Guideline on Access Malaria Indicators

The Access to Health Fund

February, 2019
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### Acronyms List

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<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>The Access to Health Fund</td>
</tr>
<tr>
<td>ACT</td>
<td>Artemisinin Based Combination Therapy</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>FB</td>
<td>Fund Board</td>
</tr>
<tr>
<td>FM</td>
<td>Fund Manager</td>
</tr>
<tr>
<td>G6PD</td>
<td>Glucose-6-phosphate dehydrogenase</td>
</tr>
<tr>
<td>GIS</td>
<td>Geographic Information System</td>
</tr>
<tr>
<td>HF</td>
<td>Health Facility</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>INGO</td>
<td>International Non-Governmental Organisation</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MIMU</td>
<td>Myanmar Information Management Unit</td>
</tr>
<tr>
<td>NMCP</td>
<td>National Malaria Control Programme</td>
</tr>
<tr>
<td>MoHS</td>
<td>Ministry of Health and Sports</td>
</tr>
<tr>
<td>NSP</td>
<td>National Strategic Plan</td>
</tr>
<tr>
<td>RDT</td>
<td>Rapid Diagnostic Test</td>
</tr>
<tr>
<td>TSG</td>
<td>Technical and Strategy Group</td>
</tr>
<tr>
<td>VHW</td>
<td>Village Health Worker</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
**Introduction**

Four donors – Sweden, Switzerland, the United Kingdom, and the United States – are committed to continue pooling funding in 2019-2023 to increase access to quality essential health services for underserved and vulnerable people in conflict-affected areas, and to enable the health system to sustain these gains. The follow-on mechanism (henceforth, The Access to Health Fund), will be open to like-minded donors interested in joining.

The Access to Health Fund builds on four core priorities:

a. A focus on conflict-affected areas and on work with both the MoHS and EHOs;
b. A focus on equity and a rights-based approach targeting vulnerable populations;
c. A focus on supporting the delivery of an Essential Package of Health Services;
d. Strengthening the health system’s capacity to ensure sustainable essential services with a particular focus on vulnerable, underserved people in conflict-affected areas.

The Access to Health has defined a number of intervention areas:

a. Essential Health Services (Maternal, New-born and Child Health)
b. Essential Health Services (Nutrition)
c. Essential Health Services (Sexual Reproductive Health and Rights)
d. HIV/Harm Reduction
e. Tuberculosis
f. Malaria
g. Health in Prisons
h. Health Systems Strengthening

**Purpose of the Malaria Indicator Guideline**

The primary purpose of this document is to provide the Access to Health Fund stakeholders with some essential information on the malaria indicators from the National M&E Plan (2016-2020). Partners are strongly encouraged to integrate the Malaria indicators into their ongoing monitoring and evaluation (M&E) activities.

These indicators are designed to help partners assess the current state of their activities, their progress towards achieving their targets, and their contribution towards the national response. This guideline is designed to improve the quality and consistency of data collected at the partner level, which will enhance the accuracy of conclusions drawn when the data are aggregated.
Indicators overview – Commonly Asked Questions

Indicators are important for two reasons. First, they can help evaluate the effectiveness of activities. Second, when data from programmes are analyzed collaboratively, the indicators can provide critical information on the effectiveness of the response at national level.

Q1: Are these indicators aligned with the National Strategy?

- **Yes.** These guidelines include indicators to implement for malaria case diagnosis and treatment. These indicators will be used to monitor the project implementation to fully align with the national strategy.

Q2: Which indicators do I report on and when?

- **Partners are expected to report on indicators as per their grant agreement and log frame.** Under no circumstances should a partner try to force inappropriate data into the indicator measurement. There are other opportunities to report achievements not related to the required indicators in the narrative report. If a partner has any questions regarding reporting, they should contact the Fund Manager’s Office before submission of the report. This guideline also provides information on the frequency of reporting.

Q3: Do I need to disaggregate data by sub-categories?

- **Yes.** For the indicators that clearly state in the guideline that sex and age data are required. In addition, *disability disaggregated data* will be requested after establishment of the disability theme by the Fund. The challenge for partners is to ensure that data remains disaggregated from the collection point all the way to reporting.

Q4: Do I need to provide village level data?

- The Access to Health Fund will use the database to see where and when activities are taking place. The Access to Health Fund will then be able to map important health information related to malaria implementation and potentially expand data collection with more partners. Partners are required to identify where basic health staff and village volunteers are working and the number of cases treated by village for reporting to the MoHS. The Access to Health Fund will work with the NMCP to compile and map this data as necessary.

- **Township level data is required for reporting by all partners.**

Q5: Do I need to count the number of patients treated in mobile clinics?
Yes cases treated in mobile clinics must be included.

Q6: How do I collect and compile village based treatment data?

All partners are expected to use the NMCP Malaria Case Register Books, ICMV guidelines.

Village tract and village name should be accordance with the name officially defined by the Ministry of Home Affairs and Myanmar Information Management Unit (MIMU). Visit http://www.themimu.info for more information.

Q7: What are the data sources we should use when collecting information?

- Primary Data sources for partners can include: (i) patient-tracking systems; (ii) programme monitoring reports; and, (iii) routine health information systems. Each indicator has a defined data source. Some names of the tools may be different in your organization compared to what is listed in this guideline, so please check with the Access to Health Fund to ensure your data sources are the right ones.

Q8: Which reporting template should be used to report indicator data?

- Recording and Reporting template should be in line with the template of NMCP and have to report regularly to NMCP and local health departments. For fund management reporting process, the Access to Health Fund will provide each partner with an updated Malaria reporting template at least one month prior to the reporting deadline. This template will have your targets filled in and is based on your log frame and grant agreement.

Please contact the Access to Health Fund office at +95-1-657280-7 for further information and support.
Reporting flow for Malaria to the Access to Health Fund

The Access to Health Fund M&E Unit

Township reports

Village level case management report

Feedback system

HQ IP M&E unit

The Access to Health Fund

FMO

HQ level

IP level

Township level

IP volunteer level

Village level
Electronic reporting flow for Malaria data

National DHIS2
  ↓
Central NMCP/WHO Data section
  ↓
State/Region focal person Data Assistant
  ↓
Township focal person Data Assistant
  ↓
Health facilities (sub-centre level)
  ↓
NMCP - VHW

Implementing partners and Private sector
  →
Implementing partners (field)

Google Drive
Inclusion of IP’s Data in the National System
A Public Health Questions Approach to M&E

| Determining Collective Effectiveness | Outcomes and impacts Monitoring | Are Collective efforts being implemented on a large enough scale to impact the epidemic? *Survey: Surveillance*
| Monitoring and Evaluating National Programs | Outcomes | Are interventions working/making a difference? *Outcome Evaluation Studies*
| | Outputs | Are we implementing programme as planned? *Output Monitoring*
| | Activities | What are we doing? Are we doing it correctly? *Process Monitoring and Evaluation: Quality Assessment*
| Understanding Potential Responses | Input | What interventions and resources are needed? *Needs, Resource, and Response Analysis: Input Monitoring*
| | | What interventions can work (efficacy and effectiveness)? Are we doing the right things? *Special Studies; Operations Research; Formative Research; Research Synthesis*
| | | What are the contributing factors? *Determinants Research; Analytic Epidemiology*
| Problem Identification | What is the nature and magnitude of the problem? *Situational Analysis*

The Third One: Monitoring and Evaluation of HIV Programs John Puvimanasinghe, Wayne Gill and Eduard Beck
Quick Reference for the Access to Health Fund Malaria Indicators

The following indicators will be collected by partners working in Malaria areas or implementing malaria projects. The following indicators are the Access to Health Fund malaria indicator.

Programme indicator framework (PIF)

| Goal: | 1. To reduce malaria morbidity and mortality by 85% and 75% respectively by 2020 relative to 2015 baseline figures. |
| Purpose: Increase Access to and availability of Malaria intervention for population under Access to Health Fund in complementary approach |
| Objective: To reduce reported incidence of malaria to less than 1 case per 1,000 population in all States/Regions by 2020. |
| To prevent the re-establishment of malaria in areas where transmission has been interrupted. |

| Impact | Malaria Mortality Rate (will refer National Published data) | Definition: Number of deaths due to confirmed malaria per 100,000 mid-year population at risk (per year). |
| | | Numerator: Number of parasitologically confirmed malaria cases admitted as in-patients in public sector health facilities dying before discharge |
| | | Denominator: National mid-year at risk population. |

| Outcome | ACT treatment rate: Percentage of confirmed malaria cases that received first-line antimalarial treatment according to national policy (Disaggregated by sex) | Numerator: Number of parasitologically confirmed uncomplicated malaria cases receiving anti-malarial treatment as per national guidelines. |
| | | Denominator: Number of parasitologically confirmed uncomplicated malaria cases. |
| | | NOT to include the cases treated with only ACT or only Primaquine or probable cases. |

| Output Treatment | Number of confirmed \textit{P.falciparum} malaria cases | Numerator: Number of confirmed \textit{P.falciparum} malaria cases treated with recommended ACT |
| **Indicator** | **Number of confirmed *P. vivax* malaria cases (by sex and age group) treated with chloroquine [plus primaquine].**  
*(Disaggregated by sex and age group: <1, 1-4, 5-9, 10-14, and 15 years of age and above)* | **Numerator:** Number of confirmed *P. vivax* malaria cases treated with chloroquine plus primaquine according to national malarial treatment guidelines |
| --- | --- | --- |
| **Output Treatment indicator** | **Number of RDTs tested and read.**  
*(Disaggregated by general population and migrant/mobile populations (if the programme serves migrant/mobile populations)* | **Number of RDTs tested and read. This indicator is used to know the number of estimated people tested using RDTs.**  
Exclude: invalid RDTs. Include: the number of RDTs tested and read |
| **Output Diagnosis indicator** | **Number of volunteers trained and supported (excluding volunteers trained exclusively for supporting migrant/mobile populations)** | **Number of volunteers trained and supported** |
| **Output Empowerment of Community Volunteers** | | |
1. Malaria Mortality Rate: Number of deaths due to confirmed malaria per 100,000 mid-year population at risk (per year)

**Definition:** Number of deaths due to confirmed malaria per 100,000 mid-year population at risk (per year).

**Numerator:** Number of parasitologically confirmed malaria cases admitted as in-patients in public sector health facilities dying before discharge.

**Denominator:** National mid-year at risk population.

**Data source (numerator):** Hospital inpatient registers.

**Data source (denominator):** National at risk mid-year population estimate.

\[
\text{Malaria Mortality Rate} = \frac{\text{Numerator}}{\text{Denominator}} \times 100,000
\]

**Rationale/Purpose:** Mortality is a major component of the burden caused by malaria, and reducing malaria related mortality is a key aspect of the overall goal of malaria control efforts globally.

**Interpretation:** Falling malaria specific mortality rate suggests that control efforts are effective and, depending on changes in API, may suggest better access to early diagnosis and treatment and/or more effective treatment of severe malaria.

**Additional Information:** Results are published by NMCP annually.

Indicator 1 matches with Impact Indicator 3 of National M&E plan for Malaria Mortality Rate.
2. **ACT treatment rate: Percentage of confirmed malaria cases that received first-line antimalarial treatment according to national policy (Disaggregated by sex)**

**Numerator:** Number of parasitologically confirmed uncomplicated malaria cases receiving anti-malarial treatment as per national guidelines.

(excluding those for whom Primaquine is contraindicated: pregnant women and children under 1 year of age)

**Denominator:** Number of parasitologically confirmed uncomplicated malaria cases. (excluding those for whom Primaquine is contraindicated: pregnant women and children under 1 year of age)

**Data source:** Malaria Case Register book

**Reporting frequency:** Every 6 months

**Rationale/Purpose:** Adherence to national treatment guidelines is the basis of ensuring appropriate treatment for malaria and reduced mortality.

**Interpretation:** This indicator provides a measure of adherence to national treatment guidelines. Confirmed malaria cases are confirmed by RDT or microscopy. Mixed infections, with *P. falciparum* present should be reported as “treated for *Plasmodium falciparum* malaria”.

Anti-malarial treatment must conform to the national treatment guidelines. This is also aligned with Outcome Indicator 4 of National M&E Plan (2016-2020). Please review the National Treatment Guideline for a more comprehensive discussion on the treatment of individuals with G6PD deficiency.

This indicator is only for the confirmed malaria cases treated with ACT + Primaquine. **NOT** to include the cases treated with only ACT or only Primaquine or probable cases.

**Additional Information:** the Access to Health Fund will request supporting documentation from implementing partners for the numerator and denominator used in the calculation of reported figures in order to verify the reported figures.

Indicator 1 matches with Outcome Indicator 4 of National M&E plan for ACT treatment rate.
3. **Number of confirmed P.falciparum malaria cases (by sex and age group) treated with recommended ACT [plus primaquine]. (Disaggregated by sex and age group: <1, 1-4, 5-9, 10-14, and 15 years of age and above)**

**Numerator:** Number of confirmed *P.falciparum* malaria cases (*P.falciparum* and mixed infections with *P.falciparum*) treated with recommended ACT together with primaquine according to national malarial treatment guidelines (excluding those for whom primaquine is contraindicated: pregnant women and children under 1 year of age)

**Denominator:** NA

**Data source:** Malaria Case Register book

**Reporting frequency:** Every 6 months

**Interpretation:**

Confirmed malaria cases are confirmed by RDT or microscopy.

Mixed infections with *P. falciparum* present should be reported as “treated for *Plasmodium falciparum* malaria”.

Anti-malarial treatment must conform to the national treatment guidelines.

This indicator is only for **confirmed** malaria cases treated with ACT + Primaquine. **DO NOT** include the cases treated with only ACT or only Primaquine or probable cases.

**Additional Information:** the Access to Health Fund will request supporting documentation for calculation of reported figures. **The Access to Health Fund will request total treatment figures by township.**

**Note:**

It will be disaggregated by **disability**. (Please see page 21 for Operational definitions of Access to Health Fund for Disability)
4. **Number of people with confirmed P.v. malaria (by sex and age group) treated with chloroquine plus primaquine (Disaggregated by sex and age group: <1, 1-4, 5-9, 10-14 and, 15 years of age and above)**

**Numerator:** Number of people with confirmed P.v. malaria cases treated with chloroquine plus primaquine according to national malarial treatment guidelines

**Denominator:** NA

**Data source:** Malaria Case Register book

**Reporting frequency:** Every 6 months

**Interpretation:**

Confirmed malaria cases are confirmed by RDT or microscopy. Anti-malarial treatment must conform to the national treatment guidelines. The applicable guideline for the Access to Health Fund is the “GUIDELINES FOR MALARIA DIAGNOSIS AND TREATMENT IN MYANMAR, 2015. Revised in 2018 (addendum)”. Anti-malarial treatment must conform to the national treatment guidelines.

This indicator is only for the **confirmed** malaria cases treated with Chloroquine + Primaquine. DO NOT include the cases treated with only Chloroquine or only Primaquine or probable cases.

**Additional Information:** The Access to Health Fund will request supporting documentation for calculation of reported figures.

**Note:**

It will be disaggregated by disability. (Please see page 21 for Operational definitions of Access to Health Fund for Disability)
5. Number of RDTs tested and read (Disaggregated by sex)

**Numerator:** Number of RDTs tested and read. Do **not** count invalid RDTs.

**Denominator:** NA

**Data source:** Malaria Case Register book

![Invalid RDT? Don’t Count]

**Reporting frequency:** Every 6 months

**Interpretation:** The indicator excludes invalid RDTs and is a reflection of the **number of people tested using RDTs.** Include the number of RDTs tested and read for the general population and also migrant/mobile populations (if the programme serves migrant/mobile populations)

**Programme Check!** Make sure to cross-check your distribution records for the number of RDTs that were distributed to service providers. Is the number different from the number of people tested? If yes, why? Include this discussion in your narrative report.
6. Number of volunteers trained and supported (Disaggregated by sex)

**Numerator:** Number of volunteers trained and supported

**Denominator:** NA

**Data source:** Training records and commodity distribution records (e.g. stationary, health promotion materials etc...)

**Reporting frequency:** Every 6 months, Cumulative annually

**Interpretation:**

‘Trained’ includes trained/retrained in prevention and/or case management. However, retrained numbers should not be included in this indicator. Volunteers must be trained and supported (supported is defined as given the resources required to perform their duties, which will include stationery, travel allowance, health promotion materials and malaria prevention and detection supplies). Each partner should stop support to “inactive” volunteers and reallocate the Access to Health Fund resources to support an active volunteer. “Inactive” volunteer is defined as a volunteer who does not submit their report(s) for four continuous months during a six month reporting period.

The below table shows as an example of a counting method used for measuring volunteers trained and supported. This indicator is related to the Access to Health Fund Malaria indicator but volunteers working with migrant and mobile populations are not included in this calculation.

### Example of trained and supported volunteer counting

<table>
<thead>
<tr>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th># Volunteer (T+S) Jan-Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (T+S)</td>
<td>A (T+S)</td>
<td>A (T+S)</td>
<td>A (T+S)</td>
<td>A (T+S)</td>
<td>A (T+S)</td>
<td>Count</td>
</tr>
<tr>
<td>B (T+S)</td>
<td>B (T+S)</td>
<td>B (T)</td>
<td>B (T)</td>
<td>B (T)</td>
<td>B (T)</td>
<td>Don’t count</td>
</tr>
<tr>
<td>C (T)</td>
<td>C (T+S)</td>
<td>C (T+S)</td>
<td>C (T+S)</td>
<td>C (T+S)</td>
<td>C (T+S)</td>
<td>Count</td>
</tr>
<tr>
<td></td>
<td>D(T+S)</td>
<td>D(T+S)</td>
<td>D(T+S)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A,B,C...= Represent name of volunteer  
T= Trained  
S= Supported  

**Additional Information:** the Access to Health Fund will request supporting documentation for calculating of reported figures, including volunteer coverage by township. The Access to Health Fund requests that partners provide the total number of volunteers trained in their narrative reports.
Only volunteers who have been trained and supported by Access to Health Fund should be counted and reported.

**The Access to Health: Cross-cutting Indicators**

<table>
<thead>
<tr>
<th>Output Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7. (5.1) Number of staff from Ministry of Health and Sports (MoHS), Implementing Partners (IPs), Ethnic Health Organisations (EHOs), local Non-Governmental Organisations (NGOs), Community-Based Organisations (CBOs), and volunteers who are trained in all cross-cutting themes (as part of package)</strong></td>
</tr>
</tbody>
</table>

**Definition**
The number of staff from MoHS, IPs, EHOs, local NGOs, CBOs and volunteers trained in all cross-cutting themes conducted by IP and Access to Health Fund resource persons disaggregated by sex and age.

**Numerator**
Number of staff from MoHS, IPs, EHOs, local NGOs and CBOs and volunteers who trained in all cross-cutting themes in a calendar year (disaggregated by sex and age).

**Denominator**
N/A

**Data Sources**
IP training records.

**Reporting Frequency**
Six monthly, and Cumulative Annually

**What it measures:** The number of staff from MoHS, IPs, EHOs, local NGOs, CBOs and volunteers receiving all cross-cutting themes training conducted.

*Trained* is defined as attendance at a cross-cutting theme-related training or workshop. The themes include (i) gender mainstreaming and social inclusion, (ii) prevention of sexual exploitation, harassment and abuse (SEA and SHA), (iii) disability inclusion, (iv) accountability and responsiveness (Community Feedback Mechanism), (v) emergency preparedness and response for disaster risk reduction, and (vi) conflict sensitivity. For cross-cutting related trainings, specific training attendance tracking sheet capturing above information should use.
Only those staff and volunteers who attend the **entire training at least one day based on training curriculum** will be counted as trained. Half day sharing session should not be counted as training. Training/workshop reports should include documentation of overall satisfaction of training/workshop given, including lessons learnt for improving upon training/workshop methods and action plan of the participants.

**Training** is defined as an organized activity aimed at imparting information and/or instruction to improve the recipient’s performance or to help him or her attain a required level of knowledge or skill.

**Workshop** is defined as a class or seminar in which the participants work individually and/or in groups to solve actual work-related tasks to gain hands-on experience.

**Age** is defined 15-24 (youth), 25-59 (adult), 60 and over as senior/pensioner. These categories are defined using the most recent information from the 2014 census and existing pension laws. These definitions are subject to change.
Output Indicator

<table>
<thead>
<tr>
<th>Definition</th>
<th>Number and percentage of feedback addressed in the reporting period based on the IP’s procedure, disaggregated by type of feedback (as defined in the procedure).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>Number of feedback received by IPs that were addressed in the reporting period based on the IP’s procedure (except positive feedback).</td>
</tr>
<tr>
<td>Denominator</td>
<td>Total number of feedback received by IPs through verbal and written feedback channels to provide feedback in the reporting period. (as defined in the procedure) (except positive feedback).</td>
</tr>
<tr>
<td>Data Sources</td>
<td>IP reports and Feedback Mechanism Records</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Six Monthly and Annually</td>
</tr>
</tbody>
</table>

**What it measures:** the extent to which feedback received by the IP through verbal and written feedback channels those are addressed by the IP based on a procedure that follows good practice.

Feedback refers to opinions, concerns, suggestions, questions, and complaints of anyone affected by the IP to improve any aspect in the interaction between themselves and the IP. This interaction can relate to decision-making processes, operations, standards of technical performance, communications or any other aspects in the IP’s work. Feedback also refers to the specific grievance of anyone who has been negatively affected by the IP or who believes that the IP has failed to meet a stated commitment. This commitment can relate to a project plan, beneficiary criteria, an activity schedule, a standard of technical performance, an organizational value, a legal requirement, staff performance or behavior, or any other point.¹

Mechanisms to provide feedback are defined as verbal and written feedback communication tools that IPs utilise to collect feedback from the communities and give response in which they work to better understand their programs and projects from community members’ perspectives.

¹ Definition adapted from HAP, The Guide to the HAP Standard, Published by Oxfam GB, 2008.
These mechanisms give the IPs information to adjust their programs and projects to best meet individual and community needs.  

Examples of feedback channel includes but is not limited to outreach sessions, community engagement meetings, focus group discussions, quarterly rural health centre meetings, feedback forms, ready to post envelopes, in person direct feedback at the organisation and at the field through health staff, field focal, and volunteers, etc.

**Addressed** means that the IP has fully followed the procedure (see below) and decided that no further action can or will be taken in relation to the feedback.

**Procedure** refers to a specified series of actions *defined by the IP* based on the context and taking into account good practice, through which the IP processes feedback and ensures that feedback is reviewed and acted upon. The procedure clarifies the purpose and limitations of feedback, how feedback can be raised, types of feedback and steps to be taken in order to decide if the feedback requires any action and/or a response to the feedback provider, the response timeframe for communicating with the feedback provider, etc. **The procedure needs to be documented and should be available on request.**

If the feedback does not require any further action to be taken (e.g., positive feedback/thank you letter), it is necessary to record but no need to include in the calculation of percentage of feedback addressed.

**Types of feedback** are categorized as Suggestion, Positive Feedback, Negative Feedback, and Others.

- **Suggestion:** It refers to an idea, plan or action that is suggested to your organization, project activities and services.
- **Positive Feedback:** It includes a positive statement of opinion about your organization, project activities and services, etc. **Thank you feedback from communities should not be counted in the list of feedback addressed by IPs.**
- **Negative Feedback:** It includes an expression of dissatisfaction, complaint or harassment relating to your organization, staff, project activities, services, etc.
- **Others:** It includes issues such as questions and concerns which are not relevant to describe in the categories mentioned above.

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3 Categories are adapted from Health for All Reporting Template
9. Operational definitions of Access to Health Fund for Disability

Rights of Persons with Disability Law, Myanmar, 2015:

“A person with disabilities refers to a person who is suffering from one or more long term physical, visual, speech, hearing, intellectual, psychological, mental, or sensory impairment, whether innate or not.”

“Disability refers to not being able to fully participate in the society due to physical, mental, or any other form of hindrances.”

UNCRPD, 2006:

“Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”

“Disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.”

Note: The term “long term impairment” is exceptional for people who inject drug/use drug (PWID/PWUD) suffering from acute or chronic mental health problems.

Washington Group Short Set Questions will be used to identify the person with disability and explained in the cross-cutting themes training. For reference, the Washington Group on Disability Statistics (2016), Short Set of Questions on Disability (PDF version) can be downloaded in this link


Number of persons with disability who receive the project services needs to be reported. The suggested indicators to report disability disaggregation are as follow.

**MNCH**

- Output 1.2.1 Number and percentage of appropriate EmOC referrals supported - Total
- Output 1.2.2 Number of appropriate EmOC referrals supported - hard to reach areas
- Output 1.2.3 Number of ECC referrals supported - Total
- Output 1.2.4 Number of ECC referrals supported - hard to reach areas
SRHR
• Output 3.2 Number of women received family planning service with SRHR information.
• Output 5.2 Number of women 30-49 who have been screened at least once for cervical cancer

TB
• Number of notified cases of all forms of TB (Disaggregated by sex)

Malaria
• Number of people with confirmed P.f malaria (by sex and age group) treated with chloroquine (plus primaquine)
• Number of people with confirmed P.v malaria (by sex and age group) treated with (plus primaquine)

IP needs to take record the achievement data related to disability in the above indicators. The disability identification will be according to the Washington Group questions.
10. Operational definitions for women representatives at decision-making positions (for Health for All narrative report)

1) Number of women representatives at decision-making positions in village track/village health committee

2) Number of women representatives at decision making positions in peer groups/self-help groups

“Women representatives in decision-making” mean number of women in health decision-making positions at community level, such as leader/chairperson, secretary, and treasurer in related health committees or volunteer groups, those have more decision making authority than other ordinary members. The ordinary female members of the health committees or volunteer groups will not be counted as women in decision-making positions.

Representatives in the respective health committee or volunteer group should be elected by community to voice up and facilitate in addressing the health needs of the entire village with the help of health service providers.

**Note:** The achievements related with women representatives in decision making have to be reported in Health for All Narrative report. Therefore, IP needs to take record the relevant activities and achievements.
| Accountability | • Accountability means using power responsibly. It means listening (and responding) to the voices of people, and keeping your commitments to others.  
• In the context of accountability and health services, this refers to the commitments of health service providers (public and private) to all the people of Myanmar regardless of gender, ethnicity, religion, age or health status.  
• Accountability also means building empowered, informed and capable communities and health system users. |
| --- | --- |
| Fairness (Equity) | • Being fair and just to all people who use the health system.  
• Recognising that people are different and need different support to ensure their rights are recognised. |
| Gender Equity | • Being fair to women and men.  
• Taking specific actions to address historical and social discrimination and disadvantages in Myanmar that prevent women and men from otherwise operating as equals. |
| Health Equity | • All people have the opportunity to have the highest level of health.  
• Understanding the different barriers to health that people face and working to address them.  
• All people can access quality health care regardless of their socio-economic position, including age, disability, gender or other circumstances.  
• Ensuring that health policies and services respond to the specific needs of different groups of people. |
| Inclusion | • Involves all people in decisions that affect their health.  
• Understanding diverse experiences and preferences, and enabling people from many different circumstances (e.g. cultural, linguistic and geographic) to participate in health care planning.  
• Mutual respect, tolerance and making all people feel valued.  
• Ensuring that all voices are considered in decision-making processes. |
| Empowerment | • People – both men women and men – taking control over their lives.  
• People setting their own agendas, gaining skills, building self-confidence, solving problems, and developing self-reliance. Supporting efforts by communities to carry out collective actions.  
• Building confident and informed users of the health system.  
• Creating ownership. |
| Conflict Sensitivity | • Capacity of an organisation to understand the context in which it operates, how its activities influence that context and vice-versa, and to act upon that understanding to maximise positive impacts and avoid negative ones (“do no harm”). |