2013 ANNUAL REPORT
summary version
June 2012 to December 2013
LETTER FROM THE FUND BOARD
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ACRONYMS

3DF  Three Diseases Fund in Myanmar
3MDG  Three Millennium Development Goal Fund
ACF  Active TB case finding
ACT  Artemisinin-based combination therapy (malaria)
ART  Anti-retroviral therapy (HIV)
ARVs  Anti-retroviral (drugs)
AMW  Auxiliary midwives
CIP  Call for Proposal
CBO  Community-based organizations
CFM  Community feedback mechanism
CTHP  Comprehensive Township Health Plan
DoA  Description of Action
DoH  Department of Health
FB  Fund Board of the Three Millennium Development Goal Fund
FFM  Fund flow mechanism
FMO  Fund Management Office
GAVI HSS  The GAVI Alliance health systems strengthening
GFATM  The Global Fund to Fight AIDS, Tuberculosis and Malaria
GPARC  Global plan for artemisinin resistance containment
HIV  Human immunodeficiency virus
HMS  Health Management Information System
IEG  Independent evaluation group
INGO  International non-governmental organization
ITN  Insecticide treated net
JIMNCH  Joint Initiative for Maternal, Newborn and Child Health
LIFT  Livelihoods and Food Security Trust Fund in Myanmar
LLIN  Long-lasting insecticidal net
LTA  Long-term agreements
M&E  Monitoring and evaluation
MARC  Myanmar artemisinin resistance containment
MDR-TB  Multi-drug resistant tuberculosis
MoH  Ministry of Health
MOUs  Memorandum of understanding
NAP  National AIDS Control Program
NGO  Non-governmental organization
NMCP  National Malaria Control Programme
PLHIV  People living with HIV/AIDS
PWID  People who inject drugs
SOP  Standard operating procedure
STI  Sexually transmitted infection
TB  Tuberculosis
US$  United States Dollar
VfM  Value for Money
VCCT  Voluntary confidential counselling and HIV testing

3MDG IS SUPPORTED BY

3MDG IS MANAGED BY
The Three Millennium Development Goal Fund (3MDG) was launched in 2012 in order to support a transformational improvement in the health of the poorest and most vulnerable people in Myanmar, and particularly of women and children. Its goal, over the lifetime of the Fund, is to provide over 6 million people in Myanmar with essential services for maternal and child health, as well as to provide critical support to the national programmes for the prevention and control of HIV, tuberculosis and malaria.

The Fund will also contribute to the development of the institutions and systems which support the delivery of health services.

Working in close partnership with the Ministry of Health of Myanmar, 3MDG combines the resources of seven donors: Australia, Denmark, the European Union, Sweden, Switzerland, the United Kingdom and the United States of America. Together, these donors will provide over US$334 million during 2012–2016. This makes 3MDG the largest contributor of external assistance for maternal and child health in Myanmar.

We have an unparalleled opportunity to save and improve lives, and to make mothers and children in Myanmar as healthy as their counterparts in other South East Asian countries.

A healthier and better nourished population will be better able to capture the benefits of Myanmar’s economic transformation.

Implementation of activities under 3MDG started in January 2013. During the period to December 2013, 3MDG received US$ 92.6 million in disbursements and awarded grants totalling over US$ 47 million.

A platform is being built where, together with the Ministry of Health and other partners, a real and sustainable difference can be made for the healthcare of people in need.

MATERNAL AND CHILD HEALTH

Improving maternal and child health is the biggest single component of the Fund’s activities, representing 74 per cent of allocated funding. 3MDG was able to move quickly to continue support to six townships in the Ayeyarwady Region which had been the focus of the earlier Joint Initiative on Maternal Newborn and Child Health. As a result of this early action, over 17,000 births have been attended by skilled health staff, over 20,000 women given a full set of four antenatal care visits, and nearly 9,000 women and children were referred for emergency care.

The longstanding experience of providing essential services in this region has provided a solid evidence base for how to work in cooperation with township authorities to plan and meet the healthcare needs of the poor. This experience is being extended to other parts of the country.

At the same time 3MDG has agreed a longer list of townships for focused support across seven states and regions of the country. These initial focus areas
account for a population of 4.5 million people, and were selected on the basis of their current health needs, giving priority to those areas with the poorest health status. The Fund conducted assessments in 32 townships to identify current gaps in the provision of basic healthcare.

The assessments formed the basis of calls for proposals in focal states and regions, to identify implementing partners who would work with township authorities. Partners were selected for four townships in Chin state, with further contracts for Chin and Magway Region due in early 2014.

Many of the townships where 3MDG will provide funding and support are in areas emerging from conflict. Bringing people together around health, and demonstrating that peace brings tangible benefits through better services has the potential to contribute to peace building, as long as it is done in a careful way. 3MDG will develop a set of principles for operations in conflict areas to ensure the Fund ‘does no harm’ in these areas.

**CONTROL OF HIV, MALARIA AND TUBERCULOSIS**

3MDG provides critical funding to activities to prevent and control major infectious diseases, supporting elements of programmes for HIV, malaria and tuberculosis not covered by growing Myanmar government funding, or support from The Global Fund to Fight AIDS, Tuberculosis and Malaria.

With regard to HIV a major focus of 3MDG’s activities is the provision of HIV prevention activity to people who inject drugs.

Through early action 3MDG has been able to provide support to nearly 25 per cent of the estimated number of people who inject drugs across the country in 37 townships, reaching nearly 19,000 people and distributing 5.7 million needles and syringes to help prevent the sharing of infected injecting equipment. 2,800 drugs users have been referred for counselling and testing for HIV. 3MDG has also begun a programme of activities in collaboration with the Joint United Nations Programme on AIDS (UNAIDS) to work towards a policy and legislative environment which helps facilitate control of HIV.

In the area of tuberculosis (TB) control, 3MDG provided funding to the National TB Programme through the World Health Organization (WHO) to support care for patients infected with multi-drug resistant MDR-TB. This small programme supported over 1,100 patients to access treatment and care, and provided the foundation for a scaling up of MDR-TB treatment services in 2014/5. Other areas of TB control were planned in 2013, including a major programme of support for community outreach and active finding of TB cases, and the strengthening of health and TB services among prison populations.

In malaria control, 3MDG funded programmes which tested over half a million people for malaria and treated nearly 80,000 confirmed cases. Over 800,000 mosquito nets were distributed and more than 3,000 community volunteers were trained and equipped to provide testing and treatment services. 3MDGs experience in the first year of implementation has shown that there are less malaria cases identified than were originally estimated, pointing to an overall decrease in prevalence. In 2014 the Fund will plan to support more comprehensive surveys which will enable the Ministry of Health and other malaria partners to assess this trend.

**STRENGTHENING HEALTH SYSTEMS**

3MDG is providing funding to initiatives to strengthen institutions and systems for the delivery of health services, including information, human resources management, quality of care, and the procurement and supply of drugs and other commodities.

In this preparatory phase of the programme 3MDG paid attention to proper analysis of health systems strengthening in the country, to inform joint plans with Government and other partners. WHO’s Asia Pacific Observatory commenced work on a comprehensive study of Myanmar’s health system, under the leadership of the Ministry of Health. The World Bank was funded to map the different organisations working on health systems strengthening initiatives. Planning began for an initiative which would bring the key United Nations agencies, including the United Nations Population Fund (UNFPA), the United Nations Children’s Fund (UNICEF), the World Health Organization (WHO), and the Joint United Nations Programme on HIV/AIDS (UNAIDS), around a common plan for health systems work.

Much has changed since the 3MDG Fund was first designed. In the year since it was launched Myanmar’s government expenditure on health continued to grow. Myanmar signed up to the International Health Partnership (IHP+). New development partners, including the World Bank, indicated a desire to provide further funding to the health sector. In this changing context 3MDG provides a platform for strong partnership between the Ministry of Health, bilateral health donors, multilateral partners including the UN system, and non-government organisations from Myanmar and outside. It offers a key commitment to transforming the lives of poor mothers and children, as well as a flexible source of support for key activities for disease control.

3MDG’s activities between June 2012 and December 2013 provide a basis for a strong contribution to the evolving health sector, and a launchpad for further health improvements for the people of Myanmar.
INTRODUCTION TO 3MDG

INTRODUCTION
The Three Millennium Development Goal Fund (3MDG) provides joint donor support to address the basic health needs of the poorest and most vulnerable people in Myanmar, in close collaboration with the Ministry of Health and other partners.

The Fund has three main components:
1. Maternal, newborn and child health
2. HIV/ AIDS, TB and malaria
3. Health systems strengthening

The 3MDG Fund was designed to build on the experience of previous health funds that were coming to an end in 2012, and complement ongoing donor programmes. The Fund identifies and fills funding and delivery gaps to improve healthcare for the poorest and most vulnerable people in Myanmar. The 3MDG Fund achieves results by focusing on:
• Aligning to national health sector strategies
• Building sector-wide partnerships
• Using assessment and planning as the basis for targeting resources
• Delivering a defined package of essential health services

Funding Breakdown
It is financed by Australia, Denmark, the European Union, Sweden, Switzerland, the United Kingdom and the United States of America, and has commitments to provide over US$334 million during 2012–2016. It is managed by the United Nations Office of Project Services (UNOPS).

The current fund programming status splits the money in the following ways:

Grants Awarded
In 2013, the 3MDG commissioned a total of 35 grants, valued at US$ 32.15 million, of which US$ 20.5 million were disbursed to 32 different implementing partners. These partners are UN organizations, international non-governmental organizations, local community-based organizations, and local non-governmental organizations.

HEALTH SECTOR CONTEXT

Political commitment
Change in the political sphere of Myanmar is paving the way for reforms in the social sectors, with substantial reforms currently underway to ensure universal access to quality health care. Myanmar’s National Health Plan for 2011-2016 is based on a primary health care approach and places emphasis on equitable access to health care. It gives priority to maternal, newborn and child health, communicable diseases and health systems strengthening, as well as to sector coordination.

Health challenges
Despite a reform-minded Myanmar Government, and increased support from external actors, challenges remain. A large number of pregnant women and children die each year, largely from preventable causes. Among specific diseases, the leading causes of death and illness for all members of the population are tuberculosis, malaria and HIV/AIDS. There 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
A range of system challenges also undermine the capacity of the public sector to deliver basic health care including financing, human resources, infrastructure, essential drugs and supplies, health information, and stewardship of the sector.

Filling the investment gap
In 2012, it was clear that Myanmar faced a serious need for increased investment in the delivery of essential health services. The Three Millennium Development Goal Fund (3MDG) was established in 2012 to fill this gap. 3MDG is now providing funding and technical support to the Government and other key partners to improve access to an evidence-based package of services for maternal and child health, HIV, TB, and malaria control, and to strengthen the systems that deliver health services.

THE HEALTH RELATED MDGs

MDG 4 - REDUCE CHILD MORTALITY
• Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.

MDG 5 - IMPROVE MATERNAL HEALTH
• Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.
• Achieve, by 2015, universal access to reproductive health.

MDG 6 - COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES
• Have halted by 2015 and begun to reverse the spread of HIV/AIDS.
• Achieve, by 2015, universal access to treatment for HIV/AIDS for all those who need it.
• Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.
CORE PRINCIPLES

BUILDING PARTNERSHIPS AND ALIGNING STRATEGIES
The Myanmar Ministry of Health is central to planning and implementation across all aspects of the 3MDG Fund, and is the direct beneficiary of the Fund’s capacity building and systems strengthening activities.

Financing is aligned to the Ministry’s sector strategies, with technical interventions based upon the specific interventions endorsed.

Other core partners include United Nations health bodies, local and international NGOs and beneficiary communities.

CONFLICT SENSITIVITY
Across areas of Myanmar, issues related to ethnicity and conflict affect the delivery of health services. In 2013, 3MDG undertook a number of conflict assessments in order to gain a fuller appreciation of preconditions for successful programme delivery.

MONITORING & EVALUATION
The Fund is committed to the promotion of a culture of transparency, accountability, evidence-based learning and efficient knowledge management. 3MDG’s monitoring and evaluation unit supports the gathering and analysis of data in order to improve upon the effectiveness and sustainability of 3MDG-supported programmes.

EVIDENCE-BASED PROGRAMMING
The Fund believes in supporting and promoting an evidence-based approach to health care. In 2013, 3MDG worked with key partners to commission research projects that identify best practices from existing health projects in Myanmar and similar settings.

VALUE FOR MONEY
3MDG works within a Value for Money Framework, which takes a practical approach to measuring 3MDG support. 3MDG has integrated value for money concepts within procurement, planning, budgeting and reporting, which will enable the Fund to gain a better understanding of health service costs.

ACCOUNTABILITY, EQUITY AND INCLUSION
3MDG follows an overarching goal to contribute to national progress towards the health MDGs through a right-based approach.

This means ensuring equal access to health services, empowering women, engaging communities in decision making and implementation, ensuring the voices of minorities and other vulnerable communities are heard, and more.

TRANSPARENCY
Information about 3MDG can be found on www.3mdg.org in English and the official language of Myanmar. As part of the Fund’s commitment to transparency, project-level information and financial information about the Fund is published on data.unops.org on a quarterly basis.

Regular information sessions are also held in Yangon to explain the growing number of funding opportunities and answer any questions from the public.

Objectives of the Beneficiary Accountability Framework

• Improve the way an agency engages with local communities in decisions that affect them by striving to enhance participation and to seek informed consent.

• Share information with beneficiaries to promote and improve transparency and information provision.

• Provide beneficiaries with channels through which concerns can be raised. This is part of the ethical commitment to listen, monitor and respond to beneficiary concerns.

• Ensure that all staff are provided with a thorough understanding of Accountability and Quality Management Principles and Standards.
Lei Lei Win, 33, is a midwife with nine years’ experience. When she started work, there was no financial support and Lei Lei Win had to use her own money to visit her patients.

Now with funding support for transportation provided by 3MDG, through its implementing partner the International Organization for Migration, Lei Lei Win can visit most pregnant women at least twice across the 15 villages she covers. In addition to ante- and post-natal care, Lei Lei Win also holds health education sessions on danger signs for pregnant women and encourages them to seek skilled birth assistance.

This can be challenging since women would normally rely on traditional birth attendants in their village for cultural and personal support. But attitudes are slowly changing.

Lei Lei Win also works with a volunteer health worker in each village to give children vaccinations and assess the nutritional status of young children.
MATERNAL, NEWBORN & CHILD HEALTH

CONTEXT
In Myanmar, at least 2,400 pregnant women and 70,000 children die every year from largely preventable causes. Antenatal care, skilled birth support and emergency obstetric care are often not adequate, available or affordable. Children under five are dying from pneumonia, diarrhea and malaria.

These high rates of preventable mortality mean that maternal and child health (MNCH) is a high priority for both the Government of Myanmar and the 3MDG Fund. It represents almost two-thirds of overall financing within the Fund, around US$200 million in investment.

Target beneficiaries
The primary beneficiaries of this Component are women of reproductive age, mothers, newborns and children under five. The Fund places special emphasis on improving access and quality of care in the most vulnerable communities.

Package of services
The package of mother and child health services supported by the Fund is based upon national strategies as well as the global evidence base related to low-cost, high-impact interventions that have been shown to reduce avoidable causes of maternal and child death.

Developing Comprehensive Township Health Plans
In order to provide these services in line with national strategies and in ways that best meet the specific needs for each location, 3MDG works in coordination with the Ministry of Health to develop Comprehensive Township Health Plans for each target township. These are based upon an assessment of local health facilities as well as available staffing, combined with a review of available health information. The final document serves both as an overall Township health plan, since it reflects all forms of financing from all sources, also the investment case for 3MDG financing to the Township and finally the means of monitoring the delivery of the services.

ACHIEVEMENTS
Completing initial township health assessments
In 2013, 3MDG conducted township health assessments in 32 priority townships in Chin, Kayah and Shan states, and the Magway Region.

In each township, the assessments were led by the Township Health Department, with input from other stakeholders.

The process was widely appreciated and served to identify many opportunities to improve health systems, train health staff, build the capacity of community health teams, and to deliver additional services beyond the scope of mother and child health.

Grants for service delivery
Following the township health assessments and a contracting and planning process, the Fund commissioned two new grants to support health service coverage across an initial four townships in Chin and Magway Region.

As the contracting process continues in Chin and Magway more grants will be issued in 2014.

In the Ayeyarwady Region, six townships that had previously been supported by the now-completed Joint Initiative for Maternal, Newborn and Child Health, received continued financing from 3MDG.

The townships selected were Bogale, Dedaye, Labutta, Mawlamyinegyun, Ngapudaw and Pyapon, representing 31,000 estimated births per year for a total population of around 1.8 million people.

These townships continued to receive a range of life-saving services.

At the end of 2013, 3MDG had commissioned nearly US$ 9.4 million in grants with six partners, covering over two million people, through to the end of 2016.

Key Developments in 2013
- Identified list of priority townships with greatest health and poverty gaps
- Continued funding services in six Ayeyarwady townships
- Conducted health assessments in 32 townships
- Signed nearly US$ 9.4 million in grants with six partners, covering over two million people through to the end of 2016.

Results 2013

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Births attended by skilled health personnel</td>
<td>17,000</td>
</tr>
<tr>
<td>Infants vaccinated against measles</td>
<td>33,500</td>
</tr>
<tr>
<td>Life-saving referrals for women and children</td>
<td>9,000</td>
</tr>
<tr>
<td>Basic Health Staff trained</td>
<td>350</td>
</tr>
</tbody>
</table>

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The Myanmar Anti-Narcotics Association (MANA) is a local NGO funded by 3MDG to deliver HIV prevention and support in Northern Shan State and Mandalay Region. MANA works closely with local authorities and communities to increase awareness and understanding of HIV and how it is transmitted, while building trust with drug users.

Their activities include condom, needle and syringe distribution; health promotion and behaviour change activities; drop-in centre services; basic health care; psycho-social support for clients and family members; and the provision of medication to prevent opportunistic infections.

Their services reach around 8,000 people who use drugs and people who inject drugs.
CONTEXT
In Myanmar, HIV has the features of a concentrated epidemic among specific groups. The latest data\(^1\) showed HIV prevalence at over 7% among female sex workers, 8.9% among men who have sex with men, and 18% among people who inject drugs.

3MDG aims to support priority gaps in the national response to HIV that are not readily funded by the Global Fund. The main focus of 3MDG support in 2013 was on harm reduction.

Target beneficiaries
Priority was given to townships where injecting drug use and HIV prevalence was higher. These townships are in areas of high injecting drug use along the border areas, drug trafficking routes and mining sites, for example in Kachin State.

ACHIEVEMENTS
Harm reduction
HIV harm reduction interventions under 3MDG are Government-led and aligned to the National Strategic Plan for HIV and AIDS.

At the end of 2013, 3MDG had commissioned nearly US$ 6.7 million in grants with 11 partners, for services in a total of 33 townships in Shan, Kachin and Mon states, and Mandalay, Sagaing and Yangon regions.

A total of 9 grants were commissioned for HIV interventions and 2 grants were commissioned for integrated HIV-TB-malaria interventions.

These partners provided a comprehensive package of harm reduction services, including:

- Clean needle and syringe distribution
- HIV counselling and testing services
- Referral for opioid substitution therapy
- Screening and treatment for TB and sexually transmitted infections
- Antiretroviral therapy

Addressing barriers to HIV prevention
Through enhanced advocacy efforts and improved awareness, it is anticipated that Myanmar may be able to effect the necessary policy and legislative reforms required in order to address its HIV epidemic.

However, substantial policy and legal barriers remain that limit the effective conduct of HIV prevention activities.

Discriminatory attitudes of health service providers, of the family and in the community at large towards key affected populations also constitute social barriers of isolation, judgment and exclusion.

In 2013, 3MDG signed a financing agreement with UNAIDS for interventions that aim to address the substantial policy and legal barriers that limit the effective conduct of HIV prevention activities.

Integrated services: HIV-TB-malaria
3MDG’s experience suggests that integrating service delivery across the three diseases will provide better access to services while costing less.

Whilst broad integration of TB/HIV services is planned for 2014, 3MDG has already financed integrated services from two implementing partners in five hard-to-reach and priority townships (Hpakan, Waingmaw, Laukaing in Kokang Special Region, Lashio and Patheingyi).

Key Developments in 2013
- Focused on harm reduction services
- Established referral networks
- Began planning integration of TB/HIV services
- Addressed social, legal and policy barriers to HIV protection
- Signed nearly US$ 6.7 million in grants with 11 partners, for services in 33 townships

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\(^1\) Result of HIV sentinel sero-surveillance 2012, Myanmar, National AIDS Programme, Department of Health, Ministry of Health, February 2013
The Asia Harm Reduction Network (AHRN) in Myanmar provides services to people who inject drugs through drop-in centres that provide primary health care, needle exchange programmes, condoms, health education, counselling, HIV testing, methadone maintenance therapy and more.

AHRN works in Laukkaing (Kokang Special Region), Waingmaw and Hpakan Township, which all have high numbers of casinos, sex workers and people who inject drugs.

AHRN is currently the only harm reduction service provider in Myanmar that also offers TB screening and treatment services to its clients as well as malaria referrals, screening and treatment.

“VOICES”
TUBERCULOSIS

Results 2013

$261,500
amount of the grant signed for MDR-TB programme

1,161
MDR-TB patient supported in accessing treatment and care

354
MDR-TB patients assisted with nutritional support

CONTEXT
Among specific diseases, Tuberculosis (TB) is one of the leading causes of death and illness in Myanmar.

Latest figures estimate TB prevalence at 489/100,000 within the population. Worryingly, multi-drug resistant TB (MDR-TB) is estimated to be 5% of new TB cases.

Updated gap analysis and programmatic refocus
An updated gap analysis for the funding of TB interventions, as well as considerable consultation with the National TB Programme and the Ministry of Health led to a redesign of the content and timeline for TB grant awards from 3MDG – with substantial programming to take place in 2014.

• Active case finding- With the additional funding support from the Global Fund New Funding Model, Myanmar has been able to scale up the national response to TB. 3MDG’s priority is to complement the national response by expanding active TB case-finding through innovative strategies not covered by the Global Fund.

• Integrated TB/HIV services - Integrating TB and HIV programmes in mining communities, hospitals, poor urban areas and in prisons, rather than providing the services independently, representing a significant opportunity for the Ministry of Health to align with WHO’s global plan to accelerate the response to TB-HIV.

ACHIEVEMENTS

Multi-drug resistant Tuberculosis (MDR-TB)
In 2013, 3MDG signed a US$261,500 grant with WHO to support ongoing efforts around the management of drug resistance by the National TB Programme.

The focus of this grant was for nutritional support and care for patients, as the bulk of the MDR-TB response is funded mainly by the Global Fund.

This US$261,500 grant resulted in:

• A significant reduction of out-of-pocket expenditure for 1,161 MDR-TB patients

Target beneficiaries (for programming to begin in 2014)
3MDG will focus its funding on high-risk populations living in poor urban areas, hospitals, prisons, underserved townships, hard-to-reach areas and mining communities.

Prison health programme
Prison populations are an underserved and hard-to-reach population for TB prevention, treatment and support, especially for those suffering from TB/HIV co-infection.

In 2013, the Ministry of Health, 3MDG and the national AIDS, TB, and malaria programmes held discussions to increase engagement with the Prison Department of the Ministry of Home Affairs and other partners.

This led to the formation of a Prison Health Advisory Committee, which then asked 3MDG to coordinate a Rapid Assessment and Response (RAR) of prison health facilities and services.

Five prisons were selected in preparation for visits scheduled to start in 2014.

Key Developments in 2013

• Completed funding gap analysis

• Refocused programming in light of new evidence

• New focus on active case finding and integrated services

• Tasked by new Prison Health Advisory Committee to coordinate review of prison health systems

• Signed a US$ 261,500 grant to support ongoing efforts around the management of MDR-TB
"We have one son and two daughters. We live in a small village called Daw Khule, which is located at the remote part of Phruso Township in Kayah State. Since there is no regular transport, travelling from the village to town is very difficult. Rain makes the road muddy and slippery. One day, my father suffered from malaria when he returned home after collecting wood in the forest. We tried our best to cure him with traditional medicines, but it was not successful and he passed away. My wife learned from our village leader who had attended a meeting organized by the Myanmar Health Assistant Association (MHAA) that a social malaria worker was being recruited from each village."

"My wife was chosen to attend this training for my village. During the training period, she was taught how to conduct blood tests. She came to know about modern malaria drugs for positive cases and how to treat mosquito-nets by using KO tabs. Moreover she knew more about malaria and its complications, so she distributed this knowledge to the villagers. Now we are able to save many lives of malaria patients in our village and its surroundings."

"I thought to myself: 'My father would not have died if this project was started earlier in my village.'"
MALARIA

Results 2013

<table>
<thead>
<tr>
<th>People/Net</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tested for malaria</td>
<td>570,000</td>
</tr>
<tr>
<td>Treated for malaria</td>
<td>80,000</td>
</tr>
<tr>
<td>Treated within 24h of onset fever</td>
<td>34,000</td>
</tr>
<tr>
<td>Long lasting insecticide treated nets distributed</td>
<td>800,000</td>
</tr>
</tbody>
</table>

CONTEXT
Malaria is a major cause of illness and mortality amongst children and adults in Myanmar. Over three-quarters of the population live in malaria endemic areas.

The emergence of artemisinin-resistant malaria on the country’s eastern borders is a serious concern, with significant global implications.

A national response strategy, the Myanmar Artemisinin Resistance Containment Framework (MARC), aims to protect Artemisinin-based Combination Therapy (ACT) as an effective anti-malaria treatment.

Financing from 3MDG will support the MARC strategy and is predominantly targeted at addressing gaps in coverage, especially amongst mobile, migrant or remote populations, particularly in former conflict areas.

Updated Malaria gap analysis
During 2013, 3MDG undertook an extensive review of all financing for MARC interventions in Myanmar to ensure that 3MDG’s support would complement all other funding initiatives planned.

Despite significant new financing commitments, estimates still highlighted a very substantial funding gap.

The Global Fund could not fully fund the MARC national response in 2013 so 3MDG continued to provide support to existing MARC activities until the Global Fund is able to assume responsibility.

Partners
At the end of 2013, 3MDG commissioned nearly US$ 13.3 million in grants with 11 partners, in a total of 75 townships in Kayin, Kachin, Kayah, Mon and Rakhine States, Bago, Chin, Tanintharyi and Sagaing Regions, covering a total of 10,481 villages.

ACHIEVEMENTS
Training of malaria volunteers
Community-based volunteers play a significant role in ensuring the early diagnosis and effective treatment that is key to containing artemisinin drug resistance.

In 2013, MARC partners trained a total of 3,246 malaria volunteers, and equipped them with rapid malaria diagnostic tests and artemisinin-based combination therapy. This included 280 volunteers providing outreach to migrant and mobile populations.

Reduction in malaria cases found
In 2013, almost 570,000 people suspected to have contracted malaria were tested by partners funded by 3MDG. Around 80,000 cases of malaria were confirmed and received treatment in line with national guidelines.

Whilst this represents only 41% of the total number of cases expected, similar declines have been noted for the last number of years from other major funding sources and this has been interpreted as being due to an overall decline in malaria prevalence across Myanmar. A number of studies will be commissioned to examine this issue in greater depth.

Malaria prevention
3DF and the Global Fund both provided significant financing for malaria prevention, in particular in areas showing drug-resistance.

In response to a request from the National Malaria Control Programme and through a grant to WHO, 3MDG extended its support to the distribution of LLINs in an additional 23 townships located in townships are high malaria endemic zones but without evidence of resistance.

Key Developments in 2013

• Completed the updated Malaria gap analysis
• Transitioned previous 3DF-funded programmes to combat malaria into 3MDG
• Overall decline in malaria prevalence across Myanmar
• Signed nearly US$ 13.3million in grants with 11 partners, for services in 75 townships.
In 2013, over 6,300 community responses were recorded, including requests for primary health care services, provision of health education sessions and for improvements to used needle and syringe re-collection in the community.

Despite this relatively high number, it has been noted that, at this stage of the program, topics related to gender are absent from the feedback; and its full potential to reach beneficiaries living in remote or unstable areas has not been met.
CONTENTS

In Myanmar, the public sector faces a number of challenges in the delivery of basic health care. 3MDG includes a health systems strengthening component as this will be critical to the achievement of the health-related MDGs and in particular to improving maternal and child health.

This component complements the mother and child health programmes of other donors and agencies.

Developments in Government coordination and strategy

Since the initiation of 3MDG, the architecture for health sector coordination has been further developed through the Myanmar Health Sector Coordinating Committee and its related Technical and Strategy Groups.

The Government has also joined the International Health Partnership (IHP+) and has set out a strategic directions paper for reaching Universal Health Coverage, which includes nine priority areas for health reforms, beginning with the elaboration of an essential package of care to be provided by different levels of the health service.

Accountability, equity and inclusion

3MDG is working within this context of reform in line with its Accountability, Equity and Inclusion Strategy. This prioritizes initiatives that address the social determinants of health, which will be achieved primarily through building the capacity of target communities, civil society organisations and the public sector.

ACHIEVEMENTS

Reviewing Myanmar’s health systems

In 2013, 3MDG funded complementary research projects to help the Ministry of Health identify:

• The most appropriate policy instruments to meet health targets, by providing in-depth analysis of evidence on Myanmar’s health system organization, coverage, performance and current reforms

• Priority areas for strengthening within the Ministry of Health and the wider health sector, as well as ways to promote coordination and knowledge sharing

Developing a Fund Flow Mechanism

Significant work was undertaken around analysis of public financial management systems within the health sector leading to the design of a mechanism for direct financing of public health service delivery.

This fund flow mechanism could be used for all sources of external financing support for the public sector, which would significantly reduce transactional costs and complexity.

WHO ASIA PACIFIC OBSERVATORY: Health Systems in Transition and Policy Dialogues

The WHO Asia Pacific Observatory in collaboration with Myanmar’s Ministry of Health and the International Health Policy Programme based in Thailand are being financed to provide:

• Technical support to the Government of Myanmar in their efforts to develop and implement evidence-based health sector policies;

• An in-depth analysis of the most up-to-date evidence on Myanmar’s health system organization, coverage, performance and current reforms.

THE WORLD BANK: Advisory and Technical Services for Health Systems Strengthening

In line with the above work, in late 2013 the World Bank began complementary work with a capacity development project in direct support of the Ministry of Health, with three main objectives:

• Designing a master plan for health system strengthening, including the identification of strategic and priority interventions;

• Strengthening institutional capacity in the Ministries of Health and Finance for improved policy making, and across all levels of the public system for improved delivery of health services;

• Promoting strong coordination among Government agencies and development partners to better share knowledge and eliminate work fragmentation and duplication.

Developing a joint initiative with UN agencies

Over 2013, 3MDG and the Ministry of Health held extensive discussions with the World Health Organization (WHO), the United Nations Children’s Fund (UNICEF), the United Nations Population Fund (UNFPA) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), to provide additional health system strengthening work at the national level.

The focus will be on planning and coordination, human resources, enhancing data and information systems, and managing vaccine cold chains and essential medicines. It is anticipated that a grant agreement will be signed in early 2014.

Key Developments in 2013

• Engaged partners to review current state of Myanmar health systems and make recommendations for improvements

• Began developing a joint health systems strengthening initiative with UN agencies

• Advanced progress towards a fund flow mechanism to provide direct financial support to public sector
GOVERNANCE STRUCTURE

Governance arrangements for 3MDG build on the experience and lessons learned from 3DF, while taking into account the expanded scope of the new Fund, as well as changes in the Myanmar context. Consideration has also been given to international best practice concerning the following principles: promoting participation and accountability; ‘do no harm’; fostering capacity building; ensuring transparency and financial probity; promoting a rights-based approach; and supporting the aid effectiveness agenda.

Fund Board

The core governance structure of the Fund is the Fund Board, which includes representatives from all contributing donors to the Fund as well as three independent experts appointed by 3MDG donors. The Board’s principal role is the oversight of the 3MDG Fund.

Senior Consultation Group (SCG)

The Senior Consultation Group is a formal advisory group for the Fund Board. It is chaired by the Ministry of Health and includes key nominated officials from the Ministry as well as elected representatives from UN health agencies and the international and local NGO community.

The SCG is one of multiple mechanisms to ensure the Ministry is fully informed of the progress of the Fund and able to direct discussions with board members before funding decisions are taken.

Independent Evaluation Group (IEG)

The Independent Evaluation Group was appointed by and reports to the Fund Board to ensure high quality evaluation that will encourage learning and programme improvement, and help to ensure the 3MDG Fund’s success.

The Evaluation Group reports to the Fund Board. The Evaluation Group is precluded from any implementation role under the 3MDG Fund to avoid any conflict of interest.

Fund Manager

The Fund Manager is responsible for effective, transparent and efficient management of the 3MDG Fund on behalf of the Fund Board, and has delegated authority for the management of the 3MDG Fund in accordance with the policies and priorities established by the Fund Board. While the Fund Manager liaises with the Ministry of Health and national coordination structures, the Fund Manager will refer any issues concerning 3MDG Fund policy, strategy and funding to the Fund Board. The Fund Board selected the United Nations Office for Project Services (UNOPS) as the Fund Manager of 3MDG.

DONORS

3MDG is configured as a multi-donor trust fund that pools all contributions received from donors into a central ledger from which programme activities are funded. The committed Fund volume increased from an initial US$ 250-300 million to US$ 334 million in 2013, with new donors joining (the United States, Sweden and Switzerland). During this period 3MDG received US$ 92.6 million in disbursements. On top of the commitments to the pooled fund, donors have also pledged earmarked contributions to address specific interventions for HIV, TB and malaria.

EXPENDITURE

The 3MDG Fund Manager has disbursed US$ 26.4 million on behalf of the Fund Board in the reporting period. Out of this total amount US$ 20.5 million were disbursed in grants to Implementing Partners, and US$ 5.9 million were disbursed for programme management, procurement pre-positioning, governance, evaluation, and FMO overhead costs.

RISK MANAGEMENT

Risk strategy and matrix

The Fund was designed as a high-risk intervention that is justified by its high impact potential, but requires effective risk management. Programme management and implementation risks under the control of the Fund Manager are managed under the risk management policies of UNOPS. For all other risks, monitoring and, where applicable, control roles are defined through the 3MDG Risk Management Matrix.

Financial risk and fraud policy

With UNOPS as the Fund Manager of 3MDG, the Fund adopted the standard UNOPS organizational policy on financial risk, anti-corruption and fraud prevention, stipulating a strict zero tolerance approach.
Annex 1: Results Matrix January to December 2013
The 3MDG results matrix for January to December 2013 underwent an external data quality assurance review by the IEG in May 2014.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Annual target</th>
<th>Jan to Dec 2013 achievement (with HMIS denominator used in bracket)</th>
<th>% achieved against annual target</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPACT: Improved maternal, newborn and child health and a reduction in communicable disease burden (HIV, TB, malaria) in areas and populations supported by the 3MDG Fund</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Maternal mortality ratio per 100,000 live births in Component 1 townships</td>
<td>238</td>
<td>Not Available</td>
<td>Not Available</td>
<td>UN modelled data for 2013 is unavailable. UN modelling in 2010 was 200 per 100,000 live births. Statistical Yearbook for Asia and the Pacific 2013. For 2013, HMIS reported 176 per 100,000 in 3MDG supported townships. This figure includes maternal deaths reported based on registered live births.</td>
</tr>
<tr>
<td>2 Under-five child mortality per 1,000 live births in Component 1 townships (disaggregated by sex)</td>
<td>69</td>
<td>Not Available</td>
<td>Not Available</td>
<td>UN modelled data is unavailable for 2013. UN modelled data for 2012 is 52 per 1000 live births. Levels and trends in child mortality 2013 (UNICEF, WHO, WB) - UNIAG</td>
</tr>
<tr>
<td>3 Neonatal mortality rate per 1000 live births in Component 1 townships (disaggregated by sex)</td>
<td>45</td>
<td>Not Available</td>
<td>Not Available</td>
<td>UN modelled data is unavailable for 2013. UN modelled data for 2012 is 26 per 1000 live births. Levels and trends in child mortality 2013 (UNICEF, WHO, World Bank)</td>
</tr>
<tr>
<td>4 HIV prevalence among people who inject drugs (disaggregated by sex) in programme areas</td>
<td>25%</td>
<td>18.7%</td>
<td>134%</td>
<td>Draft HSS 2013 data shared from National AIDS Programme. Report to be published in late-2014.</td>
</tr>
<tr>
<td>5 National TB (all forms) mortality per 100,000 population per year (disaggregated by sex and age) in programme areas</td>
<td>57</td>
<td>Not Available</td>
<td>Not Available</td>
<td>2013 data are not available for reference at the time of report preparation, 48 was reported in the Global TB Report 2013 using 2012 data.</td>
</tr>
<tr>
<td>6 Percentage of all deaths due to malaria (per confirmed malaria diagnosis) in programme areas</td>
<td>7%</td>
<td>Not Available</td>
<td>Not Available</td>
<td>Data unavailable until late 2014.</td>
</tr>
<tr>
<td>OUTCOME: Increased access to and availability of (i) essential maternal and child health services for the poorest and most vulnerable in areas supported by the 3MDG Fund and (ii) HIV, TB, and malaria interventions for populations and areas not readily covered by the Global Fund</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Number and percentage of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife) in Component 1 townships (by wealth quintile)</td>
<td>66% 22,933</td>
<td>56% 17,427 (31,395 Live birth + Stillbirth)</td>
<td>85%</td>
<td>Wealth quintile can only be collected by survey and is reported at baseline and end line. Data completeness is an issue and further data quality assurance must be conducted.</td>
</tr>
<tr>
<td>2 Number and percentage of women attended at least four times during pregnancy by skilled providers for reasons related to the pregnancy, in Component 1 townships.</td>
<td>70% 28,000</td>
<td>65% 20,273 (31,395 Live birth + Stillbirth)</td>
<td>93%</td>
<td>The indicator defines scheduled intervals for four ante-natal care services but the data collection forms do not have a clear recording format for this information. Data quality assurance should be conducted on service provision and reporting. HMIS uses live and still births recorded, not expected pregnancies as the denominator.</td>
</tr>
</tbody>
</table>

1 3MDG uses a reported population of 1,801,840 to calculate population-based achievements.
<table>
<thead>
<tr>
<th>Indicators</th>
<th>Annual target</th>
<th>Jan to Dec 2013 achievement (with HMIS denominator used in bracket)</th>
<th>% achieved against annual target</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Number and percentage of newborns receiving at least four visits post-delivery (within 24 hours, and at 3, 7 and 15 days) in Component 1 townships (disaggregated by sex)</td>
<td>20% 6,813</td>
<td>Not available</td>
<td>Not available</td>
<td>3MDG partners reported 7,495 (24%) of new-borns receiving at least 4 visits post-delivery, however, data quality assurance demonstrated that in Jan-June 2014, partners reported ‘1 visit within 3 days’ which aligns with the HMIS and not the 3MDG indicator. Jan-Dec reported data aligns with the 3MDG indicator - 4 visits post-delivery (within 24 hours, and at 3, 7 and 15 days) but only by two townships (33% data completeness). The achievement figure should be viewed with caution as time periods for each visit are not adequately documented, source documents for recording are not standardized and data collection forms do not have a clear recording format for collecting timing of visits. Sex disaggregated data is unavailable at this time. Five township health departments also reported ‘1 visit within 3 days’ - achieved 17,813.</td>
</tr>
<tr>
<td>4 Percentage of infants age 0-6 months exclusively breastfed in Component 1 townships (by sex and poorest 20%)</td>
<td>33% 5,351</td>
<td>Not Available</td>
<td>Not Available</td>
<td>23.6% reported from MICS (2009-2010). This data is collected by survey and is not routinely reported.</td>
</tr>
<tr>
<td>5 Contraceptive prevalence rate in Component 1 townships (by age and wealth quintile)</td>
<td>57%</td>
<td>51% (numerator = 178,887 eligible couples using any method; Denominator = 349,178 Eligible Couples)</td>
<td>89%</td>
<td>Age and wealth quintile can only be collected by survey. HMIS only reports contraceptive prevalence rate for married couples (eligible couples) using any method (both modern and traditional methods) of contraception, not total number of women of reproductive age using modern methods. Percentage calculation based on township reports, 2013 (HMIS). Numerator = 178,887 eligible couple using any method; Denominator = 349,178 eligible couple</td>
</tr>
<tr>
<td>6 Number and percentage of diarrhoea cases treated with Oral rehydration therapy (ORT) (by sex, age and poorest 20%) in Component 1 townships</td>
<td>ORT 69% 16,282</td>
<td>99% (6,001 (6,079 reported &lt;5 diarrhoea cases))</td>
<td>143%</td>
<td>Facility-based treatment figures are reported for children under five. HMIS uses the number of diarrhoea cases registered in the facility as the denominator. Percentages reported annually. Sex and age groups, other than under-five children, are not reported by HMIS. Wealth data can only be collected using surveys.</td>
</tr>
<tr>
<td>7 Number and percentage of children under one immunized with (i) DPT3/Penta3 combination vaccine and (ii) measles (disaggregated by sex) in Component 1 townships</td>
<td>(i) 91% 29,512 (ii) 88% 28,539</td>
<td>(i) 83% 27,647 (ii) 101% 33,585 (33,152 children &lt;1 year)</td>
<td>(i) 91% (ii) 115%</td>
<td>Changes in township administrative and geographical boundaries and the influx of under one children due to migratory populations affected under one population in 3MDG townships. Penta3 was introduced in 2013 with a revised immunization schedule, which may have led to incomplete vaccination due to drop-out or lost to follow-up. Sex disaggregated data are unavailable. Data quality assurance should be considered.</td>
</tr>
<tr>
<td>8 Number and percentage of people who inject drugs reached by HIV prevention programmes in programme areas</td>
<td>60% 23,000 (in programme area)</td>
<td>82.3% 18,934</td>
<td>137%</td>
<td>A limited number of partners report challenges with documenting head count figures. Some double counting may exist.</td>
</tr>
<tr>
<td>Indicators</td>
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</tr>
<tr>
<td>9</td>
<td>T8 case notification rate (all forms) per 100,000 population (by sex)</td>
<td>297</td>
<td>297</td>
<td>100%</td>
</tr>
<tr>
<td>10</td>
<td>Number and percentage of confirmed malaria cases treated in accordance with national malaria treatment guidelines within 24 hours of onset of symptoms (fever) in 3MDG supported townships</td>
<td>30% 59,000</td>
<td>36% 34,462</td>
<td>120%</td>
</tr>
</tbody>
</table>

**OUTPUT 1:** Delivery of essential services, with a focus on maternal and child health, strengthened in target townships

| 1 | Total number of Couple Years of Protection from pregnancy (CYPs) delivered through public sector services and private sector channels in Component 1 townships | 2,200 | 28,263 | 1285% | Two out of six Delta townships implemented this activity under 3MDG Fund. 26,082 CYPs were transferred from JIMNCH to 3MDG in 2013, without this transfer, 3MDG would just have missed its target of 2,200. The achievement covers contraceptives used by Basic Health Staff. CYP target is under-targeted as the 3MDG Description of Action (DOA) did not account for the absorption of JIMNCH. Provided commodities are intrauterine devices (IUD), oral contraceptive pills, condoms and Depo Provera injections. The reported data is based on CYP conversion factor: USAID 2011. |
| 2 | Number of appropriate EmOC referrals supported in Component 1 townships | 170/township 3,400 | 958/township 5,747 | 169% | Reported data is total EmOC referrals in 6 Delta townships, which is not just limited to EMOC cases but also includes other pregnancy related cases. |
| 3 | Number of under five mothers and caregivers with increased knowledge of hygiene practices in Component 1 townships. | To be established | Not Available | Not Available | Data to be collected by survey. UNICEF Knowledge Attitudes and Practice survey was conducted in 24 townships in 2011. Four 3MDG Funded townships (Bogalay, Pyapon, Mindat and Madupi) participated in this survey. The respondents were household members aged 15-64 years. The finding shows 30.6% of respondents have knowledge of hand washing as a hygiene activity. |

**OUTPUT 2:** Strengthened systems for delivery of essential MNCH services in Component 1 townships

<p>| 1 | Number and percentage of doctors, nurses and midwives trained in MNCH, including delivery and emergency obstetric care in Component 1 townships | &gt;80% 1280 | 39% 353 | 49% | MNCH related new trainings for doctors, nurses, midwives and lady health visitors in the township health department. In six project townships 909 health staff were present of which 353 were trained during this specific year. Some MNCH related training was conducted in the previous year. Trainings other than directly MNCH related, e.g. HMIS, behaviour change communications, community mobilization are not counted in this reported indicator. |</p>
<table>
<thead>
<tr>
<th>Indicators</th>
<th>Annual target</th>
<th>Jan to Dec 2013 achievement (with HMIS denominator used in bracket)</th>
<th>% achieved against annual target</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Number of Component 1 townships with 1 trained auxiliary midwife (AMW) per 2,000 population and 1 trained community health worker (CHW) per 2,000 population</td>
<td>20</td>
<td>AMW: 5 out of total 6 townships CHW: 6 out of total 6 townships</td>
<td>AMW: 83% in 6 townships CHW: 100% in 6 townships</td>
<td>3MDG counts old plus new trained in the reporting period. Figures are head counts. Trained AMW 1: 2,000 population is achieved in 5 out of 6 Delta townships. Pyapon AMW 1 per 2,303 was reported to 3MDG.AMW Trained (Bogalay: 224, Dedeye: 189, Laputta: 241, MawGyun: 225, Ngapudaw: 244, Pyapon: 140, Total = 1,263) Trained CHW 1: 2,000 population is achieved in all 6 Delta townships. CHW trained (Bogalay: 493, Dedeye: 204, Laputta: 383, MawGyun: 305, Ngapudaw: 223, Pyapon: 187, Total = 1,795) A common definition for ‘functioning/active’ needs to be established which would then support the calculation of attrition rates and improve data quality for this indicator.</td>
</tr>
<tr>
<td>3 Proportion of Component 1 townships with at least 3 facilities providing Basic Emergency Obstetric and Newborn Care (BEmONC ) and at least 1 facility providing Comprehensive Emergency Obstetric and Newborn Care (CEmONC) (per 200,000 population )</td>
<td>20 out of 40</td>
<td>BEmONC: 6 out of 6 reported CEmONC: 6 out of 6 reported</td>
<td>15%(14 townships did not report) 100% in reported townships</td>
<td>This achievement should be viewed with caution. A standardized checklist should be implemented to assess the availability. Currently, 3 to 4 signal functions provided in the rural/sub-rural health centres is considered BEmONC. Township hospitals have reported providing CEmONC but this has not been verified. Quality of service is not assessed by this indicator.</td>
</tr>
<tr>
<td>4 Number and percentage of auxiliary midwives and community health workers receiving monthly supervision and monitoring visits</td>
<td>30% 600</td>
<td>Not available</td>
<td>Not available</td>
<td>3MDG partners reported 1,771 (64%) of AMWs and CHWs receiving supervision. Supervision activities are conducted in collaboration with township health departments and implementing partners. Monthly supervision is not possible due to limited human resources, transportation challenges and limited communications infrastructure. Data reported is not monthly, but quarterly or annually. Monthly meetings at rural health centres are conducted but not monthly field supervision visits.</td>
</tr>
<tr>
<td>5 Stock-outs of five selected essential MNCH drugs at rural health centres and sub centre levels (defined as not available for &gt;1 week)</td>
<td>To be established</td>
<td>Not Available</td>
<td>Not Available</td>
<td>3MDG Fund does not provided essential MNCH drugs at rural health centres and sub-centre levels.</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

| 1 Number of sterile injecting equipment items distributed to people who inject drugs | 7,800,000 | 5,745,197 | 74% | Subtle data discrepancies have been noted with some partners. Further training and data quality audits are required.                                                                                                                                                                                                                                                                                                                                                                                                 |
| 2 Number and percentage of new smear-positive TB patients notified to the national TB programme per year per 100,000 population (disaggregated by age and sex) | 89 | 89 | 100% | Support to NTP to conduct CNR data for new smear-positive TB patients: NTP reports 28,291 (males) and 14,304 (females). Further support to NTP to analyse gender-based notification patterns is recommended.                                                                                                                                                                                                                                                                                                                                 |
| 3 Number of LLINs distributed (i) total (ii) migrant/mobile populations in high priority areas not readily covered by the Global Fund | i) 1,000,000 | i) 799,215 | i) 80% | 180,000 LLINs were distributed in the reporting period with 3DF funding. Targets for migrant/mobile populations were revised to zero by a major partner in late 2013 after a gap analysis on LLIN distribution conducted by NMCP/WHO. |
### Indicators

<table>
<thead>
<tr>
<th></th>
<th>Annual target</th>
<th>Jan to Dec 2013 achievement (with HMIS denominator used in bracket)</th>
<th>% achieved against annual target</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Number of people with confirmed malaria (by sex and age group) treated as per the national treatment guidelines.</td>
<td>105,000 MARC Top-Up 90,000 3MDG 43,051 Male: 28,929 Female: 14,122 &lt;1 yr: 149 1-4 yrs: 1,730 5-9 yrs: 4,178 10-14 yrs: 4,403 &gt;15 yrs: 32,591 Top Up 36,901 Male: 24,797 Female: 12,104 &lt;1 yr: 128 1-4 yrs: 1,482 5-9 yrs: 3,581 10-14 yrs: 3,774 &gt;15 yrs: 27,936</td>
<td>41%</td>
<td>Total: 79,952 Male: 53,726 Female: 26,226 &lt;1 yr: 277 1-4 yrs: 3,212 5-9 yrs: 7,759 10-14 yrs: 8,177 &gt;15 yrs: 60,527 Cases may be counted that were not treated as per the National Treatment Guideline. 14,561 cases are not included in this figure as they are not treated according to the National Treatment Guideline. Altogether, 94,513 cases are total confirmed malaria cases. Further training is required to improve data recording and reporting.</td>
</tr>
</tbody>
</table>

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

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Number of evidenced-based policies reviewed and adopted by the Ministry of Health</td>
<td>At least one per year</td>
</tr>
<tr>
<td>2</td>
<td>Human resources for health (HRH) strategy developed and implemented to increase coverage of midwives in hard-to-reach and rural townships, and to address wider HRH issues</td>
<td>Strategy launched</td>
</tr>
<tr>
<td>3</td>
<td>Number of analytical studies and systems reviews completed (e.g. of sector financing, procurement and distribution systems, HMIS)</td>
<td>Milestones for studies reviewed</td>
</tr>
<tr>
<td>4</td>
<td>Number of townships implementing schemes, in line with national policy, to address financial barriers to accessing MNCH services</td>
<td>20</td>
</tr>
<tr>
<td>5</td>
<td>Number of township health teams training in leadership and management</td>
<td>20%</td>
</tr>
</tbody>
</table>

#### OUTPUT 5:
Enhanced health services accountability and responsiveness through capacity development of target communities, civil society organizations and the public sector

<p>| | | |</p>
<table>
<thead>
<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Number of central and township Ministry of Health staff trained in accountability and responsiveness</td>
<td>8</td>
</tr>
<tr>
<td>2</td>
<td>Percentage of beneficiaries reporting receiving services of ‘good quality’ or better</td>
<td>&gt;60%</td>
</tr>
<tr>
<td>Indicators</td>
<td>Annual target</td>
<td>Jan to Dec 2013 achievement (with HMIS denominator used in bracket)</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>---------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>3 Number of civil society organizations trained in accountability and responsiveness and performing independent monitoring functions</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>4 Percentage of community members who say they have access to mechanisms to provide feedback to township health committees and the 3MDG Fund (disaggregated by sex)</td>
<td>30%</td>
<td>Not Available</td>
</tr>
<tr>
<td>5 Proportion of women representatives on (i) township health committees (ii) village health committees</td>
<td>To be established</td>
<td>(i) 31 (27%) (ii) 3,479 (44%)</td>
</tr>
</tbody>
</table>

OUTPUT 6: Fund Management demonstrates value for money and cost-effectiveness, generates evidence to inform policy, funding and programming decisions, and strengthens aid effectiveness

1 Fund Manager performance: (i) Percentage of Fund Manager annual work plan milestones achieved (ii) number FM monitoring visits conducted as planned
   (i) and (ii) >90%         i) 71% ii) 88%     i) 79% ii) 98%  Fund management monitoring visits are defined as Routine Data Quality Assessment (RDQA), Programme Monitoring, Finance/Fund Flow Monitoring, Procurement Monitoring, Communications Monitoring and Township Assessments.

2 Documented analysis of cost-efficiency and value for money based on 3MDG Fund Value for Money Framework
   Qualitative and Quantitative Assessment  Qualitative and Quantitative Assessment Conducted  Qualitative and Quantitative Assessment Conducted

3 Number of operational research studies and case studies produced and disseminated
   3                                  3                        100%                  Operational research and case studies include: The role of auxiliary midwives in supporting improved maternal and child health in Myanmar; The role of Community Health Programmes/Workers in reaching Universal Health Coverage in Myanmar; Voluntary health worker attrition

4 Number of policy dialogue and technical and strategic forums where 3MDG Fund results are presented and discussed
   At least 3 per year  14                      100%                  Forums include: SCGs, TSGs/TWG, official workshops, conferences, central/state/region meetings and partner forums

5 Perception of progress in strengthening aid effectiveness
   Not targeted in 2013     Not Reported in 2013    Not Reported in 2013
### Annex 2: Grant funding to implementing partners (at Dec 2013)

<table>
<thead>
<tr>
<th>Sector of intervention</th>
<th>Implementing partners (IP)</th>
<th>Type of org.</th>
<th>Grant Period</th>
<th>Total Grant Amount, includes Procure. (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MNCH</td>
<td>Danish Red Cross</td>
<td>INGO</td>
<td>01/09/2013 to 31/12/2016</td>
<td>185,501.00</td>
</tr>
<tr>
<td>MNCH</td>
<td>International Organization for Migration</td>
<td>INGO</td>
<td>01/01/2013 to 31/12/2013</td>
<td>1,310,533.00</td>
</tr>
<tr>
<td>MNCH</td>
<td>International Organization for Migration</td>
<td>INGO</td>
<td>01/01/2013 to 31/12/2013</td>
<td>1,289,987.00</td>
</tr>
<tr>
<td>MNCH</td>
<td>Medecins Du Monde</td>
<td>INGO</td>
<td>01/01/2013 to 30/06/2014</td>
<td>1,373,076.00</td>
</tr>
<tr>
<td>MNCH</td>
<td>Medical Emergency Relief International</td>
<td>INGO</td>
<td>01/09/2013 to 31/12/2013</td>
<td>315,820.00</td>
</tr>
<tr>
<td>MNCH</td>
<td>Medical Emergency Relief International</td>
<td>INGO</td>
<td>01/01/2013 to 30/06/2014</td>
<td>2,228,118.00</td>
</tr>
<tr>
<td>MNCH</td>
<td>Relief International-UK</td>
<td>INGO</td>
<td>01/01/2013 to 30/06/2014</td>
<td>1,874,547.00</td>
</tr>
<tr>
<td>MNCH</td>
<td>Save The Children (SCF)</td>
<td>INGO</td>
<td>01/01/2013 to 30/06/2014</td>
<td>844,733.00</td>
</tr>
<tr>
<td>HIV</td>
<td>AIDS Support Group</td>
<td>LCBO</td>
<td>01/01/2013 to 30/06/2013</td>
<td>39,916.20</td>
</tr>
<tr>
<td>HIV</td>
<td>Black Sheep Peer Support Group</td>
<td>LCBO</td>
<td>01/01/2013 to 31/12/2013</td>
<td>130,540.07</td>
</tr>
<tr>
<td>HIV</td>
<td>Malteser International</td>
<td>INGO</td>
<td>01/01/2013 to 31/12/2014</td>
<td>707,763.00</td>
</tr>
<tr>
<td>HIV</td>
<td>Myanmar Anti-Narcotics Association</td>
<td>LNGO</td>
<td>01/01/2013 to 31/03/2014</td>
<td>640,060.00</td>
</tr>
<tr>
<td>HIV</td>
<td>Mahaythi Women's Development Cooperative</td>
<td>LCBO</td>
<td>01/01/2013 to 30/06/2013</td>
<td>45,246.65</td>
</tr>
<tr>
<td>HIV</td>
<td>Ratana Metta Organization</td>
<td>LCBO</td>
<td>01/01/2013 to 30/06/2013</td>
<td>70,000.00</td>
</tr>
<tr>
<td>HIV</td>
<td>Substance Abuse Research Association</td>
<td>LCBO</td>
<td>01/01/2013 to 31/03/2014</td>
<td>631,663.00</td>
</tr>
<tr>
<td>HIV</td>
<td>UNAIDS Trust Fund</td>
<td>UNO</td>
<td>15/07/2013 to 31/10/2016</td>
<td>1,865,757.00</td>
</tr>
<tr>
<td>HIV</td>
<td>United Nations Office on Drugs and Crime</td>
<td>UNO</td>
<td>01/09/2013 to 30/11/2014</td>
<td>912,700.00</td>
</tr>
<tr>
<td>Integrated HIV-TB</td>
<td>Asian Harm Reduction Network</td>
<td>INGO</td>
<td>01/01/2013 to 31/03/2014</td>
<td>1,653,902.00</td>
</tr>
<tr>
<td>HIV, Malaria, TB</td>
<td>Phaung Daw O Monastic Education Affiliation</td>
<td>LCBO</td>
<td>01/01/2013 to 30/06/2013</td>
<td>63,953.58</td>
</tr>
<tr>
<td>Malaria</td>
<td>Community Development Association</td>
<td>LCBO</td>
<td>01/01/2013 to 31/03/2014</td>
<td>270,853.28</td>
</tr>
<tr>
<td>Malaria</td>
<td>Community Partners International</td>
<td>LCBO</td>
<td>16/09/2013 to 15/09/2014</td>
<td>1,497,135.00</td>
</tr>
<tr>
<td>Malaria</td>
<td>International Organization for Migration</td>
<td>INGO</td>
<td>01/01/2013 to 31/03/2014</td>
<td>1,021,005.00</td>
</tr>
<tr>
<td>Malaria</td>
<td>Medical Action Myanmar</td>
<td>LNGO</td>
<td>05/11/2013 to 28/02/2013</td>
<td>163,236.00</td>
</tr>
<tr>
<td>Malaria</td>
<td>Myanmar Health Assistant Association</td>
<td>LNGO</td>
<td>01/01/2013 to 31/03/2014</td>
<td>519,642.24</td>
</tr>
<tr>
<td>Malaria</td>
<td>Myanmar Medical Assoc.</td>
<td>LNGO</td>
<td>01/01/2013 to 31/03/2014</td>
<td>426,541.00</td>
</tr>
<tr>
<td>Malaria</td>
<td>Population Services International</td>
<td>INGO</td>
<td>01/01/2013 to 31/03/2014</td>
<td>2,175,310.00</td>
</tr>
<tr>
<td>Malaria</td>
<td>World Concern</td>
<td>INGO</td>
<td>01/01/2013 to 31/03/2014</td>
<td>184,001.00</td>
</tr>
<tr>
<td>Malaria</td>
<td>World Health Organization</td>
<td>UNO</td>
<td>01/01/2013 to 31/03/2014</td>
<td>5,872,110.00</td>
</tr>
<tr>
<td>Malaria</td>
<td>World Health Organization</td>
<td>UNO</td>
<td>01/06/2013 to 28/02/2014</td>
<td>414,839.00</td>
</tr>
<tr>
<td>Malaria</td>
<td>Myanmar Health &amp; Development Consortium</td>
<td>LNGO</td>
<td>25/09/2013 to 31/01/2014</td>
<td>30,000.00</td>
</tr>
<tr>
<td>Malaria</td>
<td>University of Oxford</td>
<td>INGO</td>
<td>01/09/2013 to 31/08/2015</td>
<td>697,419.00</td>
</tr>
<tr>
<td>TB</td>
<td>World Health Organization</td>
<td>UNO</td>
<td>01/07/2013 to 31/03/2014</td>
<td>261,574.00</td>
</tr>
<tr>
<td>HSS</td>
<td>The Regents of the University of California</td>
<td>INGO</td>
<td>27/09/2013 to 31/03/2014</td>
<td>105,662.00</td>
</tr>
<tr>
<td>HSS</td>
<td>IBRD-Int'l Bank for Reconstruction</td>
<td>IFI</td>
<td>29/05/2013 to 28/05/2015</td>
<td>2,228,000.00</td>
</tr>
<tr>
<td>HSS</td>
<td>World Health Organization</td>
<td>UNO</td>
<td>01/04/2013 to 30/06/2014</td>
<td>97,846.00</td>
</tr>
</tbody>
</table>

32,148,990.03
## Annex 3: Listing of 42 townships identified for maternal, newborn and child health support

<table>
<thead>
<tr>
<th>State/Region</th>
<th>Township</th>
<th>Total population</th>
<th>Urban population</th>
<th>Rural population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ayeyarwady</strong></td>
<td>Bogale</td>
<td>344,944</td>
<td>14%</td>
<td>86%</td>
</tr>
<tr>
<td></td>
<td>Dedeye</td>
<td>210,086</td>
<td>8%</td>
<td>92%</td>
</tr>
<tr>
<td></td>
<td>Labutta</td>
<td>309,527</td>
<td>7%</td>
<td>93%</td>
</tr>
<tr>
<td></td>
<td>Mawlamynegyun</td>
<td>298,079</td>
<td>5%</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td>Ngapudaw</td>
<td>316,843</td>
<td>9%</td>
<td>91%</td>
</tr>
<tr>
<td></td>
<td>Pyapon</td>
<td>322,361</td>
<td>16%</td>
<td>84%</td>
</tr>
<tr>
<td><strong>Subtotal (Ayeyarwady)</strong></td>
<td></td>
<td>1,801,840</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chin</strong></td>
<td>Falam</td>
<td>46,898</td>
<td>15%</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td>Madupi</td>
<td>51,975</td>
<td>17%</td>
<td>83%</td>
</tr>
<tr>
<td></td>
<td>Mindat</td>
<td>43,698</td>
<td>23%</td>
<td>77%</td>
</tr>
<tr>
<td></td>
<td>Tiddim</td>
<td>94,043</td>
<td>13%</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td>Hakha</td>
<td>44,483</td>
<td>43%</td>
<td>57%</td>
</tr>
<tr>
<td></td>
<td>Htanflang</td>
<td>52,332</td>
<td>12%</td>
<td>88%</td>
</tr>
<tr>
<td></td>
<td>Tonzang</td>
<td>30,002</td>
<td>11%</td>
<td>89%</td>
</tr>
<tr>
<td></td>
<td>Kanpetlet</td>
<td>21,526</td>
<td>16%</td>
<td>84%</td>
</tr>
<tr>
<td></td>
<td>Paletwa</td>
<td>91,030</td>
<td>13%</td>
<td>87%</td>
</tr>
<tr>
<td><strong>Sub-total (Chin)</strong></td>
<td></td>
<td>475,987</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Magway</strong></td>
<td>Gangaw</td>
<td>131,595</td>
<td>9%</td>
<td>91%</td>
</tr>
<tr>
<td></td>
<td>Myaing</td>
<td>253,956</td>
<td>3%</td>
<td>97%</td>
</tr>
<tr>
<td></td>
<td>Ngape</td>
<td>46,572</td>
<td>10%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Pauk</td>
<td>174,240</td>
<td>4%</td>
<td>96%</td>
</tr>
<tr>
<td></td>
<td>Seikphyu</td>
<td>104,050</td>
<td>8%</td>
<td>92%</td>
</tr>
<tr>
<td><strong>Subtotal(Magway)</strong></td>
<td></td>
<td>710,413</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Shan (South)</strong></td>
<td>Hsihseng</td>
<td>139,167</td>
<td>9%</td>
<td>91%</td>
</tr>
<tr>
<td><strong>Shan (North)</strong></td>
<td>Konkyan**</td>
<td>92,116</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td><strong>Shan (North)</strong></td>
<td>Laukaing</td>
<td>72,879</td>
<td>15%</td>
<td>85%</td>
</tr>
<tr>
<td><strong>Shan (North)</strong></td>
<td>Manton</td>
<td>42,742</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Shan (South)</strong></td>
<td>Mawkmai</td>
<td>24,860</td>
<td>22%</td>
<td>78%</td>
</tr>
<tr>
<td><strong>Shan (East)</strong></td>
<td>Mongyawng</td>
<td>33,143</td>
<td>22%</td>
<td>78%</td>
</tr>
<tr>
<td><strong>Shan (North)</strong></td>
<td>Namhsan</td>
<td>76,593</td>
<td>8%</td>
<td>92%</td>
</tr>
<tr>
<td><strong>Shan (South)</strong></td>
<td>Lahka</td>
<td>44,329</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Shan (North)</strong></td>
<td>Mongai</td>
<td>49,084</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Shan (North)</strong></td>
<td>Tangyan</td>
<td>127,567</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Shan (North)</strong></td>
<td>Hopang</td>
<td>24,637</td>
<td>44%</td>
<td>56%</td>
</tr>
<tr>
<td><strong>Mongmao</strong>**</td>
<td>100,788</td>
<td>Not available</td>
<td>Not available</td>
<td></td>
</tr>
<tr>
<td><strong>Pangwaun</strong>**</td>
<td>43,528</td>
<td>Not available</td>
<td>Not available</td>
<td></td>
</tr>
<tr>
<td><strong>Kutkai</strong></td>
<td>180,066</td>
<td>18%</td>
<td>82%</td>
<td></td>
</tr>
<tr>
<td><strong>Namtu</strong></td>
<td>57,602</td>
<td>34%</td>
<td>66%</td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal(Shan)</strong></td>
<td></td>
<td>1,109,101</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Kayah</strong></td>
<td>Loikaw</td>
<td>115,120</td>
<td>42%</td>
<td>58%</td>
</tr>
<tr>
<td></td>
<td>Demoso</td>
<td>78,704</td>
<td>15%</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td>Hpruso</td>
<td>30,507</td>
<td>13%</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td>Shadaw</td>
<td>7,367</td>
<td>32%</td>
<td>68%</td>
</tr>
<tr>
<td></td>
<td>Bawlakhe</td>
<td>8,114</td>
<td>35%</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>Hpasawng</td>
<td>32,126</td>
<td>54%</td>
<td>46%</td>
</tr>
<tr>
<td></td>
<td>Mese</td>
<td>5,490</td>
<td>19%</td>
<td>81%</td>
</tr>
<tr>
<td><strong>Subtotal (Kayah)</strong></td>
<td></td>
<td>277,428</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td></td>
<td>4,374,769</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


** Central Statistical Organization 2011
Annex 4: About Value for Money

Value for Money (VFM) approaches usually address optimal use of resources to achieve intended outcomes (VFM assessment), and transformation process of turning resources into outcomes (VFM cycle). The Department for International Development (DFID) three ‘Es’ framework is commonly used for external evaluations:

- **Economy**: Are we or our agents buying inputs of the appropriate quality at the right price?
- **Efficiency**: How well do we or our agents convert inputs into outputs?
- **Effectiveness**: How well are the outputs from an intervention achieving the desired outcome on poverty reduction?
- **Cost-effectiveness**: How much impact on poverty reduction does an intervention achieve relative to the inputs that we or our agents invest in it?
- **Equity**: How are equity issues taken into consideration in judgements on the effectiveness of an intervention?

3MDG’s Value for Money (VFM) principles
In the VFM approach of the 3MDG Fund, the interest is not solely calculating ‘cost per DALY averted’, but analysing process (and related cost) to avert DALYs in vulnerable population of hard-to-reach areas in under-served townships. This approach places Equity alongside the other ‘Es’. Moreover, the emphasis put on the aid-effectiveness agenda and the increased use of Government systems implies that the 3MDG VFM has to be increasingly and intrinsically linked to VFM of the national health system. The 3MDG VFM is assessed at two levels:

- VFM as a leverage to improve the management process and management system
- VFM based on a limited set of indicators

**Value for Money: 3MDG 2013 Assessment**
The Fund’s VFM approach enables a better understanding and articulation of costs, cost drivers and results in order to allow more evidence-base informed decisions, and encourages the Fund’s grantees to continually improve, notably in terms of organisational efficiency. The 2013 VFM assessment comprises a limited set of key indicators covering all main areas of VFM performance which can be benchmarked and are tracked over time and a case study.

---

2 DFID’s Approach to Value for Money (VFM), Department for International Development, July 2011.
Value for Money example: analysis of emergency referrals

Analysis done on the JIMNCH programme budgets for activities implemented by grantees and townships from 2010-2012 showed that the more than 80% of the budget covered:

1. Drugs and Health Commodities
2. Training of basic health staff and volunteer health workers
3. Referrals
4. Outreach work carried out by midwives

Whilst a detailed analysis of JIMNCH expenditure is not available; it is possible to analyse expenditure under 3MDG for the same townships, which will allow the Fund to track and analyse percentage spent on activities, year on year.

Table 1: Comparison of JIMNCH Budget and 3MDG Expenditure in 6 Ayeyarwady townships

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs and health commodities 38%</td>
<td>Drugs and health commodities 24%</td>
</tr>
<tr>
<td>Training 25%</td>
<td>Training 8%</td>
</tr>
<tr>
<td>Referrals 15%</td>
<td>Referrals 28%</td>
</tr>
<tr>
<td>Outreach 7%</td>
<td>Outreach 10%</td>
</tr>
<tr>
<td>Coordination, supervision, monitoring 7%</td>
<td>Coordination, supervision, monitoring 18%</td>
</tr>
<tr>
<td>Others 8%</td>
<td>Others 12%</td>
</tr>
<tr>
<td>Total 100%</td>
<td>Total 100%</td>
</tr>
</tbody>
</table>

NOTE: Capital budget and operation/management costs are not included

Significant differences between the two programmes occur in the training, referral and coordination, supervision and monitoring lines. Some of the differences may be explained by the nature of the transition from JIMNCH which were more or less extensions of the JIMNCH programme but shaped to move into the 3MDG programme. Partners were asked to focus on maintaining active village health volunteers and conducting refresher training rather than on developing new workers. Partners were also asked to integrate refresher training into the monthly meetings. This may reflect the decrease on spend on training and the increase on spend on coordination, supervision and monitoring.

As showed in the table below, in 2013 in some townships of Ayeyarwady, the range of costs amongst townships/IPs for referrals was from $54 to $130 per case for maternal referrals. The range of costs amongst townships/IPs for <5 referrals was from $35 to a $100.

Table 2: Cost of referral, cost per case and underspend against budget (Ayeyarwady 2013)

<table>
<thead>
<tr>
<th>township</th>
<th>Number of EMOC referrals</th>
<th>Total Spend (USD)</th>
<th>Cost of referral per maternal case (USD)</th>
<th>Number of Emergency child care (ECC) referrals</th>
<th>Total Spend (USD)</th>
<th>Cost of referral per &lt;5 case (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ngapudaw</td>
<td>644</td>
<td>34709</td>
<td>53.9</td>
<td>860</td>
<td>60732</td>
<td>70.6</td>
</tr>
<tr>
<td>Dedaye</td>
<td>643</td>
<td>66759</td>
<td>103.8</td>
<td>237</td>
<td>15229</td>
<td>35.4</td>
</tr>
<tr>
<td>Labutta</td>
<td>833</td>
<td>92043</td>
<td>110.5</td>
<td>1201</td>
<td>82956</td>
<td>69.1</td>
</tr>
<tr>
<td>Pyapone</td>
<td>496</td>
<td>64325</td>
<td>129.7</td>
<td>257</td>
<td>24835</td>
<td>96.6</td>
</tr>
<tr>
<td>Bogale</td>
<td>1065</td>
<td>NA</td>
<td>77.0</td>
<td>216</td>
<td>NA</td>
<td>77.0</td>
</tr>
<tr>
<td>Mawgyun</td>
<td>2066</td>
<td>NA</td>
<td>62.0</td>
<td>355</td>
<td>NA</td>
<td>62.0</td>
</tr>
</tbody>
</table>

Note: The majority of financial reports do not budget or report expense of maternal and child referrals separately. Actual separate spend on maternal and child cases were obtained from IPs. Some partners are not able to disaggregate spend in maternal and child referrals, so average of all cases computed.

The increased proportion spent on referrals under 3MDG is directly linked to the increase in the number of referrals, as compared to the previous period under the predecessor Fund. In 2013, 5,747 mothers and 3,126 children under five were supported for referral to the township hospitals, compared to 3,592 mothers and 2,410 children under five referrals made in 2012.
Because there is no available expenditure analysis for JIMNCH, it is not possible to draw year-on-year comparison; however the emergency referral unit cost calculations for 3MDG in 2013 will serve as a baseline for future analysis.

- The variation of proportion of mothers referred across townships: further analysis on the role of guidelines or other factors play in these variations.
- Why is the proportion of maternal referrals in some townships so high?
- What explains the differences in cost per case across the different areas, with the maternal referrals showing greater variation? For example, is there a higher proportion of lower segment Caesarean section (LSCS) or is the transportation much more costly in some areas?
- All referrals show a higher achievement than planned but there is uniformly an under spend against budget. Better unit cost planning with standard guidelines and systems might reduce this.
- Why is the unit cost of <5 children’s referrals and maternal referrals in some townships so low?