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FOREWORD

In 2015, the Three Millennium Development Goal Fund (3MDG) made a significant, nationwide and timely contribution to improving the health of the people of Myanmar and the systems and structures that will enable the country to achieve universal health coverage.

Working in close cooperation with the Ministry of Health, a member of the 3MDG Fund Board, 3MDG reached record levels of delivery in 2015. The programmes it supported helped improve maternal, newborn and child health, combat HIV and AIDS, tuberculosis and malaria, and strengthen health systems to deliver sustainable, efficient and responsive healthcare across Myanmar.

Since it was established in 2012, 3MDG has expanded critical maternal, newborn and child health services to 4.5 million people. It has enabled almost 100,000 pregnant women to access skilled care for childbirth, and almost 150,000 children to receive the crucial Penta 3 vaccination against common childhood diseases. Around 1.5 million people have been tested for malaria. In 2015 alone, some initiatives contributed a significant percentage of overall national targets, such as the distribution of syringes under the HIV Harm Reduction Programme (40%).

As one of the largest contributors of external assistance for health in the country, the Fund combines the resources of seven donors - Australia, Denmark, the European Union, Sweden, Switzerland, the United Kingdom and the United States of America – to provide over US$ 271 million in the period 2012–2017. By bringing key donors together in a single fund, 3MDG increases efficiency, achieves scale and provides coordinated support to government priorities.

While progress is being made, Myanmar faces significant inequalities in the health status of its population, especially in rural and remote areas, and those areas affected by conflict. The Ministry of Health and 3MDG are committed to meeting those challenges and helping to ensure equitable access to quality health for women, children, minorities and other vulnerable communities.

In 2015, 3MDG scaled up its services in conflict-affected areas. The commitment of the Ministry of Health and other 3MDG partners working with local organizations in areas controlled by non-state actors has resulted in improved coordination and access to health services.

Together, we have the chance to make mothers and children in Myanmar as healthy as their counterparts across the other countries of Southeast Asia, to combat HIV and AIDS, tuberculosis and malaria and create a health system that delivers quality services to people in need.

Myanmar is a country undergoing transformational change, creating real opportunities for millions of people to improve their lives. A healthier population is best placed to grasp these opportunities.

Billy Stewart
3MDG Fund Board Chair
**RESULTS AT A GLANCE**

**MATERNAL, NEWBORN AND CHILD HEALTH**
4.5 million people covered

- **71,597** children immunized with pentavalent 3
- **50,960** women visited four times for ante-natal care
- **50,307** births attended by a skilled person
- **14,364** pregnant women used emergency referrals

**TUBERCULOSIS**
14 states and regions covered

- **1,406** MDR-TB patients enrolled for second line of treatment
- **16,934** notified TB cases (all forms)
- **158,300** people screened for tuberculosis

**MALARIA**
1.9 million people covered

- **439,192** malaria tests taken and read
- **11,742** cases of confirmed malaria treated

---

**NATIONWIDE ACTIVITIES**

In addition to this service coverage map, 3MDG funds nationwide projects such as:

- **321 TOWNSHIPS** covered by TB active case finding implemented by the Ministry of Health National TB Programme
- **20 MIDWIFERY SCHOOLS** supported by the Midwifery Education and Training Strengthening Programme, in partnership with JHPIEGO
- **78 HEALTH CENTRES** under construction or under solicitation to provide healthcare to poor and vulnerable communities in remote areas
- **PROCUREMENT** of contraceptives nationwide, in partnership with Population Services International (PSI)
- **PUBLIC FINANCIAL MANAGEMENT** training of Ministry of Health staff at central, state/region and township levels, in partnership with the World Bank
- **COLD CHAIN SYSTEM** strengthening and expanding, in partnership with UNICEF

---

**HEALTH SERVICES COVERAGE**

FINANCED BY 3MDG

- Maternal, newborn and child health
- Tuberculosis (ACE, MDR-TB)
- HIV (Harm Reduction)
- Malaria
- HIV, TB, Malaria (integrated projects)
- \*Dots indicate townsships where more than one type of project is being implemented
EXECUTIVE SUMMARY

The 3MDG Fund was established in 2012 to provide joint donor support to address the basic health needs of the most vulnerable people in Myanmar. Across Myanmar, levels of maternal and child mortality are high, and most deaths are from preventable causes. Among specific diseases, the leading causes of death and illness are tuberculosis (TB), malaria and HIV/AIDS. These are significant inequalities in health status and in access to affordable, quality health care, especially in rural and hard-to-reach areas and among the most vulnerable populations. Health system challenges undermine the capacity of the public sector to deliver basic health care.

Beyond gains in terms of averted deaths, better health and improved well-being, global evidence shows that making the right investments in health is critical for economic growth and development. Health improvements accounted for about 11% of economic growth in low- and middle-income countries between 2000 and 2011. Improving access to and quality of health services is critical to ensure that citizens of Myanmar are healthy and enable them to become a more productive workforce for the country’s growth and development.

In partnership with the Government of Myanmar and others, the 3MDG Fund aims to have a significant, timely and nationwide impact, strengthening national ownership and working towards ensuring the sustainability of critical health services.

By pooling the contributions of seven bilateral donors - Australia, Denmark, the European Union, Sweden, Switzerland, the United Kingdom and the United States of America - 3MDG promotes the efficient and effective use of development funds. It is managed by the United Nations Office for Project Services (UNOPS). As detailed in this report, covering the period January to December 2015, the Fund was able to make substantial contributions towards targets set for the health related Millennium Development Goals, as well as Myanmar’s 2030 goal of universal health coverage (UHC) and the Sustainable Development Goals.

During 2015, the Fund made its most substantial contribution towards better health for people in Myanmar since being established in 2013. The Fund has adapted to the changing context and has taken forward important recommendations from a strategic review undertaken in 2014. This has included initiating a wide-ranging set of actions to enhance partnerships with the Ministry of Health (MoH) at both national and regional levels, an expansion of the work of the Fund to include a stronger focus on national level maternal, newborn and child health (MNCH) and health system strengthening (HSS) support work with a greater emphasis upon quality improvement, better support to the MoH’s township plans through standardized and simplified tools, and ensuring that a rights-based approach underpins service delivery. Important steps have been taken towards improving access to health services for people living in conflict-affected areas, work which is underpinned by a strategy and broad partnerships with a wide set of stakeholders.

In 2015, the Fund substantially accelerated delivery of critical support and services. This report demonstrates strong results in all areas of the Fund’s work, with high levels of achievement in terms of population coverage by health services and contribution to national results. It demonstrates a strong and shared vision for the health sector in which 3MDG is maximizing impact, strengthening national ownership and working towards ensuring the sustainability of critical health services.

Despite these achievements, major gaps remain in coverage and financing of health services as well as in levels of impact on the communicable and non-communicable disease epidemics and burden. These can only be addressed through a prolonged, sustained and accelerated drive towards universal health coverage.


WORKING TOGETHER TOWARDS UNIVERSAL HEALTH COVERAGE

Since 2010 when early design work on 3MDG first began, and in 2013 when the Fund first began its operations, there have been extensive changes in the context in which the Fund operates. During 2015, 3MDG implemented a set of recommendations arising out of a strategic review undertaken in late 2014. The reconstitution of the Fund Board to include the Ministry of Health, donors and independent experts alongside a strategic revisioning of the Fund has resulted in work that is substantially better aligned with national health priorities and strategies and better able to promote greater coordination across development partners.

FIGURE 1: KEY PROGRAMMATIC AREAS

1. MATERNAL, NEWBORN & CHILD HEALTH

- Scale-up of services in conflict-affected areas
- Support to health care in special regions
- Strengthening service delivery in public and private sectors
- Support to Ministry of Health human resources for health (HRH) strategy evidence base for national MNCH strategies

2. HIV, TUBERCULOSIS & MALARIA

- Support to the national strategic plan on HIV and AIDS (HARM REDUCTION)
- Support to the national TB strategy (TB-ACF & MDR-TB)
- Support to the national malaria strategy
- Strengthening of prison healthcare

3. HEALTH SYSTEMS STRENGTHENING

- Governance and stewardship
- Systems support
- Community engagement
- Support to evidence based strategy and human resources for health strategy
A child waiting to receive immunization in Ban Yin Hospital, Hshiseng, Shan State. Photo: 3MDG

In 2015, the 3MDG Fund supported healthcare initiatives that are making a real difference to the lives of some of the poorest and most vulnerable communities in Myanmar. Through the continuation of ongoing work as well as new initiatives, the 3MDG Fund looks forward to the opportunity to have even greater impact in 2016 and beyond and to make a substantial contribution towards Myanmar’s longer-term goal of reaching universal health coverage.

In 2015, 3MDG was able to better articulate and communicate its vision for a rights-based approach, underpinned by the four principles of responsibility, fairness, inclusion, and ‘do no harm’. The vision is contained within the Fund’s ‘Health for All’ approach and through it, 3MDG is working to promote the set of positive changes needed in the health sector. It is supporting key stakeholders to adopt improved health policies and deliver better health services in a more responsible, fair and inclusive way.

This has meant working to ensure equitable access to health services for the most vulnerable, enhancing the participation of communities in health decision making and implementation, and including the voices of women, minorities and other marginalized groups. These changes are required in order to address the very substantial inequities in access to healthcare services and health status that challenge Myanmar. It is supported by substantial work to generate learning, evidence and awareness as well as capacity to address gender-based inequities.

The vision is presented in the “Approach and Principles” section on page 20 of this Annual Report. The section details the substantial work undertaken by the Fund to address the wider range of social determinants of health and the barriers preventing equitable access to health, especially including gender-based inequalities.

### 2015 PROGRESS AND ACHIEVEMENTS

By the end of December 2015, 3MDG had achieved significant results through support to:

**Maternal, Newborn and Child Health**

Directly aligned to the Ministry of Health’s priority to reduce levels of mortality amongst women and young children, 3MDG support ensures access to essential maternal, newborn and child health (MNCH) services for a population of 4.5 million who live in remote and hard-to-reach areas. The package of services consists of proven cost-effective interventions that address the main causes of maternal, newborn and child death and illness in Myanmar. Midwives, auxiliary midwives and community health workers play a central role in achieving the impact of the Fund’s work.

The 3MDG Fund now supports MNCH service provision in Magway and Ayeayarwady Regions, the states of Chin, Kayah and Shan as well as in Wa Special Region 2 and Mongla Special Region 4. In 2015, health service coverage expanded to include additional conflict-affected areas in Shan State. ‘3MDG’s strategy for working in conflict-affected areas,’ updated in 2015, makes public the Fund’s principles, approach and commitments as well as the partnerships with the Ministry of Health (MoH) and ethnic health organizations that underpin this work.

In April 2015, an innovative programme to deliver health benefits to people living in Special Regions (Wa and Mongla) was launched. It brings together the MoH and Special Region health authorities to scale-up MNCH and TB services for people living in these areas. Key MNCH targets set for 2015 by the Fund to benchmark its performance were largely met. Around 50,000 pregnant women or 67% of total deliveries within the defined coverage areas were able to access skilled care for childbirth delivery, bringing the total since the Fund began to almost 100,000. More than 14,000 referrals for emergency obstetric care were supported, which brings the total since the Fund began to almost 30,000. Over 70,000 children were covered by Pent 3 vaccination, which brings the total number since the Fund began to almost 150,000.

Beyond the benefits brought to 4.5 million people through the scale-up of MNCH services, work continues on large scale initiatives to support improved MNCH outcomes across the country. These include a US$ 6.5 million programme to strengthen midwifery schools and midwifery services nationwide, a US$12 million infrastructure programme to construct 78 new health facilities and a US$ 19 million programme for training and support to over 4,000 auxiliary midwives. 3MDG is also supporting, through a partnership with the MoH and UNICEF, a US$ 8.7 million investment in increased cold storage capacity for vaccines across the country. The increased capacity will enable the addition of pneumococcal vaccine to the Expanded Programme on Immunization in June 2016, which will then be made available to all children. Introduction of this vaccine will lead to a reduction in the numbers of children under five who die from lower respiratory infections.

#### HIV, tuberculosis and malaria

**HIV (Harm Reduction)**

3MDG continues to support ongoing efforts to address social, legal and structural barriers to HIV prevention. The repeal in 2015 of sections 13 and 33 of the Excise Act 1917, referencing the illegal possession of hypodermic needles and syringes, is especially important, as is the inclusion of “intensified drug abuse prevention, treatment and rehabilitation” as a priority area for the newly formed Government. The impact of these policy reform and advocacy efforts will be long lasting as well as far reaching, removing some critical obstacles to implementation of one of the key components of ‘Harm Reduction’ – distribution of safe injecting equipment in the form of needles and syringes.

Piloting of introduction of low dead space syringes also began in Sagaing through a 3MDG financed initiative. This type of syringe retains less blood, greatly decreasing the likelihood of transmission of HIV and other blood borne diseases.

**Harm Reduction services are now being financed across 30 townships.** The programme prioritizes activities in areas with large numbers of people who inject drugs. In 2015, 3MDG and implementing partners overall reached over 30,000 people who inject drugs. This represents a contribution of more than 40% towards the national target for prevention activities for people who inject drugs in Myanmar. A total of more than ten million pieces of sterile injecting equipment to facilitate safe injecting conditions were distributed to reduce the risk of infection, which also represents a 40% contribution to the national target.

#### Tuberculosis

**TB Active Case Finding**

Under this programme, which is impacting upon the epidemic of TB in urban slums, in hard-to-reach areas and amongst underserved populations, the National TB Programme (NTP) and partner mobile teams are now conducting mass screenings across urban and remote locations. This is in line with government priorities to reach these populations and intensify programmes for prevention and control of communicable diseases, especially to reduce morbidity rates of TB, malaria, HIV/AIDS and hepatitis. Through 2015, nearly 160,000 cases of suspected TB cases were screened for TB – a doubling of numbers recorded for 2014 and which brings the total number screened since the start of the programme to over
MDR-TB infrastructure improvements in Yangon and Mandalay, including a new Biosafety Level 3 Laboratory in Yangon, with construction beginning in 2016 and to be completed by 2017.

Malaria

Whilst containment programmes remain vital as part of the effort to control the spread of artemisinin-resistant malaria, there is an emerging consensus that resistance can only be addressed through malaria elimination strategies. This will require a concerted and massive effort at the national, regional and global level.

The Fund is targeting an improvement in access to testing and treatment for malaria across a coverage population of around two million people. During 2015, almost 440,000 people including asymptomatic malaria cases received testing, representing over a quarter of the national target (27%), with around 12,000 confirmed cases receiving treatment. 3MDG and the Global Fund constitute the major sources of external assistance financing for malaria programmes in Myanmar today. The results of efforts in 2015 bring the total number of patients tested for malaria since 3MDG began work in 2013 to almost 1.5 million.

Evidence to guide and support policy and planning for elimination is limited. Robust data and information on the prevalence of malaria across Myanmar is lacking. In 2015, 3MDG partnered with United States Agency for International Development/President’s Malaria Initiative (PMI) to provide joint funding and technical support for Myanmar’s nationally representative Malaria Indicator Survey (MIS). Survey data collection was conducted during the peak malaria season (June – October 2015) and results are timetabled to be available around mid-2016.

Health Systems Strengthening (HSS)

The health sector in Myanmar continues to evolve rapidly. Myanmar has committed itself to achieve universal health coverage (UHC) by 2030 – ensuring people can obtain health services they need without suffering financial hardship – and to achieving the Sustainable Development Goals (SDGs), which replaced the Millennium Development Goals at the end of 2015.

For Myanmar to progress towards achieving UHC and SDG 3 (“Ensure healthy lives and promote well-being for all at all ages”), strengthening of the health system in terms of efficiency and responsiveness is critical in order to meet priority health needs. Key challenges include the need for increased investments and efforts in strengthening the service delivery systems for essential medicines and technologies, infrastructure, the health workforce and the financing system.

As a result of a strategic re-visioning exercise jointly undertaken by the MoH and 3MDG, 3MDG’s support is currently better aligned with MoH priorities and the rapidly changing national, regional and global context. This is further strengthened by 3MDG alignment with priority areas recently outlined by the newly formed government, including provision of quality medicines and initiation of modern treatment practices in government health institutions, and improvement of health management information systems. This strategic shift has resulted in a re-direction as well as expansion of 3MDG’s HSS investments. It has resulted in an HSS investment portfolio that will support a stronger and more responsive health system, which is urgently needed for sustainable progress and improved health outcomes.

3MDG programmes under the HSS component support the MoH in its efforts to strengthen national health systems through investments in the following areas: governance and stewardship; human resources for health; infrastructure; supply chain management; generating evidence and supporting evidence-based strategy, and community engagement. Amongst the areas of work in 2015 which have broad impact and nationwide relevance are support to strengthened public financial management, the midwifery workforce and the supply chain.

As part of its support for strengthening sector governance and accountability, in 2015 3MDG made resourcing available for strengthening of public financial management within the health sector to ensure better use of public funds through improved planning, budgeting, cash management, fund flows and accounting.

In line with the government priorities identified above, important work is being undertaken and significant financing provided to address the human resources for health shortage in Myanmar, with a focus on the midwifery workforce. Through technical assistance provided by Jhpiego, the Fund is supporting the MoH in transforming midwifery education to a more competency-based training by improving teaching methods and using upgraded skills labs. By the end of 2015, all midwifery school faculties were supported and skills labs were upgraded in the following schools: Taunggyi, Magway, Monywa, Hpa-An, Pyay, Loikaw, Mawlamyine, Sittwe, Myitkyina, and Pathein.

During 2015, 3MDG was additionally able to support the MoH’s scale-up plans for auxiliary midwives, financing the training of over 4000 auxiliary midwives across 178 townships in the country. Furthermore, 3MDG supported scholarships for MoH staff at a reputable university to gain knowledge, skills and exposure in public health – this is part of an effort to improve capacities of existing MoH staff at the central level.

During 2015, important work began on the Regional Supply Chain Strengthening pilot project in Bago, Magway and Ayeayarwady regions. Building upon the findings of the 2014 3MDG financed ‘National Supply Chain Baseline (NSCB) Report’ and overseen by the National Supply Chain Taskforce, substantial investments are now being made by 3MDG to strengthen supply chain management across all levels of the health system within these three regions and down to the health facility levels. This work to improve availability of medicines through
reduced stock-outs can bring benefits to a total population living across the three regions of almost 15 million.

**FINANCIAL STATUS AT DECEMBER 2015**
Seven bilateral donors - Australia, Denmark, the European Union, Sweden, Switzerland, the United Kingdom and the United States of America - pool their contributions in the 3MDG Fund, promoting the efficient and effective use of development funds.

At the end of December 2015, and taking into account the result of a reduction in the planned contribution of the Australian Government, and the impact of the strong US dollar on the value of contributions by other donor governments, the total value of the Fund over the period 2012-2017 is now expected to reach US$ 268.3 million.

Since the inception of the Fund and through December 2015, the 3MDG Fund Manager has received US$ 214.7 million in disbursements from contributing donors. By end of 2015, the 3MDG Fund had commissioned a total of 87 grants to 55 partners, which includes an additional 23 new grants awarded to a total of 15 partners during 2015. US$ 75.2 million (46%) of total expenditures were disbursements in 2015 reflecting a much greater level of financing of health investment, services and goods than in any preceding year of the Fund’s existence. The Fund’s partners are the MoH, UN organizations, international non-governmental organizations, and local civil society organizations.

**SUSTAINABILITY**
Three broad strategies are being adopted by the Fund to build sustainability: strengthening of the health system, building the capacity of key stakeholders within the health sector, including the Ministry of Health, ethnic health organizations and community-based organizations, and the capacity of national and international NGOs to deliver services at scale.

At an accelerating pace across 2015 and through opportunities created by the Fund’s enhanced relation with the Ministry of Health, important work has been started that could lead to institutionalizing services and activities currently supported by 3MDG within the public sector over time. In 2015, the reconstituted Fund Board approved a strategy for transition of MNCH programming in order to address sustainability. More detail on this complex area of work is provided on page 50 of this report.

Beyond this, sustaining programmatic gains of work currently being delivered under component 2, which addresses the burden of malaria, TB and HIV in Myanmar, is an important. The ongoing importance of these areas of work currently supported by 3MDG is reflected in their high prioritization within the new national strategic plans for malaria, TB and HIV currently being drafted. However without significant increases in either the domestic budget or levels of external assistance for the health sector, sustaining coverage at the levels currently possible through 3MDG support will become highly challenging.

An eventual exit strategy, and any realistic prospect of reducing donor support for basic health services, will however be dependent upon a significant increase in public sector expenditure on primary healthcare at the facility and community levels. It will also require substantial progress in the strengthening of systems and capacities as well as in institutionalizing services and activities currently delivered outside of the public sector. In 2016, the Fund is well placed to advance upon efforts already made, however very substantial work remains.

**FUND GOVERNANCE AND MANAGEMENT**

The goal of the 3MDG Fund is to improve maternal, newborn and child health and to reduce the burden of communicable disease in the areas of highest need in Myanmar. Initial design work on the 3MDG Fund began in 2010, the Fund Manager was selected in the second half of 2012 and new grants were first awarded in 2013.

When the Fund was designed, there were fewer opportunities to work with the Government of Myanmar and an urgent need to expand access to health services. Following a strategic review in 2014, the 3MDG Fund reconstituted its Fund Board to include the Ministry of Health (MoH), 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.

A year after these changes were made, a review led by one of the Fund Board’s health experts found that the Fund’s governance arrangements were “fit for purpose.” Following the inclusion of the MoH on the Fund Board, decision-making by the Fund is better aligned to health sector priorities and better able to support the MoH as they move towards universal health coverage.

The Fund Board also accepted recommendations to streamline decision making and to improve transparency by convening more regularly with implementing partners.

**FIGURE 2: GOVERNANCE AND STEWARDSHIP OF THE HEALTH SECTOR**

**GOVERNANCE AND STEWARDSHIP OF THE HEALTH SECTOR**

- Ministry of Health
- Seven donors
- Three independent experts

**PROGRAMMATIC AREAS:**
- Maternal Newborn & Child Health
- HIV, TB and Malaria
- Health Systems Strengthening

**3MDG FUND TARGETS HEALTH-RELATED MILLENNIUM DEVELOPMENT GOALS, SUSTAINABLE DEVELOPMENT GOALS, AND UNIVERSAL HEALTH COVERAGE**

3- 3MDG (2015). 3MDG Fund support to MNCH services delivery: a strategy for transition and to address sustainability
APPREACH AND PRINCIPLES

3MDG is committed to reducing inequalities in health and improving access to affordable, quality healthcare, especially in rural and hard-to-reach areas and among poor and vulnerable groups in Myanmar. The country has a largely rural population with a high degree of ethnic and linguistic diversity, alongside historical and ongoing insecurity and inter-ethnic conflicts. There are significant levels of poverty, and women often experience limited decision-making power within families, a fact mirrored by lower levels of leadership and representation in public forums and institutions.

Against this background, equitable access and people-centered health systems and services are crucial. Major reviews of the Fund’s overall strategy across 2014 and 2015 clearly set out the role 3MDG can play in contributing to Myanmar’s vision for universal health coverage (UHC). The Fund is now well placed to support central UHC commitments, including improving access to a package of essential health services and reducing catastrophic out-of-pocket health expenditure often faced by people seeking healthcare in Myanmar.

To do this 3MDG is guided by a rights-based approach, underpinned by the principles of responsibility, fairness, inclusion and ‘do no harm.’ These principles are emphasized in the 3MDG’s Description of Action and form the basis for the 3MDG’s Accountability, Equity and Inclusion Strategic Framework. They are also reflected in the Fund’s financing decisions, which target resources to those who cannot otherwise access services or afford healthcare including women and children, people living with HIV, and those in conflict-affected areas.

This year 3MDG has streamlined these principles under the banner, ‘Health for All.’ This has 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, NGOs, civil society organizations and communities. Through ‘Health for All,’ 3MDG has supported all stakeholders to adopt health policies and deliver health services in a more responsible, fair and inclusive way. This has meant:

- Working to ensure equitable access to health services for the most vulnerable
- Enhancing the participation of communities in health decision making and implementation
- Including the voices of women, minorities and other marginalized groups

RESPONSIBILITY

The principle of responsibility is about good governance and mutual accountability. It means that people can voice their health needs and receive responses, are informed on health issues, and have the information and confidence necessary to access quality services. 3MDG’s work in 2015 to advance this objective is covered throughout this report. Examples of successful work financed by 3MDG include:

- Trainings for the Ministry of Health, Ministry of Finance, civil society and development partners to strengthen their understanding of universal health coverage and health financing options. (see page 81)
- Training and resources to help implementing partners improve approaches to participation, inclusion, information-sharing and responding to community feedback. (see page 88)
- Co-financing Myanmar’s first demographic health survey with USAID. The survey will provide much needed evidence of health needs across the country, disaggregated by gender and wealth quintiles. (see page 80 and 94)

FAIRNESS

This principle emphasizes the importance of being fair and just towards all people who use health services, fostering mutual respect, and taking action to address discrimination. Ill-health and threats to health affect women and girls, men and boys differently, and discrimination can prevent many women and at-risk men from receiving information and healthcare they need.

3MDG uses every opportunity to promote gender equality and address social norms that undermine people’s right to health.

In its 2015 pamphlet entitled ‘Healthy Women, Healthy Men,’ the Fund uses simple language to articulate four concrete gender sensitive steps that reflect the gender equality commitments made in the 3MDG Description of Action.

- Improve understanding
- Examples of successful work financed by 3MDG to improve levels of understanding of how gender affects health, health seeking behaviour, and other gender-related issues, include:
  - Training partners in gender and conflict-sensitivity approaches.
  - Holding focus groups to hear beneficiary perspectives from both sexes (569 females and 505 males in 2015) to assess the impact of 3MDG-funded services and using these views to improve health programmes.
  - Supporting gender-related health research, for example UNAIDS situational analyses on addressing HIV for drug users, men who have sex with men, transgender people and sex workers.

Inclusion

Ensure all people are considered in health planning and decision-making
- Understand diverse experiences and needs, and foster mutual respect and tolerance
- Engage communities to plan and deliver quality health services
- Partners operate
- Ensure health activities do not create or worsen conflict
- Where possible, use health activities to improve opportunities for peace
- Ensure all people are considered in health planning and decision-making
- Understand diverse experiences and needs, and foster mutual respect and tolerance
- Engage communities to plan and deliver quality health services

Do no Harm

- Understand the context in which 3MDG partners operate
- Ensure health activities do not create or worsen conflict
- Where possible, use health activities to improve opportunities for peace

In 2015, the Fund co-financed Myanmar’s first demographic health survey with USAID. The survey will provide much needed evidence of health needs across the country, disaggregated by gender and wealth quintiles. (see page 80 and 94)

3MDG has supported all stakeholders to adopt health policies and deliver health services in a more responsible, fair and inclusive way. This has meant:

- Working to ensure equitable access to health services for the most vulnerable
- Enhancing the participation of communities in health decision making and implementation
- Including the voices of women, minorities and other marginalized groups

Responsibility

The principle of responsibility is about good governance and mutual accountability. It means that people can voice their health needs and receive responses, are informed on health issues, and have the information and confidence necessary to access quality services. 3MDG’s work in 2015 to advance this objective is covered throughout this report. Examples of successful work financed by 3MDG include:

- Trainings for the Ministry of Health, Ministry of Finance, civil society and development partners to strengthen their understanding of universal health coverage and health financing options. (see page 81)
- Training and resources to help implementing partners improve approaches to participation, inclusion, information-sharing and responding to community feedback. (see page 88)
- Co-financing Myanmar’s first demographic health survey with USAID. The survey will provide much needed evidence of health needs across the country, disaggregated by gender and wealth quintiles. (see page 80 and 94)
Improving governance and accountability in Myanmar

A major Ministry of Health (MoH) initiative supported by 3MDG to improve governance and accountability across all township health departments in Myanmar was launched in October, 2015. This complements the Fund’s wider efforts to improve coverage and quality of health services nationwide.

Under the MoH/World Bank’s four-year Essential Health Services Access Project (EHSAP), which focuses on achieving improved coverage of essential maternal, newborn and child health services, a number of Disbursement Linked Indicators (DLI) must be satisfied to trigger disbursements of the World Bank loan that finances the project. Progress in achieving the DLI targets is reviewed annually.

To track community engagement and improvements in service delivery accountability, DLI 4 measures the number of townships where the township health departments have prepared an annual integrated and inclusive township health plan. ‘Inclusive’ refers to the participation of ethnic and vulnerable groups, and incorporation of social analysis findings.

In 2015, the MoH requested support from the 3MDG Fund to achieve its targets under DLI 4, to build the capacity of staff to listen to community needs, include vulnerable and marginalized groups and incorporate their views in township health planning. The MoH proposed that a civil society organization with strong community links and in-depth understanding of participatory approaches would be best suited to provide training. It was agreed that the work would be conducted by Charity Oriented Myanmar, a partner under the 3MDG-funded Collective Voices initiative, bringing the MoH and civil society together to improve health in Myanmar.

A community engagement training curriculum was agreed and a training manual developed. The MoH staff received practical training in the use of ‘participatory learning tools’ with communities, and learned about the principles of responsibility, gender equality, social inclusion and ‘do no harm’. This better equips them to prioritize community needs when planning health services. Training was conducted in seven states and regions for Ministry of Health staff through the final quarter of 2015, using a Training of Trainers approach. Feedback received from participants was overwhelmingly positive.

Voices: Community participation is crucial

“I can see a lot of younger people here in this training, and it is very good that these young people are working enthusiastically for the country. In the past we were more successful in engaging communities, but we lost their trust for a certain period of time for various reasons. Now it’s a good time to receive this training to encourage us to reassert our community engagement.”

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

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

Daw Than Than Win, Health Assistant, Tanway Township Community Engagement Training Participant, 2015

Increase access to health

Examples of successful work financed by 3MDG to increase women’s access to health include:

• Financing referral costs so that women can be referred to the nearest hospital in emergencies (see page 38).
• Training village women health promoters, establishing village savings loan associations, conducting men’s engagement groups, and training volunteer village health committee (VHC) members on gender equality through the Collective Voices initiative.

Women’s representation and voice

Examples of successful work financed by 3MDG to support health services that are responsive to the needs of women include:

• Supporting the participation of women in community health education sessions and village health committees;
• Training and evaluating partners in information-sharing, participation and feedback mechanisms to reach women and girls;
• Promoting and monitoring women’s participation in health planning and decision-making bodies.

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, as the community is 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.”

Ja Htoo Aung is the Accountability, Equity, Inclusion and Conflict Sensitivity Officer at CESVI.

INCLUSION

This principle is about recognising the high degree of diversity that exists in Myanmar and ensuring that health policies, plans and services address the needs of these different groups. 3MDG provides services to a wide range of population groups who are considered vulnerable. This includes pregnant women and young children; people living with HIV and those most at risk, including people who inject drugs, sex workers and men who have sex with men; people living in hard-to-reach rural areas;
3MDG Assessment Tool

3MDG partners working on maternal health and disease interventions performed an annual assessment at the end of 2015 to evaluate how well they are practicing the principles of responsibility, fairness, inclusion, and ‘do no harm’ in their 3MDG health interventions. The 3MDG assessment tool evaluated the inclusion of traditionally disadvantaged groups (e.g. elderly, ethnic and religious minorities, and people with disabilities) in 3MDG-funded initiatives. The results indicate that for a majority of partners, people within these groups have equitable access to project activities and derive equitable benefit.

Nevertheless, the results show that more work needs to be done to improve inclusive practices, including better consulting and informing disadvantaged groups on certain aspects of the project. Further, traditionally disadvantaged groups do not appear to provide much feedback via feedback mechanisms. This may have to do with language barriers – only a small number of partners indicated that feedback can be provided in local languages and dialects.

To address this and other concerns, in 2016, 3MDG will engage an external specialist to conduct a case study on 3MDG partners’ community feedback mechanisms, and provide recommendations on how to improve the accessibility and inclusivity of health projects.

DO NO HARM

Across many areas of Myanmar, issues related to ethnicity and conflict affect the delivery of health services. 3MDG’s ‘do no harm’ commitment forms a central element of the Fund’s strategy to operate in conflict-affected areas and this commitment ‘to do no harm’ is being applied across all aspects of 3MDG’s work in these areas. It demands an in-depth and thorough understanding of the context in areas where the Fund operates in order to ensure that health activities do not create or worsen conflict.

The commitment to adhere to international best practices related to ‘do no harm’ is further detailed and made public through the communication by the Fund of a set of principles that guide the engagement of 3MDG and its partners in conflict-affected areas.

Beyond the tailoring of programme interventions to ensure that they are appropriate to different operating contexts in conflict-affected areas, the Fund is maximizing the peace-building opportunities of its interventions where possible. Read more from 3MDG’s ‘Strategy to operate in conflict-affected areas in Myanmar’ in the box on the right, which outlines the principles of conflict sensitivity.

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

In 2015, important work at both the strategic as well as operational level was undertaken in order to better inform the Fund’s ‘do no harm’ approach and to further the Fund’s work of supporting healthcare provision across areas affected by conflict. Examples of this work include:

- Strategic guidance and oversight
  - Reviewed its strategy to operate in conflict-affected areas, to gain a fuller appreciation of pre-conditions for successful programme delivery
  - Established conflict-sensitive learning groups, to promote the exchange of best practices among 3MDG partners working in conflict-affected areas
  - Drafted a conflict-sensitivity monitoring and evaluation framework

- Service delivery
  - Scaled-up services in conflict-affected areas, including in Shan and Kayah State
  - Supported TB mobile team visits in Rakhine State
  - Supported an innovative, integrated maternal, newborn, child health and TB

Principles of conflict sensitivity

In order for 3MDG to adhere to international best practices related to ‘do no harm,’ the following set of principles have been adopted by 3MDG to guide its engagement in conflict-affected areas:

1. Understand the conflict
2. Prior and on-going consultation with all key stakeholders
3. Meaningful involvement and participation of civil society organizations
4. Work with existing health structures and providers
5. Inclusion and non-discrimination
6. Transparency and information
7. Recruit local staff from all population groups
8. Balance process and achieving health results
9. Pragmatism and flexibility
10. Cooperation and coordination

Community Feedback

Under the 3MDG Collective Voices initiative, six qualitative reports (see 3MDG website for details) were completed by local civil society organizations based on more than 500 community meetings, highlighting feedback provided directly by community members about the key social barriers experienced in accessing health services. The results identified language barriers, poor health knowledge and education, lack of family planning and health decision-making power of women; limited functioning of and participation in village health committees; weak coordination among healthcare providers; and community reliance on traditional and informal practitioners.

A 3MDG display booth at the Gender Equality Network 16 Days of Activism Forum. Photo: 3MDG
FLOOD RESPONSE

Devastating rains in July 2015 caused massive flooding in twelve states and regions in Myanmar, and landslides that affected hill communities and destroyed vital access roads. More than 1.6 million people were severely affected, with a large majority (about 240,000 households according to the Office for the Coordination of Humanitarian Affairs) forced into temporary displacement.

This natural disaster increased the vulnerability of affected communities, especially women and children. They were forced to live in crowded conditions or without proper shelter, had limited access to sufficient food, contamination of their water sources, and increased susceptibility to infectious diseases. The township health departments’ ability to provide essential services was severely impacted.

Prior to the flooding, 3MDG was working through partners to support local health services. 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 focused on affected geographic areas that were already part of its regular programme and adjacent townships, utilizing existing structures to affect a timely and efficient response. The response prioritized the needs of 148,000 people in 26 townships in six states and regions, primarily in those most-affected: Magway, Chin andSagaing, but also in Ayeyarwady, Rakhine and Bago.

Working in partnership with the government and international and local organizations, 3MDG allocated a total amount of US$ 510,000 for its implementing partners to mobilize resources. These resources were used to support the immediate flood response in 3MDG project areas, to conduct needs assessments and to support township health departments to undertake contingency planning in areas not yet affected by floods.

Through work implemented by eleven 3MDG partners (seven international NGOs and four local organizations), 3MDG was able to respond in a manner tailored to local needs at the time, primarily in the health, water, sanitation and hygiene sectors, the provision of emergency food relief and in disaster management training.

KEY PARTNER INTERVENTIONS

- Ar Yone So Social Development Association facilitated supply of essential food and non-food items, as well as clean water for 15 days, for 3,000 people of southern Chin State in Mindat, Kanpetlet and Madupi Townships.
- Myanmar Health Assistant Association provided assistance to 14 TB patients and their households in 14 townships in Sagaing Region, Bago Region and Rakhine State; US$ 4,000 was reallocated to supply basic food and non-food items for these households for three months.
- Myanmar Anti-Narcotics Association distributed 14,100 water purification sachets and reallocated US$ 11,800 to provide 250 methadone maintenance treatment and antiretroviral therapy clients affected by the floods with a daily cash transfer to cover the cost of food, clothing and minor treatments in two townships of Sagaing Region.
- Population Services International facilitated procurement of 3.2 million household water treatment sachets to provide 150,000 people with clean water for three months, and 300,000 sachets of oral rehydration salts (ORS) to treat diarrhoea.
- The Danish Red Cross and the Myanmar Red Cross Society were responsible for the distribution of household water treatment sachets for 25,000 people in Magway and Madupi townships of Chin State, providing hard-to-reach communities with access to clean water for 20 days, and hygiene kits to 201 households that had lost their homes.
- Marie Stopes International supported health service delivery and health education through mobile outreach, in coordination with township health departments in Kale Township (Sagaing Region) and Pwintbyu Township (Magway Region), helping in TB, water treatments and ORS sachet distribution. (For ORS kits to distribute in the townships of Kale, Pwintbyu and Hakha (Chin State).
- Save the Children provided immediate assistance to nearly 1,800 people in four severely affected townships of northern Chin State: Hakha, Thantlang, Palam and Tiddim. This included facilitating distribution of water treatment and ORS sachets, 1,895 hygiene kits, and other items to families who had lost their homes.

PHOTO: Save the Children International
This component covers the Fund’s work to improve maternal, newborn and child health through achieving increases in access and availability of essential maternal, newborn and child health services. It supports all mothers and young children in entire townships with a special focus on the poorest and most vulnerable populations in Myanmar.
MATERNAL, NEWBORN AND CHILD HEALTH

TABLE 1: MATERNAL, NEWBORN AND CHILD HEALTH (MNCH) 2015 RESULTS AND TARGETS

<table>
<thead>
<tr>
<th></th>
<th>2015 TARGETS</th>
<th>2015 ACHIEVEMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ante-natal care: 4 visits per woman</td>
<td>59,513</td>
<td>50,972</td>
</tr>
<tr>
<td>Births attended by skilled person</td>
<td>57,110</td>
<td>64,572</td>
</tr>
<tr>
<td>Post-natal and newborn care provided ≤3 days after birth</td>
<td>11,800</td>
<td>28,900</td>
</tr>
<tr>
<td>Referrals for emergency obstetric care</td>
<td>14,364</td>
<td>71,497</td>
</tr>
<tr>
<td>Children immunized with Penta ≥2</td>
<td>34,499</td>
<td></td>
</tr>
<tr>
<td>Diarrhoea treated with Oral Rehydration Therapy</td>
<td>30,000</td>
<td></td>
</tr>
</tbody>
</table>

* The target numbers (except Diarrhoea treated with ORT) are calculated based on coverage targets set in the 3MDG Logframe as percentages and the use of respective demographic data in the 34 townships supported by 3MDG.

3MDG saw considerable progress in this component in 2015, as evidenced by the data above. In real terms, this means that a pregnant woman in townships that are supported by 3MDG, some of which are in remote or conflict-affected areas, now has a considerably better chance to survive childbirth complications and for her baby to be born healthy. The interventions funded by 3MDG mean that she has a better chance to get the professional ante-natal care she needs, to give birth assisted by a skilled attendant, or be sent to a hospital if needed, and for her older children to be fully vaccinated and to receive routine basic care at the community level, and receive emergency care if needed. She also receives this free-of-charge, so her family is not pushed further into poverty by catastrophic healthcare costs.

The 3MDG Fund supports access to services for women, newborns and children under five in order to contribute to Myanmar’s goal of attaining MDGs 4 and 5 through:

- Scale-up of services in conflict-affected areas
- Support to health care in Special Regions
- Strengthening service delivery in public and private sectors
- Support to Ministry of Health human resources for health (HRH) strategy
- Evidence base for national MNCH strategies

Across all supported areas, supply side and demand side interventions are being used to address the challenges people face in accessing an essential package of healthcare. On the supply side, the 3MDG Fund is providing financial and capacity building support to the public sector in order to strengthen service delivery. On the demand side and through public as well as private sector work, the 3MDG Fund supports the strengthening of community-based health services, the referral of emergency cases and private sector health care services. The following chapter explains how the Ministry of Health, with the support of partners funded by 3MDG, was able to successfully deliver this level of healthcare to increasing numbers of women and children in Myanmar.

KEY DEVELOPMENTS

- 3MDG met its target to provide an essential package of MNCH services to 4.5 million people – a tenth of Myanmar’s total population – compared to 3.5 million at the end of 2014.
- Improved health services are now reaching poor and vulnerable rural populations in remote areas within Magway and Ayeayarwady Regions, across seven conflict-affected townships within Shan State, and across all of Chin and Kayah states. The townships that are receiving 3MDG support are amongst those indicated by the ‘UNDP Integrated Household Living Conditions Survey’ (2009-2010) to have the highest incidence of poverty (Chin – 73%, Shan – 33%, Ayeayarwady – 32%) and those where there is clustering of people around the poverty line such that any major expense would send them below the poverty line. Additionally, Shani, Kayah and the Wa and Special Region 4 are affected by conflict.
- The first half of 2015 saw the start of an integrated healthcare programme in Wa Region and Shan Special Region 4.
- The MNCH programme reached its targets for critical indicators, including emergency obstetric referral numbers. Aggregate reporting shows a year-on-year rise in results achieved.
- More than two-thirds of births (67%) were attended by a skilled birth attendant, a significant improvement over last year. Additionally, 83% of newborns received postnatal care within three days as compared with 75% in 2014.
- Throughout 2015, more than 14,000 mothers and 12,000 young children made use of 3MDG-financed emergency referral pathways. This means they were able to access the healthcare they needed without facing crippling transportation and other costs.
- Master mentors in all 20 midwifery schools in Myanmar have been trained in skills and competency based teaching and assessments. Additionally, the supervisors of clinical practice sites have also received similar training. The skills laboratories of ten midwifery schools have been renovated and fully equipped. This will result in the improved training of all future midwives in the country.
- 3MDG, through its partner Jhpiego, has supported the Ministry of Health to roll out skills based refresher Basic Emergency Maternal and Neonatal Care training to the whole country.
- Other important trainings in community based newborn care and community based case management have been rolled out through 3MDG support in the supported townships. This will result in better care and effective referral of young children that is easily available at the community level.

CONTEXT AND POLICY ENVIRONMENT

Myanmar is not on track to meet the millennium development goals that aim to reduce maternal and child mortality.

In fact, the 2014 Myanmar Population and Housing Census demonstrated higher than previously understood levels of child and infant mortality.
PROGRESS

The six areas for MNCH work, jointly agreed by 3MDG and the Ministry of Health, remain as priority focus areas. A brief description of the achievements for each follows. Together they are contributing to progress towards universal health care.

While most supported townships have been able to meet the Pentavalent 3 coverage target, the measles coverage is below the target. It is important to note that a national measles rubella campaign held over the first two months of the year was well supported by all partners, but the resulting data was not age disaggregated. Therefore the measles coverage figures do not include the information for these two months.

There were additional targets that, whilst seeing improvement, were not met. These include training of professional staff in the townships and the supervision of volunteers. The training depends on availability of the township trainers and they are often busy with their routine work and meetings at the centre or state/region. One of the challenges to achieving volunteer supervision included difficulties in travel due to weather and terrain.

1. Scale-up of services in conflict-affected areas

In 2015, 3MDG was able to implement grants in all seven townships of Kayah State, seven townships in Northern and Southern Shan State and in the Wa and Special Region 4 self-administered zones. In agreement with the Ministry of Health and other stakeholders, 3MDG continued to support policy and strategy working groups and technical support groups in order to contribute to:

- The formulation of the Child Health Strategy 2015–2018
- The implementation plan for the Family Planning 2020 framework
- The development of the Child Death Surveillance and Response reporting system
- The generation of evidence through partners, which is shared with the MoH and other stakeholders, will also potentially influence policies and strategies in the country.

3MDG continued to support policy and strategy setting, including participating in the relevant working groups and technical support groups in order to contribute to:

- The formulation of the Child Health Strategy 2015–2018
- The implementation plan for the Family Planning 2020 framework
- The development of the Child Death Surveillance and Response reporting system

The generation of evidence through partners, which is shared with the MoH and other stakeholders, will also potentially influence policies and strategies in the country.

Kayah State

Work in Kayah State began in July 2014 and involves bringing a large number of disparate actors together to provide essential healthcare to isolated villages through a variety of approaches that also include mobile clinics.

Partners in this effort include township health departments, the International Rescue Committee (IRC), International Organization for Migration (IOM), and ethnic health organizations (EHOs). The EHOs have joined to form the Community and Health Development Network (CHDN) which works and liaises with IRC, IOM and the government health authorities. CHDN and its members serve some of the most remote and isolated villages of Kayah State.

Coordination and collaboration between township health departments and CHDN continued to move forward this year. By way of example, in order to foster mutual learning and discussions around MNCH issues, exchange visit activities were organized in two townships (Shadaw and Hpruso) between the township health departments and CHDN. This coordination is critical to improving access to health services in these remote and conflict-affected areas.

In 2015, this collaboration led to a highly successful measles-rubella campaign that reached areas previously not accessible for

mortality, confirming the importance of the work undertaken by 3MDG. The three states and regions with the highest reported mortality burdens (Chin, Magway and Ayeyarwady) were already prioritized areas under 3MDG but now are receiving increased attention from the Ministry of Health (MoH).

During 2015, the MoH committed to move towards an integrated approach to reproductive, maternal, newborn and adolescent care as the basis for service provision while also integrating communicable and non-communicable disease interventions within this approach.


7- Reproductive Maternal Neonatal Child and Adolescent Health ++ (where the plusses (+++) represent communicable and non-communicable diseases)
vaccinators. Better coordination and more regular contact also enabled children from these remote areas to receive birth registration documents.

Referral services in the state are now well-established. They exceeded targets for emergency obstetric care referrals by 50% and for child emergency referrals by over 100%. In 2015, on average, the seven Kayah townships met their targets for almost all health indicators including deliveries by skilled birth attendants, four ante-natal visits, facility-based deliveries and Pentavalent 3 vaccine.

In 2015, health service coverage financed by 3MDG was extended to areas within Wa Special Region and Shan Special Region 4 (Mongla). This innovative programme brings the Ministry of Health, Special Region Health Authorities, 3MDG and Health Poverty Action (HPA) together to scale-up maternal, newborn, child health and HIV and tuberculosis services for people living in these areas. HPA has a long history of engagement in these Special Regions through other funding.

The ‘Special Regions’ are territories under control of ethnic armed groups that entered into ceasefire agreements with the previous military government. Many of them have their own health departments and provide basic services to the population in these areas.

There is very limited Ministry of Health (MoH) health staff in these regions and the township structures are also limited in number. The MoH staff serve mainly a curative purpose and limited public health activities are implemented by the health departments of the Special Regions and some INGOs/NGOs. The bringing together of the MoH and the Special Authorities to enter this collaborative approach with the support of 3MDG has been an important achievement.

3MDG support has enabled access to services for previously unserved populations in Wa and Special Region 4 (SR4). Communities are supportive of immunization activities as they now have confidence that these will be delivered regularly. Support to emergency referrals of mothers and young children has been instigated but remains very challenging.

The programme benefits from strong partner engagement in Shan. Both health departments are making use of existing trained staff as the means for scaling-up access to a broader package of services. In Wa, the health department is making use of an existing Global Fund malaria programme as a helpful entry point to introduce MNCH services. This now involves an auxiliary midwife training programme being done in Lashio. In SR4, traditional birth attendants who have been trained in the past using other funding sources are providing basic MNCH care and have improved healthcare-seeking behaviour in the communities. They continue to provide basic services whilst new auxiliary midwife training is underway.

Infrastructure

To support the scale-up of the health workforce in Shan Special Region 4 (Mongla), the construction of a new training centre was completed at a cost of US$ 100,000. The 3MDG investment was matched by funds from local authorities.

Training

Training and capacity building has formed a strong basis for collaboration between the Ministry of Health and the Special Region Health Departments. The MoH, special health departments and the implementing partners...
have worked together to provide trainings in community-based newborn care, refresher training for basic emergency obstetric care and helping babies breathe. This training of trainers approach will enable a more efficient rollout of trainings to staff and community health workers of the health departments in Wa and SR4. However, identifying suitably qualified trainers able to overcome language barriers remains a significant challenge.

3. Strengthening service delivery in public and private sectors

**Ayeyarwady Region**

The 2014 census report highlighted Ayeyarwady as a region with some of the worst mortality rates for children and mothers. Poor communication networks and transportation difficulties are some of the underlying causes. However, all six townships in the Ayeyarwady Region where 3MDG provided support in 2015 are now reporting improvements in their health outcomes. This programme is benefitting women and children across a total catchment population of 1.8 million.

Facility-based deliveries have increased from 21% in 2013, when support from 3MDG began, to 28% in 2015. The proportion of deliveries conducted by skilled birth attendants was 68% compared to 56% in 2013. Targets for both Pentavalent 3 and measles vaccine coverage were reached and there is more than 90% coverage for both vaccines.

Maternal emergency referrals reached 22% of the total estimated pregnant women in these townships, up from 13% in 2013. The target set internally for all 3MDG partner townships is 15% to 20% of all expected births, in order to account for the number of high risk pregnancies that will need referral. In two of the townships all first time pregnancies are required to be referred to hospital for delivery, even though they might have no complication, potentially increasing the proportion of referrals supported. The supported townships are also making progress towards meeting target levels set for child emergency referrals. These are currently around 3% of the total under five children, against an internal target of 5% of all under-five.

Well-resourced and trained township health departments are better able to respond to unanticipated events. During 2015, this was evidenced when support was rapidly mobilized following outbreaks of dengue haemorrhagic fever. Similarly, in response to the risk of serious flooding in August 2015, partners were able to quickly support townships.

**Chin State**

Geographical, cultural and language barriers remain substantial across most areas in Chin State. Although challenges remain in relation to retaining staff, reaching remote communities, supplying health facilities and the training and deployment of community health volunteers, the results confirm progress.

Heavy rains in July and August caused flooding and major landslides across many areas of Chin State. Already challenging travel conditions became totally impassable across many major routes. Many people in Chin lost their homes, and many of the routine health activities were suspended. 3MDG was able to make flexible financing available to its partners who already had an established presence. These partners were able to link an emergency response to their ongoing support to healthcare (see page 26).

Against the background of this disruption and the catastrophic losses experienced by many households, some improvements in healthcare provision can still be reported in 2015. Immunization coverage in most townships of Chin State is improving due to the adoption of flexibility in approaches, including methods of outreach and transport modalities for midwives. Coverage for Pentavalent 3 vaccine is over 95% in seven out of nine townships. Most townships report an increase in deliveries by skilled birth attendants by 2% to 17% between 2014 and 2015, though in the disaster affected townships there was a decrease due to lack of access to care. Maternal emergency referrals have increased compared to the previous reporting period. 10% of estimated pregnant women are now referred on account of an obstetric emergency whilst 3% of the total of under five children are referred for an emergency, as compared with 6% and 2% in 2014.

Through community meetings, important issues have been brought to the attention of health departments in Kanpetlet, Mindat and Matupi. This has resulted in changes in how healthcare services are planned and delivered. For example, in Kanpetlet the basic health staff now have fixed dates when outreach is conducted in various villages in order to optimise vaccination uptake, based on feedback that planning was previously difficult.

**Magway Region**

Though initial programming in Magway was slow to take off, townships have since shown good progress. Magway reported the highest proportion of skilled birth attendants and facility-based deliveries, and the highest newborn care achievements of all 3MDG supported areas, though antenatal care 4 remains low, as in other states and regions. Coverage in Magway has benefited from a range of supply side strengthening interventions, including infrastructure upgrades. New construction in Magway through 3MDG funding of 17 health facilities was completed in 2015.

All townships supported by 3MDG have seen a substantial increase in emergency referrals. This has seen 6% of all children under five years old referred for emergency care to a hospital...
and 24% of all estimated pregnant women referred and treated for obstetric emergencies. The high percentage of children under five who were referred include unnecessary referrals for Stage 1 dengue, as well as referrals of those from outside the township in Gangaw. This will be addressed in 2016 through better training and raising awareness on eligibility criteria.

Targets for both Pentavalent 3 and measles vaccines have mostly been reached among the townships. This has been supported by initiatives such as community voices through the Village Health Committees advocating for improvements in access to immunization services in Gangaw. In reaction to this, the township health department has mandated implementing partners and midwives to undertake joint outreach work to improve services. The strong community support and voice in Gangaw and Ngape also resulted in the mobilization of local resources to contribute to the renovation of 13 health facilities, in addition to 3MDG support.

Emergency Referrals
About 20% of expected pregnancies will need to be referred for emergency obstetric care, as 15% of all pregnancies will have complications that cannot be predicted, and 5% will be high risk pregnancies and are referred because access to care is difficult.

In Magway and Ayeyawady, this figure is higher partly because some obstetricians insist that all women should deliver their first child in the hospital. In Chau and Kyauk, 10% and 13% of expected pregnancies have been referred, showing good progress, but also reflecting the challenges of terrain and seasonal disruption of the roads. Additionally, the floods in Chin had an impact on access and travel. In Shan only 5% of expected pregnancies were referred, reflecting the facts that the programmes there have recently started and the challenges of insecurity and inaccessibility.

As the proportion of under-fives who will need emergency support varies from country to country due to disease burden and epidemiology, there are no global standards to measure against. Between 3% and 6% of all under-five children were referred for emergency care in Ayeyawady, Magway, Chin and Kayah against a rough target of 5%. Only 1% of under-five children were referred in Shan, again reflecting the challenges of start-up, insecurity and lack of access.

Please see more detail on emergency maternal and young child referrals below.

Emergency Maternal Referrals: The township health departments and the implementing partners reported a total of 14,364 emergency obstetric referrals in 2015. In 2015, 17% of all expected pregnant women were referred for comprehensive emergency obstetric care, compared with 15% in 2014. More than 60% of these referrals needed a caesarean section, instrumental delivery or other intervention. This is indicative of the use of appropriate selection criteria.

Timely supported referral to station and township hospitals where Comprehensive Emergency Obstetric Care is available has contributed to reducing maternal case fatality amongst this cohort of referred women from 0.3% in 2012 to 0.05% in 2015. However, newborn fatality rates and still births remained at around 2%, for the past three years. Recognition of foetal distress may need to be strengthened alongside improvements in the quality of newborn care at facilities.

Around 7% of referrals are related to abortions, indicating a need for further analysis and investigation into this issue to clarify if these are illegal and septic abortions. If this is the case, then access to contraception needs to be increased.

Emergency Young Child Referrals: Over 12,000 children under five were referred for emergency care in 2015. This corresponds to 3% of the total number of children under five years old that are estimated to be living in the townships supported by 3MDG. Pneumonia and diarrhoea are the most common causes of the referral of children, together they constitute about 50% of all cases referred.

It is recognized globally that the majority of child deaths occur during the neonatal period.
Neonatal referrals have increased from 4% of all young child referrals in 2012 to about 14% in 2015. This suggests the effectiveness of awareness-raising of danger signs and sustained efforts to support referrals. Case fatality amongst young children referred for emergency care has decreased from 1% of all referrals in 2012 to 0.6% in 2015.

The criterion for referral of children with diarrhoea with severe dehydration is vomiting and inability to eat or drink. Since so many children are being referred for diarrhoea, this highlights the need to increase access to oral rehydration therapy at the community level to prevent severe dehydration.

Furthermore, the inclusion of the rota virus vaccine in the vaccination schedule in 2017, made possible with the support to the cold chain under Joint UN Funding from 3MDG, will help in the reduction of diarrhoea. Similarly, the introduction of the pneumococcal vaccine in 2016, supported by the same stream of funding, will reduce the incidence of childhood pneumonia and acute respiratory infection.

Private sector: strengthening service delivery
In Myanmar, many people currently access healthcare services through the private sector. 3MDG supports interventions that improve the quality and availability of private sector services and that are complementary to public health services. Population Services International (PSI) and Marie Stopes International (MSI) were contracted to support private sector work, largely to increase access to a range of contraception, including long-term methods.

PSI provides services in 34 townships through its Sun Quality Franchise and their Sun Primary Care network while MSI provides family planning services through static and mobile clinics across 15 townships. Both partners also market contraceptives and other health products through retail outlets.

PSI also provides other health products such as oral rehydration salts and zinc, and pneumonia treatment kits. In 2015, they received approval to market multiple micronutrient caplets for pregnant and lactating women and micronutrient powders for young children and will be rolled out in 2016. Micronutrient supplementation has been shown to decrease preterm births and help the growth and weight gain of young children.

In 2015, PSI began to train women micro-entrepreneurs in initiatives which innovatively combines the sale of household and medical goods. The women are supplied with oral rehydration salts, contraceptives and household goods such as cosmetics and food whose sales enable them to earn a living, with the health products available at a discounted price.

Understanding community attitudes and engaging around deeply held beliefs is an important part of community mobilization work, which forms a vital part of all public health work. This has been especially important for 3MDG implementing partners who are working to scale-up access to interventions that will improve reproductive health and reduce maternal mortality rates. As part of its work, with religious bodies in Chin state, which has a majority Christian population, MSI has been able to gather the support of the influential church establishment for awareness-raising and uptake of contraceptives for birth spacing.

Global evidence shows that the use of modern contraceptives to plan families is a cost-effective measure that saves lives and improves the health of both mothers and children. In 2015, 3MDG was able to achieve against targets for providing contraceptive protection to couples and reducing the overall disease burden, as shown in the tables below. The underachievement in 2014 was due to challenges related to start up and supply chain issues. Higher achievement is related to more uptake of longer term methods like Depo Provera and implants, and an improved supply chain.

**TABLE 3: DALYS* AVERTED BY PRIVATE SECTOR IP**

<table>
<thead>
<tr>
<th>Group</th>
<th>TARGET</th>
<th>ACHIEVEMENT</th>
<th>TARGET</th>
<th>ACHIEVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSI (15 TOWNSHIPS)</td>
<td>2,975</td>
<td>1,414</td>
<td>3,017</td>
<td>2,816</td>
</tr>
<tr>
<td>PSI (42 TOWNSHIPS)</td>
<td>10,000</td>
<td>8,664</td>
<td>17,758</td>
<td>17,423</td>
</tr>
<tr>
<td>PSI (ADDITIONAL 247 TOWNSHIPS)</td>
<td>1,764</td>
<td>0</td>
<td>14,124</td>
<td>20,231</td>
</tr>
<tr>
<td>TOTAL</td>
<td>14,739</td>
<td>10,078</td>
<td>34,899</td>
<td>40,470</td>
</tr>
</tbody>
</table>

*The disability-adjusted life year (DALY) is a measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death.

**TABLE 4: CYP* ACHIEVED BY PRIVATE SECTOR IP**

<table>
<thead>
<tr>
<th>Group</th>
<th>TARGET</th>
<th>ACHIEVEMENT</th>
<th>TARGET</th>
<th>ACHIEVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSI (15 TOWNSHIPS)</td>
<td>31,730</td>
<td>9,485</td>
<td>36,901</td>
<td>51,573</td>
</tr>
<tr>
<td>PSI (42 TOWNSHIPS)</td>
<td>38,017</td>
<td>17,642</td>
<td>38,017</td>
<td>52,630</td>
</tr>
<tr>
<td>PSI (ADDITIONAL 247 TOWNSHIPS)</td>
<td>17,250</td>
<td>0</td>
<td>156,750</td>
<td>222,187</td>
</tr>
<tr>
<td>TOTAL</td>
<td>86,997</td>
<td>27,127</td>
<td>231,668</td>
<td>326,390</td>
</tr>
</tbody>
</table>

*Couple-Years of Protection (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.

4. Support to Ministry of Health human resources for health (HRH) strategy
The 3MDG Fund is supporting the Ministry of Health in the strengthening of its health workforce, by financing the training of midwives and auxiliary midwives. This support will lead to more and better quality health services across the country. In 2015, significant progress was made across many aspects of this work.

Auxiliary midwife training by the ministry
The 3MDG-funded Auxiliary Midwife Training Project implemented by the Ministry of Health started on 1st November 2014, and was completed by the end of December 2015. This grant allowed for the basic training of 4,520 auxiliary midwives in 178 townships.
Support to pre-service and in-service training of midwives

3MDG is financing technical assistance to strengthen the midwifery health workforce in Myanmar. This work comprehensively addresses quality improvement, through curriculum and accreditation reviews, standard setting improvements, and improved training. Jhpiego, an affiliate of John Hopkins University, was contracted as a technical assistance partner to the ministry.

During 2015, Jhpiego supported the Myanmar Nursing and Midwifery Council in their work on setting standards for the accreditation of nurses and midwives. The council has also been supported to develop guidelines for registered nurses and midwives and, with the Ministry of Health, to conduct a rapid assessment of eleven midwifery schools.

A range of capacity building interventions were carried out in 2015 to ensure that future training will be skills and competency based.

Changing behaviour through collaborative participation

Due to political challenges and difficulty in transportation, some villages in Demoso townships have been inaccessible for the Demoso Township Health Department. After receiving training from 3MDG, midwife Daw Saw Moe became one of the first basic health staff members to access these communities with the support of 3MDG partners International Rescue Committee and International Organization for Migration (IOM).

When Daw Saw Moe visited Daw So Phya village, Ma Phyu, a mother of three children, came to see her to receive immunizations for her youngest child. The child looked very healthy, which caught the attention of IOM staff because children born in similar socioeconomic situations tend to lag behind in key health markers. When they asked Ma Phyu about caring for her children, she demonstrated her knowledge, saying, “Because my baby is just five and a half months, I feed him only breast milk. I know that the babies should be fed solid food only after reaching six months of age.”

Ma Phyu didn’t always have access to good advice about her children’s health, she says. “Before the midwife came to our village, we had no chance to learn about nutrition advice, but now, with frequent visits from our midwife, I have learnt a lot about the importance of caring for the health of my children.” In the visit, Ma Phyu and Daw Saw Moe continued to discuss good feeding practices for young children with the group of mothers in the local language.

3MDG support has enabled access to health service providers and resulted in successful dynamic interactions between a service provider and a community and behaviour changes that serve as a positive example for the community.

68 ‘master mentors’ were trained across 20 midwifery schools in clinical skills and standards, who then trained 164 other faculty members and service providers in the best practices in maternal and newborn care. Skills laboratories were upgraded in ten midwifery schools with the provision of simulators and equipment.

A number of initiatives have also been undertaken to strengthen in-service training. During 2015, 3MDG provided support to the Ministry of Health to plan for and rollout master mentor training for a refresher course in Basic Emergency Obstetric Care, which will be rolled out to all midwives nationally. 3MDG partners have supported the cascade training in the 34 townships.

Service quality improvement for maternal, newborn and child health

Efforts to improve service quality improvement are part of 3MDG’s wider work, as well as being undertaken through important stand-alone initiatives. Progress in a number of these areas is described here. As mentioned, Jhpiego has made a significant commitment to improving maternal and newborn care in their support to the MoH skills-based training for midwives, and a continuing supervision system that will be delivered throughout the country. Other work has included addressing the gaps in the legal framework, introducing legislation, and Training of Trainers programme and equipment to improve neonatal resuscitation, which has been delivered on to 34 townships.

Supervision of health facilities helps to improve services, yet is challenging due to human resource constraints and transportation challenges. 3MDG supports supervision of facilities at state, township, rural and sub-rural health centre levels. As part of these efforts and in order to improve the health information system, 3MDG in partnership with the HMIS section of the MoH is now piloting the introduction of the District Health Information System 2 across 3MDG supported townships, which will enable health planning decisions to be based on updated data and analysis.

5. Evidence base for national MNCH strategies

One of the ways 3MDG contributes to the work of the Ministry of Health is through documenting evidence generated by the programmes it finances.

Standardizing national guidelines

During 2015, systematic work continued to document the impact of maternal and young child emergency referral support. Efforts include the systematic tracking of coverage, cost and outcomes, and the standardization of approaches to ensure work is based on examples of best practice. During 2015, a set of guidelines have been developed in collaboration with the Ministry of Health, and results from the referral programme have been presented at national forums in order to influence policy development and to advocate for wider financing.
Supporting improved township health planning

In 2015, 3MDG worked with implementing partners to identify strengths and weaknesses of the tools currently used for township based planning. This is part of wider ongoing efforts to improve health service provision through better planning, including helping townships improve their budgeting in order to access World Bank funding.

The Ministry of Health, 3MDG and implementing partners developed a standardized reporting system for volunteer health workers and trained over 2,500 volunteers across 16 townships in its use. This will generate important information on where healthcare is delivered in Myanmar and support health worker supervision.

Working in conflict-affected areas

In order to support the work of its partners, and to optimize improvements in access to services through a ‘do no harm’ approach, the Fund made its ‘Conflict Sensitivity Strategy’ public in 2015.

Conducting research

With a major programme of MNCH work, 3MDG is increasingly able to generate evidence from work being undertaken across Myanmar. A growing portfolio of operational research and evaluations are being undertaken in partnership with the Ministry of Health and the Department of Medical Research. This covers supply side and demand side interventions, including:

- Access and utilization of maternal and child health services among migrants – Ministry of Health and IOM
- Lessons from Dedaye: Automating the reproductive health commodity logistics system – Ministry of Health and Relief International
- Learning Paper: Improving areas of support to AMWs for effective delivery of MNCH services in the community – Ministry of Health and Save the Children

To inform work financed by 3MDG, Population Services International has undertaken a set of studies in collaboration with the University of San Francisco, publishing papers on reproductive health and child nutrition practices; a study on barriers to exclusive breastfeeding; and a consumer survey relating to micronutrient powder in order to appropriately brand and price their product.

CHALLENGES AND LESSONS LEARNED

The 3MDG Fund has worked with the Ministry of Health to increase access to improved health services to a tenth of Myanmar’s population across five states and regions, and Wa and Special Region 4. It is crucial to reflect on experiences, challenges and lessons learned across the various health systems components of Myanmar towards its commitment to achieving universal health coverage. For the MNCH component, they are as follows:

Human resource issues

The number of doctors, nurses and midwives in Myanmar are at a ratio of 1.49 per 1,000 people, against a WHO recommendation of 2.28 per 1,000.11 The recruitment, distribution and retention of staff is an issue that presents challenges, particularly in areas that are remote or affected by conflict. Where there is no township medical officer for example, both medical and public health services suffers as a result. The Ministry of Health is committed to consider task shifting and sharing in order to overcome some of these challenges but the measures that have been put in place will take some time to have any effect.

Prioritization

The 2014 census indicated higher than expected child and maternal mortality in Ayeyarwady, Magway and Chin. While it indicates that 3MDG support is being provided in the right places, it also implies that a substantial and sustained effort will be needed to move towards universal health coverage.

Learning from efforts to scale-up services in conflict-affected and self-administered areas, particularly those areas which are not accessible to the Ministry of Health, shows that progress is incremental, that trust building is critical alongside the scale-up of service provision and that approaches need to be flexible enough to adjust to the changing environment.

Emergency referrals

The support to emergency referrals for mothers and young children has proven to be a critically important and cost-effective measure that saves lives and contributes to Myanmar’s path to universal health care. An analysis of possible DALYs averted through support to maternal referrals is about 4,000. The possible DALYs averted with support to emergency young child referrals is about 11,000. Both supply side interventions to improve services and demand side intervention of cash transfer have contributed to the effectiveness of this measure.

Scale-up and coverage

Scale-up of work has taken longer than anticipated. The support of the Ministry of Health has greatly facilitated this process of scale-up and increased coverage in 2015. Progress has been slower in the challenging environments of Chin, the conflict-affected areas of Kayah and Shan and in Wa and Special Region 4, compared to the Delta and Magway.

However, the commitment of the ministry and 3MDG partners working with local organizations in areas controlled by non-state actors has resulted in improved coordination and access to health services. This work is of critical importance as the country grappling with how best to begin to address its universal health care commitments.

Planning and co-ordination

3MDG will ensure that lessons around planning and coordination, emergency referrals, and community based healthcare are documented and shared with all stakeholders.

MNCH MONITORING AND QUALITY ASSURANCE

PROGRAMME MONITORING ASSESSMENT

• High staff turnover as well as lengthy vacant posts: is a common challenge encountered by both implementing partners and township health departments, particularly in remote and conflict affected areas.
• The follow up home visit, an integral part of the referral monitoring system, is rarely conducted in some townships.
• Volunteers are not always provided with supplies: upon completion of the training and stock out also happens.
• Both volunteer and basic health staff trainings are ambitiously planned throughout the year, at times beyond the capacity of township health departments due to staffing constraints.
• Activities under procurement and investment categories are frequently delayed due to various reasons.
• Often quite junior field office staff require better support from senior staff in the Yangon headquarters.
• Unrealistic programme planning for example, high referral unit costs and inappropriate outreach plans, is observed in nascent programme townships.

RECOMMENDATIONS

• Referral follow up should be properly planned and executed, especially in the townships, where cross township referral support is inevitable due to the proximity of hospitals in other townships.
• Plan the procurement of supplies in advance: Align the timing of volunteer training with the estimated arrival of supplies.
• Set realistic training targets based on the needs and available staff.
• Implementing partners should have staff retention strategies and find innovative way to address HR issues.
• Planning and follow up on procurement and investment plans are essential for minimizing underachievement and under spend at the year end.
• Intensify technical and management oversight to the field staff.
• The current programme experiences should be reflected in next year’s budget revision.

ROUTINE DATA QUALITY ASSURANCE

• Good collaboration with township health departments for data management and information sharing with most implementing partners.
• Good practices, such as proper filing of source documents, development of forms and formats, and clarity of role of staff in data collection, reporting and checking.
• A few information in consistencies between database and source documents, and incomplete information in some source documents.
• In some start up townships, source documents could not be accessed and data collection needs to be improved.
• There are different forms/tools to collect data in townships of the same implementing partner.
• Field level staff need proper MNCH related capacity building and regular supportive supervision visits from higher level in some implementing partners.
• Vacant M&E positions and high turnover are key challenges, especially for geographically difficult or conflict affected areas.
• Operational: M&E guide needs: updating to reflect the current situation.
• Measurement of some indicators is not in line with 3MDG guidelines in a few townships.

• A systematic procedure for data quality checking should be in place.
• Source documents should be kept with a systematic filing system. Forms/formats to collect a specific indicator should be standardized in townships under the same implementing partner.
• Capacity building and regular supportive monitoring to township staff needs to be planned and carried out.
• Senior M&E technical staff need to ensure that MNCH guidelines are developed and updated and made available to the field staff. 3MDG MNCH indicator guidelines need to be followed.
• Regular information sharing and use of data for better planning should be fostered.

Tackling maternal mortality, childbirth and newborn health with hands-on training

At the 3MDG-funded, Jhpiego-led basic emergency obstetric and newborn care (BEmONC) training held in North Okkalapa Hospital, Master Mentors learnt the safest, cleanest and most comfortable way for a mother to deliver in order to prevent complications. Through hands-on practice, participants also learnt what to do in the case of complications such as continuous bleeding for the mother, or when the baby is not breathing after birth.

Workshop head trainer, Professor Mya Thida, said, “Trainee midwives don’t get a chance to improve their skills by practicing on dummies or by experiencing real cases. Our midwives may have the knowledge, but without this training they have little chance to improve their skill.”

Participant Moe Moe Kham, a Senior Nurse from Matman Hospital in Shan State, was surprised at how out-of-date her skills had become, highlighting the importance of regular training. “I didn’t know the exact procedure that should be followed in each situation. I also didn’t know how to manage different problems when they came up.”

She was excited to return and relay her new skills to her colleagues. “I will teach the trainers in my hospital with the knowledge and skills I learned today. I will teach them how to receive births correctly, and what to do when we face problems during birth.”

“This will be beneficial for mothers and children in the villages.”

VOICES
VALUE FOR MONEY
Maternal, newborn and child health interventions

The average cost of maternal referrals across all states and regions was US$ 65, with large variations across areas. This is due to difficulties related to terrain and transport but also partly due to the costs of some investigations and additional drugs outside of the hospitals.

3MDG’s ongoing reporting system and database has allowed for cost effectiveness analysis in all townships. The disability adjusted life years (DALYs) averted were calculated using the Global Burden of Disease from WHO as a central reference. Two methods were used to analyse cost-effectiveness of both the entire spectrum of activities supported and through the cost analysis of emergency referrals.

The first approach, the Incremental Cost Effectiveness Ratios (ICER) approach, computes the incremental increase in the number of DALYs averted through the achievements against all the indicators. The increase in the indicators is then used to calculate the DALYs averted by linking it with the Global Burden of Disease. An assumption was made that 3MDG contributes to 75% of incremental DALYs averted. This assumption is based on relative financial contributions to the effort from the Ministry of Health and 3MDG and an average of high and low cost effectiveness estimates. Table 7 summarizes the cost per DALY averted per region/state: from US$ 550 in Chin to US$ 135 in Kayah. Using the WHO CHOICE12 method, it is shown to be highly cost-effective.

The second approach uses the cost analysis of emergency referrals to calculate the DALYs averted. The number of lives saved through the emergency referrals was calculated on the basis of 3 conservative scenarios:

- Low scenario: 0.1% of pregnant women referred and 0.5% of children referred would have died (if the referrals had not occurred)
- Medium scenario: 0.5% of pregnant women referred and 1% of children referred would have died (if the referrals had not occurred)
- High scenario: 1% of pregnant women referred and 1.5% of children referred would have died (if the referrals had not occurred)

Table 8 shows the cost per DALY averted for each scenario: from US$ 68 to US$ 266 per DALY averted or, with project management costs of the partners included, from US$ 103 to US$ 398. Again using the WHO CHOICE method cited above, it can be seen that referrals are (highly) cost-effective interventions.

12 - Myanmar GDP per capita varies from US$ 1,000 to 1,500 according to various sources. The most common approach for cost effectiveness, promoted by the World Health Organization’s Choosing Interventions that are Cost-Effective (WHO-CHOICE) project, involves the use of thresholds based on per capita gross domestic product (GDP). An intervention that, per disability-adjusted life-year (DALY) avoided, costs less than three times the national annual GDP per capita is considered cost-effective, whereas one that costs less than once the national annual GDP per capita is considered highly cost-effective. See also: Mansell et al (2015). Thresholds for the cost-effectiveness of interventions: alternative approaches, Bull World Health Organ 93:118–124.

**TABLE 5: COST OF MATERNAL REFERRALS BY STATE/REGION, 2015**

<table>
<thead>
<tr>
<th>REGION/STATE</th>
<th>REFERRALS*</th>
<th>COST 2015 (US$)</th>
<th>AVERAGE COST PER REFERRAL (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AYEYARWADY</td>
<td>8,342</td>
<td>493,848</td>
<td>$59</td>
</tr>
<tr>
<td>CHIN</td>
<td>1,290</td>
<td>125,665</td>
<td>$97</td>
</tr>
<tr>
<td>MACWAY</td>
<td>3,205</td>
<td>235,378</td>
<td>$73</td>
</tr>
<tr>
<td>KAYAH</td>
<td>882</td>
<td>43,441</td>
<td>$49</td>
</tr>
<tr>
<td>SHAN (SOUTH)</td>
<td>521</td>
<td>31,865</td>
<td>$61</td>
</tr>
<tr>
<td>SHAN (NORTH)</td>
<td>137</td>
<td>8,315</td>
<td>$61</td>
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<tr>
<td>TOTAL</td>
<td>14,377</td>
<td>938,512</td>
<td>$65</td>
</tr>
</tbody>
</table>

*Final results may be slightly different from the figures in this study

**TABLE 6: COST OF YOUNG CHILD EMERGENCY REFERRALS BY STATE/REGION, 2015**

<table>
<thead>
<tr>
<th>REGION/STATE</th>
<th>REFERRALS*</th>
<th>COST 2015 (US$)</th>
<th>AVERAGE COST PER REFERRAL (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AYEYARWADY</td>
<td>5,142</td>
<td>236,317</td>
<td>$46</td>
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<tr>
<td>CHIN</td>
<td>1,711</td>
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<td>MACWAY</td>
<td>3,243</td>
<td>162,756</td>
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<tr>
<td>KAYAH</td>
<td>1,446</td>
<td>61,358</td>
<td>$42</td>
</tr>
<tr>
<td>SHAN (SOUTH)</td>
<td>385</td>
<td>16,485</td>
<td>$43</td>
</tr>
<tr>
<td>SHAN (NORTH)</td>
<td>129</td>
<td>6,949</td>
<td>$54</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12,056</td>
<td>606,922</td>
<td>$50</td>
</tr>
</tbody>
</table>

*Final results may be slightly different from the figures in this study

**TABLE 7: COST OF DALYs AVERTED**

<table>
<thead>
<tr>
<th>REGION/STATE</th>
<th>ADDITIONAL DALYS AVERTED</th>
<th>CONTRIBUTION OF 3MDG TO ADDITIONAL DALYS AVERTED (75%)</th>
<th>3MDG ACTUAL EXPENDITURE, 2015 (US$)</th>
<th>COST PER DALY AVERTED (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHIN</td>
<td>8,039</td>
<td>6,029</td>
<td>$5,727,029</td>
<td>$950</td>
</tr>
<tr>
<td>MAGWAY</td>
<td>27,691</td>
<td>20,768</td>
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<td>KAYAH</td>
<td>11,629</td>
<td>8,772</td>
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<tr>
<td>AYEYARWADY</td>
<td>15,468</td>
<td>11,601</td>
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<td>TOTAL</td>
<td>62,827</td>
<td>47,120</td>
<td>$17,858,886</td>
<td>$379</td>
</tr>
</tbody>
</table>

**TABLE 8: COST OF DALYs AVERTED THROUGH EMERGENCY REFERRALS**

<table>
<thead>
<tr>
<th>SCENARIOS</th>
<th>3MDG SUPPORT TO MNCH INTERVENTIONS</th>
<th>COST PER DALY AVERTED (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW</td>
<td>774</td>
<td>3,868</td>
</tr>
<tr>
<td>MEDIUM</td>
<td>2,357</td>
<td>258</td>
</tr>
<tr>
<td>HIGH</td>
<td>5,133</td>
<td>10,785</td>
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<tr>
<td>&lt;5 REFERRALS</td>
<td>5,393</td>
<td>10,785</td>
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<td></td>
<td>COST PER DAILY AVERTED (US$)</td>
<td>$119</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>14,653</td>
</tr>
<tr>
<td>ALL REFERRALS</td>
<td>6,166</td>
<td>14,653</td>
</tr>
<tr>
<td></td>
<td>COST PER DAILY AVERTED (US$)</td>
<td>$266</td>
</tr>
<tr>
<td></td>
<td>INCLUDING PMB COST</td>
<td>$398</td>
</tr>
<tr>
<td></td>
<td>COST PER DAILY AVERTED (US$)</td>
<td>$103</td>
</tr>
</tbody>
</table>
BEYOND 2017: TRANSITION AND SUSTAINABILITY

Despite its considerable successes so far, 3MDG remains focused on ways to increase the use of national systems for maternal, newborn and child health (MNCH) service delivery, to ensure these services can be sustained beyond the lifetime of the Fund.

The Fund’s achievements so far include delivering MNCH services to a population of 4.5 million people, including those women and children who live in conflict-affected areas and Special Regions. However, whilst coordination and planning for health services is being led by the Ministry of Health and 3MDG’s financing is being used to support the work of basic health staff, critical aspects of the work are still heavily reliant on the additional capacity of non-governmental organizations (NGOs).

The Fund has adopted three broad strategies to build sustainability: strengthening the health system; building the capacity of key stakeholders in the health sector; and ensuring sustained health benefits, including through institutionalizing services and activities. The long-term goal is to achieve institutional and financial sustainability of public sector health services and government stewardship of the wider health sector.

In 2015, efforts to better align the work of 3MDG with national priorities and to promote sustainability included the reconstitution of the Fund Board to include representation from the Ministry of Health, donors and independent experts. This led to the strategic revision of the Fund. 3MDG is now acting in closer accordance with the principles of the International Health Partnership (IHP+), to which Myanmar as well as the donors to the Fund are signatories.

At the planning and programmatic level, there is the need for increased use and strengthening of government systems for delivery. This is critical for a range of reasons, including limiting health sector fragmentation caused by aid flows, limiting disruptions to service delivery should levels of external financing fluctuate and for longer-term sustainability.

Transitioning and sustaining 3MDG programming will be complex. It is contingent on the availability of financing from a source other than the Fund, and the readiness and capacity of national systems and delivery channels.

The work currently being undertaken under the Fund’s health system strengthening portfolio, such as the strengthening of public financial management, supply chains and planning processes, will help prepare national systems for use by external donors in the future. However, because it has not been possible in the past to be solely reliant on the use of country systems for the delivery of 3MDG financed MNCH services, these services are still heavily reliant on the existence of 3MDG and without a change are unlikely to be sustained beyond the Fund.

Beginning in 2015, extensive work has been undertaken to address this concern. In 2015, the Fund released an interim strategy entitled ‘3MDG Fund support to MNCH service delivery: A strategy for transition and to address sustainability’. This serves as a starting point for joint work with the Ministry of Health and other development partners, many of whom also need to move away from a reliance on parallel systems. The interim strategy outlines how the Ministry of Health, 3MDG and World Bank, by working together, can achieve the institutional, programmatic and financing transition required to sustain the work currently being delivered and beyond the lifetime of 3MDG.

Following publication, the Fund has further developed the strategy to include more detailed planning as well as the identification of assumptions and risks. This planning has involved the costing of delivery of a basic package of MNCH services, including indicative costing for scale-up nationwide using national systems of community-based healthcare and also an MNCH emergency referral pathway, and has shared this with the Ministry of Health.

This information will inform the transition of the Fund’s work. It presents 3MDG with a major opportunity to work more closely with the Ministry of Health and all other development partners to address the set of constraints that need to be overcome and the policies that need formulating for the scale up in healthcare that is required if the country is to achieve its universal health coverage goal.

TABLE 9: SUMMARY VERSION - WHAT MNCH “TRANSITION WOULD LOOK LIKE AND WHAT SHOULD BE DONE TO MAKE IT HAPPEN”*

<table>
<thead>
<tr>
<th>AREAS</th>
<th>2015 - CURRENT DELIVERY MODALITIES</th>
<th>2016 - PREPARATION FOR 2017 TRANSITION</th>
<th>2017 AND BEYOND - SUSTAINABLE SERVICE DELIVERY</th>
<th>ASSUMPTIONS, RISKS AND PRE-CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility based services and outreach</td>
<td>3MDG support to planning and financing of BHS meetings, training and outreach</td>
<td>Townships are supported to undertake planning required spend in 2017 and beyond using Govt budget</td>
<td>BHS meetings, trainings and outreach are included in township plans and budgets and are undertaken</td>
<td>Sufficient levels of financing are available</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Township prioritize essential activities within their budgeting so they are funded under increased township health funds.</td>
<td></td>
<td>Activities are prioritized within township resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Planning and financial management capacity is sufficient.</td>
<td></td>
</tr>
<tr>
<td>Community-based health care provision</td>
<td>Community-based programmes are being supported through partnerships with INGOs and as part of township led plans</td>
<td>Joint review of 3MDG Fund support to community-based health programmes in Delta and Magway (package and providers, linkages to wider health system, sustainability and institutionalization, performance and incentivization)</td>
<td>Piloting of options Agreement on rollout/scale-up Training and development of agreements on options to take forward review findings</td>
<td>Sufficient financing is available</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>An enabling environment conducive to policy changes</td>
</tr>
<tr>
<td>Support and financing for emergency referrals</td>
<td>Established programme for financing of MNCH emergency referrals Guidelines in place which define eligibility and costs Payments disbursed by INGOs</td>
<td>Summary documentation related to 3MDG financing of emergency referrals to date Design process for payment mechanisms for emergency referral support managed by the MoH Identify levels of financing currently available as well as sources of financing to fill any gaps</td>
<td>Emergency referrals are supported through financing against agreed eligibility criteria and through payments managed by the MoH</td>
<td>Policy commitment forthcoming from the MoH regarding emergency referral mechanism</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sufficient financing is available; payment mechanism designed</td>
</tr>
</tbody>
</table>

*3MDG Fund support to MNCH service delivery: a strategy for transition and to address sustainability
The treatment course for multi-drug resistant tuberculosis (MDR-TB) is 20 months, and ensuring patients are able to complete it is critical. Many patients with MDR-TB are poor and few may be able to work during treatment. Cash transfers can increase adherence rates and the use of cash machines at hospital locations where patients go for their monthly check-up are convenient for patients and can help MDR-TB programme management. In collaboration with KBZ Bank and through a public-private partnership, 3MDG is supporting the Ministry of Health to introduce innovations that yield better public health results.

For more on cash transfers, see page 64 or read patient testimonial on page 66.

Innovative initiatives, such as the collective voices: understanding community health experiences, began in March 2015 and includes 25 local civil society organizations. It empowers local organizations to explore the social determinants of health, which is a largely unexamined area in Myanmar. It is one of 3MDG’s first major initiatives to directly fund CSOs, with local organizations, rather than external academia, undertaking the work. CSOs map the situation and causes of limited access to healthcare in six states and regions using their own language and conceptual framework, and then test ways to address the social determinants of health.

For more, see page 87.

The low dead space syringe is less likely to transmit HIV and other blood-borne diseases because it retains less blood between uses. As part of 3MDG’s Harm Reduction programme, 3MDG is working with Population Services International to introduce and scale-up access to safer syringes.

For more, see page 60.

Innovation in the face of complex issues finding innovative interventions can be crucial. 3MDG is committed to reaching new populations with new technologies and ideas, as Myanmar moves towards universal health coverage.

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INNOVATION

INNOVATION in the face of complex issues finding innovative interventions can be crucial.

3MDG is committed to reaching new populations with new technologies and ideas, as Myanmar moves towards universal health coverage.

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For more on cash transfers, see page 64 or read patient testimonial on page 66.

PHOTO: International Organization for Migration
3MDG funds partners who provide HIV, tuberculosis (TB) and malaria related services to vulnerable groups, often in hard-to-reach, rural and urban slum areas across Myanmar. The results of 3MDG-funded interventions to address each disease are explained in this chapter.
HIV-HARM REDUCTION

TABLE 10: HIV 2015 RESULTS AND TARGETS

<table>
<thead>
<tr>
<th></th>
<th>PEOPLE WHO INJECT DRUGS REACHED BY PREVENTION PROGRAMMES</th>
<th>NEEDLES AND SYRINGES DISTRIBUTED</th>
<th>PEOPLE WHO INJECT DRUGS GIVEN VOLUNTARY CONFIDENTIAL COUNSELLING AND TESTING FOR HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 TARGETS</td>
<td>29,050*</td>
<td>8,000,000</td>
<td>6,250</td>
</tr>
<tr>
<td>2015 ACHIEVEMENTS</td>
<td>30,411</td>
<td>10,057,064</td>
<td>8,272</td>
</tr>
</tbody>
</table>

*It was estimated that 41,500 PWID exist in programme area, 3MDG targeted to cover 70% of PWID in programme area equivalent to 29,050 PWID

Harm Reduction aims to reduce harmful consequences of behaviour through public health policies. Harm Reduction is supported by the WHO as an approach to preventing HIV and providing treatment and care for people who inject drugs. This can include needle exchange programmes and other HIV prevention services.

People who inject drugs have the highest vulnerability of any population group to multiple infections of HIV, as well as hepatitis B and C and tuberculosis. In Myanmar, studies reveal HIV prevalence of almost 30% among intravenous drug users. In Myanmar, data for HIV prevalence among female sex workers was 14.6%, and 11.57% among high-risk men who have sex with men. Prevalence of Hepatitis C is estimated at 70-80%, although this is based on non-representative testing samples.

In 2015, 3MDG continued to support measures to address social, legal, and structural barriers to HIV prevention, while funding partners who offer Harm Reduction services such as providing sterile injecting equipment to reduce infection.

KEY DEVELOPMENTS
- Ongoing advocacy efforts to address policy and legal barriers to HIV prevention saw significant success, such as the repeal of laws making the possession of hypodermic needles illegal.
- 3MDG-funded Harm Reduction work continued to make a major contribution towards public health targets, with scaled-up access to Harm Reduction services, despite significant challenges faced by service providers.
- 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.
- Over 10 million needles and syringes were distributed - 125% of the target.
- The Fund Board made a further year’s financing available for Harm Reduction work. This ensures that Harm Reduction will remain a strong focus for 3MDG through the end of 2017.
- Innovative approaches to scaling-up Harm Reduction services are being supported by 3MDG, for example promoting ‘low dead space syringes,’ which have been shown to reduce the transmission of disease. 13

CONTEXT AND POLITICAL ENVIRONMENT
In 2015, successful efforts were made to strengthen political commitment to an enabling environment for Harm Reduction. Key contributions were the amendment of the Burma Excise Act (1917) and amendments to the Narcotic Drugs and Psychotropic Substances Law (1993), which is now in Parliament for ratification.

However, remaining legal barriers at operational levels still need to be addressed. This includes the lack of distinctions between people who use drugs, small-scale dealers and major traffickers, which results in a high percentage of people who use drugs experience violence, arbitrary arrest and incarceration, ignoring their individual health needs. These law enforcement practices hinder clients’ access to health services, and as a result, major efforts are needed to tackle high HIV prevalence among people who inject drugs.

From the IBBS, the highest rates, where nearly one in two who participated in the survey tested HIV positive, were found in Kachin State and Muse Township in Shan State. Additional funding was allocated to Harm Reduction partners to support expansion of Harm Reduction activities in Kachin and Shan in 2015 and 2016. Further additional funding was approved for a community-based technical support and Harm Reduction activity partnership between Metta Development Foundation and Medecins du Monde to begin in 2016 in Kachin State.

Drug and narcotics laws must continue to be reviewed and amended to ensure they are consistent with, and not impediments to, public health and human rights-based approaches.

PROGRESS
The 3MDG-supported UNAIDS project, “Creating an Enabling Environment,” responds to the legal, social and policy context of people who inject drugs as well as other Key Affected Populations, which includes identifying opportunities to improve service reach and efficacy, reduce vulnerability and increase support, and reduce obstacles such as incorrect information and discriminatory laws.

The findings from three situational analyses along with policy briefs conducted by UNAIDS concerning Key Affected Populations (people who inject drugs, men who have sex with men and transgender persons, and female sex workers) provided an update on the status and context of the response. They also helped shape a better understanding of key programmatic needs and gaps of key populations and ways to address them, which was useful to prioritize interventions in the development of the National Strategic Plan.

2015 saw greater levels of results than the previous year of the Fund, despite the escalation

Voices: Now I can support my family again

When he was 19, Hkaw Yaw began to work in the gold mines in Kachin State with his friends. For relief from the pain of the backbreaking work, he quickly began to use drugs. That was more than six years ago.

“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. In the beginning, they didn’t notice, but as I began to ask for more and more money, they began to suspect. I stopped using drugs for a while to prove to my parents that I could, and slowly they began to trust me again. Soon after though, I began to use again, but to my parents I kept pretending. They even sold their farmland and gave me the money for a new business, but I spent all the money buying drugs. They were so disappointed and told me they couldn’t help me anymore. Slowly, I became ill, contracting herpes, and lost a lot of weight.

“At that time, a peer volunteer and a staff member from Metta Harm Reduction Centre came to my house, to give me counseling and health education. They helped me to decide to get an HIV test. I found out that I was HIV-positive in May 2015, and received Anti-Retroviral Therapy with the help of Metta staff. They also invited me to participate in peer group meetings, and now I attend every month. We share experiences with each other, and receive health education from centre staff.

“I have also received methadone treatment at the government hospital, and my health status is now significantly improved. I can support my family again, and I am working as a peer educator in my village. 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.”

Hkaw Yaw is from Mading village, Waingmaw Township in Kachin State.

Distributing needles

Over 10 million needles and syringes were distributed in 2015, achieving 125% of the 3MDG target, which represents 40% of the annual national target of 25 million. This total distribution means that each person who injects drugs received 331 needles and syringes on average, higher than last year (260 needles per person in 2014). Utilization of other key services by people who inject drugs rose in 2015 compared with 2014: 8,200 people who inject drugs received HIV counselling and testing, which means that 53% of people who inject drugs who visited drop-in-centres had undertaken HIV testing and counselling. In addition, 7,800 people who inject drugs were tested for Hepatitis B, and of those almost 6,000 were vaccinated.
The low levels of treatment for sexually transmitted infections (STIs) could be a result of two competing factors. On the one hand, partners have reported that treatment seeking behaviour for STIs is not common amongst persons who use drugs, who are not always informed of the risks of their drug use. In remote areas, there is also still strong belief in traditional healers. On the other hand, the reduction in treatment needs could be due to increase in awareness as a result of health education sessions.

Methadone maintenance therapy is another important activity, yielding benefits for both demand and Harm Reduction. Six pharmacies received training to distribute subsidized low dead space syringes, functioning as community-based outlets and ensuring continuing access to safe injecting equipment. Population Services International, the implementing partner, is experienced in initiating and strengthening collaboration with pharmacies and others in the private sector.

**PLEASURES OPPORTUNITY TO NATIONAL CONTRIBUTION**

The number of qualified NGOs working in Harm Reduction, especially in remote and conflict areas remains inadequate to respond to the needs of people who inject drugs. People who use drugs remain highly stigmatized and discriminated against by much of the population and many service providers, and the issue of drug dependence as a human rights and public health issue is little understood. People who use drugs in areas such as Kachin State experience frequent crackdowns by anti-drug movements at community level.

Working with local partners who are already engaged in community development is regarded as a potential game changer for addressing anti-drug movements at community level. The 3MDG Fund will provide financing to the Metta Development Foundation to implement a community-based Harm Reduction project with the technical assistance of Medicins du Monde, an international NGO that has also been providing Harm Reduction services in Kachin for many years. The project is planned to begin in early 2016 until the end of 2017.

**HIV MONITORING AND QUALITY ASSURANCE**

**RECOMMENDATIONS**

- Hold regular coordination meetings and share information to strengthen implementation.
- Implementing partners should regularly conduct advocacy and community education about Harm Reduction activities to create a more sustainable enabling environment.
- Implementing partner beneficiary counting mechanism is not totally aligned with the 3MDG M&E guideline for consistent reporting.
- Ensure availability of all source documents during assessment visits.
- Change the database system to align with the correct calculation method according to indicator guidelines.
- Establish a recording and reporting system to avoid double counting among service providers where there are shared service delivery areas.

**FINDINGS**

- As a result of good collaboration with the National Programme, there is a significant increase in the number of methadone clients in the programme, leading to reduced waiting times for Methadone Maintenance Therapy.
- Establishment of a good rapport with the local community supports programme implementation despite the local movement against drug use.
- As methadone referral and supporting treatment are newly promoted activities, source documents and reporting forms were not kept systematically for auditing purposes.
- Implementing partner beneficiary counting mechanism is not totally aligned with the 3MDG M&E guideline for consistent reporting.

**PROGRAMME MONITORING ASSESSMENT**

- An urgent need to raise community awareness and understanding of the benefits of Harm Reduction. Increased support for the public health and rights-based approach will allow partners to better respond to the multiple epidemics of drug use, HIV, TB, and hepatitis B and C, especially in high HIV-burden areas such as Kachin State.

**PLANNED ACTIVITIES**

- Integrating TB diagnosis
  - Due to high levels of co-infection and the importance of early diagnosis, detecting and treatment for TB are among the core elements of the comprehensive Harm Reduction package. A total of 1,526 people who use drugs were screened for TB, of which 164 received anti-TB treatment in 2015.

  - Low dead space syringes
    - Low dead space volume syringes retain less blood and evidence from studies shows that their use is associated with a greatly decreased likelihood of transmission of HIV and other blood borne diseases. A Population Services International project providing technical assistance to the introduction of these syringes in Myanmar began in early 2015 with funding from 3MDG. Under a technical assistance agreement with Harm Reduction partners working in Kale and Tamu in Sagaing Region, 47,020 low dead space syringes were distributed through the partners’ outreach and drop-in centre services. Six pharmacies received training to distribute subsidized low dead space syringes, functioning as community-based outlets and ensuring continuing access to safe injecting equipment. Population Services International, the implementing partner, is experienced in initiating and strengthening collaboration with pharmacies and others in the private sector.

  - Collection and destruction of syringes in Pyi Gyi Ta Gon, Mandalay is carried out by the Myanmar Anti-Narcotics Association (MANA) to keep the community safe. Photo: MANA.

  - In Myanmar began in early 2015 with funding from 3MDG. Under a technical assistance agreement with Harm Reduction partners working in Kale and Tamu in Sagaing Region, 47,020 low dead space syringes were distributed through the partners’ outreach and drop-in centre services. Six pharmacies received training to distribute subsidized low dead space syringes, functioning as community-based outlets and ensuring continuing access to safe injecting equipment. Population Services International, the implementing partner, is experienced in initiating and strengthening collaboration with pharmacies and others in the private sector.

  - Methadone maintenance therapy is another important activity, yielding benefits for both demand and Harm Reduction. On the other hand, the reduction in treatment needs could be due to increase in awareness as a result of health education sessions.

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In line with targets, 2015 saw 158,300 Mobile teams became fully operational and in collaboration with NTP and the Ministry of Health (MoH), 3MDG successfully launched a new innovative cash transfer system for nutritional package and implement a cash transfer to patients undergoing treatment.

The patient support programme delivered their work to combat the different strains of the disease. With an estimated 9,000 cases of multi drug-resistant TB (MDR-TB), 3MDG is committed to supporting the National TB Programme in their work to combat the different strains of the disease.

**KEY DEVELOPMENTS**

- **Support to the National TB Programme’s scale-up of enrolment of MDR-TB patients in Yangon and Mandalay onto second line treatment, with 1,406 enrolled in 2015.**
- The patient support programme delivered through national and national NGOs was also scaled up to support evening directly observed treatment, deliver a nutritional package and implement a cash transfer to patients undergoing treatment.
- In collaboration with NTP and the Ministry of Health (MoH), 3MDG successfully launched a new innovative cash transfer system for MDR-TB patients, using the Kanbawza Bank’s ATM system.
- Mobile teams became fully operational and conducted 149 mobile screening missions.
- In line with targets, 2015 saw 158,300 presumptive TB cases examined by the Active Case Finding activity, with 16,934 of TB (all forms) detected. This represented a three-fold scale-up in people screened for TB through TB active case finding compared to 2014, and a four-fold increase in TB case detection.

**CONTEXT AND POLICY ENVIRONMENT**

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. The strategic plan will be the key resource document for informing the proposal to the Global Fund new funding round in 2016.

3MDG also provided technical support to the in-country consultation process for the development of the new Global Fund Concept Note for Tuberculosis. Prison health facilities and services require significant strengthening, including infection control, health facility infrastructure and routine entry and exit health examinations. However, action on these requires completion of internal negotiations between the Ministry of Health and the Ministry of Home Affairs, which are currently limited.

Concurrent with these negotiations, there has been an increase of TB routine testing in prisons and planning for improvements to infection control, but further scale-up is required. The current 3MDG grant to the national programme provides support for increasing their coverage to all 43 prisons and eleven work sites/labour camps in 2016, but successful scale-up is dependent on the government opening access to all relevant partners and donors.

**PROGRESS**

**Coordination and TB-active case finding**

3MDG continues to support well-coordinated planning by the National TB Programme with the six implementing partners in all aspects of active case finding including: strengthening the referral system, TB case follow up, treatment adherence, and identifying more TB cases in the community. Nine mobile teams are operating and functioning well under the leadership and coordination of regional TB teams, supported by the respective partners in the states and regions.

**Mobile screening missions**

There was considerable improvement in the operational readiness of mobile teams during this reporting period, with nine mobile teams being fully staffed, and equipped with mobile digital x-ray machines and operating according to plan.

In this reporting period, 149 mobile screening missions were conducted, each lasting five days and covering multiple villages. The National TB Programme’s case detection increased to 103% of its target, identifying 9,536 TB cases, compared to 1,193 TB cases in 2014. Increased operational efficiency and case detection are the result of good coordination and collaboration between mobile teams and local health staff.

Mobile team activities prioritize remote sites and hard-to-reach populations and work sites. The teams target these groups because in remote areas, access to TB testing services is not always readily available and working or living in cramped or dusty conditions, such as on a work site, is a risk factor for TB. This coverage will expand to private sector mine sites and border areas including special regions.

One important new initiative within this is 3MDG funding to Health Poverty Action in Wa and Special Region 4, which includes TB screening and referral as one of the key activities within integrated healthcare services.

In 2015, the team conducted 149 visits in the target townships and five prisons. As a result, 122,709 presumptive TB cases were tested for TB in 2015, which is nearly three times higher than 2014 achievements. A total of 16,934 TB cases were diagnosed and initiated treatment.
In December 2015, 3MDG amended the NTP grant to expand coverage from 75 to 104 townships, 43 prisons and eleven prison work sites/labour camps to be implemented from early 2016.

MDR-TB patient enrollment
Patients suspected of suffering from multi-drug resistant TB (MDR-TB) require speedy diagnosis and then a course of second line drugs. The national TB programme reached its targets for MDR-TB patients with 1,406 MDR-TB patients starting treatment in 2015 against the target of 1,400.

Treatment adherence is the key criteria for the success of the MDR-TB programme, with 3MDC funding of patient support making a critical contribution. The MDR-TB patient support package delivered through implementing partners in Yangon and Mandalay provides regular monthly patient support including a cash transfer (supported by KBZ bank) and food, and directly observed treatment (DOT) to patients by trained volunteers and basic health staff.

Their morning injection is overseen by the government funded basic health staff, who provide directly observed treatment in patients’ homes, and the evening dose is supported by the 352 trained volunteers of 3MDG partners and other donor-supported volunteers.

The electronic cash transfer system provides a cost effective, reliable, time saving mechanism for the NTP and partners with significantly reduced financial risk. TB is a disease towards which there is significant discrimination, stigma and fear among health care providers and communities. Consequently, a cash transfer system that is electronic and does not require physical delivery of cash alleviates some of conditions and the opportunity for discrimination, stigma and fear.

The MDR-TB grant to the National TB Programme was extended until the end of 2017, and includes construction and renovation of health facilities in Yangon and Mandalay regions. 3MDG-supported TB active case finding mobile teams and partners screened 158,300 people and detected a total of 16,934 TB patients of which 3,401 patients had bacteriologically confirmed TB. The sputum positive rate is 2.77%, which falls within the national estimate of 2%. However, the target for the people screened by TB mobile teams is set based on the assumption of the drainage population in target villages or peri-urban slum areas, and the possibility of people screened per mobile team visit, which is higher than the actual population reached by the mobile team. Due to high coverage population estimate, total detected TB cases reached 75% of its target and sputum positive TB cases were only 46%.

NTP have not operated large scale TB mobile team activities previously so some assumptions did not match with the actual situation on the ground. Therefore, 3MDC will discuss revising these targets with NTP and WHO.

In 2015 which is 75% achievement of the target (22,484) compared with 4,262 cases reported in 2014. The underachievement of the target was due to a delay in the procurement of vehicles and portable digital x-ray machines, and the establishment of mobile teams and new locations, but still showed a significant increase from 2014.

This partnership is led by the National TB Programme (NTP) with international and national NGO partners, to ensure the smooth running of TB mobile teams in peri-urban slums and in more remote areas amongst hard-to-reach populations.

3MDG coordinated with the Global Fund Principal Recipients to standardize operating procedures, avoid overlap in geographic coverage, and ensure the complementary use of equipment and diagnostic machines.

Voices: Helping U Hla Aung to work again
U Hla Aung is an 38 year old man who lives in Kangyidount Township in Ayeyarwady Region. When active case finding community volunteer, Daw Khin Hla, examined U Hla Aung and found he was suffering from a cough and weight loss, she suspected tuberculosis and referred him for testing at the township hospital. She knew the signs and symptoms after receiving extensive training from the Myanmar Medical Association.

For U Hla Aung, finding out he had TB was devastating because he couldn’t work. “I worried because I have a three year old child and wife to look after,” he says, “So when I couldn’t earn money because I was sick, it was hard.”

“But Daw Khin Khin Hla told me she was a volunteer from Myanmar Medical Association active case finding team, and could help me find relief from my illness. I had been so worried about money for diagnosis, travel cost and treatment, but was happy when I found out it was free of charge. Now I am healthy and can work again!”

U Hla Aung is from Kangyidount Township in Ayeyarwady Region.
MDR-TB national database

3MDG contracted the Clinton Health Access Initiative (CHAI) to develop a database system for MDR-TB case management in Myanmar. CHAI completed a range of tasks in 2015 including mapping the current MDR-TB clinic data flow, an assessment of IT infrastructure needs and a literature review on unique patient identifier systems. The National TB Programme (NTP) will gradually roll out the national MDR-TB database throughout the country in 2016.

Operational research

3MDG funded a survey, “Establishment of baseline assessment for catastrophic cost in TB in Myanmar,” developed by the National TB Programme with the support of World Health Organization global TB experts. The survey had a sample size of 1,000 TB patients, with data collected conducted in 25 sites across the country in December 2015. Results will be shared in mid-2016. Data from this operational research will inform programme development and modification of case finding strategies in the new National Strategic Plan.

CHALLENGES

MDR-TB programme

There are multiple and continuing demands on the National TB Programme and the Ministry of Health to effectively utilize Global Fund and 3MDG support for ambitious target setting and other aspects of scaling up the national MDR-TB programme in a relatively short timeframe.

A second challenge for the MDR-TB programme is that limited technical expertise is available in country for setting up good infection control systems in health facilities, and for the design and construction of the Biosafety Level 3 National TB Reference Laboratory to support the national MDR-TB control programme.

Some MDR-TB patients diagnosed and referred for treatment by the national programme were missed at the township register. Partners need to ensure that all eligible MDR-TB patients are receiving monthly support and treatment, and undertake weekly tracking to solve these operational issues.

TB active case finding

The TB active case finding programme faces some challenges, including the need for long-term recurrent financing of mobile team operations for hard-to-reach sites and populations. There is limited available manpower from the national programme to operate mobile teams as well as regular TB service provision at state and regional TB units. There is also a great need for continuing, high-level political commitment and support from the Ministry of Health and the Ministry of Home Affairs, and engagement with the Prison Department, to strengthen prison health facilities and services.

In some townships, inadequate x-ray and laboratory facilities caused difficulties. The National TB Programme is planning a series of technical trainings on x-ray reading in early 2016, funded by the Global Fund with technical support from the 5% Initiative.

PLANNED ACTIVITIES

In 2016, a review meeting and training for mobile team staff will be conducted to reflect on previous implementation and integrate lessons learned into future activities.

The National TB Programme and the Health Education Bureau of the Ministry of Health worked closely with the private sector in preparations for a nationwide mass media programme to coincide with the World TB day event on March 24, 2016. The aim of the 3MDG-supported campaign is to improve public awareness of TB and free treatment, and highlight the benefits of early detection for treatment and cure. Three media agencies were selected to develop print materials, radio and television spots, and conduct a public media programme.

TB MONITORING AND QUALITY ASSURANCE

PROGRAMME MONITORING ASSESSMENT

• Community health workers have to be aware of the importance of referral of suspected cases, contact tracing and childhood TB cases and their referrals need to be supervised by project management.

• Monitoring of community health workers needs to be strengthened with more supportive supervision and technical assistance.

ROUTE DATA QUALITY ASSURANCE

• There is no defined instruction to volunteers to avoid double counting of referral cases by community health workers in some areas.

• Written guidelines and standard operating procedures for reporting and data management systems should be available for all levels.

• Supportive supervision needs to be strengthened for recording and reporting at all levels.

Voices: Helping Pyae Oo Khine stick to her MDR-TB treatment with patient support

When Pyae Oo Khine, 26, from South Okkalapa Township lost a lot of weight, she remembered that her close friend had MDR-TB. She had told her it was contagious, so she made sure that she was tested. Now, she is halway through her treatment period of 20 months.

Every day, a nurse comes to her house to give her the morning dosage, and a volunteer comes to her house in the evening for the evening dosage. These visits are part of a patient support package from the 3MDG MDR-TB programme. As part of the programme, Pyae Oo Khine also receives 30,000 MMK per month in support, which helps with the transportation fees to the hospital and back. This cash transfer is made in conjunction with Kanbawza Bank’s ATM system, and allows patients to easily access the money because it is available at a place where they are receiving treatment. She also receives staple food items like rice and legumes.

Education about the disease and the importance of being treated is also shared with patients. Pyae Oo Khine says, “I want to live a healthy life in the future, and to do that, I need to get this treated. And I’m also worried that my family will be affected since it’s highly contagious.”

Though there are side effects, she can get through it, and the support of her family and friends has made all the difference. “I have friends and volunteers that care for me, and that really helps a lot.”

Pyae Oo Khine is from South Okkalapa Township in Yangon Region.
FINDING TB IN WOMEN AND GIRLS

3MDG supports women and girls through TB mobile team coverage in peri-urban and hard-to-reach areas, screening at public hospitals, and at maternal, newborn and child health clinics. For 3MDG in 2015, TB cases among females were lower than males in the urban poor population and mobile team screening sites; with 442 female cases compared with 603 male cases in peri-urban settings; and 977 female cases compared with 1,350 male cases in mobile team operation sites.

A recent study in Yangon Region revealed that only 34% of the nationally reported cases are women. This is also shown by the 149 mobile teams visits carried out in 2015, with 1,419 female cases and 1,953 male detected. This highlights the need to modify programme design to detect more female cases and explore socio-demographic and other factors. Interestingly, the majority of attendees of TB mobile teams are women and children but the case detection is higher in men. The screening diagnostic method used by mobile teams is mainly chest x-ray followed by sputum examination; however, fewer females are routinely screened by chest x-ray, which may contribute to the lower case detection.

Some studies also indicate that tuberculosis stigma has greater socioeconomic consequences for women, which affects their care-seeking decisions. The National Tuberculosis Programme could review the low sensitivity of TB diagnosis at health centres and by mobile teams to explore the potential of under diagnosis of TB among women.

Apart from the mobile teams, improved TB screening at maternal, newborn and child health clinics has meant that the number of women reached and TB cases detected significantly increased and were higher than cases in men. In this reporting period, a total of 6,501 women were diagnosed with TB compared to 3,035 men, of the total 9,536 TB cases detected. The contribution from MNCH clinics was 4,436 women, which means that further strengthening and improvement of TB screening in MNCH clinics is likely to contribute to higher detection of TB cases in women.
MALARIA

TABLE 12: MALARIA 2015 RESULTS AND TARGETS

<table>
<thead>
<tr>
<th></th>
<th>NUMBER OF MALARIA TESTS TAKEN AND READ</th>
<th>NUMBER OF CONFIRMED MALARIA CASES TREATED</th>
<th>NUMBER OF CONFIRMED MALARIA TREATED WITHIN 24 HOURS OF ONSET OF FEVER</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-2015 TARGETS</td>
<td>1,598,623</td>
<td>315,000</td>
<td>112,300</td>
</tr>
<tr>
<td>2015 ACHIEVEMENTS</td>
<td>439,192</td>
<td>11,742</td>
<td>5,923</td>
</tr>
<tr>
<td>PROJECT-TO-DATE</td>
<td>1,477,368</td>
<td>121,224</td>
<td>56,114</td>
</tr>
<tr>
<td>ACHIEVEMENTS (2013 TO 2015)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

With malaria a leading cause of morbidity and a significant cause of mortality in Myanmar, 3MDG supports efforts to understand the scope of the problem, including the National Malaria Indicator Survey and, through support to the national response, remains focused on priority townships.

KEY DEVELOPMENTS
- In 2015, 3MDG implementing partners carried out almost 440,000 rapid diagnostic tests, and treated over 10,000 cases of malaria.
- 3MDG support to the national response to combat malaria remains primarily focused on the current coverage area of 52 priority townships.
- Expansion of malaria services focused on engaging migrant populations, reaching 258% of the target.
- 3MDG has also provided additional critical investment for conducting the National Malaria Indicator Survey. The findings of the survey will help shape the new National Strategic Plan to contain artemisinin-resistant malaria in the country.

CONTEXT AND POLICY ENVIRONMENT
The estimated population of Myanmar is 51.9 million, and with approximately 28 million people living in malaria-endemic townships, malaria remains a leading cause of morbidity and a significant cause of mortality in the country in 2015.

However, malaria incidence is declining in all priority townships due to the collective efforts of the National Malaria Control Programme and its partners, who have implemented a major expansion in service coverage and prevention interventions since 2012, including bed nets and other protective measures.

3MDG is working within this continually changing environment to ensure the situation is fully understood, knowledge is shared effectively, partners are co-coordinating well and all resources are best placed to continue the fight against drug-resistant malaria.

Policy development
In 2015, 3MDG worked to support the National Malaria Control Programme (NMCP) in the development of the Malaria National Strategic Plan (2018-2020) in collaboration with all other malaria stakeholders in the country. The strategy will be the key resource document for informing the proposal to the Global Fund new funding round in 2016.

3MDG has also been heavily involved in the core writing group for the development of the new Global Fund concept note. 3MDG has established a database set for the coverage and distribution of village malaria volunteers, and is updating it and sharing it with other malaria stakeholders. The Global Fund Secretariat, NMCP and other key stakeholders and implementing partners see this as highly useful for future programme development and implementation planning.

During the reporting period, design and data collection for the Malaria Inductor Survey was to begin during the peak malaria season. They were to be deployed in early August when Cyclone Komen severely hit in Myanmar, rendering many areas inaccessible. This may also have epidemiological impact on malaria incidence.

Preliminary malaria test results done with rapid tests in the field survey revealed declining malaria incidence in Myanmar at 10 malaria positive cases out of 13,779 tested during the survey. The first draft report will be shared in June 2016 and the final results will be disseminated in December 2016. Where relevant, findings will be integrated into the new Malaria National Strategic Plan 2016-2020.

Co-ordination
To ensure complementarity and avoid any duplication, 3MDG works closely with its fellow malaria stakeholders. For example, given that the Global Fund and other key players had already planned on national distribution of bed nets, 3MDG did not procure additional bed nets, instead only distributing stocks remaining from the former Three Diseases Fund.

PROGRESS
Testing and treatment
Due to the decline in malaria prevalence, the malaria test positivity rate among 3MDG-supported partners dropped from 6% in 2014 to 2.7% in 2015. Nevertheless, 3MDG partners reached 102% of 3MDG’s testing target for 2015, which is approximately 440,000 cases tested.

In this context of significantly declining incidence, national strategies are now focused more on testing asymptomatic malaria cases residing in the drug-resistant containment priority areas.

With one trained village volunteer testing an average of 18 cases per month, this indicates that 3MDG partners are on track and in line with the elimination strategy to improve malaria testing for asymptomatic malaria cases.
TABLE 13: MALARIA RESULTS VS. 3MDG TARGETS

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>TARGET</th>
<th>ACHIEVEMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PF-PV TREATED</td>
<td>15,000</td>
<td>11,742</td>
</tr>
<tr>
<td>RDT TAKEN AND READ</td>
<td>430,200</td>
<td>439,192</td>
</tr>
<tr>
<td>VOLUNTEER TRAINED AND ACTIVE</td>
<td>2,241</td>
<td>2,105</td>
</tr>
<tr>
<td>TESTED AMONG MIGRANT/ MOBILE POPULATION</td>
<td>7,953</td>
<td>20,491</td>
</tr>
</tbody>
</table>

3MDG has been supporting partners to expand their service coverage to focus on reaching migrant and mobile populations. Reaching these populations is the biggest challenge for partners, as there are difficulties with treatment adherence and follow-up and in some cases lower immunity due to a lack of previous exposure.

Partners used a range of innovative approaches to reach these groups, such as the deployment of volunteers to construction sites to screen workers and test all fever cases. As a result, testing of mobile populations in this reporting period is significantly higher than the target (258% achieved).

However, malaria treatment levels are still somewhat low, only reaching 78% of the 3MDG target or 11,742 cases in 2015, which could be reflective of low incidence rates with the identified continuing decline in malaria prevalence. In 2014, 29,530 malaria cases were treated which was 28% of the 2014 3MDG target. In this context of rapidly declining incidence 3MDG will need to revise the malaria treatment target for 2016.

Malaria Indicator Survey
Since early 2015, 3MDG and the President’s Malaria Initiative (PMI) of USAID have jointly funded and technically supported the Myanmar Malaria Indicator Survey. The aim of the survey is to provide up-to-date baseline data on malaria intervention coverage, prevalence, population awareness and availability of services. The survey is nationally representative and is a complex and large undertaking, conducted in a relatively short period of time. Covering 145 villages across 92 townships in malaria endemic areas, it targeted over 4,500 households and up to an estimated 20,000 household members. It included blood sampling and a questionnaire relevant to all household members with particular attention to high-risk populations and pregnant women. Samples were sent to the Department of Medical Research for analysis with advanced diagnostic techniques. All laboratory work will have been completed by mid-2016.

Preliminary test results have reconfirmed the suspected massive decline in malaria incidence in Myanmar with only ten malaria positive cases found out of 13,779 people tested. However, more conclusive evidence on the prevalence of the malaria parasite amongst the general population will be provided by molecular diagnostics (PCR). The results of this will be available later in 2016. The first draft report will be shared in mid-2016 and the final results will be disseminated in December 2016. Where relevant, findings will be integrated into the new Malaria National Strategic Plan 2016-2020.

CHALLENGES
• Lack of an existing mechanism for donor coordination in-country. The Global Fund Regional Artemisinin Initiative is overseen by an independent regional steering committee but meetings are usually held outside of Myanmar and there is limited timely sharing of key recommendations and plans. Donor coordination at the local level is improving but there is no mechanism for the prioritization of service delivery areas and development of national level work plans. Operational research has been done with different funding support, but there is insufficient coordination for identifying research priorities and evaluation of research data to date. As a result, there has been some duplication of efforts by technical partners.

3MDG also continued to support organizational capacity development for national NGO partners. This was implemented through the international organization Pact, with a combination of training, workshops and mentoring. The focus was broad, including administration, logistics and procurement, strategic planning, human resources, advocacy and programme management, and will continue through 2016.

Strengthening the capacity of community partners
3MDG’s non-state partners have an important role to play in malaria containment activities. To improve effective engagement with these partners, 3MDG conducted monitoring trips to identify gaps in their capacity and then ran a range of trainings to fill those gaps, for example in supply chain management and data recording.
Voices: Accessing malaria treatment in Lagang N Bau Tu Village

Lagang N Bau Tu village is more than 190 kilometres from Myitkyina town, so it can be challenging for villagers to access medical care. When vegetable farmer U Zaw Mai’s son had a fever last September, he couldn’t afford to travel to the hospital, as the nearest health facilities are located at least one day – and 10,000 Myanmar Kyats (about US$ 8-9) – away. “The only option,” says U Zaw Mai, “was to seek traditional remedies, which sometimes reduced the fever, but it kept coming back. But because there were no health facilities nearby, we didn’t know what else to do.”

Fortunately, U Zaw Mai heard about a local health volunteer, Kai Ra, who received training in malaria treatment from the 3MDG-funded Kachin Baptist Convention at Myitkyina. He decided to take his son to see her, and after testing with the RDT test kit, it was shown that he had the malaria falciparum parasite. Kai Ra explained everything she had learnt about malaria to U Zaw Mai, and provided him with the anti-malaria drugs that his son needed, all free of charge.

After a week, he recovered fully. As the treatment is free-of-charge, U Zaw Mai says, “It is not a burden on us. I cannot express how thankful I am, and I am so happy that now we can get malaria drugs at our village, because the traditional remedies don’t work.” As a result of what happened to him and his son, U Zaw became interested in malaria prevention and health awareness activities. He has since shared his story with his community, to make sure they also know what to do if they suspect malaria in their family.

U Zaw Mai and his son are from Lagang N Bau Tu Village in Kachin State.

PLANNED ACTIVITIES

- The revision of programme design, budget reduction, and early closure of grants minimally contributing towards overall performance without having a significant impact on containment efforts and service delivery to affected populations. New national targets will be developed as part of the development of the new National Strategic Plan for Malaria for 2016-2020 period.
- Expansion to reach remote sites and mobile migrant populations through engagement with non-state actors and private providers.
- Close monitoring on the progress of the national survey, timely completion of laboratory tests and analysis of findings, and timely dissemination of survey data.
- Assist the national programme to develop the new strategy (2016-2020) and future containment and pre-elimination of plasmodium falciparum malaria programme.
- Coordinate with new donors, including the Asian Development Bank, for the development of a national malaria database, and support for linkages with the District Health Information System 2 and eHealth development.

There is a need for stronger technical leadership from the National Programme to Control Malaria. The programme has competing commitments that detract from their efforts in malaria containment, including other vector borne diseases and emergency responses to natural disasters.

There is declining malaria prevalence even in malaria endemic townships, which is clearly a success, but requires a programmatic refocus. For example, there are difficulties with payment of volunteers, which are based on cases treated. Further, there is pressure on the government to reduce funding when prevalence drops, but risk of resurgence remains (particularly due to migration).

With the expansion of priority areas with limited presence of partners (for example Rakhine, which remains largely uncovered), there is a challenge for the national programme to expand the scope of containment activities by including a surveillance system and case investigation.

More investment is needed to strengthen surveillance activities. 3MDG has limited available resources for malaria and cannot support real time reporting from villages and volunteers. There is a need for technical and financial support to develop a national database and strengthen the M&E system.

MALARIA MONITORING AND QUALITY ASSURANCE

**PROGRAMME MONITORING ASSESSMENT**
- It is necessary to strengthen township level coordination in some remote townships.
- Partners need to report regularly to the Township Medical Officer and participate in state and regional malaria coordination meetings.
- Partners’ project management should monitor the quality of service and operational needs for implementation (including supply chain management) and regular technical support.

**ROUTINE DATA QUALITY ASSURANCE**
- Recording and reporting on diagnosis and treatment with Artemisinin-based combination therapy and Primaquine with direct observed treatment still needs to be consistently practiced.
- Electronic reporting system needs to be strengthened.
- Supportive supervision and regular monitoring need to be strengthened for the data management system across all levels.
- Capacity building for computerized data entry is required.
A responsive, resilient and people-centered health system is critical for sustainable progress and improved health outcomes. 3MDG’s health systems strengthening component is supporting the Ministry of Health across its strategic investments in governance and stewardship, human resources, supply chain management, evidence-based medicine and community engagement.
3MDG SUPPORT TO MYANMAR UNIVERSAL HEALTH COVERAGE HEALTH FOR ALL - VISION 2030

UNIVERSAL HEALTH COVERAGE

IMPROVED COVERAGE
FINANCIAL PROTECTION
BETTER HEALTH FOR ALL

GUIDANCE

COVERAGE AND STEWARDSHIP

HUMAN RESOURCES FOR HEALTH

WELL TRAINED HEALTH PROVIDERS AVAILABLE

FUNCTIONING HEALTH FACILITIES CLOSE TO COMMUNITIES

BUILDING

RENOVATION

INFRASTRUCTURE

COMMUNITY ENGAGEMENT

FAIRNESS

INCLUSION

1. Investing in people to strengthen the technical capacity of the ministry, civil society and other stakeholders.
2. Investing in improving approaches to promote efficiency and to enhance regulatory environment.
3. Investing in building an enabling environment for frontline staff by ensuring medicine, supplies and infrastructure are available when needed.

A responsive, resilient and people-centered health system is critical for sustainable progress and improved health outcomes. 3MDG’s health system strengthening component is supporting the Ministry of Health across its strategic investments in governance and stewardship, human resources, supply chain management, evidence-based medicine and community engagement.

In each area, 3MDG focuses on three dimensions:

1. Economic and financial management training to strengthen public financial management
2. Improvement in supply chain management in the Ayeyarwady, Bago and Magway regions
3. Modernisation of midwifery education into a more competency-based format
4. Support in evidence-based policy making through commissioning of analytical work on key aspects of the health system
5. Strengthening the Ministry of Health, Ministry of Finance, Ministry of Labor, Employment, and Social Welfare, civil society partners and ethnic health organisations’ knowledge of universal health coverage through short-courses
6. Showcasing health sector achievements at the first Myanmar Health Forum and strengthening political will for further investments in health
7. Development of a community engagement manual and running national micro-plan training sessions
8. Building 17 health centres in the Magway region, improving health care access for approximately 61,000 poor and vulnerable people

KEY DEVELOPMENTS

In 2015, 3MDG helped to:

- Conduct financial management trainings to strengthen public financial management
- Improve supply chain management in the Ayeyarwady, Bago and Magway regions
- Modernise midwifery education into a more competency-based format
- Support evidence-based policy making through commissioning of analytical work on key aspects of the health system
- Strengthen the Ministry of Health, Ministry of Finance, Ministry of Labor, Employment, and Social Welfare, civil society partners and ethnic health organisations’ knowledge of universal health coverage through short-courses
- Showcase health sector achievements at the first Myanmar Health Forum and strengthen political will for further investments in health
- Develop a community engagement manual and run national micro-plan training sessions
- Build 17 health centres in the Magway region, improving health care access for approximately 61,000 poor and vulnerable people

CONTEXT AND POLICY ENVIRONMENT

The health sector in Myanmar continues to evolve rapidly. The government has committed to achieving universal health coverage by 2030. Annual public health expenditure has increased from 0.3% of GDP in 2010-2011 to 0.8% in 2012-2013. New health posts have been established, and the government is actively working to improve the availability and affordability of health services.

FIGURE 20: HSS INVESTMENT STRATEGY ALIGNED WITH MINISTRY OF HEALTH

An instructor demonstrates how to use a midwifery kit during a training session in Pyay Midwifery School. Photo: 3MDG

Government spending on health has increased over recent years. As of 2013/2014, government spends approximately US$ 6 per person per year (compared to US$ 7 per person in 2012/13).

But challenges persist – it continues to remain low compared to other Southeast Asian countries.

The share of out-of-pocket spending fell from 82% in 2009/10 to an estimated 60% in 2012/13, mainly due to the increase in government spending. This also remains high compared to neighboring countries such as Lao People's Democratic Republic and Thailand with their out-of-pocket spending at 40% and 14% respectively.

High out-of-pocket spending on health means that many families living in, or near, poverty are further pushed into poverty, and many people delay seeking care or entirely forego the care they need.

There are no systematic mechanisms to ensure availability of medicines and supplies across the system, health facilities are run down and often non-functional due to insufficient investment, and there is a shortage of qualified staff, particularly in rural and remote areas.

**GOVERNANCE AND STEWARDSHIP**

- Conducted assessment of public financial management
- Supported the Ministry of Health in drafting the financial management standard operating procedures
- Conducted trainings on financial management

**EVIDENCE-BASED STRATEGY AND POLICY**

- Conducted research to support the development of a health financing strategy that included studies on equity, tobacco tax and targeting the poor
- Conducted research to support human resources for health including task analysis of midwives
- Presentation of analytical work to support private sector regulation and engagement
- Supported the country’s first demographic health survey (co-financed with USAID)
- Conducted the roll-out of the District Health Information System (DHIS2)

**HEALTH AND HUMAN RESOURCES FOR HEALTH (HRH)**

- Concept development for the Centre of Excellence for Health Policy
- Technical assistance to the Myanmar Nursing and Midwifery Council
- Conducted auxiliary midwife trainings

**SUPPLY CHAIN**

- Strengthening technical capacity for ministry logistics officers including supply chain management training
- Implementation of mechanisms to improve supply chain forecasting
- Assessment of nationwide cold chain capacities
- Purchase of 1,292 refrigerators to be installed by 2016

**INFRASTRUCTURE**

- Improved access to health facilities for approximately 60,000 people in rural and remote areas through construction of 17 health facilities
- Assessment of nationwide cold chain capacities
- Purchase of 1,292 refrigerators to be installed by 2016

**COMMUNITY ENGAGEMENT**

(covered in the following chapter)

- Surveying of communities on social factors limiting access to care
- Engaging communities to develop solutions to these barriers
- Building of partner capacity to strengthen community engagement

**PROGRESS**

**Goverance and stewardship**
According to the WHO, governance refers to “a wide range of steering and rule-making functions carried out by governments/decision makers as they seek to achieve national health policy objectives that are conducive to universal health coverage.” As health systems mature, governance and stewardship become two of the main functions of a health ministry. Towards this goal 3MDG supported the following programmes:

- **Universal health coverage knowledge improvement.** 3MDG provided funding to the World Bank to conduct a series of courses on universal health coverage. In 2015, 125 stakeholders, including policy makers and staff from several ministries, community-based organizations, and ethnic health organizations attended the course.

Public Financial Management: Public financial management (PFM) involves planning, budgeting, cash management, fund flows, accounting, financial reporting, internal controls, and accountability. These elements have a direct effect on how services are delivered and who has access to them, and how payments are made.

With funding support from 3MDG, the World Bank initiated a multi-year programme (2015-2017) to strengthen PFM. Activities in 2015 included a rapid assessment of key PFM functions, development of standard operating procedures and tailored trainings on financial management. Support to strengthen PFM will accelerate in 2016 and 2017 with the roll-out of a nation-wide mentorship programme.

**Myanmar Health Forum:** 3MDG provided financial support to UNAIDS for the organization of the first Myanmar Health Forum in Nay Pyi Taw. Over 700 international and national participants attended and discussed the unmet health and development needs, progress and challenges to reaching universal health coverage and linkages between health and other sectors.

**Supporting evidence-based policy**

- **Analytical work:** To improve service delivery and design a people-centered health system for Myanmar, 3MDG collaborated with the ministry to build on the existing evidence base of health systems research and translate evidence into policy. Studies include:

Voices: From policy to practice: Attending the Royal Tropical Institute in Amsterdam

Dr. Su Mon Myat, Assistant Director of School and Adolescent Health Division, Department of Public Health was offered a scholarship to attend the Royal Tropical Institute in Amsterdam, Netherlands, in order to gain her master’s degree in public health. On graduation, she was excited to return to Myanmar and begin to contribute to developing the Ministry of Health’s five-year strategic plan 2016-20 for adolescent health, which is her specialty. “I really like that the course links policy to practice,” she said. “What I have learned is really effective for me, and investing in capacity building of health personnel is one of the best ways to strengthen the health system. We are really grateful to 3MDG offering scholarships to us,” she added.

The scholarship also covered accommodation, insurance and monthly allowance to the participants while studying the international course in health development.

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Strengthening the health workforce

In 2015, 3MDG invested in the following areas to strengthen human resources for health:

- **Midwifery**: Midwives are frontline workers and often the first point of contact for families seeking care in rural areas. As such, it is critical that they are well trained and receive continuing education. Furthermore, regulation, including accreditation of schools and licencing of midwives, is critical to ensure quality of care.

- **Health Systems in Transition**: In 2015, 3MDG invested in the following areas to strengthen human resources for health:

**Midwifery health workforce**: Midwives are frontline workers and often the first point of contact for families seeking care in rural areas. As such, it is critical that they are well trained and receive continuing education. Furthermore, regulation, including accreditation of schools and licencing of midwives, is critical to ensure quality of care.

3MDG provides US$ 6.5 million to support midwifery education and improve standards. To ensure continuity in technical assistance, USAID has agreed to provide an additional US$ 3.5 million starting in 2016 to strengthen in-service training.

**Human resource for health management**: 3MDG provided financing for a human resources (HR) consultant to work with the Ministry of Health to review progress towards objectives outlined in the Health Workforce Strategy 2012-2017.

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**Emergency referral**

- ‘Emergency referral lessons learned’ (3MDG)

**Evidence for policy**: While producing high-quality evidence is critical, the presentation of key findings in ways that enables policy makers to make informed policies is just as important.

In 2015 3MDG, in partnership with WHO – Asia Pacific Observatory, launched the first ‘Myanmar Health Systems in Transition (HiT) Review.’ The HiT review provides a comprehensive overview of the health care system in Myanmar.

To strengthen the country’s capacity to generate policy-relevant evidence and to formulate evidence-based policy options, 3MDG initiated consultation with a wide range of stakeholders on the establishment of a policy forum to strengthen the country’s capacity to generate policy-relevant evidence and formulate evidence-based policy options.

**Strengthening technical capacity**: 3MDG supported scholarships for master’s degrees in public health at the Royal Tropical Institute in Amsterdam, Netherlands. Six MoH staff attended the year-long course, and returned to Myanmar after graduation to undertake important policy work, including drafting of the Reproductive Maternal Adolescent and Child Health Strategy, and coordinating training on community engagement for township planning.

- **Supply chain management**

- ‘National baseline assessment’ (The Partnership For Supply Chain Management)

**Universal health coverage**

- ‘Essential package of health services policy note’ (World Bank (unpublished))

**Health financing**

- ‘Review of evidence on reducing out-of-pocket expenditure’ (World Bank (unpublished))

- ‘Summary of experiences in Myanmar to target the poor’ (World Bank (unpublished))

- ‘Options for health financing’ (World Bank (unpublished))

- ‘Public financial management in the health sector preliminary assessment’ (World Bank (unpublished))

- ‘Health system overview’

- ‘Four policy briefs on universal health coverage, health equity, township health systems and financial risk protection’ (WHO-APO)

- **Midwifery**

- ‘Assessment of eleven midwifery training schools’ (Jhpiego) (unpublished)

- ‘Rapid task analysis on three pillars of midwifery: education, practice, and regulation’ (Jhpiego) (unpublished)

- **Health Systems in Transition**

- ‘Health in Transition’ report, including an overview of the historical and current context and analysis of the health system in Myanmar.

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**Health Systems in Transition presented at 43rd Health Research Congress**

The 43rd Myanmar Health Research Congress held in Yangon in January 2015, with support from 3MDG, was an opportunity for national and international experts to present their work.

National guest speakers were all distinguished Myanmar researchers, with years of experience in the Ministry of Health.

They were joined by representatives from the International Health Policy Program, Ministry of Public Health, Kingdom of Thailand and the Director of the Asia Pacific Observatory.

The symposium provided an opportunity to discuss key findings from the ‘Health in Transition’ report, including an overview of the historical and current context and analysis of the health system in Myanmar.
Findings from the consultation recommend a focus on improving HR information and data to improve forecasting, improving the technical capacity of HR management in departments, and conducting analytical studies to better understand key HR issues such as rural retention and the mix of skills required.

US$ 2 million has been earmarked for this effort and an expression of interest has been drafted. Support for this programme is expected to begin in 2016.

Training of auxiliary midwives: 3MDG continues to support the Ministry of Health (MoH) in training and deploying auxiliary midwives into communities in need (see page 41-42).

Supply chain strengthening
Regional supply chain management: To strengthen the supply chain system and to reduce stock-outs of essential medicines in selected regions, 3MDG awarded a US$ 4.2 million grant to the Partnership for Supply Chain Management in March 2015.

This followed a first grant, whereby the organization supported the MoH in conducting a nationwide assessment of the supply-chain system. The national assessment report highlighted several areas that required additional support. They include improved logistics management, strengthened technical capacities at the state/region levels, updated and streamlined procurement and distribution process, and upgraded warehouse space and information management systems.

Based on recommendations of the Phase 1 report, 3MDG in collaboration with the MoH, selected three regions (Bago, Ayeyarwady, and Magway) to implement an approach which focuses on developing and strengthening a dedicated state/regional level logistics management unit. In 2015, the Partnership For Supply Chain Management supported the MoH in training staff at the regional and township levels on forecasting and supply planning, development of procurement handbooks and development of a training curriculum based on the newly approved procurement guidelines.

In addition, 3MDG with co-financing by USAID, supported the renovation of the central medical warehouse in Mandalay. The facility serves the health supply needs of six states and regions covering approximately 14.7 million residents of Upper Myanmar.

This new model warehouse will become a training site for other facilities and will provide a basis for building a more integrated and efficient national health supply chain.

Cold Chain: 3MDG is investing in strengthening the cold chain to improve immunization coverage. With funding provided through the joint UN grant, UNICEF conducted a nationwide assessment of capacities to store and manage vaccines at township and rural health centres. Following the assessment, 1292 refrigerators have been procured. Of these, 80% have been distributed to health facilities and will be installed in 2016. With the increased capacity (and through GAVI financing for the vaccines), it is expected that pneumococcal vaccine, an essential immunization that protects children against pneumonia and meningitis, will be added to the Expanded Programme on Immunization and made available nationwide by June 2016.

Infrastructure
Communities in rural and hard-to-reach areas continue to face geographic barriers to access services. 3MDG has committed resources to construct up to 78 health facilities by 2017. The team, in consultation with the ministry, selected 66 sites based on a set of criteria including accessibility, population coverage, security, and availability of water and electricity. Discussions on site selection for the remaining 12 health facilities are underway.

In 2015, 17 health facilities in Magway region were constructed. The 2015 annual target for the infrastructure team was 28 health facilities. However delays in the approval process led to slower progress. An additional 26 health facilities are under construction and plans are in place for the remaining 12 health facilities.
LESSONS LEARNED

- Ownership of HSS initiatives by the Ministry of Health is needed to ensure programmes are effectively operationalized.
  —In addition to getting high-level MoH approval, buy-ins from relevant directors, deputy directors, and programme managers are important to the success of the program.
- Shared understanding of universal health coverage remains a challenge.
  —Targeted trainings have been useful to improve understanding among key stakeholders, but ongoing training is needed.
  —Media (especially Facebook) may be used to inform various stakeholders, particularly the public and should be further explored.
- A majority of 3MDG’s HSS investments have been at the central level, but it is evident that technical support is also needed at the state/region and townships levels.
- To ensure sustainability of the health system, there needs to be continued investment in key functions, including delivery and financing beyond the life of the 3MDG Fund.
  —There is limited evidence on health system bottlenecks and more research is needed to improve understanding of barriers to provision as well as access to care at all levels.
- 3MDG, as one of the main HSS financing vehicles in Myanmar, should ensure collaboration amongst various implementing partners through informal coordination meetings on specific HSS topics, as well as cross-cutting issues. In 2015, 3MDG initiated coordination on health management information systems and human resources for health.

COMMUNITY ENGAGEMENT

Communities have unique strengths, skills and knowledge. Community engagement enables community voices to be used to inform health policies, programmes, services and projects. 3MDG supports people in communities by providing them with increased information and the confidence to help them access health services. At the same time, health service organizations are supported to listen to people’s voices and respond to them. The three main ways in which this has been achieved in 2015 is through the Collective Voices initiative, tailored capacity development interventions, and community feedback mechanisms.

COLLECTIVE VOICES: UNDERSTANDING COMMUNITY HEALTH EXPERIENCES

In 2015, the Fund launched its 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).

Collective Voices is a new and important initiative for 3MDG. It draws upon the expertise of local organizations that are often better placed to bring about some of the fundamental changes needed in the relationships between healthcare providers and the communities they serve. This is especially critical for poor and marginalized population groups who are often intentionally or unintentionally excluded from access to quality healthcare.

In 2015, across all partners, the main aims and objectives were achieved:

- More than 500 community consultations were held, producing a situational assessment of community needs.
- Six qualitative reports were produced that highlight some of the key social barriers experienced in accessing health services across areas of the country and within target groups.
- The results detail how language barriers, poor health knowledge and education, lack of family planning and health decision-making power of women, limited functioning and participation in Village Health Committees, weak coordination among healthcare providers, and community reliance on traditional and informal practitioners all contribute towards ill-health.

These situational assessments are being followed by a further project implementation phase (through to the end of 2017), testing a range of approaches to addressing the social determinants of health. In particular, the organizations are focusing on how to:

- Empower women to make personal and family health decisions
- Improve health seeking behaviour in the
community
— Increase participation and engagement between healthcare providers and target communities
— Strengthen the capacity of partner community-based organizations to scale-up these approaches

Through this innovative initiative, the Fund learned that:

1. Direct 3MDG funding to civil society has been well received. Local partners highlighted the importance of projects which identify ‘social barriers relating to health services.’

2. Relationships have been strengthened between health care providers and civil society organizations (CSOs). Collective Voices were encouraged to gather community voices, and work closely with local health authorities, including them as key stakeholders in projects from the beginning.

3. The grants have successfully produced cross-cutting projects that are not limited to disease prevention, but aim to address the social determinants of health. This includes gender, culture, language, ethnicity, poverty, marginalization, discrimination and stigma.

4. There has been a strong focus on gender and ethnic minority issues. In particular, the Chin State organizations have provided access and insight into remote areas, and are developing appropriate local solutions. The partnership approach between lead CSOs and partner CBOs has expanded geographical reach beyond Yangon, to Ayeyarwady Region, Chin State, Shan State and Magway Region.

5. There has been a strong focus on gender and ethnic minority issues. In particular, the Chin State organizations have provided access and insight into remote areas, and are developing appropriate local solutions. The partnership approach between lead CSOs and partner CBOs has expanded geographical reach beyond Yangon, to Ayeyarwady Region, Chin State, Shan State and Magway Region.

Capacity Development
To know how to engage communities effectively, partners and other stakeholders need tools and resources, awareness, skills and confidence. This year the Fund sought to increase the capacity of all of its partners through a range of initiatives, with additional attention given to strengthening the capacity of local organizations.

3MDG undertook an ambitious set of interventions including 1) training related to accountability, equity, inclusion and conflict sensitivity training of trainers, 2) information sharing, participation and feedback and response mechanisms, 3) gender and project cycle management, 4) gender and conflict sensitivity, 5) disability and social inclusion, 6) 3MDG orientation and introduction to participatory learning action (PLA) tools for Collective Voices organizations, 7) collective voices monitoring and evaluation strategy workshop, 8) community engagement training for Ministry of Health, 9) training of trainers on accountability, equity, inclusion and conflict sensitivity assessment, and 10) 3MDG orientation and introduction to participatory learning action (PLA) tools for Collective Voices organisations.

Organizational Capacity Development (OCD) Support
Tailored OCD support provided by Pact Myanmar to 13 local 3MDG partners (financial management, human resources management, advocacy, fundraising strategies, administrative and logistical support, programme management and strategic planning).

3MDG Partner Exchange Programme
To enhance the capacity of partner organizations and create stronger linkages and synergies between MNCH, HIV/TB/Malaria and Collective Voices partners, 3MDG facilitated exchange visits between organizations.
Providers: Health Care Providers

Bright Future, a 3MDG partner, held 48 meetings with healthcare providers in Mon State as part of its 3MDG Collective Voices project. Attendees included basic health staff, doctors from the township and station hospitals, medics from non-state partners, private practitioners, drug sellers, community health volunteers and traditional healers.

The providers shared their experiences, recognizing the role that customs, myths, language barriers, gender discrimination and cultural norms play in limiting access to health information and services. Healthcare providers also noted that due to the history of conflict between ethnic Mon militants and government armed forces, local communities do not easily trust the government health system or staff, preferring to use ethnic traditional healers, especially in remote ethnic minority areas.

Healthcare providers explained that a key barrier was a perceived lack of full commitment, interest and support from the communities for their services. Along with a need for co-operation and coordination among health service providers, it was cited that communities are often unaware of free-of-charge services in township hospitals and other health facilities, especially for maternal newborn and child health. This means that patients often visit health facilities as a last resort.

The providers indicated that they are enthusiastic and willing to develop healthcare knowledge and practices in their respective communities. Bright Future held additional meetings with providers to review understanding of local dialects and customs by healthcare staff and to encourage the health staff to learn about cultural barriers for Mon and ethnic minorities. In addition, the project team has been helping healthcare providers to learn minimum local language terms, and the consequences of conflict on health.

Bright Future, Collective Voices Stage 1 Completion Report, November 2015

In 2015:

- Personal feedback during field visits
- Written feedback through suggestion boxes, ready-made envelopes for mailing, and email
- Verbal feedback through focus group discussions, regular coordination meetings, community meetings and by phone
- Feedback in the second half of the year

Nevertheless, 3MDG partner reports showed that feedback mechanisms for communities in hard-to-reach or unstable areas need strengthening to encourage full participation in health projects. For example, there were some challenges in mobilising communities to use feedback channels, in addition to ethnic language barriers, low literacy rates, and designs that were not always user-friendly.

Assessments showed that implementing partners are taking on board and acting upon the feedback that they receive. For example:

- Additional postnatal care services, health education sessions and cooking demonstrations were provided by basic health staff in Chin State, based on the feedback from communities provided to International Rescue Committee.
- Community feedback in Magway region indicated that information-sharing on referral support services provided by Marie Stopes International (MSI) was insufficient in some areas, so the field visit schedule was planned to ensure greater information sharing and distribution of information, education and communication (IEC) materials.
- Based on feedback received by Burnet Institute about used needles and syringes scattered in neighborhoods, a community meeting was organised, and outreach peers were recruited to more promptly collect discarded needles and syringes.

Community feedback

3MDG has encouraged partners to establish community feedback and response mechanisms, and has provided guidance on how to do this effectively. Feedback can be provided in a number of ways:

- Verbal feedback through focus group discussions, regular coordination meetings, community meetings and by phone
- Written feedback through suggestion boxes, ready-made envelopes for mailing, and email
- Personal feedback during field visits

In 2015:

- In 15 of the 34 townships where MNCH partners are implementing projects, partners have an operational community feedback and response mechanism (FRM). In the remaining townships, partners plan to implement mechanisms in 2016 or in 2017 for some conflict-affected areas.
- In January-December 2015, 3MDG partners received a total of 3,947 instances of feedback and provided responses to 2,115 (54%).
- Amongst the HIV/TB/malaria partners, ten out of 14 had an operating FRM in 2015, with the remaining projects planning to implement one in 2016. These partners received feedback 1,896 times and responded to 70% of this feedback.
- The majority of partners set up mechanisms allowing for verbal feedback, which has often been articulated as a preference by community members in Myanmar.
- Sex-disaggregated data shows that female community members are using feedback mechanisms, with more than 70% instances of feedback in the second half of the year.
- Plenty of positive feedback was received, in addition to complaints and concerns.

TABLE 16: TYPES OF FEEDBACK RECEIVED: JANUARY-DECEMBER 2015

<table>
<thead>
<tr>
<th>TYPE</th>
<th>SUGGESTION</th>
<th>POSITIVE FEEDBACK</th>
<th>NEGATIVE FEEDBACK</th>
<th>QUESTION</th>
<th>CONCERN</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>468</td>
<td>459</td>
<td>48</td>
<td>143</td>
<td>58</td>
<td>2771</td>
</tr>
</tbody>
</table>

* The ‘other’ category includes feedback received during Jan-Jun 2015, at which time feedback was not disaggregated by type.
PROCUREMENT AND DISTRIBUTION

The 3MDG procurement unit placed a total of 184 purchase orders on medical commodities for implementing partners in 2015, with a combined value of US$ 4,323,000. A total of US$ 2,397,000 worth of health commodities have been distributed from the two 3MDG warehouses. Approximately 92% of the distributed commodities were for the implementation of maternal, newborn and child health activities.

TABLE 17: PROCUREMENT AND DISTRIBUTION STATISTICS 2016

<table>
<thead>
<tr>
<th>NO.</th>
<th>COMPONENT</th>
<th>SUB-GROUP</th>
<th>NUMBER OF PURCHASE ORDERS</th>
<th>TOTAL VALUE PROCURED</th>
<th>TOTAL VALUE DISTRIBUTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>C1/C2</td>
<td>In-country storage &amp; transport charges, warehousing, packing materials, etc.</td>
<td>5</td>
<td>US$ 82,181</td>
<td>US$ 663,361</td>
</tr>
<tr>
<td>2</td>
<td>C1</td>
<td>MNCH implementing partners – medical supplies for voluntary health workers</td>
<td>21</td>
<td>US$ 833,855</td>
<td>US$ 663,361</td>
</tr>
<tr>
<td>3</td>
<td>C3</td>
<td>Ministry of Health auxiliary midwives – training supplies</td>
<td>9</td>
<td>US$ 140,201</td>
<td>US$ 117,358</td>
</tr>
<tr>
<td>4</td>
<td>C1</td>
<td>MNCH township health departments* – medical supplies</td>
<td>68</td>
<td>US$ 822,775</td>
<td>US$ 434,455</td>
</tr>
<tr>
<td>6</td>
<td>C2</td>
<td>Malaria** – supplies to combat malaria</td>
<td>15</td>
<td>US$ 154,321</td>
<td>US$ 117,358</td>
</tr>
<tr>
<td>7</td>
<td>C2</td>
<td>Tuberculosis – supplies to combat TB</td>
<td>54</td>
<td>US$ 2,068,495</td>
<td>US$ 2,068,495</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td>184</td>
<td>US$ 4,322,619</td>
<td>US$ 2,397,438</td>
</tr>
</tbody>
</table>

* The distributed value is greater than the procured value because it includes commodities purchased in 2014.
** The distributed value exceeded the procured value in this case because commodities purchased with funds from the predecessor Three Diseases Fund were included in the 2015 distributions.

COMMODITY TRACKING SYSTEM REVIEW

The supply chains of all partners receiving health commodities are externally assessed annually to ensure all 3MDG-funded goods are protected from deterioration and theft. For each aspect they are responsible for, partners are rated unsatisfactory, needs development, satisfactory, or exceeds expectations.

There were 15 organizations reviewed in 2015 and the overall ratings showed that all partners except one were scored as satisfactory. One partner was rated as needs development and a subsequent plan was made to address the issues, which were mostly related to insufficient documentation of supply activities, and special attention will be given as follow-up.

JOINT SUPPLY CHAIN MANAGEMENT TRAINING

A large number of 3MDG partners are also sub-recipients of the Global Fund. To strengthen the supply chain management skills of these organizations, training sessions were jointly funded by 3MDG and Global Fund principal recipient Save the Children for 162 participants.

Seven multi-day sessions were held in Yangon and the regions, to include actual supply chain staff who would have been unlikely to be selected for sessions in the capital.

Maternal, newborn and child health

Procurement under this component is separated into commodities for voluntary health workers, which are standardized and can be procured in advance for quicker distribution, and commodities for township health departments, which include all health supplies except pharmaceuticals, as these are currently provided by the Ministry of Health.

In total, US$ 1,797,000 was spent on maternal, newborn and child health commodities during 2015. The total value procured for voluntary health workers was approximately US$ 834,000 with US$ 663,000 distributed. US$ 823,000 was spent on township health department commodities in 2015, with a total value of US$ 1,444,000 distributed from 3MDG warehouses.

The distributed value is greater than that procured because it includes commodities purchased in 2014. To support midwife training, 478 training models for delivery and subsequent care simulations were purchased for US$ 108,000.

HIV, tuberculosis and malaria

HIV and AIDS commodities cannot be pre-stocked due to variations in pharmaceuticals used for opportunistic infections. A total US$ 221,000 worth of HIV and AIDS commodities, consisting mostly of pharmaceuticals, and hepatitis B vaccines and test kits were procured in 2015.

Tuberculosis commodities cannot be pre-stocked as requirements are difficult to predict and over-stocking is a risk. A total of US$ 2.1 million was spent through 54 purchase orders for comprehensive tuberculosis care simulations were purchased for US$ 478 training models for delivery and subsequent care simulations.

TB drugs, ancillary drugs, biochemical analysers, ultra-deep freezers, refrigerators, motorcycles and IT equipment. Two bespoke mobile TB screening units were procured in 2015 and are expected to arrive in mid-2016.

Essential malaria drugs and rapid diagnostic test kits are pre-stocked for faster distribution. Almost US$ 174,000 of malaria commodities were distributed from 3MDG warehouses in 2015. The total value of malaria commodities procured by 3MDG was US$ 155,000 in 2015.

Due to declining malaria incidence, partners face the problem of excess malaria commodities.

3MDG has coordinated with the two Global Fund principal recipients and other donors for more realistic quantification of malaria commodities for 2016.

A total value of US$ 2,444,000 of HIV, TB and malaria commodities was procured for Component 2 in 2015, through 81 purchase orders. The average delivery lead-time increased from six months to between seven and eight months. The lengthening of the delivery lead time was mostly due to three factors: 1) a change in procedures requiring three additional weeks for customs clearance and 2) delayed availability of additional requested HR resources, 3) inefficient planning of NTP procurement needs.

3MDG also provided assistance with customs clearances.
ROUTINE MONITORING IN 2015

- 74 programme monitoring visits held in 2015
- 88 routine data quality assessments were completed
- 21 organizations underwent these assessments
- Ten states and regions were covered (Ayeyawady, Chin, Kachin, Kayah, Magway, Mandalay, Rakhine, Sagaing, Shan, Yangon)

STRENGTHENING NATIONAL HEALTH INFORMATION SYSTEM

Electronic public health information system rollout in 3MDG townships

To improve the timeliness and quality of health data reporting, the Ministry of Health (MoH) has begun the rollout of a web-based District Health Information System (DHIS2) so township health departments can submit aggregated data on services provided and demographics. The system will improve the quality of data and its timeliness, and strengthen the evidence base for planning and policy making in the long term.

The rollout will be gradual, and based on the availability of funding and internet connectivity. DHIS2 training sessions were conducted in collaboration with the MoH HMIS focal point in December 2015. Staff from 26 township health departments were trained, as were implementing partner staff who will support data entry. 3MDG also provided laptops, modems and internet-enabled SIM cards. By March 2016, 14 townships were using DHIS2. These were the first townships nationwide where DHIS2 has been deployed.

Data system for community health

After observing varying approaches among implementing partners to collecting data on services provided by community health volunteers, and discussion with the Ministry of Health and implementing partners, 3MDG initiated development of a standardised volunteer recording system (VRS).

The aim was to deliver a simple and user-friendly tool to collect the minimum essential data on deliveries, maternal and child care, referrals, case management and health education activities of the volunteer health workers.

Forms were designed and field tested in 2015 on 186 volunteers in three townships. Following feedback, the forms were simplified and training was conducted for the implementing partners. They have subsequently trained volunteers with the support of township health staff since December 2015.

The volunteer recording system will be in use at 34 3MDG-supported townships by the end of 2016. Data will be used to improve planning of community-based interventions, support commodity forecasting, assist in routine monitoring of volunteers and planning supervision by the basic health staff.

Funding national surveys and implementation research

The 3MDG Fund is committed to funding research and supporting evidence generation for improving the programming and development of health strategies and policies. At the national scale, 3MDG is co-funding the implementation of the national Demographic Health Survey (DHS) conducted in Myanmar for the first time, and the Malaria Indicator Survey (MIS). Both surveys will be completed in 2016. The Fund is also providing financing support to its implementing partners for operational research and other studies. In 2015, 19 studies were completed with 3MDG support across all areas of the Fund’s operations.

CAPACITY BUILDING IN M&E

3MDG collaborated with principal recipients (PR) of the Global Fund, including UNOPS-PR and Save the Children-PR, in May 2015 to run two major data and service quality training sessions that were attended by more than 170 staff members from the government, local or international NGOs. These events were the first M&E capacity building events conducted at a such a scale across multiple programmes. 3MDG also conducted monitoring and evaluation workshops throughout 2015.

EXTERNAL DATA QUALITY ASSURANCE

The Independent Evaluation Group (IEG) conducted an annual data quality assessment of the 3MDG monitoring and evaluation system and shared its findings, along with recommendations, in June 2015. The assessment included checking if gaps identified in 2014 were addressed, verification of 3MDG reporting against partner reports for 2014, and a review of the routine data quality assurance process.

The exercise found that 3MDG had made considerable progress in addressing gaps from the prior assessment, but recognized the limitations in terms of data quality assurance of the Health Management Information System (HMIS) data.

External data quality assurance (DQA) found complete correspondence between reported results and recount based on finalised implementing partner reports, except for three minor discrepancies. Finally, the assessment found that the 3MDG M&E unit has extensive and well-described DQA procedures and systems in place. The majority of the recommendations from external DQA have been implemented by 3MDG by March, 2016.

SUPPORTING MOBILE TECHNOLOGY

Mobile technology has a major role in bridging information gaps between service providers and beneficiaries, so in 2015 3MDG organized the “eHealth Networking and Lessons Learnt” workshop for planning deployment of mobile technology in healthcare services.

The workshop was a platform to share the short and long term plans to deploy mobile technology in health, to support service provision, data collection and health education.

Participants included representatives of the Department of Medical Research, donors, NGOs, academic institutions and mobile technology developers. Outputs were used by WHO in their 2016 assessment of the eHealth landscape.
FUND STATUS

Programme delivery in 2015 greatly exceeded previous years with US$ 75.2 million disbursements in 2015. This is 46% of the 2013-2015 total to-date of US$ 164.3 million 3MDG expenditure.

Since the Fund began, 87 grants have been awarded to 54 partners. In 2015 there was an increase of 21 grants (32%) and 13 new partners (32%) from 2014.

DONORS

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

At the end of December 2014, the forecast size of the Fund was US$ 334 million, but after the Australian Government reduced its planned contribution and the strong US dollar impacted on the value of other donor contributions, the total value is now expected to be US$ 268 million.

3MDG is a multi-donor trust fund that pools all contributions from donors into one central ledger to fund programme activities. Donors have also pledged specific contributions earmarked for HIV and malaria interventions in addition to commitments to the pooled fund. The total volume of funds committed as of December 2015 stands at US$ 268.3 million. 3MDG has received US$ 214.7 million in disbursements from contributing donors since inception.

TABLE 18: DONOR CONTRIBUTION RATIO TO 3MDG (INCLUDING EARMARKED TOP-UPS)

<table>
<thead>
<tr>
<th>DONOR CATEGORY</th>
<th>OVERALL COMMITMENTS (MILLION USD)</th>
<th>OVERALL COMMITMENTS (PERCENTAGE)</th>
<th>DISBURSEMENTS RECEIVED (MILLION USD, JUNE 2012-DECEMBER 2015)</th>
<th>DISBURSEMENTS RECEIVED (PERCENTAGE, JUNE 2012-DECEMBER 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>THE UNITED KINGDOM (THROUGH THE DEPARTMENT FOR INTERNATIONAL DEVELOPMENT - DFID)</td>
<td>138.3</td>
<td>51.5%</td>
<td>114.1</td>
<td>53.1%</td>
</tr>
<tr>
<td>AUSTRALIA (THROUGH THE DEPARTMENT OF FOREIGN AFFAIRS AND TRADE - DFAT)</td>
<td>48.2</td>
<td>18.0%</td>
<td>48.2</td>
<td>22.5%</td>
</tr>
<tr>
<td>THE EUROPEAN UNION (EU)</td>
<td>31.2</td>
<td>11.6%</td>
<td>18.9</td>
<td>8.8%</td>
</tr>
<tr>
<td>SWEDEN</td>
<td>25.4</td>
<td>9.5%</td>
<td>11.8</td>
<td>5.5%</td>
</tr>
<tr>
<td>DENMARK</td>
<td>9.2</td>
<td>3.4%</td>
<td>9.2</td>
<td>4.3%</td>
</tr>
<tr>
<td>SWITZERLAND (THROUGH THE SWISS AGENCY FOR DEVELOPMENT AND COOPERATION - SDC)</td>
<td>4.2</td>
<td>1.6%</td>
<td>4.2</td>
<td>2.0%</td>
</tr>
<tr>
<td>THE UNITED STATES (THROUGH THE AGENCY FOR INTERNATIONAL DEVELOPMENT - USAID)</td>
<td>5.0</td>
<td>1.9%</td>
<td>5.0</td>
<td>2.3%</td>
</tr>
<tr>
<td>ROLL OVER FROM 3DF</td>
<td>5.2</td>
<td>1.9%</td>
<td>3.3</td>
<td>1.5%</td>
</tr>
<tr>
<td>ROLL OVER FROM JMNCH</td>
<td>1.6</td>
<td>0.6%</td>
<td>TBD</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL</td>
<td>268.3</td>
<td>100%</td>
<td>214.7</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

EXPENDITURE

3MDG’s Fund Manager had disbursed US$ 164.3 million on behalf of the Fund Board by December 2015, with US$ 146.9 million being for programme activities, and US$ 17.4 million for programme management, governance, monitoring, evaluation, and fund management overhead costs.

US$ 75.2 million (46%) of total expenditure were disbursements in 2015, a much greater investment in health than in any preceding year.

GRANTS AWARDED

A competitive grant commissioning process is used to select implementing partners. The Fund Manager evaluates proposals through a constituted review panel (usually with external representation including the Ministry of Health) to make recommendations for funding decisions. In some particular cases, and upon authorisation from the Fund Board, 3MDG will commission a direct grant from a particular partner if a number of specific criteria are met and the situation demands it. 3MDG has established standardised competitive calls for proposals as the default selection method based on best practices and lessons learned from previous funds. A standard grant agreement is used as the default legal instrument for engaging most of the implementing partners.

GRANTS TO PARTNERS

Performance management is a shared responsibility between the Fund Management Office and the implementing partners to ensure projects are completed on time and to agreed standards. All work by partners is supported and managed through regular meetings and site visits to review performance and develop risk mitigation measures.

GRANTS AWARDED

3MDG had commissioned a total of 87 grants to 54 partners by the end of 2015. The combined value of grants is US$ 226.4 million over the lifetime of the Fund. 3MDG increased the investment into health services and systems in 2015 by commissioning US$ 45.4 million in new grants to partners including the Ministry of Health, UN organizations, international NGOs, and local civil society organizations. The graph above (Figure 23) shows the value of all grants per component.

FUNDING BREAKDOWN

The graph above (Figure 24) shows funds already disbursed plus funds planned for disbursement per component as legally committed in grants.

Within the components funding is allocated against twelve key programmatic areas, providing a further breakdown of 3MDG funding.
TABLE 19: 12 KEY PROGRAMMATIC AREAS

<table>
<thead>
<tr>
<th>MATERNAL, NEWBORN AND CHILD HEALTH</th>
<th>HIV, TB AND MALARIA</th>
<th>HEALTH SYSTEMS STRENGTHENING</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Scale-up of services in conflict-affected areas</td>
<td>• Support to the National Strategic Plan on HIV/AIDS (Harm Reduction)</td>
<td>• Governance and stewardship</td>
</tr>
<tr>
<td>• Support to health care in Special Regions</td>
<td>• Support to the National TB Strategy (MDR-TB and ACF)</td>
<td>• Systems support</td>
</tr>
<tr>
<td>• Strengthening service delivery in public and private sectors</td>
<td>• Support to the National Malaria Strategy</td>
<td>• Community engagement</td>
</tr>
<tr>
<td>• Support to Ministry of Health human resources for health (HRH) strategy</td>
<td>• Strengthening of prison healthcare</td>
<td>• Support to evidence based strategy and policy</td>
</tr>
<tr>
<td>• Evidence base for national MNCH strategies</td>
<td></td>
<td>• Human resources for health strategy</td>
</tr>
</tbody>
</table>

FIGURE 25: MNCH FUNDING BREAKDOWN

FIGURE 26: HIV, TB, MALARIA FUNDING BREAKDOWN

FIGURE 27: HSS FUNDING BREAKDOWN

FIGURE 28: AREAS CUTTING ACROSS MNCH AND HSS COMPONENTS

ANNUAL AUDIT FOR THE 2014 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.

An annual audit of expenditure for the 2014 financial year was conducted by external auditors on the Fund Manager and all partners. Every US dollar spent from 3MDG funds is audited.

For better risk contextualization, the ratings pertaining to audit recommendations are illustrated in Table 20 below. Audit recommendations mitigate risks by highlighting issues and identify remedial actions around the implementation of 3MDG funding, strengthening existing processes for more effective delivery.

The audit report for the Fund Manager only listed one medium-priority audit recommendation for the Fund. This has been implemented already.

The five recommendations from the 2013 Fund Manager audit report were not rated as high priorities but have all been addressed through improved processes and subsequently closed. All Fund Manager audit reports are published on the UNOPS website and are accessible to the interested public.

The 2014 audit reports for implementing partners raised a total of 275 recommendations, of which 11 were high priority, 161 medium priority, and 103 low priority. Action was taken on 101 of these and they were subsequently already closed in 2015.

The majority of audit recommendations fall into the functional areas of Finance and Project Management. Findings in these areas in majority relate to overspending or underspending on individual budget lines and the potential impact on results and value for money, as well as to the fair and equitable allocation of resources cost-shared between different funding sources.

TABLE 20: AUDIT RISK RATING CATEGORIES

<table>
<thead>
<tr>
<th>RATING</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td>Action that is considered imperative to ensure that the 3MDG Fund is not exposed to high risks (i.e. failure to take action could result in major consequences and issues).</td>
</tr>
<tr>
<td>MEDIUM</td>
<td>Action that is considered necessary to avoid exposure to significant risks (i.e. failure to take action could result in significant consequences).</td>
</tr>
<tr>
<td>LOW</td>
<td>Action that is considered desirable and should result in enhanced control or better value for money.</td>
</tr>
</tbody>
</table>

22: Available at www.unops.org/english/About/accountability/IAIG/Pages/Disclosure-of-internal-audit-reports.aspx
ANNEXES

ANNEX I - RESULT MATRIX (JANUARY TO DECEMBER 2015) 102
ANNEX II - IP GRANTS VS. DISBURSEMENT 111
ANNEX III - FINANCIAL STATUS 118
### 2015 Annual Report

#### Impact

The Performance Bands are defined as follows:

- Weak but potential demonstrated (between 30% - 59% of the target achieved)
- Substantially not meeting expectations (below 30% of the target achieved)
- Meeting or Exceeding expectation (above 90% of the target achieved)
- between 60% - 90% of the target achieved

#### Annex I - Results Matrix

**JANUARY-DECEMBER 2015**

<table>
<thead>
<tr>
<th>NO.</th>
<th>OUTCOME</th>
<th>2014 ACHIEVEMENT</th>
<th>2015 TARGET</th>
<th>2015 ACHIEVEMENT</th>
<th>2015 PERFORMANCE BAND</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Number of children under five years who were immunized</td>
<td>65% (GTP)</td>
<td>70%</td>
<td>72%</td>
<td>Meeting or Exceeding expectation</td>
</tr>
<tr>
<td>2</td>
<td>Number of newborns who were immunized within 24 hours</td>
<td>67%</td>
<td>70%</td>
<td>71%</td>
<td>Meeting or Exceeding expectation</td>
</tr>
<tr>
<td>3</td>
<td>Percentage of newborns who received a second dose</td>
<td>69%</td>
<td>70%</td>
<td>70%</td>
<td>Meeting or Exceeding expectation</td>
</tr>
<tr>
<td>4</td>
<td>Percentage of newborns who received a third dose</td>
<td>69%</td>
<td>70%</td>
<td>70%</td>
<td>Meeting or Exceeding expectation</td>
</tr>
<tr>
<td>5</td>
<td>Percentage of newborns who received a fourth dose</td>
<td>69%</td>
<td>70%</td>
<td>70%</td>
<td>Meeting or Exceeding expectation</td>
</tr>
</tbody>
</table>

**NOTES:**

- All targets are provided in the Log Frame in late 2014.
- **EHO only**
- All indicators included in the Log Frame in late 2014.
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<tr>
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</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>Not available</td>
</tr>
<tr>
<td>2</td>
<td>Under-five child mortality per 1,000 live births</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>3</td>
<td>Neonatal mortality rate per 1,000 live births</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>4</td>
<td>HIV prevalence among people who inject drugs in programme areas</td>
<td>53</td>
<td>53</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>5</td>
<td>National TB (all forms) mortality per 100,000 population per year in programme area</td>
<td>100,000</td>
<td>100,000</td>
<td>Not available</td>
<td>Not available</td>
</tr>
</tbody>
</table>

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<th>2015 PERFORMANCE BAND</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Number of mothers who received antenatal care services</td>
<td>63%</td>
<td>63%</td>
<td>65%</td>
<td>Meeting or Exceeding expectation</td>
</tr>
<tr>
<td>2</td>
<td>Number of newborns who received antenatal care services</td>
<td>63%</td>
<td>63%</td>
<td>67%</td>
<td>Meeting or Exceeding expectation</td>
</tr>
<tr>
<td>3</td>
<td>Percentage of women who had a skilled birth attendant</td>
<td>63%</td>
<td>63%</td>
<td>67%</td>
<td>Meeting or Exceeding expectation</td>
</tr>
<tr>
<td>4</td>
<td>Percentage of births that were preterm</td>
<td>63%</td>
<td>63%</td>
<td>67%</td>
<td>Meeting or Exceeding expectation</td>
</tr>
<tr>
<td>5</td>
<td>Percentage of births that were low birth weight</td>
<td>63%</td>
<td>63%</td>
<td>67%</td>
<td>Meeting or Exceeding expectation</td>
</tr>
</tbody>
</table>

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#### Annex I - Results Matrix

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<tr>
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</tr>
<tr>
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<td>Not available</td>
</tr>
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<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
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<td>Not available</td>
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<td>100,000</td>
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<td>Not available</td>
</tr>
</tbody>
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### OUTPUT 1

**Delivery of essential services, with a focus on maternal and child health, strengthened in target townships**

<table>
<thead>
<tr>
<th>NO.</th>
<th>INDICATORS</th>
<th>2014 RESULT</th>
<th>2015 TARGET</th>
<th>2015 ACHIEVEMENT</th>
<th>2015 PERFORMANCE VS TARGETS</th>
<th>CUMULATIVE ACHIEVEMENT</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Total number of Couple Years of Protection (CPY) delivered through public sector services and private-sector channels in Component 1 townships (i) non-Component 1 Townships</td>
<td>(i) 2,749,000</td>
<td>(i) 108,327</td>
<td>(i) 106,080</td>
<td>Meeting or Exceeding expectation</td>
<td>(i) 104,080</td>
<td>(i) Private sector MSI = 51,573 (75 Tsps); PSI = 52,630 (34 Tsps); Public Sector 4,024 (77 Tsps)</td>
</tr>
<tr>
<td>2</td>
<td>Number and proportion of appropriate EmOC referrals supported in Component 1 townships</td>
<td>8,007</td>
<td>14,364</td>
<td>8,187</td>
<td>Meeting or Exceeding expectation</td>
<td>8,187</td>
<td>PSI (247 Tsps)</td>
</tr>
<tr>
<td>3</td>
<td>Number of under-five children delivered in hospitals treated with ORS at Health Facilities</td>
<td>(i) 2,749,000</td>
<td>(i) 108,327</td>
<td>(i) 106,080</td>
<td>Meeting or Exceeding expectation</td>
<td>(i) 104,080</td>
<td>(i) Private sector MSI = 51,573 (75 Tsps); PSI = 52,630 (34 Tsps); Public Sector 4,024 (77 Tsps)</td>
</tr>
<tr>
<td>4</td>
<td>Number of under-five children suspected pneumonia cases treated with antibiotics at Health Facilities</td>
<td>0.11</td>
<td>0.10</td>
<td>0.10</td>
<td>Moderate achievement</td>
<td>0.10</td>
<td>PSI (247 Tsps)</td>
</tr>
</tbody>
</table>

### OUTPUT 2

**Strengthened systems for delivery of essential MNCH services**

<table>
<thead>
<tr>
<th>NO.</th>
<th>INDICATORS</th>
<th>2014 RESULT</th>
<th>2015 TARGET</th>
<th>2015 ACHIEVEMENT</th>
<th>2015 PERFORMANCE VS TARGETS</th>
<th>CUMULATIVE ACHIEVEMENT</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>1,371</td>
<td>2,500</td>
<td>2,500</td>
<td>Moderate achievement</td>
<td>2,500</td>
<td>All 34 townships reported for this indicator. PSI = 52,630 (34 Tsps); Public Sector 4,024 (77 Tsps)</td>
</tr>
</tbody>
</table>

### NOTE

- **Not reported for 2015**
- **Not reported for 2016**
- **Not reported for 2015 and 2016**
- **Not available**

### REFERENCES

- Not available - Not applicable
- Information source is the NTP Annual Report. Most recent published data is from 2014. 2014 result = 369 (against national target of 319).
- 200,000 population – (bacteriologically confirmed plus clinically diagnosed)
- 10 Case notification rate of all forms of TB per 100,000 population – (bacteriologically confirmed plus clinically diagnosed)
- Output 1 Delivery of essential services, with a focus on maternal and child health, strengthened in target townships
- Output 2 Strengthened systems for delivery of essential MNCH services

### TABLE HEADERS

- **NO.**
- **INDICATORS**
- **2014 RESULT**
- **2015 TARGET**
- **2015 ACHIEVEMENT**
- **2015 PERFORMANCE VS TARGETS**
- **CUMULATIVE ACHIEVEMENT**
- **COMMENTS**
2015 ANNUAL REPORT

<table>
<thead>
<tr>
<th>NO.</th>
<th>INDICATORS</th>
<th>2014 RESULT</th>
<th>2015 TARGET</th>
<th>2015 ACHIEVEMENT</th>
<th>2015 PERFORMANCE VS TARGETS</th>
<th>CUMULATIVE ACHIEVEMENT</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Number and percentage of auxiliary midwives and community health workers receiving quarterly supervision and monitoring</td>
<td>63%</td>
<td>70%</td>
<td>37%</td>
<td>Weak but potential demonstrated</td>
<td>Not applicable</td>
<td>All 14 Townships reported for this indicator. Status Region wise coverages are as follow: Delta 52%, Chin 44%, Magway 56%, Kayah 3% and Shan 6%. Low achievements due to a number of logistic workplace of BHS, healthcare challenges due to flooding and landslides in Q3, election process and various BHS trainings which affected routine outreach and supervision activities. In addition, some Townships could not report results because of not using checklist especially during Q4 and Q5. For example, 2 out of 17 Shan Townships supervision was conducted without use of a checklist during the start-up period (thus, these visits could not be included in the result based on the indicator guidelines).</td>
</tr>
<tr>
<td>3</td>
<td>Number and percentage of functioning ANMs and CHWs who report no stock-outs of essential medicines and supplies</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td>-</td>
<td>Out of 60 sites commissioned in 2015, 17 facilities in Magway were completed: Drayen meeting construction targets in the main explained by interruption of activities due to extreme 2015 floods. 2015 target will be reached by the end of May 2016.</td>
</tr>
<tr>
<td>4</td>
<td>Proportion of midwifery students demonstrating competency</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Number of health facilities built and renovated per annum with 3MDG support</td>
<td>28</td>
<td>17</td>
<td></td>
<td>Moderate achievement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OUTPUT 3
Prioritized HIV, TB and malaria interventions not readily covered by the Global Fund provided to targeted populations or areas

<table>
<thead>
<tr>
<th>No.</th>
<th>Indicators</th>
<th>2014 Result</th>
<th>2015 Target</th>
<th>2015 Achievement</th>
<th>2015 Performance VS Targets</th>
<th>Cumulative Achievement</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>6,956,394</td>
<td>8,000,000</td>
<td>10,053,664</td>
<td>Meeting or Exceeding expectation</td>
<td>22,765,655</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Number of bacteriologically confirmed DR-TB cases who began second-line treatment</td>
<td>-</td>
<td>1,406</td>
<td>1,477,368</td>
<td>Meeting or Exceeding expectation</td>
<td>1,477,368</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Number of RDTs taken and read</td>
<td>489,714</td>
<td>489,712</td>
<td>489,712</td>
<td>Meeting or Exceeding expectation</td>
<td>489,712</td>
<td></td>
</tr>
</tbody>
</table>

OUTPUT 4
Prioritized components of the health system are strengthened for greater sustainability

<table>
<thead>
<tr>
<th>No.</th>
<th>Indicators</th>
<th>2014 Result</th>
<th>2015 Target</th>
<th>2015 Achievement</th>
<th>2015 Performance VS TARGETS</th>
<th>Cumulative Achievement</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Specific health sector policies, strategies and plans that 3MDG is supporting are developed and delivered to the MoH</td>
<td>-</td>
<td>-</td>
<td></td>
<td>Not applicable</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

- Consultations conducted and first draft completed. | On track. | Meeting or Exceeding expectation |                      |
The national Essential Package of Health Services has been defined, costed and submitted to the MoH with support from 3MDG. Consultations conducted and key elements identified:

- Most of the equipment still in the process of being distributed and installed.
- The result is an estimate based on CEPI/MoH annual evaluation reports, comprehensive cold chain equipment inventory and immunization forecasting and logistics tools. (As of December 2015).

Percentage of township with functional cold chain equipment and a adequate storage space:

- Not applicable (2014).

Not applicable

- A series of consultations held with >40 partners. 15 thematic areas identified.

- Under Component 1 - 34 townships conducted trainings, with the total of 1,129 participants. (Male - 577, Female - 552)
- Under Component 2 - ATM, 12 implementing partner organizations conducted trainings, with the total of 1212 participants. (Male - 754, Female - 458)
- Under AEI - 6 Collective Voice Project implementing partners conducted trainings, with the total of 450 participants. (Male - 204, Female - 246)
- Total: ZPF (Male - 1,532, Female - 1,252), of which:
  - IP Staff - 1,629
  - MoH Staff - 466
  - NGO Staff - 208
  - CBO Staff - 488

Enhanced health services accountability and responsiveness through capacity development of target communities, civil society organizations and the public sector:

- 196 training in Accountability, Equity, Inclusion and Conflict Sensitivity (AEI & CS) and 200 training in Comprehensive Township Health Plan (CTHP) review workshop.
- 2,791 training in Accountability, Equity, Inclusion and Conflict Sensitivity (AEI & CS) and 2,987 training in Comprehensive Township Health Plan (CTHP) review workshop.

Output 5

Enhanced health services accountability and responsiveness through capacity development of target communities, civil society organizations and the public sector:

- Under Component 1 - 34 townships conducted trainings, with the total of 1,129 participants. (Male - 577, Female - 552)
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- Total: ZPF (Male - 1,532, Female - 1,252), of which:
  - IP Staff - 1,629
  - MoH Staff - 466
  - NGO Staff - 208
  - CBO Staff - 488

Output 6

- Fund Manager performance:
  - Percentage of Fund Manager annual work plan milestones achieved: 63%. (85 out of 1074 community members participating in Focus Group Discussions)
  - 85% of 947 feedbacks is provided in response to 2,135 (54%)
  - Note: (i) and (ii) are not linked because (i) is based on responses from community members in Focus Groups as-part of the AEI&CS assessment conducted by PIs, whereas (ii) collects data from PIS and feedback from people from PI(2) and received a response. During the review of Community Feedback mechanisms planned for June 2015, the PMU will explore ways to make a better link between (i) and (ii).

- Proportion of women representatives on (i) township health committee (ii) village trachal health committees/village health committees
  - 19% (105 women among 582 participants) Meeting or exceeding expectation (2015). (12,606*** among 28,422 total)
  - 20% (12,606*** among 28,422 total)
  - 26% (12,606*** among 28,422 total)

- Proportion of women representatives on (i) township health committee (ii) village trachal health committees/village health committees
  - 43% (105 women among 240 total)
  - 30% (105 women among 240 total)
  - 33% (105 women among 240 total)

- Proportion of women representatives on (i) township health committee (ii) village trachal health committees/village health committees
  - 43% (105 women among 240 total)
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## ANNEX II - 3MDG FUNDED IP GRANTS FOR THE PERIOD OF 1 JANUARY 2013 TO 31 DECEMBER, 2015

### COMPETENT SUB-PARTNER DESCRIPTION

<table>
<thead>
<tr>
<th>NO.</th>
<th>COMPONENT</th>
<th>DESCRIPTION</th>
<th>IMPLEMENTING PARTNER</th>
<th>GRANT ADDED 2015</th>
<th>TOTAL AMOUNT (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>COMPONENT 1: MATERNAL NEWBORN AND CHILD HEALTH SCALE-UP OF SERVICES IN CONFLICT-AFFECTED AREAS</td>
<td>Supporting implementing Maternal Newborn and Child Health services (MNCH) in Kayah State</td>
<td>C1 MNCH International Rescue Committee</td>
<td>$7,758,954.00</td>
<td>$16,476,117.00</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Supporting implementing Maternal Newborn and Child Health services (MNCH) in Southern Shan State</td>
<td>C1 MNCH Relief International-UK</td>
<td>$4,102,762.00</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Supporting implementing Maternal Newborn and Child Health services (MNCH) in Northern Shan State</td>
<td>C1 MNCH Cooperazione e Sviluppo</td>
<td>$1,595,317.00</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Supporting implementing Maternal Newborn and Child Health services (MNCH) in Northern Shan State</td>
<td>C1 MNCH Save the Children</td>
<td>$3,019,084.00</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>SUPPORT TO HEALTH CARE IN SPECIAL REGIONS</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>
<td>C1 MNCH Health Poverty Action</td>
<td>$7,484,282.00</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>STRENGTHENING SERVICE DELIVERY IN PUBLIC AND PRIVATE SECTORS</td>
<td>Supporting implementing Maternal Newborn and Child Health services (MNCH) in the Ayeyarwady Region</td>
<td>C1 MNCH Medical Emergency Relief International</td>
<td>$6,479,225.00</td>
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<td>7</td>
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<td>Supporting implementing Maternal Newborn and Child Health services (MNCH) in the Ayeyarwady Region</td>
<td>C1 MNCH Medicins Du Monde</td>
<td>$4,161,153.00</td>
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*FIGURES IN US$*

### INDICATORS

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<tr>
<th>NO.</th>
<th>INDICATOR</th>
<th>2014 PERFORMANCE VS. 2015 PERFORMANCE VS. 2015 TARGETS</th>
<th>2015 ACHIEVEMENT</th>
<th>COMMENTS</th>
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<tr>
<td>1</td>
<td>Number of operational research studies and case studies produced and disseminated</td>
<td>7</td>
<td>8</td>
<td>Meeting or Exceeding expectation</td>
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<td>2</td>
<td>3 Number of operational research studies and case studies produced and disseminated</td>
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<td>Meeting or Exceeding expectation</td>
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<td>3</td>
<td>48 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2)</td>
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</table>

**Notes**

1. indicators and targets are based on 3MDG Fund’s revised Log Frame version 4 Approved by the Fund Board in August 2015. The Outcome and Criterion 3, 5, 6, 13, 15, and 16 were removed during the Log Frame revision in August 2015.

2. All additional contributions: 2015 Achievement figures for MNCH indicators are based on HMIS township level data. Achievement figures other than from HMIS are presented as additional contributions. These additional contributions may have some operational definition inconsistencies as HMIS, therefore they should be interpreted in a cautious manner. Calculation of coverage percentages is based on the revised Log Frame which was approved by the Board in August 2015.

3. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

4. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

5. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

6. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

7. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

8. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

9. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

10. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

11. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

12. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

13. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

14. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

15. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

16. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

17. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

18. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

19. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

20. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

**Notes**

1. Indicators and targets are based on 3MDG Fund’s revised Log Frame version 4 Approved by the Fund Board in August 2015. The Outcome and Criterion 3, 5, 6, 13, 15, and 16 were removed during the Log Frame revision in August 2015.

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12. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

13. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

14. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

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19. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).

20. Addition to targets: 3MDG Fund results were presented and discussed in 17 fora at national/central level (C1: 8; C2: 6; Other: 2).
## Component 1: Maternal Newborn and Child Health (MNCH)

<table>
<thead>
<tr>
<th>Sub-Component</th>
<th>Partner Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Total Amount</th>
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<td>C1 MNCH</td>
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## Component 2: HIV, TB, and Malaria

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<td>C2 HIV</td>
<td>Substance Abuse Research Association</td>
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<td>Black Sheep Peer Support Group</td>
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<td>C2 HIV</td>
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## Support to the National Malaria Strategy

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<td>World Concern Myanmar</td>
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<td>C2 Malaria</td>
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## Support to the National TB Strategy

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## Support to the National DNLD Strategy

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<td>C2 DPLD</td>
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## Support to the National Harm Reduction Strategy

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### Component 1: Malaria

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<th>Programmatic Area</th>
<th>Implementing Partner(s)</th>
<th>Grant Period</th>
<th>Total Amount (US$)</th>
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<tr>
<td><strong>Community-based Artemisinin Resistance Containment for Mobility-impacted Communities in Mon state, Myanmar</strong></td>
<td>C2 MALARIA</td>
<td>01/01/2013 - 31/03/2014</td>
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<td><strong>Community Development Association</strong></td>
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<td><strong>Community-based malaria prevention, control and MARC Project</strong></td>
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<td><strong>Containment of Artemisinin Resistance in Eastern Myanmar</strong></td>
<td>C2 MALARIA</td>
<td>01/01/2013 - 31/03/2014</td>
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<td><strong>National Malaria Control Programme including Artemisinin Resistance Containment</strong></td>
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<td>01/01/2013 - 30/06/2014</td>
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<td><strong>3MDG Fund Flow Mechanism</strong></td>
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<td><strong>Economic-epidemiological modeling to support the containment of artemisinin resistance in the MARC regions of Myanmar (MARCMOD)</strong></td>
<td>C2 MALARIA</td>
<td>01/09/2013 - 31/08/2015</td>
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<td><strong>Containment of Artemisinin Resistance in Eastern Myanmar</strong></td>
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<td>16/09/2013 - 30/09/2015</td>
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<td><strong>Development of private public partnership (PPP) research products</strong></td>
<td>C2 MALARIA</td>
<td>25/09/2013 - 31/01/2014</td>
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<td><strong>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</strong></td>
<td>C2 MALARIA</td>
<td>05/11/2013 - 31/07/2015</td>
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<td><strong>Community-based malaria prevention, control and MARC project</strong></td>
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<td><strong>Containment of Artemisinin Resistance in Eastern Myanmar</strong></td>
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<td><strong>Malaria services for most hard to reach populations</strong></td>
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<td><strong>Myanmar Malaria Indicator Survey (MIS)</strong></td>
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**Programmatic Area Total:** $25,078,834.00

### Component 2: TB

<table>
<thead>
<tr>
<th>Programmatic Area</th>
<th>Implementing Partner(s)</th>
<th>Grant Period</th>
<th>Total Amount (US$)</th>
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<tr>
<td><strong>Sustaining MDR-TB management in Myanmar</strong></td>
<td>C2 TB ACF</td>
<td>01/07/2013 - 30/06/2014</td>
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<td><strong>MHAA TB ACF Project</strong></td>
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<td><strong>TB ACF in Hard to Reach areas</strong></td>
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<td>01/04/2014 - 31/12/2016</td>
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<td><strong>Accelerated TB active case finding among urban slum dwellers and clients of MNCH services</strong></td>
<td>C2 TB ACF</td>
<td>01/04/2014 - 31/12/2016</td>
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<tr>
<td><strong>Scaling up of active case finding activities</strong></td>
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<td>01/04/2014 - 31/12/2016</td>
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<td><strong>Patient-centred Community-based MDR TB care model</strong></td>
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<td>01/05/2014 - 31/12/2016</td>
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<tr>
<td><strong>Patient-centred Community-based MDR TB Care Model</strong></td>
<td>C2 TB ACF</td>
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<tr>
<td><strong>Patient-centred Community- based MDR-TB Care and treatment support Model</strong></td>
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<td>05/02/2015 - 31/12/2016</td>
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<tr>
<td><strong>Community Based Care for Multi-Drug Resistant Tuberculosis Cases [CBC-MDR-TBC]</strong></td>
<td>C2 TB ACF</td>
<td>01/04/2015 - 31/12/2016</td>
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<td><strong>Strengthening MDR-TB patient data management system of National TB Program</strong></td>
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<td>15/07/2015 - 31/03/2017</td>
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**Programmatic Area Total:** $18,588,456.00

**Component 2 Total:** $82,122,906.00

### Component 3: Support to the National TB Strategy (MDR-TB)

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<th>Grant Period</th>
<th>Total Amount (US$)</th>
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<tr>
<td><strong>Technical support for TB Care and prevention activities</strong></td>
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<td>15/09/2014 - 31/12/2016</td>
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<td><strong>Implementation of a Grant in Myanmar provided by the Three Millennium Development Goal Fund</strong></td>
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<td>01/10/2014 - 31/12/2016</td>
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<td><strong>Patient-centred Community-based MDR-TB care model</strong></td>
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<td><strong>MMA-MDR-TB Project (Patient-centred Community-based MDR-TB Care and treatment support Model)</strong></td>
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<tr>
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**Programmatic Area Total:** $4,955,624.00

**Component 3 Total:** $51,584,955.00

**Component 2 Total:** $82,122,906.00

**Programmatic Area Total:** $25,078,834.00
### Component 3: Health System Strengthening

#### Governance and Stewardship

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<td>UNDAFF001</td>
<td>C3 HSS UNAIDS UN joint assistance to strengthen health systems in Myanmar</td>
<td>07/11/2014 - 31/12/2015</td>
<td>$1,335,592.00</td>
</tr>
<tr>
<td>UNFPA001</td>
<td>C3 HSS ICF Macro Inc. Demographic Health Survey in Myanmar</td>
<td>01/10/2015 - 31/12/2016</td>
<td>$882,586.00</td>
</tr>
</tbody>
</table>

**2015 Grants Added for Programmatic Area:** $882,586.00

**Programmatic Area Total:** $5,036,178.00

#### Community Engagement

<table>
<thead>
<tr>
<th>Grant ID</th>
<th>Description</th>
<th>Grant Period</th>
<th>Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAF970001</td>
<td>C3 HSS HAP International Provision of HAP Technical Support for Implementation of the 3MDG Accountability, Equity and Inclusion (AEI) Framework in Myanmar</td>
<td>24/03/2014 - 16/07/2015</td>
<td>$1,980,276.00</td>
</tr>
<tr>
<td>MAF970001</td>
<td>C3 HSS PACT Institute Organizational capacity development for 3MDG local NGO/CBO Implementing Partners</td>
<td>20/10/2014 - 15/01/2015</td>
<td>$1,150,000.00</td>
</tr>
<tr>
<td>MAF970001</td>
<td>C3 HSS Charity Oriented – Myanmar Supporting the Accountability, Equity and Inclusion (AEI) in the access to health services in Ayeyarwady and Magway Regions</td>
<td>02/03/2015 - 31/08/2015</td>
<td>$303,409.00</td>
</tr>
<tr>
<td>MAF970001</td>
<td>C3 HSS Ar Yone Oo Social Development Association Supporting the Accountability, Equity and Inclusion (AEI) in the access to health services in Southern Chin State</td>
<td>02/03/2015 - 31/08/2015</td>
<td>$250,000.00</td>
</tr>
<tr>
<td>MAF970001</td>
<td>C3 HSS Bright Future Supporting the Accountability, Equity and Inclusion (AEI) in the access to health services in Mon State</td>
<td>02/03/2015 - 31/08/2015</td>
<td>$250,000.00</td>
</tr>
<tr>
<td>MAF970001</td>
<td>C3 HSS Community Agency for Rural Development Supporting the Accountability, Equity and Inclusion (AEI) in the access to health services in Northern Chin State</td>
<td>02/03/2015 - 31/08/2015</td>
<td>$250,000.00</td>
</tr>
<tr>
<td>MAF970001</td>
<td>C3 HSS Community Driven Development &amp; Capacity Building Enhancement Team Supporting the Accountability, Equity and Inclusion (AEI) in the access to health services in Mon State</td>
<td>02/03/2015 - 31/08/2015</td>
<td>$250,000.00</td>
</tr>
<tr>
<td>MAF970001</td>
<td>C3 HSS 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</td>
<td>02/03/2015 - 31/08/2015</td>
<td>$250,000.00</td>
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</tbody>
</table>

**2015 Grants Added for Programmatic Area:** $1,553,409.00

**Programmatic Area Total:** $4,683,685.00

#### System Support

<table>
<thead>
<tr>
<th>Grant ID</th>
<th>Description</th>
<th>Grant Period</th>
<th>Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAF970001</td>
<td>C3 HSS Partnership for Supply Chain Management National Supply Chain Baseline</td>
<td>19/03/2014 - 15/11/2014</td>
<td>$249,397.00</td>
</tr>
<tr>
<td>MAF970001</td>
<td>C3 HSS Partnership for Supply Chain Management Regional Supply Chain Strengthening (RCSC) Myanmar</td>
<td>23/03/2015 - 31/12/2016</td>
<td>$4,700,000.00</td>
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</tbody>
</table>

**2015 Grants Added for Programmatic Area:** $1,512,000.00

**Programmatic Area Total:** $5,212,000.00

#### Support to Evidence Based Policy and Strategy

<table>
<thead>
<tr>
<th>Grant ID</th>
<th>Description</th>
<th>Grant Period</th>
<th>Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAF970001</td>
<td>C3 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</td>
<td>01/04/2013 - 31/12/2014</td>
<td>$97,846.00</td>
</tr>
<tr>
<td>MAF970001</td>
<td>C3 HSS The Regents of the University of California Framework for Private Health Sector Engagement in Myanmar</td>
<td>27/09/2013 - 30/04/2014</td>
<td>$105,662.00</td>
</tr>
<tr>
<td>MAF970001</td>
<td>C3 HSS Myanmar Partners Co. LTD 3MDG contribution to the Family Planning Best Practice Conference</td>
<td>12/06/2014 - 31/07/2014</td>
<td>$32,225.00</td>
</tr>
<tr>
<td>MAF970001</td>
<td>C3 HSS 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”)</td>
<td>01/01/2015 - 31/12/2016</td>
<td>$3,490,610.00</td>
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</tbody>
</table>

**2015 Grants Added for Programmatic Area:** $3,490,610.00

**Programmatic Area Total:** $3,726,343.00

#### Human Resources for Health

<table>
<thead>
<tr>
<th>Grant ID</th>
<th>Description</th>
<th>Grant Period</th>
<th>Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAF970001</td>
<td>C3 MNCH Johns Hopkins Program for International Education in Gynecology and Obstetrics (Jhpiego) Improved Midwifery for Maternal, Newborn and Child Health Services</td>
<td>01/07/2014 - 31/12/2016</td>
<td>$10,000,000.00</td>
</tr>
<tr>
<td>MAF970001</td>
<td>C3 MNCH Ministry of Health Implementation of a Grant in Myanmar provided by the Three Millennium Development Goal Fund</td>
<td>01/11/2014 - 30/11/2015</td>
<td>$1,947,655.00</td>
</tr>
<tr>
<td>MAF970001</td>
<td>C3 HSS United Nations Population Fund 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”)</td>
<td>01/01/2015 - 31/12/2016</td>
<td>$909,500.00</td>
</tr>
</tbody>
</table>

**2015 Grants Added for Programmatic Area:** $909,500.00

**Programmatic Area Total:** $12,857,155.00

**2015 Grants Added for Component 3:** $26,499,445.00

**Component 3 Total:** $46,216,098.00

**Total New Grants for 2015 (all components):** $45,429,183.00

**Total Grants (for all components):** $226,423,266.00
ANNEX III - FINANCIAL STATUS

The Three Millennium Development Goal Fund
Interim Financial Statement (in USD)
As of 30 Nov 2015

<table>
<thead>
<tr>
<th>Project ID</th>
<th>Description</th>
<th>2010</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Funds Received</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multi-Donor BMGF Fund for Myanmar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DKF (Australia)</td>
<td>33,005,065</td>
<td>14,082,073</td>
<td>20,181,871</td>
<td>48,285,009</td>
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<td></td>
</tr>
<tr>
<td>Denmark</td>
<td>4,100,100</td>
<td>5,046,257</td>
<td>6,776,441</td>
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<tr>
<td>DFID</td>
<td>36,905,565</td>
<td>28,785,325</td>
<td>33,037,935</td>
<td>37,294,908</td>
<td>114,279,733</td>
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<tr>
<td>DfID</td>
<td>5,793,569</td>
<td>19,071,895</td>
<td>18,852,464</td>
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</tr>
<tr>
<td>Sweden (SID)</td>
<td>3,019,175</td>
<td>7,029,550</td>
<td>5,600,005</td>
<td>11,847,730</td>
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<tr>
<td>Switzerland (SDC)</td>
<td>3,323,334</td>
<td>1,036,098</td>
<td>2,029,366</td>
<td>4,191,807</td>
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<tr>
<td>UNPAD</td>
<td>5,500,000</td>
<td>1,000,000</td>
<td>2,000,000</td>
<td>5,000,000</td>
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<td></td>
</tr>
<tr>
<td>Inter-project transf*</td>
<td>598,752</td>
<td>(598,752)</td>
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</tr>
<tr>
<td><strong>Total Contributions</strong></td>
<td>44,100,488</td>
<td>58,135,528</td>
<td>64,884,753</td>
<td>56,196,015</td>
<td>215,276,766</td>
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</tr>
<tr>
<td><strong>Funds Expended</strong></td>
<td>44,002,777</td>
<td>58,389,362</td>
<td>65,188,643</td>
<td>56,608,658</td>
<td>212,227,110</td>
<td></td>
</tr>
<tr>
<td><strong>Amounts Receivable</strong></td>
<td>201,000,000</td>
<td>201,000,000</td>
<td>201,000,000</td>
<td>201,000,000</td>
<td>804,000,000</td>
<td></td>
</tr>
</tbody>
</table>

**Funds Expended**

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>44,002,777</td>
</tr>
<tr>
<td>2013</td>
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</tr>
<tr>
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<tr>
<td>2015</td>
<td>56,608,658</td>
</tr>
<tr>
<td>TOTAL</td>
<td>212,227,110</td>
</tr>
</tbody>
</table>

**Amounts Receivable**

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>201,000,000</td>
</tr>
<tr>
<td>2013</td>
<td>201,000,000</td>
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<tr>
<td>2014</td>
<td>201,000,000</td>
</tr>
<tr>
<td>2015</td>
<td>201,000,000</td>
</tr>
<tr>
<td>TOTAL</td>
<td>804,000,000</td>
</tr>
</tbody>
</table>

Note:
* The correction of the project transfer of the USD 972,772 was carried out in FY2014.
** The correction of FY 2013 personnel salaries between DFID and BMGF of USD 58,174.97 following BMGF’s advice was effective in FY2013.
*** The correction of proposed working expenses in the amount of USD 1,816,964 under Project 40 (Funding 57) was effective in FY2014.
**** The correction of non-recoverable direct costs charged to grant (USD 100,000) was effective in FY2014.
***** The correction of MNU funds (USD 2,441,463) from Component 4 - MNUF to Component 3 - BMGF was effective in FY2014.
****** The correction of MNUF funds (USD 2,441,463) from Component 4 - MNUF to Component 3 - BMGF was effective in FY2014.
******* The correction of BMGF funds (USD 1,400,000) from Component 4 - MNUF to Component 3 - BMGF was effective in FY2014.
******** The correction of BMGF funds (USD 1,400,000) from Component 4 - MNUF to Component 3 - BMGF was effective in FY2014.
********* The correction of BMGF funds (USD 1,400,000) from Component 4 - MNUF to Component 3 - BMGF was effective in FY2014.
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************ The correction of BMGF funds (USD 1,400,000) from Component 4 - MNUF to Component 3 - BMGF was effective in FY2014.
************* The correction of BMGF funds (USD 1,400,000) from Component 4 - MNUF to Component 3 - BMGF was effective in FY2014.
************** The correction of BMGF funds (USD 1,400,000) from Component 4 - MNUF to Component 3 - BMGF was effective in FY2014.
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**************** The correction of BMGF funds (USD 1,400,000) from Component 4 - MNUF to Component 3 - BMGF was effective in FY2014.
*************** The correction of BMGF funds (USD 1,400,000) from Component 4 - MNUF to Component 3 - BMGF was effective in FY2014.
***************** The correction of BMGF funds (USD 1,400,000) from Component 4 - MNUF to Component 3 - BMGF was effective in FY2014.
****************** The correction of BMGF funds (USD 1,400,000) from Component 4 - MNUF to Component 3 - BMGF was effective in FY2014.
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