health workers were recruited from local areas. When it was evident that poor supervision and unreliable commodity supply affected the motivation of community-based health workers, they were improved where possible.

The Ministry built on this work by demonstrating their commitment to change and to address the root causes of ongoing human resource challenges. For example, the development of a ‘Community-Based Health Worker Policy’ supported by 3MDG, was a signal that the Ministry of Health and Sports’ acknowledged the structural challenges that contribute to poor human resources for health in Myanmar. The policy attempts to standardize the workforce and address key weaknesses in quality, training, support and incentivization.

Access to Health Fund has a role to play in supporting the Ministry in implementation. In a sign that the Ministry is aware that continuing human resource weaknesses are amongst the impediments to the achievement of universal health coverage, a dedicated unit for human resources has been re-established: the Central Human Resources for Health Unit.

This growing commitment from the Ministry of Health and Sports will go a long way to improving human resource management, and reducing vacant health posts and community-based health workers’ attention. However, there are limitations to what can be achieved without sweeping changes that require buy-in from a number of government units, ministries and parliamentarians to address the root problems.

They include, among other things, challenges with centralized, uncoordinated and slow deployment, low remuneration, limited hardship allowances, and poor security in some areas.

For too long, health partners have accepted that particular systemic problems are outside of their control. Now, with the Ministry of Health and Sports reaffirming its commitment to improving human resources for health, the Access to Health Fund, and other development partners must recognize their need to improve human resource management, and systems were improved for better forecasting and deployment of health staff.

BOLDER STEPS ARE NEEDED TO IMPROVE HUMAN RESOURCES

There are too many vacant health posts in Myanmar, especially in remote areas. Without the right people in the right places, health disparities in health will persist and Myanmar cannot achieve universal health coverage. 3MDG and other partners have worked to improve the quality of the health workforce, but more sweeping changes are needed. The Ministry of Health and Sports is committed to changing, as evident by their development of a standardized policy for village health workers and the formation of a dedicated Ministry department for human resources for health.

This should be used as a starting point for all future initiatives – but partners need to do more to advocate beyond the Ministry of Health and Sports to facilitate the needed reforms in remuneration and deployment of government workers.

REACHING THE MOST VULNERABLE REQUIRES THE RIGHT DATA, CLEAR DEFINITIONS AND CONCERTED EFFORT

The 3MDG Fund has learnt over six years of programming that in order to reach the most vulnerable people in Myanmar, it is necessary to have adequate data, concerted and explicit effort to navigate complex, highly political areas of unclear control, and a robust definition of what vulnerability means.

SITUATION

When the 3MDG Fund was designed and set-up, Myanmar suffered from poor health outcomes: high maternal and infant mortality, high burden of communicable diseases – such as malaria, HIV, and tuberculosis – and poor health seeking behaviour and health literacy.

Findings from the 2010 Census demonstrated and confirmed a lack of health equity across the country. In general, urban areas had better health outcomes than rural areas, with some important exceptions for specific communicable disease.

RESPONSE

The 3MDG Fund was designed with the intention to restore health equity by addressing disparities and targeting health services towards poor and vulnerable people.

A person’s vulnerability can be understood across a number of axes. An individual may be vulnerable to a specific health condition, for example, those who live in crowded places, such as urban slums, are vulnerable to tuberculosis (TB) because the disease is airborne. An individual may be vulnerable more broadly because of social, environmental, cultural or economic factors. Poor people who live in conflict-affected areas, or people with disabilities, for example, may find it more difficult to access the health services they need. Additionally, people who live far from health services, or in areas inaccessible to health workers, may also be unable to access care.

The Fund’s ability to target services towards the poorest and most vulnerable people in Myanmar was uneven across the programme. There were challenges at each step of the process, which was to first clearly define vulnerability, identify who was vulnerable, target services towards these populations, and finally measure who had been reached.

Defining Vulnerability

For the HIV, TB and malaria programmes, defining vulnerability was straightforward and built primarily on disease-specific risk factors. For example, TB services were targeted towards those most at-risk of contracting the disease: miners, prisoners, factory workers, and those living in urban slums. For HIV, the three groups with the highest prevalence are considered most vulnerable: people who inject drugs, sex workers, and men who have sex with men. 3MDG worked primarily with people who inject drugs as other partners were already covering the other vulnerable groups. Malaria services were targeted to the most endemic areas, and populations who were at high risk: forest workers and migrants.

Defining vulnerability for maternal, newborn and child health is more complicated. Health-related risk factors, such as high blood pressure or diabetes, are just one aspect of vulnerability. Globally, the World Health Organization suggests that globally, there is a 15% chance that a women will need emergency obstetric care during pregnancy or childbirth. Thus, ability to access care is in a timely, affordable manner is crucial. In Myanmar, this may be impacted by distance and geographical remoteness, security and conflict, cost, and availability and quality of health services.

Data on these factors is not available in Myanmar in a systematic or disaggregated way, which made it difficult to properly define vulnerability.
Identifying Who Was Vulnerable

It was possible to identify vulnerable populations for HIV, TB and malaria interventions. Data from national programmes and other surveys made clear the key affected populations, and implementing partners could target those populations where they were located. Target groups could be adjusted as the programme learned more about vulnerability.

For example, in the Harm Reduction programme, analysis of gender disaggregated data identified that though women were estimated to make up about five percent of the drug using population, they only represented two percent of those reached by 3MDG partners. Measures were put in place to identify and target the group. More women staff were employed at drop-in centres and for outreach, and women-only centres and ‘corners’ helped women feel safe and welcome in the typically male-dominated environment.

For the maternal, newborn and child health programme, data from the 2010 Census and other sources allowed for the identification of the states and regions with the worst health status along a number of indicators – maternal mortality, infant mortality, under-five mortality, for example. Within those states and regions, it was also possible to identify the townships with the worst health outcomes. 3MDG selected townships for maternal, newborn and child health interventions based on this information, as well as the need to avoid gaps and overlaps with other actors.

Limited availability and disaggregation of data made further identification of vulnerable people and places difficult. For instance, maternal mortality could not be ascertained at the village level in Myanmar, long-standing mistrust of government also means that data on other aspects of vulnerability, such as poverty or ethnicity, is not easy to collect. There is also limited data on people living in conflict-affected areas outside of government control. These factors combined meant it was not possible in Myanmar to identify vulnerable villages or individuals.

It is important also to note that a system-wide approach is preferred for maternal, newborn and child health interventions. This is because the services are needed by a large percentage of the population, they may be required over long periods, and the nature of pregnancy, childbirth and infancy can mean immediate care is required in an unpredictable manner. The entire system needs to be strong to account for this. 3MDG interventions were targeted to the township-level system.

Targeting Services Towards the Most Vulnerable

The HIV, TB and malaria projects and programmes were able to target key affected populations. TB active case finding teams could travel to known areas of risk, such as garment factories, mines and urban slums. HIV Harm Reduction services were delivered directly to a highly vulnerable population, people who use and inject drugs, through drop-in centres and outreach to injection sites. Prisoners, who are vulnerable because of poor health conditions and their crowded nature, could be targeted through outreach visits to prisons and work sites. Malaria endemic areas were prioritized under the national programme, and testing, referral and treatment was offered to those populations most at-risk.

Maternal, newborn and child health services could also target the most vulnerable populations in a number of ways. Within townships, health knowledge from the Township Health Department, implementing partners, and community-based organizations was used to further aim services towards places where vulnerability was highest. Outreach visits saw basic health staff travel long distances – sometimes on foot in the rainy season – to reach remote communities.

At an output level, all partners worked to overcome barriers to healthcare. Health providers attended trainings to improve their delivery of services in a gender sensitive, inclusive and accountable manner. Community feedback mechanisms were set up to start dialogue between the community and health service providers. Barriers like trust and language were addressed by employing more local people, and utilizing local civil society and community based organizations as intermediaries. Collective Voices partners, in particular, focused on demand generation activities to encourage better health seeking behaviour and build relationships.

These activities undoubtedly improved access to care; however, the Fund learnt that explicit effort is needed to reach those who are most vulnerable. For example, evidence gathered from the 3MDG emergency referral programme suggests that even when a programme is designed to overcome specific barriers to care – in this case, distance, cost and knowledge – it is often still more commonly accessed by those who are relatively less vulnerable. 3MDG partners were explicitly asked to focus on locating people in need of care in hard-to-reach locations. In the end, only 9% of total child referrals, and 8% of maternal referrals provided by 3MDG were confirmed to have come from this group, and the rest were from non-hard-to-reach locations (though they could have been vulnerable in other ways).

This demonstrates that approaches must address all barriers to care. Though emergency referrals could overcome some barriers of distance and cost, they were not able to adequately change the strong preference for home delivery, or overcome the lack of trust in government health providers. The bureaucratic system on which the referral programme relied could be confusing and impeding, as patients could only be referred within townships (even when the facility is not close). In some limited cases, this could be overcome with advocacy work to highlight the importance of reaching the closest or most accessible facility in emergencies.

Measuring Who Has Been Reached

Measuring whether vulnerable people have been reached with health services is critical to accountability and for meeting the objectives of the Fund, and allows for project adjustments to be made when necessary.

For the HIV, TB and malaria programme, it is evident that vulnerable populations such as prisoners, people who use drugs, and people living in malaria endemic areas were reached with health services. Though gaps remain – such as the high number of hidden cases of TB and the stigma that restrict access to services for some groups – important progress has been made in combating communicable diseases in Myanmar. More cases of TB are notified than ever before, and malaria prevalence has dropped drastically.

However, for township-wide services, such as maternal, newborn and child health, identifying and measuring vulnerability at a granular, individual level was not possible in Myanmar during the 3MDG Fund. The Myanmar Health Management Information System (HMIS) does not disaggregate based on any aspect of vulnerability, except gender, and it does not record access to services. As 3MDG was reliant on HMIS data, this meant that the ability of the Fund to measure who had been reached with maternal, newborn and child health services was often not possible at the individual level. However, townships were selected based on their poor health outcomes (and the outcomes of their state or region), and services themselves endeavoured to overcome barriers to care at the output level through training, community engagement, trust building, demand generation and outreach. There are also many qualitative examples, as documented throughout the lifetime of the 3MDG Fund, where highly vulnerable people received access to care.

Way Forward

Without clear definitions and adequate data, health services will more often reach those who are relatively less vulnerable. Some barriers to healthcare can be overcome through project design and community engagement, but without the ability to explicitly identify and target vulnerable people, the impact to these populations and the ability of any fund to impact overall health equity is unclear.

This does not undercut the achievements of the 3MDG Fund. Services often reached people who did not have access, in many cases, the work of partners was lifesaving. It does mean, however, that the Access to Health Fund needs to do more work to target, identify and measure health services reaching vulnerable people. That work has already begun.

Compared to when 3MDG was established, more data about vulnerability in Myanmar is available at the township level along a number of parameters, such as conflict, natural disaster, poverty, education, health access. This will be utilized to pinpoint townships and their ‘type’ of vulnerability. However, as of yet, there is not a systematic way of ascertaining who is vulnerable at lower levels – such as village or individual level.

Closing this data gap is necessary, but difficult in a country like Myanmar. Mistrust of government, especially in areas affected by the world’s longest running civil war, means people are unwilling to hand over information that would make the targeting of services (in a number of areas) more attainable. There is fear in some areas that this information would be used by armed groups for forced recruitment. Many do not have access to national registration, even if they do want it. To overcome these challenges, Access to Health Fund is exploring the potential use of proxy data, such as mobile phone usage patterns, to identify vulnerable villages.

Harnessing existing local knowledge, such as that held by Village Health Committees, Village Administrators, and community leaders, provides additional opportunities to identify vulnerability. For example, 3MDG learnt that community leaders charged different rates of interest depending on the borrowers’ poverty level and personal situation. Harnessing this knowledge that is already known by communities could help identify vulnerable people at the individual level and improve the accessibility of services.

For Access to Health to live up to its name of targeting the most vulnerable and ensuring everyone can access care, it needs to build on the preliminary efforts of the 3MDG Fund, but go much further to truly support health equity in Myanmar.
I. List of 3MDG-funded grants

II. Results Matrix 2018

III. Results Matrix (all years)
## I - 3MDG-funded grants

All figures are in USD

<table>
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<tr>
<th>#</th>
<th>Grant ID</th>
<th>Implementing Partner</th>
<th>Description</th>
<th>Grant Period</th>
<th>Total amount (US$)</th>
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<td>CESVI-MNCH-3MDG-C1-15-00093265</td>
<td>Cooperazione e Sviluppo (Cooperation and Development)</td>
<td>Supporting implementing Maternal Newborn and Child Health services (MNCH) in Northern Shan State</td>
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<td>Health Poverty Action</td>
<td>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</td>
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<td>IOM-MNCH-3MDG-C1-16-10636-006</td>
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<td>15-Oct-16 to 31-Dec-18</td>
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<td>Myanmar Health Assistant Association MNCH Project in Rakhine State</td>
<td>15-Oct-16 to 31-Dec-17</td>
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<td>MSI-MNCH-3MDG-C1-14-00088215</td>
<td>Marie Stopes International</td>
<td>Supporting implementing Maternal Newborn and Child Health Services (MNCH) in the Magway Region</td>
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<td>PSI-MNCH-3MDG-C1-14-00088702</td>
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<td><strong>Population Services International</strong> Supporting implementing Maternal Newborn and Child Health services (MNCH) in the Ayeyarwady Region</td>
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<td>25</td>
<td>MNCH</td>
<td><strong>Myanmar Partners Company Limited</strong> Family Planning Best Practice Conference to be held in Nay Pyi Taw</td>
<td>12-Jun-14 31-Jul-14</td>
<td>$32,224</td>
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<td>26</td>
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<td><strong>Ministry of Health</strong> Implementation of a Grant in Myanmar provided by the Three Millennium Development Goal Fund</td>
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<td>27</td>
<td>HIV</td>
<td><strong>AIDS Support Group - Tachilek</strong> Preventing HIV Spread</td>
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<td>28</td>
<td>HIV</td>
<td><strong>Burnet Institute Myanmar</strong> Enhancing education and health services to reduce harms related to drug use</td>
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<td>HIV</td>
<td><strong>Black Sheep Peer Support Group</strong> Harm Reduction Care and Support for (Injecting) Drug Users</td>
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<td>HIV</td>
<td><strong>Mahaythi Women's Development Co-operative Society Ltd</strong> HIV/AIDS Prevention, Treatment, Care &amp; Support for Poor and Marginalised Female Youth</td>
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<td>HIV</td>
<td><strong>Malteser International</strong> Prevention and Treatment of Sexually Transmitted Infections and HIV/AIDS in Wa Special Region II and Shan Special Region IV Shan State – Myanmar</td>
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<td>32</td>
<td>HIV</td>
<td><strong>Médecins du Monde</strong> Reduction of HIV prevalence among People Who Inject Drugs (PWID) through Community-led Harm Reduction in Kachin State</td>
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<td>33</td>
<td>HIV</td>
<td><strong>Myanmar Anti-Narcotics Association</strong> Comprehensive HIV prevention and care among drug users with effective harm reduction intervention</td>
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**Total MNCH** $119,356,069

**Total HIV, Tuberculosis, and Malaria** $136,364,025
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<td>MANA-HIV-3MDG-C2-14-00089800</td>
<td>Myanmar Anti-Narcotics Association</td>
<td>Comprehensive HIV prevention and care among drug users with effective harm reduction intervention</td>
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<td>HIV</td>
<td>Metta-HIV-3MDG-C2-16-10636-001</td>
<td>Metta Foundation</td>
<td>Reduction of HIV prevalence among People Who Inject Drugs (PWID) through Community-led Harm Reduction in Kachin State</td>
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<td>Pilot Distribution of Needles and Syringes, Kachin State, Mandalay Region and Sagaing Region</td>
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<td>Treatment, Care and Support for People Living With HIV/AIDS (PLHIV)</td>
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<td>Substance Abuse Research Association</td>
<td>Scaling-up the capacities of communities to deliver HIV and drug abuse prevention and support activities in high-risk townships of Kachin and neighbouring Sagaing Regions.</td>
<td>01-Jan-13</td>
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<td>HIV</td>
<td>SARA-HIV-3MDG-C2-14-00089801</td>
<td>Substance Abuse Research Association</td>
<td>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</td>
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<td>HIV</td>
<td>UNODC-HIV-3MDG-C2-13-00086224</td>
<td>United Nations Office for Drug and Crime</td>
<td>Expanding access to HIV prevention services among people who inject drugs</td>
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<td>HIV</td>
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<td>UNAIDS</td>
<td>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 transgenders in Myanmar.</td>
<td>15-Jul-13</td>
<td>31-Dec-18</td>
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<td>United Nations Office for Drug and Crime</td>
<td>Programme on Improving Prison Health in Myanmar.</td>
<td>01-Sep-16</td>
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<td>Malaria</td>
<td>BI-MARC-3MDG-C2-14-00089847</td>
<td>Burnet Institute Myanmar</td>
<td>Malaria services for most hard to reach populations</td>
<td>01-Apr-14</td>
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<td>International Organization for Migration</td>
<td>Community-based Artemisinin Resistance Containment for Mobility-impacted Communities in Mon state, Myanmar</td>
<td>01-Jan-13</td>
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<td>Community-based malaria prevention, control and MARC Project</td>
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<td>Myanmar Medical Association</td>
<td>Quality Diagnosis and Standard Treatment of Malaria</td>
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<td>PSMARC-3MDG-C2-16-10636-005</td>
<td>Population Services International</td>
<td>Mapping of Private Medical Doctors to Inform Future Malaria Control and Elimination Efforts</td>
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<td>Optimising operational use of artemether-lumefantrine: An open-label randomized controlled trial to evaluate the effectiveness and safety of a 3 day versus 5 day course of artemether-lumefantrine for the treatment of uncomplicated falciparum malaria in Myanmar</td>
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<td>Development of private public partnership (PPP) research products</td>
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<td>The University of Oxford</td>
<td>Economic-epidemiological modeling to support the containment of artemisinin resistance in the MARC regions of Myanmar (MARCMOD)</td>
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<td>Malaria Consortium in Myanmar</td>
<td>Strengthening an integrated ICCM Pilot implementation in three hard-to-reach townships of Sagaing Region</td>
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<td>Myanmar Health Assistant Association</td>
<td>Patient-centred Community-based MDR TB Care Model</td>
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<td>Accelerated TB active case finding among urban slum dwellers and clients of MNCH services</td>
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<td>NTP-TB-MDR-3MDG-C2-14-00091915</td>
<td>National TB Program</td>
<td>Implementation of a Grant in Myanmar provided by the Three Millennium Development Goal Fund</td>
<td>01-Oct-14</td>
<td>31-Dec-18</td>
<td>6,823,313</td>
</tr>
<tr>
<td>74</td>
<td>TB</td>
<td>Magway, Sagaing, Shan (South)</td>
<td>UNION-TB-3MDG-C2-14-00089854</td>
<td>International Union against Tuberculosis and Lung Diseases</td>
<td>Program to Increase Catchment of Tuberculosis Suspects (PICTS) 2</td>
<td>01-May-14</td>
<td>31-Dec-17</td>
<td>1,010,910</td>
</tr>
<tr>
<td>75</td>
<td>TB</td>
<td>Mandalay</td>
<td>UNION-TB-3MDG-C2-15-00094806</td>
<td>International Union against Tuberculosis and Lung Diseases</td>
<td>Community Based Care for Multi-Drug Resistant Tuberculosis Cases [CBMMDR-TBC] in Mandalay Region</td>
<td>01-Apr-15</td>
<td>31-Dec-17</td>
<td>975,855</td>
</tr>
<tr>
<td>76</td>
<td>TB</td>
<td>Yangon</td>
<td>PGK-TB-3MDG-C2-15-00093872</td>
<td>Pyi Gyi Khin</td>
<td>Patient-centred Community-based MDR TB care model</td>
<td>05-Feb-15</td>
<td>31-Dec-17</td>
<td>1,149,154</td>
</tr>
<tr>
<td>77</td>
<td>TB</td>
<td>Yangon</td>
<td>MMA-TB-3MDG-C2-15-00093923</td>
<td>Myanmar Medical Association</td>
<td>MMA-MDR-TB Project (Patient-centred Community-based MDR-TB Care and treatment support Model)</td>
<td>05-Feb-15</td>
<td>31-Dec-18</td>
<td>1,396,378</td>
</tr>
<tr>
<td>79</td>
<td>TB</td>
<td>Yangon, Ayeyarwaddy, Magway, Mandalay, Mon, Kayin, Shan, Kachin</td>
<td>MMA-TB-SRHR-3MDG-C2-15-10636-015</td>
<td>Myanmar Medical Association</td>
<td>Promoting Access to Adolescent Sexual and Reproductive Health Information and Adolescent and Youth Friendly Reproductive Health Services</td>
<td>01-Mar-18</td>
<td>31-Dec-18</td>
<td>353,797</td>
</tr>
<tr>
<td>81</td>
<td>HIV TB Malaria</td>
<td>Kachin, Shan (North)</td>
<td>AHRN-3MDG-C2P1-13-66750</td>
<td>Asian Harm Reduction Network</td>
<td>Harm Reduction and HIV/TB Health Promotion Services to (injecting) Drug Users</td>
<td>01-Jan-13</td>
<td>31-Mar-14</td>
<td>1,411,883</td>
</tr>
<tr>
<td>82</td>
<td>HIV TB Malaria</td>
<td>Kachin, Sagaing, Shan (North)</td>
<td>AHRN-Integ-3MDG-C2-14-00089794</td>
<td>Asian Harm Reduction Network</td>
<td>Harm Reduction and HIV/TB Health Promotion Services for PWID/PWUD and their partners &amp; household members</td>
<td>01-Apr-14</td>
<td>31-Dec-18</td>
<td>12,388,006</td>
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<tr>
<td>83</td>
<td>HSS</td>
<td>Chin</td>
<td>AYO-AEI-3MDG-C3-15-00093874</td>
<td>Ar Yone Oo Social Development Association</td>
<td>Supporting the Accountability, Equity and Inclusion (AEI) in the access to health services in Southern Chin State</td>
<td>02-Mar-15</td>
<td>31-Dec-18</td>
<td>397,420</td>
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<tr>
<td>84</td>
<td>HSS</td>
<td>Mon</td>
<td>BF-AEI-3MDG-C3-15-00093924</td>
<td>Bright Future (La Yee Anar Gut)</td>
<td>Supporting the Accountability, Equity and Inclusion (AEI) in the access to health services in Mon State</td>
<td>02-Mar-15</td>
<td>31-Dec-18</td>
<td>350,848</td>
</tr>
<tr>
<td>#</td>
<td>Region</td>
<td>Code</td>
<td>Organization</td>
<td>Project Description</td>
<td>Start Date</td>
<td>End Date</td>
<td>Amount (USD)</td>
<td>Status</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>85</td>
<td>Ayeyarwady, Magway</td>
<td>COM-AEI-3MDG-C3-15-00093849</td>
<td>Charity Oriented-Myanmar</td>
<td>Supporting the Accountability, Equity and Inclusion (AEI) in the access to health services in Ayeyarwady and Magway Regions</td>
<td>02-Mar-15</td>
<td>19-Oct-18</td>
<td>$329,713</td>
<td></td>
</tr>
<tr>
<td>86</td>
<td>Chin</td>
<td>CAD-AEI-3MDG-C3-15-00093944</td>
<td>Community Agency for Rural Development</td>
<td>Supporting the Accountability, Equity and Inclusion (AEI) in the access to health services in Northern Chin State</td>
<td>02-Mar-15</td>
<td>31-Dec-18</td>
<td>$351,529</td>
<td></td>
</tr>
<tr>
<td>87</td>
<td>Mon</td>
<td>CDDCET-AEI-3MDG-C3-15-00093948</td>
<td>Community Driven Development &amp; Capacity Building Enhancement Team</td>
<td>Supporting the Accountability, Equity and Inclusion (AEI) in the access to health services in Mon State</td>
<td>02-Mar-15</td>
<td>31-Dec-18</td>
<td>$364,901</td>
<td></td>
</tr>
</tbody>
</table>
| 88 | Kachin, Shan, Kayah, Kayin, Rakhine | CDA-HSS-3MDG-C3-17-10636-021 | CDA Collaborative Learning Projects | The Support to Strengthening Conflict Sensitivity | 15-Jan-18 | 24-Jun-18 | $75,308 | ✔️
| 90 | Nationwide | NIMU-HSS-3MDG-C3-17-10636-011 | The National Health Plan Implementation and Monitoring Unit | Implementation of a Grant in Myanmar provided by the Three Millennium Development Goal Fund | 01-Apr-17 | 31-Dec-18 | $869,630 | |
| 91 | Nationwide | NNC-3MDG-C3-18-10636-015 | The National Nutrition Center | Implementation of a Grant in Myanmar provided by the Three Millennium Development Goal Fund | 01-Mar-18 | 31-Dec-18 | $75,399 | ✔️
| 92 | Rakhine, Chin, Kayah, Kayin, Shan, Kachin, Yangon | RAFT-HSS-3MDG-C3-17-10636 | RAFT Myanmar | The Support to Strengthening Conflict Sensitivity | 25-Jun-18 | 31-Dec-18 | $163,527 | ✔️
| 93 | Rakhine | UNICEF-HSS-3MDG-C3-16-10636-010 | UNICEF | Health Systems Strengthening Support to the Rakhine State Health Department | 01-Oct-16 | 31-Dec-18 | $939,455 | |
| 94 | Nationwide | UNICEF-HSS-3MDG-C3-15-00094363 | UNICEF | UN Assistance to Health System Strengthening (HSS) in The Republic of the Union of Myanmar (the "Activities") in support of the Three Millennium Development Goal Fund ("3MDG") | 01-Jan-15 | 31-Dec-17 | $12,370,916 | |
| 95 | Nationwide | JHPIEGO-HSS-3MDG-C3-17-10636-013 | JHPIEGO Corporation | Support to Strengthen Management of Human Resources for Health | 01-Jan-15 | 31-Dec-17 | $1,988,672 | |
| 96 | Nationwide | 3MDG-C3P1-13-34692 HSS | World Bank | Strengthening the Ministry of Health capacity to guide stewardship for improved health systems | 29-May-13 | 31-Dec-18 | $3,344,731 | |
| 97 | Nationwide | PFSCM-3MDG-HSS-C3-14-00089734 | PFSCM | National Supply Chain Baseline | 19-Mar-14 | 15-Nov-14 | $249,396 | |
| 99 | Nationwide | UNAIDS-HSS-3MDG-C3-14-00092409 | UNAIDS | UN joint assistance to strengthen health systems in Myanmar | 07-Nov-14 | 31-Dec-17 | $989,861 | |
| 100 | Nationwide | 3MDG-C3P1-13-66972 HSS | World Health Organization | Technical support to the Government of Myanmar efforts to develop and implement evidence based health sector policies in support of Universal Health Coverage | 01-Apr-13 | 31-May-16 | $93,566 | |
| 101 | Nationwide | WHO-HSS-3MDG-C3-15-00094541 | World Health Organization | UN Assistance to Health System Strengthening (HSS) in The Republic of the Union of Myanmar (the "Activities") in support of the Three Millennium Development Goal Fund ("3MDG") | 01-Jan-15 | 31-Dec-17 | $2,636,998 | |
| 102 | Nationwide | PACT-HSS-3MDG-C3-14-00092039 | PACT | Organizational capacity development for 3MDG local NGO/CBO Implementing Partners | 24-Oct-14 | 31-Dec-17 | $1,940,615 | |
|   | HSS   | Nationwide | UNFPA-HSS-3MDG-C3-15-00094375 | United Nations FPA | UN Assistance to Health System Strengthening (HSS) in The Republic of the Union of Myanmar (the “Activities”) in support of the Three Millennium Development Goal Fund (“3MDG”) | 01-Jan-15 | 31-Dec-16 | $  | Notes |
|---|-------|------------|-------------------------------|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----------|-----|--
| 103 | HSS   | Nationwide | UNFPA-HSS-3MDG-C3-15-00094375 | United Nations FPA | UN Assistance to Health System Strengthening (HSS) in The Republic of the Union of Myanmar (the “Activities”) in support of the Three Millennium Development Goal Fund (“3MDG”) | 01-Jan-15 | 31-Dec-16 | $ 789,500 | |
| 104 | HSS   | Ayeyarwady, Yangon, Shan | PTE-AEI-3MDG-C3-15-00093950 | Phan Tee Eain (Creative Home) | Supporting the Accountability, Equity and Inclusion (AEI) in the access to health services in Ayeyarwady Region, Yangon Region and Shan State | 02-Mar-15 | 31-Dec-16 | $ 228,508 | |
|   | HSS   |            |                               |                    |                                                        |           |           | $ 32,879,293 | |
|   | Total |            |                               |                    |                                                        |           |           | $ 247,010,562 | |

Notes:
Above total figures are approximate USD totals for all grants to implementing partners funded under 3MDG. Grants funded in MMK are excluded from the total count but included in the above list.
The Performance Bands are defined as follows:

<table>
<thead>
<tr>
<th>Meeting or Exceeding expectation</th>
<th>Weak but potential demonstrated</th>
<th>Substantially not meeting expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>The achievement is &gt;90% of the target</td>
<td>The achievement is 60-90% of the target</td>
<td>The achievement is &lt; 30% of the target</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No.</th>
<th>Indicators</th>
<th>2017 Result</th>
<th>2018 Annual Target</th>
<th>2018 Result</th>
<th>2018 Performance vs. Targets</th>
<th>Cumulative Result</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Maternal mortality ratio per 100,000 live births</td>
<td>Not available*</td>
<td>Not available**</td>
<td>Not available***</td>
<td>-</td>
<td>Not applicable</td>
<td>*For Impact-level indicators the target-setting is national, as opposed to 3MDG-specific. These targets were set by the UN Inter-agency group (UNIAG for maternal and child health) based on modelling of available data. In July 2017, the UNIAG advised that estimations beyond 2015 have not been made yet. ** Maternal mortality was not measured in the Myanmar DHS (2016). Pregnancy-related Mortality Ratio 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 354 in Ayeyarwaddy. *** There were no national-level surveys to report the 2018 result.</td>
</tr>
<tr>
<td>2</td>
<td>Under-five child mortality per 1,000 live births (disaggregated by sex)</td>
<td>Not available*</td>
<td>Not available**</td>
<td>Not available***</td>
<td>-</td>
<td>Not applicable</td>
<td>*For Impact-level indicators the target-setting is national, as opposed to 3MDG-specific. These targets were set by the UN Inter-agency group (UNIAG for maternal and child health) based on modelling of available data. In July 2017, the UNIAG advised that estimations beyond 2015 have not been made yet. ** According to Myanmar DHS (2016), the U5 mortality rate per 1,000 live births was 50. Based on the Census (2013-2014), the Union-average under-5 mortality rate was 72 per 1,000 live births, from the lowest of 48 in Mon to the highest of 108 in Magway and 105 per 1,000 live births in Ayeyarwaddy. *** There were no national-level surveys to report the 2018 result.</td>
</tr>
<tr>
<td>3</td>
<td>Neonatal mortality rate per 1,000 live births (disaggregated by sex)</td>
<td>Not available*</td>
<td>Not available**</td>
<td>Not available***</td>
<td>-</td>
<td>Not applicable</td>
<td>*For Impact-level indicators the target-setting is national, as opposed to 3MDG-specific. These targets were set by the UN Inter-agency group (UNIAG for maternal and child health) based on modelling of available data. In July 2017, the UNIAG advised that estimations beyond 2015 have not been made yet. ** According to Myanmar DHS (2016), the neonatal mortality rate per 1,000 live births was 25. Based on the Census (2013-2014), the Union-average neonatal mortality rate was 43 per 1,000 live births, from 34 on average in rural areas to 46 per 1,000 live births on average in urban areas. *** There were no national-level surveys to report the 2018 result.</td>
</tr>
<tr>
<td>No.</td>
<td>Indicators</td>
<td>2017 Result</td>
<td>2018 Annual Target</td>
<td>2018 Result</td>
<td>2018 Performance vs. Targets</td>
<td>Cumulative Result</td>
<td>Comments</td>
</tr>
<tr>
<td>-----</td>
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<td>------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>4</td>
<td>HIV prevalence among people who inject drugs in programme areas</td>
<td>34.9%</td>
<td>Not available</td>
<td>Not available*</td>
<td>_</td>
<td>Not applicable</td>
<td>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. HIV Prevalence among PWID is 34.9% based on 2017 IBBS Results. The latest available result of 26% is from 2016 HIV sentinel surveillance. The latest target was set in 2015 at 22%. * There was no national level surveys to report the 2018 results.</td>
</tr>
<tr>
<td>5</td>
<td>National TB (all forms) mortality per 100,000 population per year in programme areas</td>
<td>51</td>
<td>43</td>
<td>Not available*</td>
<td>_</td>
<td>Not applicable</td>
<td>* 2018 reported mortality figure is not available currently. The 2017 result was 51 with its target 45, which is higher than 47 in 2016 (Source: Global TB report 2018). Achieving the mortality target requires progress in reducing health-related risk factors for TB infection and disease, as well as broader social and economic determinants of TB infection and disease.</td>
</tr>
<tr>
<td>6</td>
<td>Malaria mortality rate</td>
<td>0.06</td>
<td>0.04</td>
<td>Not available*</td>
<td>_</td>
<td>Not applicable</td>
<td>The impact indicator changed in 2016 due to changes in the National M&amp;E framework due to reduction in malaria burden. The 2017 data is 0.06. In 2017 there were 30 reported malaria deaths. (Source: World Malaria reported 2018). (Note: The indicator denominator is total population and not population-at-risk, as stated in the M&amp;E Plan. This is due to the challenges of estimating population-at-risk, as village-level microstratification is not done in all villages yet) * 2018 reported mortality figure is not available currently.</td>
</tr>
<tr>
<td>No.</td>
<td>Indicators</td>
<td>2017 Result</td>
<td>2018 Annual Target</td>
<td>2018 Result</td>
<td>2018 Performance vs. Targets</td>
<td>Cumulative Result</td>
<td>Comments</td>
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</tr>
<tr>
<td>1</td>
<td>Number and percentage of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife) in Component 1 townships</td>
<td>64% (72,307 out of 112,863 total deliveries)</td>
<td>66%</td>
<td>60% (43,908 out of 73,577 total deliveries)</td>
<td>Meeting or Exceeding expectation</td>
<td>265,583</td>
<td>State &amp; Region Achievement: Chin - 66%, Kayah - 82%, Shan - 59% and Rakhine - 54%. All states and regions show increased coverage of skilled birth attendance (SBA) compared to 2017 (Chin: 6% point, Kayah: 2% points, Shan 4% and Rakhine 3% points). Phasing out of high achieving townships in Delta and Magway significantly impacted the overall result in 3MDG-supported townships which dropped from 64% in 2017 to 60%. Rakhine contributes largely to the overall achievement. Although its coverage in Skill Birth Attendance is the least among 3MDG supported state/regions, it shows an increase at 54% compared to the 2017 achievement of 51%. Low coverage is seen in Shan and Rakhine states: Rakhine: In Buthidaung and Sittwe townships which are highly populated townships, MW were not residing in their facilities due to post-conflict security concerns. In Sittwe, RHC-level disaggregated data show that SBA in Muslim community is lower, because their deliveries were mainly attended by traditional birth attendants (TBA), and only in case of emergency, they were referred to Thet Kel Pyin Observation center and Sittwe General Hospital. Shan: There was low SBA coverage in several townships which are geographical hard-to-reach and conflict-prone. Manton suffered shortage of BHS in both senior management (TMO and THN) and field level due to staff transfers and long leaves. In Laihka, it is reported that Pa-Laung women, an ethnic group, preferred TTBA for their delivery. Additional contribution: 5,058 (All) - Ref.notes (1) and (2) at the bottom of the table</td>
</tr>
<tr>
<td>2</td>
<td>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.</td>
<td>68% (76,884 out of 112,863 total deliveries)</td>
<td>71%</td>
<td>65% (47,852 out of 73,577 total deliveries)</td>
<td>Meeting or Exceeding expectation</td>
<td>280,683</td>
<td>State &amp; Region Achievement: Chin - 72%, Kayah - 75%, Shan - 70% and Rakhine - 59%. All states and regions show increased coverage of ante-natal care compared to 2017 (Chin: 11% points, Kayah: 3% points, Shan: 7% points, and Rakhine: 4% points). Phasing out of high achieving townships in Delta and Magway impacted the overall result in 3MDG-supported townships which dropped from 68% in 2017 to 65%. Coverage in Rakhine state improved from 55% to 59% because of improved access to villages by MW in Northern townships due to comparatively less conflict than 2017. But still there are challenges which contribute to low ANC 4 times in Rakhine such as MW prioritizes immunization over AN care during her outreach especially in socially hard-to-reach areas in Buthidaung and Sittwe townships, vacancy of BHS in Mrauk-U townships. Townships still have challenges around reporting correcting ANC4 indicators (counting the time of visits) in accordance with the indicator definition, and difficulties in reaching 1st AN visit to early pregnant women within 14 weeks, especially in hard-to-reach areas. Additional contribution: 4,832 (All) - Ref.notes (1) and (2) at the bottom of the table</td>
</tr>
<tr>
<td>No.</td>
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</tr>
<tr>
<td>3</td>
<td>Number and percentage of mothers and newborns who received postnatal care visit within three days of childbirth</td>
<td>78% (87,375 out of 111,387 total live births)</td>
<td>82%</td>
<td>76% (54,947 out of 72,619 total live births)</td>
<td>Meeting or Exceeding expectation</td>
<td>316,134</td>
<td>State &amp; Region Achievement: Chin - 83%, Kayah - 93%, Shan - 77% and Rakhine - 70%. All the state and regions show increase in % in compared with 2017 (Chin: 4% points, Kayah: 1% point, Shan: 5% points and Rakhine: 6% points). Phasing out of high achieving townships in Delta and Magway impacted the overall result in 3MDG-supported townships which dropped from 78% in 2017 to 76%. There was improvement in coverage of post natal care from 64% to 70% in Rakhine state due to better access, and improved awareness of newborn care after AMW/TBA training. Similar to ANC 4 times, low coverage in Rakhine is reported because of prioritization of immunization by MW in HfR areas in Buthidaung and Sittwe townships. Shan State also shows a notable increase in 2018; key contributing factors are that there was comparably less conflict in some of its townships resulting in better BHS movement and improved SBA compared with 2017. Though all state/regions show improvement, the target 82% is not met because it is still difficult to arrive to the post natal mother within 3 days of delivery especially in geographically challenging townships. Additional contribution: 9310 All- Ref.notes (1) and (2) at the bottom of the table.</td>
</tr>
<tr>
<td>4</td>
<td>Number and percentage of newborns that initiate immediate breastfeeding within one hour after birth in Component 1 townships</td>
<td>77% (86,224 out of 111,387 total live births)</td>
<td>84%</td>
<td>72% (52,547 out of 72,619 total live births)</td>
<td>Moderate achievement</td>
<td>263,416</td>
<td>State &amp; Region Achievement: Chin - 96%, Kayah - 91%, Shan - 72% and Rakhine - 62%. All the state and regions show increase in % compared to 2017 except Kayah (Chin: 4% points, Shan: 2% points and Rakhine: 4% points). Phasing out of high achieving townships in Delta and Magway significantly impacted the overall result in 3MDG-supported townships which significantly dropped from 77% in 2017 to 72%. Rakhine contributes largely the overall achievement. Its coverage in immediate breastfeeding is the least among 3MDG supported state/regions with 62%, yet an improvement from the 2017 achievement of 58%. The reasons for low coverage in Rakhine state are multidimensional. Firstly, there is limited awareness of importance of immediate breastfeeding. Secondly, midwives do not always record the data in HMIS, unless they see the actual breastfeeding. Thirdly, data from camps is not included in HMIS. Some townships in Shan and Kayah reported similar recording issues. In Chin, Falam reported that the volunteer attrition impacted this indicator achievement because volunteers encourage immediate breastfeeding and help MW record the data. Additional contribution: 828 (EHO only)- Ref.notes (1) and (2) at the bottom of the table.</td>
</tr>
</tbody>
</table>

Page 4
<table>
<thead>
<tr>
<th>No.</th>
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</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Contraceptive prevalence rate in Component 1 townships</td>
<td>70% (451,861 out of 648,776 married couples)</td>
<td>33% (22,350 out of 69,988 married couples)</td>
<td>Meeting or Exceeding expectation</td>
<td>Not applicable</td>
<td>This indicator is reported for the townships of Chin State only, where both public sector and private sector support to FP commodity supports continued in 2018. NB: the private sector support covered 7 out of 9 townships. Though the target is almost met, the overall CPR coverage in Chin is low. The reasons reported are i) reluctance of community to use long term contraceptives due to cultural beliefs, ii) phasing out of IRC’s Family Planning project in Paletwa, iii) low coverage in urban areas by Urban Health Center for FP in Hakha and iii) data collection challenges. Additionally, it was reported that the women would like to have babies, not using any contraception, thanks to the Maternal Conditional Cash Transfer Program (MCCT) which provides cash to pregnant women until their children reach 2 year of age.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Percentage of under five children who had diarrhoea receiving ORT (disaggregated by sex and age)</td>
<td>Not available*</td>
<td>NA**</td>
<td>NA**</td>
<td>-</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Percentage of under five children with suspected pneumonia who received appropriate antibiotics (disaggregated by sex and age)</td>
<td>Not available*</td>
<td>NA**</td>
<td>NA**</td>
<td>-</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Number and percentage of children under one immunized with (i) DPT3/Penta3 and (ii) Measles in Component 1 townships</td>
<td>89% (100,150 out of 112,491 children under 1 year old)</td>
<td>92% (66,153 out of 73,014 children under 1 year old)</td>
<td>Meeting or Exceeding expectation</td>
<td>385,655</td>
<td>State &amp; Region Achievement: Chin - 96%, Kayah - 99%, Shan - 91% and Rakhine - 87%. All states/regions have shown increases in coverage compared to 2017. Notable increase is seen in Rakhine state from 77% to 87%. The increase is evident in both Northern and Southern Rakhine townships. Still, there are challenges in post-conflict affected townships (Buthidaung) in reaching immunization in HR areas especially in December 2018 due to security constraints. Additional contribution: 7,504 (HPA Special Regions except KSR1) - Ref.notes (1) and (2) at the bottom of the table.</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Number and percentage of people who inject drugs (PWID) reached by HIV prevention programmes in programme areas</td>
<td>Number: 42,977 Coverage: 104% (42,977/41,500 PWID in programme area), 67% of PWID in programme area (28,000)</td>
<td>Number: 40,422 Coverage: 97% (40,422/41,500 PWID in programme area)</td>
<td>Meeting or Exceeding expectation</td>
<td>42,977</td>
<td>As PWIDs are mobile in nature, implementing partners expanded their implementation work to more hard-to-reach sites where PWIDs are located. Partners also covered surrounding townships for comprehensive reach to beneficiaries. Furthermore, mobile outreach to new areas was conducted. Almost 1 out of estimated 2 PWIDs in Myanmar were reached by HIV prevention services of 3MDG partners. Our of the PWID reached, more than half (57%) of total PWIDs accessed services through drop-in-centres.</td>
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<tr>
<td>10</td>
<td>Case notification rate of all forms of TB per 100,000 population – (bacteriologically confirmed plus clinically diagnosed)</td>
<td>249</td>
<td>290</td>
<td>Not reported</td>
<td>-</td>
<td>Not applicable</td>
<td>2018 CNR data is not available yet. This indicator is based on national reporting by NTP. The 2017 NTP CNR (all forms) of TB is 249/100,000 against the target of 292/100,000 for 2017 (Global TB Report 2018). Calculation is based on the population of 53 million. The indicator targets are from the TB NSP and are based on the global commitment to End-TB strategy. Government had issued instruction to all private sectors for mandatory case notification and which can bring narrow the gap of notification. A national TB prevalence survey conducted in 2017-2018 found that TB prevalence declined from 613 per 100,000 populations in 2009 to 466/100,000 (Model 3, MI+IPW) in 2018. Based on the results of the recently completed nationwide TB Prevalence Survey, the NTP will revise TB epidemiological data, targets and policies and control strategies to reach the End TB strategy goals.</td>
</tr>
<tr>
<td>11</td>
<td>Percentage of confirmed MDR TB cases successfully treated (disaggregated by sex and age)</td>
<td>80%</td>
<td>NA**</td>
<td>-</td>
<td>-</td>
<td>Not applicable</td>
<td>3MDG-supported patients enrolled in 2015 finished their treatment in 2017. MDR-TB treatment success rate (TSR) of the 2015 cohort is already published (80%).</td>
</tr>
<tr>
<td>12</td>
<td>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</td>
<td>72.3%</td>
<td>65%</td>
<td>62.3%</td>
<td>Meeting or Exceeding expectation</td>
<td>Not applicable</td>
<td>Many patients are migrant people who work in road construction, rubber plantation, forest area and mining, and experience challenges of accessing VHW services within 24hr of fever. This explains a slight underachievement.</td>
</tr>
<tr>
<td>14</td>
<td>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</td>
<td>100%</td>
<td>80%</td>
<td>100%</td>
<td>Meeting or Exceeding expectation</td>
<td>Not applicable</td>
<td>All implementers (21 organizations) reported events/meetings that include participation and engagement between health care providers and target communities.</td>
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<td>1</td>
<td>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</td>
<td>62,154</td>
<td>114,941 (TBC)</td>
<td>274,752</td>
<td>Meeting or Exceeding expectation</td>
<td>972,256</td>
<td>274,752 (MSI- 126,264, PSI- 126,924, Public tsp-17,564)</td>
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<td>State &amp; Region Achievements: Delta - 5,362 (22%), Chin - 2,218 (15%), Magway - 3,525 (26%), Kayah - 907 (13%), Shan -2,277 (15%), Rakhine - 5,822 (14%)</td>
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<td>Overall, EmOC referrals exceeded 2018 targets, however there was a slight decline in referral rates as a percentage of estimated pregnancies - from 18% in 2017 to 17% in 2018. This is largely attributable to better management of excessive referrals by IPs in some of the townships.</td>
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<td>Increased community awareness and BHS referral contributed to improving referral coverage in Rakhine. Chin and Kayah maintained the Emergency referral momentum. The decrease of referral rates in Shan was contributed by Lahka (which show over-referrals previously) where referral system was changed to improve program quality and increase area coverage by setting targets for each RHC areas based on their expected pregnancies.</td>
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<td>New emergency referral package was piloted in Delta which along with reduced number of supported townships led to a notable decrease in referral coverage % in Delta (from 28% in 2017 to 22%). This new referral package (comprising a fixed amount of support to patients) served as a foundation for referral support under ACCESS.</td>
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<td>Additional contribution = 787 (All) - Ref.notes (1) and (2) at the bottom of the table.</td>
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<tr>
<td>2</td>
<td>Number and percentage of appropriate EmOC referrals supported in Component 1 townships</td>
<td>23,041 (18% of 130,557 estimated pregnancies)</td>
<td>16,000* (17% of 117,434 estimated pregnancies)</td>
<td>20,111</td>
<td>Meeting or Exceeding expectation</td>
<td>87,882</td>
<td>State &amp; Region Achievement: : Chin -9,080 , Kayah- 5,279, Shan - 7,071, Rakhine - 20,457</td>
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<td>In 2018, Delta and Magway region phased out. The reported figures are from Chin, Kayah and Shan townships.</td>
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<td>Additional contribution: 4,052 (All) - Ref.notes (1) and (2) at the bottom of the table.</td>
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<tr>
<td>3</td>
<td>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</td>
<td>48,277</td>
<td>42,000</td>
<td>41,887</td>
<td>Meeting or Exceeding expectation</td>
<td>183,651</td>
<td>State &amp; Region Achievement: : Chin -9,080 , Kayah- 5,279, Shan - 7,071, Rakhine - 20,457</td>
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<td>In 2018, Delta and Magway region phased out. The reported figures are from Chin, Kayah and Shan townships.</td>
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<td>Additional contribution: 4,052 (All) - Ref.notes (1) and (2) at the bottom of the table.</td>
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</table>
| 3   | Number of under five children diarrhoea cases i) treated with ORT at Health Facilities ii) treated with ORS + Zinc at community by volunteers                                                                  | 15,638      | 7,800               | 9,733       | Meeting or Exceeding expectation | 33,309         | State & Region Achievement: : Chin - 8,258 Shan - 1,475  
In 2018, Delta and Magway region phased out. The reported figures are from Chin and Shan townships.  
Chin contributed majority of cases in 2018 although the cases treated decreased than 2018. The challenges included ORS stock out and less VRS report collection in Southern Chin township especially due to 3MDG project closure, and armed conflict (Paletwa). Similarly the decrease is also seen in Shan due to high volunteer attrition in Namtu, Laihka and Mawkmai townships and less VRS reports collection in the last quarter due to reduced field level activities because of project closure.  
Additional contribution: 8,679 (Wa+SR4+KSR1+Mawkmai) - Ref.notes (1) and (2) at the bottom of the table. |
| 4   | Number of under five children suspected pneumonia cases treated with antibiotics i) at Health Facilities ii) at community by volunteers                                                                       | 25,991      | 27,000              | 20,178      | Moderate achievement          | 116,106         | State & Region Achievement: : Chin -5,005 , Kayah- 2,678, Shan - 3,815, Rakhine - 6,580  
In 2018, Delta and Magway region phased out. The reported figures are from Chin, Kayah and Shan townships.  
Additional contribution: 3,565 (All) - Ref.notes (1) and (2) at the bottom of the table. |

3MDG Result Matrix Jan-Dec2018_V3 update.xlsx
<table>
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<tbody>
<tr>
<td>1</td>
<td>Number of doctors, nurses and midwives who participated in at least one MNCH training including delivery and emergency obstetric care in Component 1 townships</td>
<td>2,772 (Coverage = 67% of total eligible functioning 4,134)</td>
<td>500</td>
<td>1,905 (Coverage = 67% of total eligible functioning 2,859)</td>
<td>Meeting or Exceeding expectation</td>
<td>Not applicable</td>
<td>The target 500 had been set on the assumption that only Rakhine townships are supported for BHS training in 2018 due to budget reduction at the time LF preparation. However, more budget became available in late S2 of 2017, resulting in CTHP support of BHS training in all townships, not limited to only Rakhine townships. That's why the achievement is much more than expected.</td>
</tr>
<tr>
<td>2</td>
<td>Average percentage of auxiliary midwives and community health workers receiving quarterly supervision and monitoring</td>
<td>74%</td>
<td>60%</td>
<td>64%</td>
<td>Meeting or Exceeding expectation</td>
<td>Not applicable</td>
<td>Phasing out of high achieving townships in Delta and Magway, and start-up phase of Rakhine townships in VHW supervision activities impacted the overall result in 3MDG-supported townships which dropped from 74% in 2017 to 64%. However, the overall target of 60% is met.</td>
</tr>
</tbody>
</table>
| 3   | Number and percentage of functioning AMWs and CHWs who report no stockouts of essential medicines and supplies | 43%                                                                          | 44%                | 47%         | Meeting or Exceeding expectation | Not applicable | The achievement 47% is based on data only from Chin and Shan townships where data collection is done through VRS. Kayah is not included in the achievement because it uses different stock reporting, and is shown separately.  
This indicator performance has improved compared to 2017 with 4% points increase. It is reported that IP could do more monitoring and supply drugs accordingly. Although a slight increase is seen and target is met, the % is still low for stock performance because several townships receiving drugs late from FMO (in Southern Chin townships), delay in distribution in geographic difficult areas (Northern Shan) and VRS report collection was challenging especially in last quarter due to reduced field activities.  
NB: the result of 47% is based on the total number of VRS trained and functioning volunteers. If the scope is limited to those volunteers who submitted VRS reports, the % increases to 67%. |
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<tbody>
<tr>
<td>4</td>
<td>Proportion of midwifery students demonstrating competency</td>
<td>60%</td>
<td>NA**</td>
<td>72%</td>
<td>Meeting or Exceeding expectation</td>
<td>Not applicable</td>
<td>Target was not set for 2018, as there was no clarity on continuation of support to JHPIEGO at the time of LF preparation. As the grant was subsequently approved and activities continued, the indicator was reported in Jan-Dec 2018. The target was set “80%” for 2018 in the Implementation Partner LF.</td>
</tr>
<tr>
<td>5</td>
<td>Number of health facilities built and renovated per annum with 3MDG support</td>
<td>20</td>
<td>7</td>
<td>7</td>
<td>Meeting or Exceeding expectation</td>
<td>88</td>
<td>The construction of 88 out of 93 Facilities were completed as follows: • 2015: 17 facilities completed • 2016: 44 facilities completed • 2017: 20 facilities completed • 2018: 7 facilities completed The remaining five facilities in Shan state were transferred to the Access fund and are scheduled to be completed in 2019.</td>
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<tr>
<td>1</td>
<td>Number of sterile injecting equipment distributed to people who inject drugs</td>
<td>17,240,002</td>
<td>10,000,000</td>
<td>18,588,094</td>
<td>Meeting or Exceeding expectation</td>
<td>71,565,135</td>
<td>With the expanded reach of the People who inject drugs (PWIDs) in the intervention areas, more needles and syringes were distributed and average of 460 needles and syringes for each PWID. Furthermore, Mobile Outreach to new areas was conducted resulting in more Needle distribution, as some areas encountered seasonal migrations (e.g. Laukkai). NB: this indicator is repeatedly over-achieving its targets in the past years. Besides the enabling factors on the ground, there will be efforts to improve target-setting under Access to Health.</td>
</tr>
<tr>
<td>2</td>
<td>Number of bacteriologically confirmed DR TB cases who began second line treatment.</td>
<td>Not reported*</td>
<td>NA**</td>
<td>-</td>
<td>-</td>
<td>Not applicable</td>
<td>Most of the partners are testing well for malaria diagnosis in their operation areas as targeted. 158,640 out of 533,894 (30%) of RDT were tested by PSI-AMTR Project and 5,644 RDTs were contributed by malaria testing by integrated ICMV sites of MNCH operation area. The over-achievement is largely attributable to the addition of PSI-AMTR achievements - this grant was not part of 3MDG in 2017 when the target-setting was done.</td>
</tr>
<tr>
<td>3</td>
<td>Number of people with confirmed malaria (disaggregated by sex and age) treated as per the national treatment guidelines.</td>
<td>10,821 (Male:6,305, Female:4,516) &lt;1 year: 15 1-4 years: 1,561 5-9 years: 1,925 10-14 years: 1,355 &gt;15 years: 5,965</td>
<td>8,000</td>
<td>10,851 (Male:6,722, Female:4,129) &lt;1 year: 14 1-4 years: 1,635 5-9 years: 1,781 10-14 years: 1,291 &gt;15 years: 6,130</td>
<td>Meeting or Exceeding expectation</td>
<td>151,090</td>
<td>Overall, Pf to Pv ratio is 57% and 43%. Most of the cases; 57% are from age group of more than 15 years old. Malaria case positivity rate is 2% for this reporting period. The over-achievement is mainly attributable to the MHAA grant achievements - contributed 6,748 cases to the reported result (which is 62% of 3MDG overall achievement). This is due to Paletwa township with the highest case-load which contributed 37% of malaria cases. It should be noted that the positivity in Paletwa reduced from 29% in 2017 to 23.6% in 2018. Excluding Paletwa, the positivity is 1.3% in 2018, a decrease from 1.7% in 2017.</td>
</tr>
<tr>
<td>4</td>
<td>Number of RDTs taken and read</td>
<td>366,002</td>
<td>450,000</td>
<td>533,894</td>
<td>Meeting or Exceeding expectation</td>
<td>2,821,746</td>
<td>Most of the partners are testing well for malaria diagnosis in their operation areas as targeted. 158,640 out of 533,894 (30%) of RDT were tested by PSI-AMTR Project and 5,644 RDTs were contributed by malaria testing by integrated ICMV sites of MNCH operation area. The over-achievement is largely attributable to the addition of PSI-AMTR achievements - this grant was not part of 3MDG in 2017 when the target-setting was done.</td>
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<tr>
<td>5</td>
<td>Number of LLINs distributed (i) total (ii) migrant/mobile populations in high priority areas not readily covered by the Global Fund</td>
<td>2,013,938</td>
<td>NA**</td>
<td>-</td>
<td>-</td>
<td>Not applicable</td>
<td>There was no LLIN supported during this reporting period from 3MDG. The Global Fund supported LLIN to NMCP and nationwide.</td>
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<td>With the expanded reach of the People who inject drugs (PWIDs) in the intervention areas, more needles and syringes were distributed and average of 460 needles and syringes for each PWID. Furthermore, Mobile Outreach to new areas was conducted resulting in more Needle distribution, as some areas encountered seasonal migrations (e.g. Laukkai). NB: this indicator is repeatedly over-achieving its targets in the past years. Besides the enabling factors on the ground, there will be efforts to improve target-setting under Access to Health.</td>
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<td>Most of the partners are testing well for malaria diagnosis in their operation areas as targeted. 158,640 out of 533,894 (30%) of RDT were tested by PSI-AMTR Project and 5,644 RDTs were contributed by malaria testing by integrated ICMV sites of MNCH operation area. The over-achievement is largely attributable to the addition of PSI-AMTR achievements - this grant was not part of 3MDG in 2017 when the target-setting was done.</td>
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<td>Overall, Pf to Pv ratio is 57% and 43%. Most of the cases; 57% are from age group of more than 15 years old. Malaria case positivity rate is 2% for this reporting period. The over-achievement is mainly attributable to the MHAA grant achievements - contributed 6,748 cases to the reported result (which is 62% of 3MDG overall achievement). This is due to Paletwa township with the highest case-load which contributed 37% of malaria cases. It should be noted that the positivity in Paletwa reduced from 29% in 2017 to 23.6% in 2018. Excluding Paletwa, the positivity is 1.3% in 2018, a decrease from 1.7% in 2017.</td>
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<td>There was no LLIN supported during this reporting period from 3MDG. The Global Fund supported LLIN to NMCP and nationwide.</td>
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| 2   | i) Number of feedback received by IPs from community members, and  

ii) Percentage of feedback from community members addressed by the implementing partners. | 14,648       | -           | 13,113      | -                          | Not applicable   | 13,113 feedbacks are received and 11,881 are addressed during 2018. Some positive feedbacks were thank you letters and did not need to be addressed. |
<p>| 4   | Number and proportion of women representatives attending the annual Comprehensive Township Health Plan (CTHP) review workshop | 72%         | 50% (TBC)   | 77%         | Meeting or Exceeding expectation | Not applicable   | 25 townships reported this indicator. There was no CTHP review meeting in 3 townships of Shan. There were 1,467 female participants in CTHP review workshop among 1,901 total participants. The over-achievement of this indicator is attributable to the fact that the majority of the CTHP review workshop participants are midwives who are the main implementers of CTHPs. |
| 5   | Proportion of women representatives on (i) township health committee (ii) village tract health committees/ village health committees | 29%         | 28%         | 33%         | Meeting or Exceeding expectation | Not applicable   | Data is reported from 29 townships where township and village health committees are already established. There were 121 women among 372 participants. |
|     |                                                                                                                                           | 43%         | 45% (TBC)   | 42%         | Moderate achievement         | Not applicable   | 6,513 women participated in village health committees out of total 15,627 (5692 women participated among 13,991 in MNCH-supported townships and 821 women participated among 1,636 members through Collective Voices) |</p>
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<tr>
<td>1</td>
<td>Fund Manager performance: (i) Percentage of Fund Manager annual work plan milestones achieved (ii) Percentage of FMO monitoring visits conducted as planned</td>
<td>97%</td>
<td>&gt;90%</td>
<td>89%</td>
<td>Meeting or Exceeding expectation</td>
<td>Not applicable</td>
<td>8 out of 74 eligible workplan items not achieved</td>
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<td>86%</td>
<td>&gt;90%</td>
<td>83%</td>
<td>Meeting or Exceeding expectation</td>
<td>Not applicable</td>
<td>FMO conducted 33 monitoring missions (including 18 routine data quality assessments) covering 25 organizations in 8 states and regions. The target of 40 missions could not be reached, as in the second half of 2018 the FMO had to prioritise the processes related to establishing the successor fund and 3MDG final evaluation.</td>
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<td>3</td>
<td>Number of operational research studies and case studies produced and disseminated</td>
<td>17</td>
<td>5</td>
<td>24</td>
<td>Meeting or Exceeding expectation</td>
<td>90 (Ref. Note (3) below)</td>
<td>Overall 24 studies were completed across HIV (2), TB (3), Malaria (5), HSS (6), MNCH (8). Most studies were disseminated in meetings with relevant stakeholders with some of the studies already released in public domain. Considerable over-achievement of this indicator is attributable to the inclusion of evaluation and annual assessment reports, as well as strategic purchasing learning briefs from PSI and CPI (added to the scope of support at a later stage).</td>
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<tr>
<td>4</td>
<td>Number of policy dialogue and technical and strategic forums where 3MDG Fund results are presented and discussed</td>
<td>57</td>
<td>At least 10 per year</td>
<td>53</td>
<td>Meeting or Exceeding expectation</td>
<td>Not applicable</td>
<td>The results reflects meetings across all 3MDG components, mainly at Central and State/Region level and TSG meetings.</td>
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</table>

**Notes:**

1. Additional contribution: 2018 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 contributions may have some operational definition inconsistencies of indicators, therefore they are not included in coverage % calculation of concerned indicator.

2. Shan = (a) HPA (Health Poverty Actions) contributed MNCH activities at Shan Special Region 4, Wa, and Kokang Special Region (b)3 Ethnic Health Organizations (EHOs) working as consortium with RI (Relief International) contributed activities in Lahka and Mawkmai Townships.

3. Kayah = CHDN (Civil Health & Development Network), a local EHO working as consortium with IRC (International Rescue Committee) contributed activities in all Kayah 7 townships.

### IMPACT

<table>
<thead>
<tr>
<th>No.</th>
<th>Indicators</th>
<th>Baseline (YYYY)</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>Cumulative Result</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Maternal mortality ratio per 100,000 live births</td>
<td>200 (UN-MMIEG 2013)</td>
<td>Target</td>
<td>201</td>
<td>190</td>
<td>187</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
<td>Not applicable</td>
</tr>
<tr>
<td>2</td>
<td>Under-five child mortality per 1,000 live births (disaggregated by sex)</td>
<td>52 (UN-IGME 2012)</td>
<td>Target</td>
<td>48</td>
<td>45</td>
<td>43</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
<td>Not applicable</td>
</tr>
<tr>
<td>3</td>
<td>Neonatal mortality rate per 1,000 live births (disaggregated by sex)</td>
<td>26 (UN-IGME 2012)</td>
<td>Target</td>
<td>24</td>
<td>22</td>
<td>21</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
<td>Not applicable</td>
</tr>
<tr>
<td>4</td>
<td>HIV prevalence among people who inject drugs in programme areas</td>
<td>34.9% (2009)</td>
<td>Target</td>
<td>25%</td>
<td>22%</td>
<td>19%</td>
<td>Not available*</td>
<td>Not available*</td>
<td>Not available*</td>
<td>Not applicable</td>
</tr>
<tr>
<td>5</td>
<td>National TB (all forms) mortality per 100,000 population per year in programme areas</td>
<td>59 (National TB Prevalence Survey 2009-2010)</td>
<td>Target</td>
<td>57</td>
<td>55</td>
<td>53</td>
<td>48</td>
<td>45</td>
<td>43</td>
<td>Not applicable</td>
</tr>
<tr>
<td>6</td>
<td>Malaria mortality rate (per 100,000 population)</td>
<td>0.08 (2015)</td>
<td>Target</td>
<td>Not available</td>
<td>0.07</td>
<td>0.06</td>
<td>0.04</td>
<td>Not available</td>
<td>Not applicable</td>
<td>In 2013 and 2014, 3MDG used the indicator of Percentage of all deaths due to malaria (per confirmed malaria diagnosis), based on national M&amp;E framework. It was changed to malaria mortality rate indicator in 2015 due to changes in the National M&amp;E framework. The 2018 data is not available yet. In 2017, malaria mortality rate per 100,000 based on the population of 53 millions is 0.06 showed some increase compared to 2016 result. The malaria death cases total in 2016 was 27 and out of that, 16 cases were from Chin, In 2017, out of 30 total malaria death cases, 13 were from Palaww.</td>
</tr>
<tr>
<td>No.</td>
<td>Indicators</td>
<td>Baseline (YYYY)</td>
<td>2013</td>
<td>2014</td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
<td>Cumulative Result</td>
<td>Comments</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------------------------------------------------------------</td>
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<td>--------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>Number and percentage of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife) in Component 1 townships</td>
<td>66% (2011)</td>
<td>68%</td>
<td>71%</td>
<td>70%</td>
<td>72%</td>
<td>71%</td>
<td>66%</td>
<td>Not applicable</td>
<td>Note 3: In reviewing coverage of Outcome indicators 1 - 8, it is important to note that the 3MDG-supported MNCH portfolio composition continuously evolved between 2013 and 2018. Namely, it was as follows: 2013 - 6 townships in Ayeyawady; 2014 - 20 townships (6 - in Ayeyawady; 9 in Chin and 5 in Magway); 2015 - 34 townships (all above + 7 in Kayah and 7 in Shan); 2016 - 34 townships; 2017 - 43 townships (all above + 9 in Rakhine); 2018 - 32 townships (6 townships in Ayeyawady and 5 townships in Magway no longer covered). Coverage of Skil Birth Attendance was increasing from 2013 to 2016. From Decreasing trend was observed from 2017 because (i) highly populated Rakhine 9 townships with considerably lower coverage were added in the 3MDG-supported portfolio in 2017 and (ii) phasing out of townships with high coverage in Delta and Magway regions in 2018. Despite decrease in 2017 and 2018 at the portfolio level, in individual states and regions, SBA coverage increased since the start of 3MDG support. With the support to maternal emergency referral, pregnant women were referred to township and station hospitals for their deliveries or emergency treatment. This support partly contributed the achievement of skilled birth attendance. Additional contribution : 1,196 in 2015, 2,483 in 2016, 2,234 in 2017 and 5,058 in 2018. Cumulative result is 10,971 (All)- Ref. notes (1) and (2) at the bottom of the table.</td>
</tr>
<tr>
<td>2</td>
<td>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</td>
<td>64% (2012)</td>
<td>70%</td>
<td>75%</td>
<td>71%</td>
<td>73%</td>
<td>74%</td>
<td>71%</td>
<td>Not applicable</td>
<td>Important: See Note 3 under Outcome Indicator 1. Same applies here. Coverage of Antenatal care 4 times (ANC4) was increasing from 2013 to 2016. From Decreasing trend was observed from 2017 because (i) highly populated Rakhine 9 townships with considerably lower coverage were added in the 3MDG-supported portfolio in 2017 and (ii) phasing out of townships with high coverage in Delta and Magway regions in 2018. Despite decrease in 2017 and 2018 at the portfolio level, in individual states and regions, ANC4 coverage increased since the start of 3MDG support. There are several challenges in ANC4 coverage (i) it is still difficult for women to be reached by basic health staff (BHS) to have early AN visit within 14 weeks especially in geographic difficult areas and conflict areas (ii) there are sociocultural barriers, whereby women often do not attend ANC during first trimester (iii) there are challenges in the reporting to count as per indicator definition. Progress is more evident where there is improved health access due to better staffing and comparatively less conflict. Additional contribution : 2,486 in 2015, 3,168 in 2016, 3,446 in 2017 and 4,832 in 2018. Cumulative result is 13,844 (All)- Ref. notes (1) and (2) at the bottom of the table.</td>
</tr>
<tr>
<td>3</td>
<td>Number and percentage of mothers and newborns who received postnatal care visit within three days of childbirth</td>
<td>89.3% (PH Statistics Report: 2012)</td>
<td>20%</td>
<td>40%</td>
<td>80%</td>
<td>80%</td>
<td>83%</td>
<td>82%</td>
<td>Not applicable</td>
<td>Ref. Note 1 for Outcome Indicator 1. Same applies here. Coverage of postnatal care (PNC) was increasing from 2013 to 2016. From Decreasing trend was observed from 2017 because (i) highly populated Rakhine 9 townships with considerably lower coverage were added in the 3MDG-supported portfolio in 2017 and (ii) phasing out of townships with high coverage in Delta and Magway regions in 2018. Despite decrease in 2017 and 2018 at the portfolio level, in individual states and regions, PNC coverage increased since the start of 3MDG support. Similar to ANC4 indicator, the coverage in new born care depends on the health access. Volunteers especially auxiliary midwives (AMW) play an important role in informing BHS about non skilled deliveries in their villages, which prompts midwives (MW) to visit within 3 days of delivery. Additional contribution : 3,801 in 2015, 4,048 in 2016, 5,375 in 2017 and 9,310 in 2018. Cumulative result is 22,534 (All)- Ref. notes (1) and (2) at the bottom of the table.</td>
</tr>
</tbody>
</table>
### Indicators

<table>
<thead>
<tr>
<th>No.</th>
<th>Indicators</th>
<th>Baseline (YYYY)</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
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<th>Cumulative Result</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Number and percentage of newborns that initiate immediate breastfeeding within one hour after birth in Component 1 townships</td>
<td>3MDG ResultMatrix_2013-2018_FINAL.xlsx</td>
<td>Not reported in 2013</td>
<td>Not reported in 2014</td>
<td>80% (62,315 out of 79,860 total livebirths)</td>
<td>82% (62,330 out of 74,120 total livebirths)</td>
<td>84% (66,224 out of 111,387 total livebirths)</td>
<td>84%</td>
<td>(52,547 out of 72,619 total live birth)</td>
<td>Coverage of newborns that initiate immediate breastfeeding within one hour after birth (IBF) was increasing from 2013 to 2016. Decreasing trend was observed from 2017 because (i) highly populated Rakhine 9 townships with considerably lower coverage were added in the 3MDG supported portfolio in 2017 and (ii) phasing out of townships with high coverage in Delta and Magway region in 2018. Despite decrease in 2017 and 2018 at the portfolio level, in individual states and regions, IBF coverage increased since the start of 3MDG support.</td>
</tr>
<tr>
<td>5</td>
<td>Contraceptive prevalence rate in Component 1 townships</td>
<td>38.4% (Fertility and Reproductive Health Survey 2007)</td>
<td>45%</td>
<td>47%</td>
<td>63%</td>
<td>65%</td>
<td>56%</td>
<td>33%</td>
<td>Not applicable</td>
<td>Education about importance of immediate breastfeeding is important to achieve this indicator. In 3MDG supported townships, BHS and volunteers were trained for nutrition such as Essential Nutrition training. Community Based Newborn Care training. There were data quality issue in this indicator (i) recall bias of mother and (ii) willingness of MN to record only if they see the actual act of breastfeeding.</td>
</tr>
<tr>
<td>6</td>
<td>Percentage of under five children who had diarrhoea receiving ORT (disaggregated by sex and age)</td>
<td>66% (MICS 2009-2010)</td>
<td>69%</td>
<td>74%</td>
<td>75%</td>
<td>-</td>
<td>78%</td>
<td>NA</td>
<td>Not applicable</td>
<td>There was significant increase in contraceptive prevalence rate (CPR) in 3MDG supported townships from 2013 to 2017. It was achieved through combination of public and private sector implementation where Basic health staff and volunteers provided a continuous supply of family commodities to families who need them, and MSH/MSH through their clinics provided family planning services.</td>
</tr>
<tr>
<td>7</td>
<td>Percentage of under five children with suspected pneumonia who received appropriate antibiotics (disaggregated by sex and age)</td>
<td>34.2% (MICS 2009-2010)</td>
<td>43%</td>
<td>52%</td>
<td>57%</td>
<td>-</td>
<td>66%</td>
<td>NA</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Number and percentage of children under five immunized with (i) DPT3/Penta and (ii) Measles in Component 1 townships</td>
<td>85% (PONREP 2010)</td>
<td>63% (37,647 out of 53,152 children under 1 yr old)</td>
<td>97% (47,305 out of 48,565 children under 1 yr old)</td>
<td>91% (71,597 out of 78,875 children under 1 yr old)</td>
<td>95% (72,863 out of 76,962 children under 1 yr old)</td>
<td>89% (100,150 out of 112,491 children under 1 year old)</td>
<td>91% (66,153 out of 73,014 children under 1 year old)</td>
<td>385,655</td>
<td>Pentac3 coverage was increasing steadily from 2013 to 2016. Then the trend became decreasing in 2017, because highly populated Rakhine 9 townships started their implementation, and their achievement was lowest among 3MDG supported states/regions, contributed by Conflict in Northern and Central state. Then the coverage increased again in 2018 due to better access by BHS because of comparability stable security conditions in Rakhine and Shan states, and special outreach supported by 3MDG.</td>
</tr>
</tbody>
</table>

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**Additional information:**

- The reported result in 2016 based on DHS 2015-16 is national and includes ORS and recommended home fluid.
- There was no national-level survey to report for this indicator in 2014, 2015 and 2017.
- Pentac3 coverage was increasing over 2014 to 2018 due to better access by BHS because of comparability stable security conditions in Rakhine and Shan states, and special outreach supported by 3MDG.
- Measles coverage was increasing steadily from 2013 to 2016. Then the trend became decreasing in 2017, because highly populated Rakhine 9 townships started their implementation, and their achievement was lowest among 3MDG supported states/regions, contributed by Conflict in Northern and Central state. Then the coverage increased again in 2018 due to better access by BHS because of comparability stable security conditions in Rakhine and Shan states, and special outreach supported by 3MDG.
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<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Number and percentage of people who inject drugs (PWID) reached by HIV prevention programmes in programme areas</td>
<td>Target</td>
<td>60% of 38,600 PWID</td>
<td>23,000 PWID in programme area</td>
<td>65% of 38,800 PWID</td>
<td>25,000 PWID in programme area</td>
<td>70% PWID in programme area (29,050)</td>
<td>70% of PWID in programme area (29,050)</td>
<td>70% of PWID in programme area (29,050)</td>
<td>67% of PWID in programme area (29,000)</td>
</tr>
<tr>
<td></td>
<td>Result</td>
<td>Number: 18,934</td>
<td>Coverage: 82.3% (18,934/23,000 PWID in programme area)</td>
<td>Number: 26,661</td>
<td>Coverage: 70% (26,661/38,800 PWID in programme area)</td>
<td>Number: 30,411</td>
<td>Coverage: 73% (30,411/41,500 PWID in programme area)</td>
<td>Number: 40,053</td>
<td>Coverage: 96% (40,053/41,500 PWID in programme area)</td>
<td>Number: 42,977</td>
</tr>
<tr>
<td>10</td>
<td>Case notification rate of all forms of TB per 100,000 population – (bacteriologically confirmed plus clinically diagnosed)</td>
<td>Target</td>
<td>Not available*</td>
<td>319</td>
<td>327</td>
<td>294</td>
<td>292</td>
<td>290</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Result</td>
<td>297</td>
<td>369</td>
<td>276</td>
<td>263</td>
<td>249</td>
<td>Not available yet</td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Percentage of confirmed MDR TB cases successfully treated (disaggregated by sex and age)</td>
<td>Target</td>
<td>Not available*</td>
<td>Not available*</td>
<td>Not available*</td>
<td>81%</td>
<td>81%</td>
<td>Not available*</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Result</td>
<td>Not available*</td>
<td>Not available*</td>
<td>80%</td>
<td>Not available yet</td>
<td>Not available yet</td>
<td>Not applicable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>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</td>
<td>Target</td>
<td>30% (59,000)</td>
<td>Coverage: 45%</td>
<td>Number: 44,590</td>
<td>60%</td>
<td>60%</td>
<td>60%</td>
<td>65%</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td>Result</td>
<td>Coverage: 38%</td>
<td>Number: 34,462</td>
<td>Coverage: 46%</td>
<td>Number: 15,729</td>
<td>Denominator: 33,324</td>
<td>49%</td>
<td>Number: 5,923</td>
<td>Denominator: 12,046</td>
<td>64%</td>
</tr>
<tr>
<td>13</td>
<td>Number of IPs: % of all IPs (including C1, C2 and C4s), reporting events/meetings that include participation and engagement between health care providers and target communities</td>
<td>Target</td>
<td>76% (baseline)</td>
<td>The current indicator was introduced in 2017 to replace the indicator “Proportion of community members reporting receiving services of ‘good quality or better’” (not feasible to report)</td>
<td>Baseline to be established by end 2016</td>
<td>80%</td>
<td>80%</td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Result</td>
<td>76% (baseline)</td>
<td>100% (24 IPs reported)</td>
<td>100% (21 IPs reported)</td>
<td>Not applicable</td>
<td>76% (baseline)</td>
<td>100% (24 IPs reported)</td>
<td>100% (21 IPs reported)</td>
<td>Not applicable</td>
<td>76% (baseline)</td>
</tr>
</tbody>
</table>

Starting from 2013, 3MDG PWID prevention reach increased year by year. In 2017, 42,977 PWID were reached with HIV prevention program by 3MDG IPs which is the maximum figure reached along the 3MDG project life time. In 2018, the numbers reached reduced to 40,422 because of closure of one HIV grant close in end of 2017, and country level police crackdown and chasing drug user and dealers in 2018. Besides, as PWIDs were mobile in nature, implementing partners explored their implementation work to more hard to reach sites where PWIDs located. However, partners also covered surrounding gap area from nearby townships for comprehensive reach to beneficiaries and expansion in Mobile Outreach new areas were conducted. The coverage estimates in % are based on the number actually reached out of estimated number of PWID. The latter is based on PWID population size estimates from IBBIS 2014.

Since 2014, the case notification rate of all forms of TB has notably declined with the scale-up of case findings efforts. The 2018 TB Prevalence Survey indicates that the decline could be attributable to two main causes (i) declining national TB incidence and (ii) missing (unreported) cases from the urban poor, private sector and conflict affected areas.

The National TB Prevalence Survey conducted in 2017-2018 found that TB prevalence declined from 613 per 100,000 populations in 2009 to 466 per 100,000 (Model 3, MY-IPW) in 2018. The survey demonstrated success of the efforts of the National TB Programme to remove smear-positive cases from the community, as there was a 50% reduction from 502,100,000 in 2009/10 to only 242,100,000 in 2017/18. Case notification targets for future years will be reviewed and revised during the preparation of NISP for 2021-2026.

The 2016 MDR-TB patients cohort outcome was published in WHO 2018 report. 3MDG supported 64% of total MDR-TB patients in 2015. Nutritional and socio-economic support to MDR-TB patients positively affected treatment adherence and resulted in good treatment success rate.

The achievement increased year by year from 2013 to 2017 due to partner organizations had trained volunteers in migrant sites and expanding more testing services in mobile migrant populations. Partners also enhanced the health education sessions to improve the health seeking behaviours of the beneficiaries to visit to providers within 24 hours of fever.

The achievement in 2019 was lower than 2017 because of the changes in 3MDG 2018 extension such as shifting of some existing intervention sites to Global Fund and newly established townships in 2018.

Reporting on this indicator started in 2017. IPs conducted quarterly stakeholder/RHC meeting and community engagement session including service providers (BHS) and target groups (community representatives). These meetings/events provided a platform to listen to the voices of project community, discuss barriers in accessing health services, and identify ways to overcome these challenges. They were essential to strengthening collaboration, coordination, information sharing and feedback between health service providers and local authorities, community members and other relevant stakeholders.

Clear information sharing and transparency at community engagement sessions promoted community trust towards health service providers and enhanced awareness about available services. Discussion of challenges from each side and misperceptions helps getting to know each other’s perspective and improve engagement. There were some examples of such meetings resulting in more regular service provision.
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Total number of Couple Years of Protection (CPYPs) delivered through private sector services and private sector channels in Component 1 townships</td>
<td>2000 (2012)</td>
<td>Target</td>
<td>2,200</td>
<td>86,997</td>
<td>(i) 74,900</td>
<td>(ii) 156,700</td>
<td>(i) 81,000</td>
<td>(ii) 240,000</td>
<td>(i) 9,409</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Result (i) 28,263</td>
<td>(ii) not applicable</td>
<td>(i) 27,490</td>
<td>(ii) not applicable</td>
<td>(i) 108,327</td>
<td>(ii)222,187</td>
<td>(i) 107,302</td>
<td>(ii) 141,782</td>
<td>(i) 62,154</td>
</tr>
<tr>
<td>2</td>
<td>Number and percentage of appropriate EmOC referrals supported in Component 1 townships</td>
<td>8.8% (UMINCH Final Report 2010-12)</td>
<td>Target</td>
<td>5,406</td>
<td>7,500</td>
<td>11,800</td>
<td>11,800</td>
<td>16,000</td>
<td>16,000</td>
<td>71,106</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Result (i) 5,747</td>
<td>(13% of estimated pregnancies 44,558)</td>
<td>(ii) 8,007</td>
<td>(15% of estimated pregnancies 53,765)</td>
<td>(i) 14,364</td>
<td>(17% of estimated pregnancies 85,152)</td>
<td>(ii) 16,612</td>
<td>(19% of estimated pregnancies 86,384)</td>
<td>(ii) 23,041</td>
</tr>
<tr>
<td>3</td>
<td>Number of under five children diarrhoea cases treated with ORS + Zinc at community by volunteers</td>
<td>(i) 17,445 (HRMS 2014)</td>
<td>(ii) 7,938 (VRS, 2016)</td>
<td>Target</td>
<td>-</td>
<td>-</td>
<td>(i) 28,900</td>
<td>(ii) TBC</td>
<td>(i) 54,600</td>
<td>(ii) 8,758</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Result (i) 6,001</td>
<td>(ii) Not collected in 2013.</td>
<td>(i) 17,445</td>
<td>(ii) Not reported for 2014</td>
<td>(i) 34,499</td>
<td>(ii) Not reported for 2015</td>
<td>(i) 35,542</td>
<td>(ii) 7,398</td>
<td>(i) 48,277</td>
</tr>
<tr>
<td>4</td>
<td>Number of under five children suspected pneumonia cases treated with antibiotics at Health Facilities</td>
<td>(i) 14,150 (HRMS 2012)</td>
<td>(ii) 7,433 (VRS, 2016)</td>
<td>Target</td>
<td>-</td>
<td>-</td>
<td>(i) 21,300</td>
<td>(ii) TBC</td>
<td>(i) 26,300</td>
<td>(ii) 9,944</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Result (i) 14,150</td>
<td>(ii) Not reported for 2014</td>
<td>(i) 22,126</td>
<td>(ii) Not reported for 2015</td>
<td>(i) 27,233</td>
<td>(ii) 7,433</td>
<td>(i) 25,991</td>
<td>(ii) 17,491</td>
<td>(i) 20,178</td>
</tr>
<tr>
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<td>Not collected in 2013</td>
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### OUTPUT 2

**Strengthened systems for delivery of essential MNCH services**

<table>
<thead>
<tr>
<th>No.</th>
<th>Indicators</th>
<th>Baseline (YYYY)</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>Cumulative Result</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Number of doctors, nurses and midwives who participated in at least one MNCH training including delivery and emergency obstetric care in Component 1 townships</td>
<td>472 (JIMNCH Final Report 2010-12)</td>
<td><strong>Target</strong></td>
<td>&gt;80%</td>
<td>&gt;85%</td>
<td>2,500</td>
<td>2,200</td>
<td>2,200</td>
<td>500</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td><strong>Result</strong></td>
<td></td>
<td>353 (coverage = 39% of total functioning 909) (achievement = 49% of 3MDG 2013 target 1,280)</td>
<td>1,371 (coverage = 51% of total functioning 2,712) (achievement = 50% of 3MDG 2014 target 2,732)</td>
<td>2,167 (coverage = 69% of total functioning 3,132) (achievement = 87% of 3MDG 2015 target 2,500)</td>
<td>1,386 (coverage = 62% of total functioning 3,184) (achievement = 96% of 3MDG 2016 target 2,200)</td>
<td>2,772 (Coverage = 67% of total eligible functioning 4,134)</td>
<td>1,905 (Coverage = 67% of total eligible functioning 2,859)</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Average percentage of auxiliary midwives and community health workers receiving quarterly supervision and monitoring</td>
<td>30% (2012)</td>
<td><strong>Target</strong></td>
<td>30%</td>
<td>50%</td>
<td>1,500</td>
<td>70%</td>
<td>80%</td>
<td>66%</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td><strong>Result</strong></td>
<td></td>
<td>Not available</td>
<td>63%*</td>
<td>57%</td>
<td>62%</td>
<td>74%</td>
<td>64%</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Number and percentage of functioning AMWs and CHWs who report no stock-outs of essential medicines and supplies</td>
<td>NA</td>
<td><strong>Target</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td><strong>Result</strong></td>
<td></td>
<td>Not available</td>
<td>Not available</td>
<td>Not reported for 2015</td>
<td>32%</td>
<td>43%</td>
<td>47%</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Proportion of midwifery students demonstrating competency</td>
<td>NA</td>
<td><strong>Target</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td><strong>Result</strong></td>
<td></td>
<td>Not available</td>
<td>Not available</td>
<td>Not reported for 2015</td>
<td>24%</td>
<td>60%</td>
<td>72%</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Number of health facilities built and renovated per annum with 3MDG support</td>
<td>NA</td>
<td><strong>Target</strong></td>
<td>-</td>
<td>-</td>
<td>28</td>
<td>32</td>
<td>15</td>
<td>7</td>
<td>82</td>
</tr>
<tr>
<td></td>
<td><strong>Result</strong></td>
<td></td>
<td>Not available</td>
<td>Not available</td>
<td>17</td>
<td>44</td>
<td>20</td>
<td>7</td>
<td>88</td>
<td>The remaining 5 facilities in Shan state were completed in March 2019 and were transferred to ACCESS.</td>
</tr>
</tbody>
</table>

*In 2014, the indicator counted the volunteer who received at least one time supervision visit in a year. That is why the achievement was high. Since 2015, the indicator definition was changed to “the volunteer who received supervision quarterly.”

The indicator performance was improving till 2017 but it dropped in 2018 because Rakhine township just started supervision activities in this period and counted in overall achievement, and high-achieving townships in Delta and Magway phased out.

This indicator was measured through competency assessment conducted through a sample of students in selected Midwifery school. 2016 was the first year that JHPIEGO started its assistance Pre Service Education Strengthening to MoHS. Baseline conducted in 2015 showed that only 1% of the students were competent in assessed BEmONC essential skills and knowledge. Throughout implementation period, the % increased yearly and reached 72% in final year, which is almost meeting the target 80%.

Although the performance of this indicator continually improved, it remained at lower level than desirable. The reasons for underperformance included delayed receipt of drugs from FMoH, delayed distribution to geographically-difficult areas and challenges of VRS report collection.

This indicator was reported since 2016 with the implementation of Volunteer Recording System (VRS) in Delta, Chin, Magway and Shan townships. Note: the % reported here is counted among total functioning volunteers trained in VRS. If the % is counted only among volunteers who submitted VRS reports, the result in 2018 would be 67%.

Note: the % reported here is counted among total functioning volunteers trained in VRS. If the % is counted only among volunteers who submitted VRS reports, the result in 2018 would be 67%.

Throughout its lifetime, 3MDG supported trainings to BHS such as Basic Emergency Obstetric Care, Helping Baby Breath, Essential Nutrition Action, Immunization, Maternal Death Surveillance and Response, Child Death Surveillance and Response, Health Management Information System, etc.

With increasing number of township implemented, total number of eligible BHS trained in at least one MNCH training in a reported year was increasing till 2017. In 2018, the decrease was due to phasing out of Delta and Magway townships.

*In 2014, the indicator counted the volunteer who received at least one time supervision visit in a year. That is why the achievement was high. Since 2015, the indicator definition was changed to “the volunteer who received supervision quarterly.”

This indicator was reported since 2016 with the implementation of Volunteer Recording System (VRS) in Delta, Chin, Magway and Shan townships. Note: the % reported here is counted among total functioning volunteers trained in VRS. If the % is counted only among volunteers who submitted VRS reports, the result in 2018 would be 67%.

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Note: the % reported here is counted among total functioning volunteers trained in VRS. If the % is counted only among volunteers who submitted VRS reports, the result in 2018 would be 67%.
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<tr>
<th>No.</th>
<th>Indicators</th>
<th>Baseline (YYYY)</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>Cumulative Result</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Number of sterile injecting equipment distributed to people who inject drugs</td>
<td>2,342,073 (3DF, 2012)</td>
<td>Target</td>
<td>7,800,000</td>
<td>8,000,000</td>
<td>8,000,000</td>
<td>8,000,000</td>
<td>10,000,000</td>
<td>10,000,000</td>
<td>49,800,000</td>
</tr>
<tr>
<td>2</td>
<td>Number of bacteriologically confirmed DR TB cases who began second line treatment</td>
<td>667 (2013)</td>
<td>Target</td>
<td>Not available*</td>
<td>Not available*</td>
<td>1,400</td>
<td>600</td>
<td>Not available*</td>
<td>Not available*</td>
<td>2,000</td>
</tr>
<tr>
<td>4</td>
<td>Number of RDTs taken and read</td>
<td>412,466 (3DF 2012)</td>
<td>Target</td>
<td>Not available*</td>
<td>483,300</td>
<td>430,200</td>
<td>415,000</td>
<td>415,000</td>
<td>450,000</td>
<td>2,193,500</td>
</tr>
<tr>
<td>5</td>
<td>Number of people with confirmed malaria disengaged by sex (age) treated as per the national treatment guidelines</td>
<td>NA</td>
<td>Target</td>
<td>79,952</td>
<td>79,952</td>
<td>29,530</td>
<td>29,530</td>
<td>11,742</td>
<td>8,194</td>
<td>10,821</td>
</tr>
<tr>
<td>6</td>
<td>Number of LLINs distributed (i) total (ii) migrant/mobile populations in high priority areas not readily covered by the Global Fund</td>
<td>4,468,655 (i) 94,269 (ii) (2012)</td>
<td>Target</td>
<td>1,000,000</td>
<td>82,000</td>
<td>423,000</td>
<td>Not available*</td>
<td>Not available*</td>
<td>2,000,000</td>
<td>3,505,000</td>
</tr>
<tr>
<td>No.</td>
<td>Indicators</td>
<td>Baseline (YYYY)</td>
<td>2013</td>
<td>2014</td>
<td>2015</td>
<td>2016</td>
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<td>2018</td>
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<td>Comments</td>
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</tr>
<tr>
<td>1</td>
<td>Specific health sector policies, strategies and plans that the 3MDG is supporting are developed and delivered to the MoH</td>
<td>-</td>
<td>Target</td>
<td>Final draft submitted to MoH</td>
<td>Implementation plans developed and costed</td>
<td>Policy and implementation plans developed and costed</td>
<td>Not applicable</td>
<td>Health system strengthening activities were supported by 3MDG Fund since 2015 until the end of the Fund. The main outputs throughout this period are: 1) Situational Analysis and Consultations of Community-based Health Workers is being finalized with 3MDG funding and technical support. This forms part of the national policy development on VBHWs. 2) MoHS NHP second year AOP (2018-2019) finalized 3) MoHS NHP M&amp;E framework (2017-2021) finalized 4) Regional Supply Chain System Support Endline Evaluation Report finalized and disseminated 5) MOHS Human Resource Information System roadmap updated 6) MoHS Operational Manual for Preceptship in Midwifery Pre-service Education Finalized and disseminated in April 2018 7) National drug control policy was launched during Feb, it was continuing process of 2017. 8) Sub national plan for HIV developed for Khachin and Sagaing States (Technical support) and Shan North (Both Technical and Financial) 9) National SFHII Policy developed 10) 3MDG contributed (partially) to the development of Multi- Sectoral National Plan of Action for Nutrition (MS-NPAN) 11) Draft Community-based Health Worker policy developed and submitted for MoHS review.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>The national Essential Package of Health Services has been defined, costed and submitted to the MoH with support from 3MDG.</td>
<td>-</td>
<td>Target</td>
<td>Final package submitted to MoH</td>
<td>Implementation plans developed and costed</td>
<td>Implementation plans developed, costed and prepared for roll-out</td>
<td>Not applicable</td>
<td>1) 3MDG funding was used by the National Health Plan Implementation and Monitoring Unit (NMUI) to support the Procurement and Supply Chain Management Unit to convene meetings to define the Essential Medicine List for township and below facilities. Nationwide procurement for 2018-19 Financial Year was made by the MoHS based on that list 2) Basic Essential Package of Health Services has two components - Public Health and Clinical. The Public Health content (except TB, Malaria and HIV related services) was finalized and costing completed in 2017. During 2018, Contents of both contents were finalized. Costing of Public Health contents and SOPs for Clinical contents were made through a series of consultations and meetings.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Percentage of townships with functional cold chain equipment and adequate storage space</td>
<td>20% (2014)</td>
<td>Target</td>
<td>50%</td>
<td>60%</td>
<td>80%</td>
<td>NA** (activity no longer supported in 2018)</td>
<td>Not applicable</td>
<td>The result is calculated based on CEP/MoH 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.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Percentage of stock-out incidents at health facilities in 3 PFSCM-supported States/Regions</td>
<td>65% (2016, health facility survey)</td>
<td>Target</td>
<td>Not reported for 2015</td>
<td>Baseline to be established by end 2016</td>
<td>Decline of 2% per year</td>
<td>NA** (activity no longer supported in 2018)</td>
<td>Not applicable</td>
<td>There was no error in reporting baseline as 46% in 2018 Result Matrix, but it is corrected as 65% in 2017 Result Matrix. The facility endline survey conducted in 2017 reported 71% stock-out incidence which is an increase from the baseline of 65% in 2016. 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. 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 LUMS activities are finally handed over to the MOHS.</td>
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<td></td>
</tr>
<tr>
<td>1</td>
<td>Number of staff from Ministry of Health (MoHS), 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 &amp; CS)</td>
<td>Target</td>
<td>0</td>
<td>25</td>
<td>200</td>
<td>300</td>
<td>500</td>
<td>500</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Result</td>
<td>0</td>
<td>196</td>
<td>2791</td>
<td>3,192</td>
<td>5,121</td>
<td>3,405</td>
<td></td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>

Starting from 2014, the number of trained participants increased considerably year by year. In 2017, 5,121 staff from MoHS, IPs, NGOs and CBOs attended AEI & CS relating trainings, the highest achievement in the Fund’s lifetime.

This indicator has significantly exceeded the target. This is attributable to:

1. extended AEI&CS related trainings beyond 3MDG projects to cover whole organizations and partnering community-based organizations.
2. conservative targets were set in some years because of the lack of clarity on budgetary allocation for AEI related trainings at the time of LF preparation.

IPs received more feedback year by year. The percentage of feedback addressed by IPs to community members also increased owing to the following:

1. community feedback mechanisms of all IPs becoming better functioning by using more engagement approaches to stimulate two-way discussions;
2. community becoming more aware of the existence of the mechanism and more empowered to provide feedback thanks to awareness raising and information sharing by IPs.

This indicator is reported since 2015 when the related programmatic activities were introduced. This indicator achieved more than targetted because majority of the CTHP review workshop participants were midwives who are among the main implementers of CTHPs.

Township Health Committee (THC) formation and women representation is based on ToR of THC. IPs support to the committee to encourage and promote representation by women.

In VHC/VTHC guideline and terms of reference, proportion of women representatives in VHC & VTHC was set. Women committee members were offered capacity building and empowerment opportunities.
<table>
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<tr>
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<th>Cumulative Result</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Fund Manager performance: (i) Percentage of Fund Manager annual work plan milestones achieved (ii) Percentage of FMO monitoring visits conducted as planned</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Target</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Result (i) 71%</td>
<td>(i) 71%</td>
<td>(i) 61%</td>
<td>(i) 87%</td>
<td>96%</td>
<td>97%</td>
<td>89%</td>
<td></td>
<td>After a slower start-up at the outset of the Fund, since 2015 both indicators performed well - in some years nearly meeting and in other years exceeding the targets.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Target</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Result (i) 88%</td>
<td>(i) 88%</td>
<td>(i) 85%</td>
<td>(i) 109%</td>
<td>110%</td>
<td>86%</td>
<td>83%</td>
<td></td>
<td>Monitoring represents one of the core priorities of the FMO. Performance of this indicator was either nearly meeting or exceeding the targets for all years, except 2018. The 2018 target could not be reached, as in the second half of 2018 the FMO had to prioritise the processes related to establishing the successor fund and 3MDG final evaluation. Both were very resource-intensive initiatives for FMO's staff.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Number of operational research studies and case studies produced and disseminated</td>
<td>3 (2011)</td>
<td>3</td>
<td>5</td>
<td>7</td>
<td>10</td>
<td>10</td>
<td>5</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Target</td>
<td>At least 3 per year</td>
<td>At least 3 per year</td>
<td>At least 8 per year</td>
<td>At least 10 per year</td>
<td>At least 10 per year</td>
<td>At least 10 per year</td>
<td></td>
<td>Overall 90 studies were completed across various thematic areas as follows: MNCH-33, HSS-28, ATM-29 (HIV-12, Malaria-10, TB-7). Most studies were disseminated in meetings with relevant stakeholders with some of the studies already released in public domain. Considerable over-achievement of this indicator is attributable to the inclusion of evaluation, annual assessment reports, and case study reports from strategic purchasing. Some of these outputs were programmed after finalisation of the latest 3MDG LogFrame.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Result</td>
<td>14</td>
<td>18</td>
<td>16</td>
<td>50</td>
<td>57</td>
<td>53</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Number of policy dialogue and technical and strategic forums where 3MDG Fund results are presented and discussed</td>
<td>3 per year (3DF, 2012)</td>
<td>3</td>
<td>5</td>
<td>7</td>
<td>10</td>
<td>10</td>
<td>5</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Target</td>
<td>At least 3 per year</td>
<td>At least 3 per year</td>
<td>At least 8 per year</td>
<td>At least 10 per year</td>
<td>At least 10 per year</td>
<td>At least 10 per year</td>
<td></td>
<td>Performance of this indicator considerably exceeded its targets throughout the lifetime of the Fund. Primarily this is attributable to the broad scope of work funded by 3MDG Fund in the health sector, inclusive approach in working with the MoHS and other stakeholders, and health reforms in Myanmar which accelerated in 2015.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Result</td>
<td>14</td>
<td>18</td>
<td>16</td>
<td>50</td>
<td>57</td>
<td>53</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:

(1) Additional contribution: 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.

(2) Shan = (a) HPA (Health Poverty Actions) contributed MNCH activities at Shan Special Region 4, and Wa from 2015 to 2018 and Kokang Special Region in 2018 only (b) Ethnic Health Organizations (EHOs) working as consortium with RI (Relief International) contributed activities in Laihka and Mawkmai Townships from 2015 to 2018.

Kachin= HPA contributed MNCH activities in Kachin Special Region 1, Kachin Special Region 2 (E-div & C-Div (Waingmaw, Momauk, Mansi)), and Kachin Special Region 2 (W-div & N-Div (Irrawaddy, Tanai, Sumpurabu)) only in 2018.

Kayah = CHIN (Civil Health & Development Network), a local EHO working as consortium with IRC (International Rescue Committee) contributed activities in all Kayah 7 townships from 2015 to 2018.
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