Programme Description
Access to Health Fund – 2019-2023

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This document includes parts of the Appraisal Mission report, which aimed specifically at helping Donors define and design the Successor Fund. For ease of reading, text from that Report is not referenced nor in quotation marks.
Country context

Over the last half a century of isolation, and with limited resources, Myanmar has seen very low levels of basic health services, poor infrastructure, shortage of trained medical and paramedical staff, a chronic shortage of essential drugs and supplies, and high levels of out-of-pocket payments for health. This situation, magnified by conflicts and geographical remoteness, has led to considerable inequities in the utilization of health services.

There are, however, reasons for optimism. The Government of Myanmar is committed to Universal Health Coverage by 2030, effectively putting at the centre of its priorities questions of equity and access to health for the most marginalized populations. The Ministry of Health and Sports (MOHS) has launched the 2017-2021 National Health Plan identifying the country’s priorities, needs, and gaps. It provides a roadmap for the Successor Fund, including:

- An inclusive and participatory formulation process;
- Phased access to an ‘Essential Package of Health Services’ for the entire population;
- An emphasis on primary health care delivered at Township level and below;
- A defined role for health providers outside the MOHS, including Ethnic Health Organizations (EHOs), non-government organizations (NGOs), and private providers;
- A shift away from top-down planning and towards a more inclusive bottom-up approach;
- Recognition of the critical role of health systems strengthening in creating a health system that is self-reliable and supports universal access.

At the core of the National Health Plan, the basic Essential Package of Health Services reduces fragmentation by integrating health care services delivered at Township level and below. The Plan strengthens the health system’s capacity to identify disparities in access (including gender, disability, poverty levels, and geographies) and take action to overcome them. Positive changes can already be observed. Public spending on health has considerably increased over the past few years, with a nine-fold increase in absolute amount (from US$ 94 million in 2010-11 to US$ 850 million in 2016-17, according to MOHS data). In relation to the GDP, the World Bank shows the following 1995-2014 evolution of public spending on health (2016 is at 1.2%):

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1 This includes maternal, newborn, child and adolescent health; sexual and reproductive health; nutrition services; TB, HIV and malaria; as well as to some non-communicable diseases.

2 Ministry of Health and Sports, 2016, National Health Plan 2017 - 2021

3 Our own calculation, with GDP at US$ 67.43 billion (World Bank) and Health budget at US$ 850 million.
This increase, which is still insufficient in comparison to needs, was mainly used to finance free medical care in hospital settings and expansion of service-coverage. Based on the preliminary findings from a recent household expenditure survey, even if households’ out-of-pocket spending remains extremely high by international standards, it is showing some initial signs of decrease (from more than 80% to around 70% of total health expenditure\(^4\)).

Myanmar has ratified five human rights treaties\(^5\) which include the right to health. While the Constitution guarantees citizens equal rights before the law,\(^6\) the legal framework and other standards on gender equality have contradictory and stereotypical messages.\(^7\) For example, the 2008 Constitution includes references to women principally as mothers, and contains a passage which states that “nothing in this section shall prevent appointment of men to positions that are naturally suitable for men only.” Myanmar ranks 85\(^{th}\) out of 188 countries in the 2015 Gender Inequality Index. Within traditional patriarchal structures common in Myanmar family life, men are the primary decision-makers, including when it comes to health and finances. Gender norms,\(^8\) roles and inequalities limit women’s opportunities to seek appropriate health care for themselves or their children – including family planning services – and lead to health risks for women and girls: women may not be able to access or pay for the health-care services that they need; they may have lower levels of education than men, increasing the probability of illiteracy and subsequent inability to read health education material, or inability to communicate in Burmese – which is the primary language of many health care providers.

A number of studies have shown that violence against women is widespread and higher for women and girls from ethnic minorities\(^9,10\); few victims of gender-based violence report such violence or access health services. Women who do not conform to gender norms (such as lesbian women, women with disabilities, and women from ethnic and religious minorities) may experience compounded effects of these intersecting vulnerabilities. Stigma and marginalization may impede their access to services.

People with disabilities also face discrimination and do not receive adequate protection under the Myanmar law. Stigma and discrimination, as well as the non-readiness of the health system, hamper their access to health care and education.\(^11\)

\(^4\) The 2014-15 Myanmar Poverty and Living Conditions Survey
\(^5\) The Universal Declaration of Human Rights, The International Covenant on Civil and Political Rights, The Convention of the Elimination of all forms of Discrimination Against Women (CEDAW); the Convention of the Rights of Persons with Disabilities (CRPD); and the Convention of the Rights of the Child (CRC).
\(^6\) Government of Union of Myanmar, 2008 Constitution, Section 347. Section 348 rejects discrimination on the basis of “race, birth, religion, official position, status, culture, sex and wealth.”
\(^8\) For example, men’s control over healthcare and reproductive choices, women’s duty to have children, women’s roles as care givers, women’s double or triple labor burdens, women’s lack of economic independence (3MDG-Collective Voices Stage 1 report, [2016]: Exploring the barriers to health care access in Myanmar. Available at: https://www.3mdg.org/sites/3mdg.org/files/publication_docs/2016_collective_voices_report_-_english_full_version.pdf [Accessed 12 March.2018])
\(^10\) Eight Women and Girls Centres in Kachin State (in both government and non-government controlled areas) reviewed available information on 300 cases seen in 2016. The types of GBV perpetrated included psychological/emotional abuse (58%); physical assault (28.5%); sexual assault (8.5%); rape (3%); forced/early marriage (1%); and denial of resources (0.6%) -- Yamada, M. (2017). Question on data on GBV in the country.
\(^11\) Global Justice Centre and Gender Equality Network (2016). Report on Obstacles to Gender Equality in Myanmar. Prepared for the 64\(^{th}\) session of the Committee on the Elimination of Discrimination against Women p.9. Available at:
1. ACCESS TO HEALTH FUND: A FOCUS ON EQUITY

With the 3MDG Fund ending in December 2018, four donors – UK, Sweden, US, and Switzerland – 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, the Access to Health Fund (Access), will be open to like-minded Donors interested in joining.

Access builds on two core priorities:
- A focus on conflict-affected areas, as described below;
- A focus on equity, with the Fund adopting a rights-based approach promoting inclusiveness, and explicitly targeting underserved and vulnerable populations. This focus on equity defines, to a large extent, the population the Fund will strive to serve.

1.1 Theory of Change

The diagram below illustrates the Access to Health Fund’s Theory of Change – namely the logical path through which the Fund’s key focus (delivery of the Essential Package of Health Services in conflict-affected areas) leads to outputs (better planning, increased capacity, improved efficiency) which in turn leads to increased health outcomes and to the desired goal/impact: Better overall health status of populations in remote and conflict-affected areas and reduced health inequalities.

(See diagram on next page)
Goals

- Better overall health status of populations in remote and conflict-affected areas
- Reduced disparities (Reduced health inequalities)
- Reduced poverty
- Health work promotes dialogue and contributes to peace
- Reduced maternal, neonatal, and child mortality
- Reduced unplanned pregnancies and abortions
- Reduced new HIV infections among people who inject drugs
- Reduced TB and malaria incidence
- Better mutual understanding between government and non-government actors

Outcomes

- Increased service coverage:
  - Increased TB, HIV & malaria cases properly treated/referred
  - Increased coverage of skilled birth attendance and ante/post-natal care
  - Improved coverage of basic vaccines
  - Improved SRHR knowledge; changed behaviour; contraception access;
- Increased population coverage: populations in remote and conflict-affected areas have same access to essential health services and are empowered
- Increased financial protection: less out of pocket spending resulting in increased resilience of vulnerable populations
- Increased accountability (towards recipient communities) and responsiveness of service providers: Health services delivery assure quality, timeliness, dignity and building on principles of equality, gender, and human rights
- Improved delivery environment: conducive policies and regulations

Contribute to progress towards UHC, with increased population access to and use of services

Key Strategies

- Build MOHS and EHO capacity
- Improved collaboration of government and EHOs around health
- Improved delivery and quality of services
- Increased capacity of public, private, EHO providers to deliver the basic Essential Package of Health Services:
  - Increased skills (including soft skills) of service providers
  - Better capacity to use data and manage knowledge
  - More decisions and policies based on evidence
- Improved efficiency and effectiveness of service-provision:
  - Improved coordination and communication among stakeholders
  - Improved Public Financial Management
  - Improved Health Information System
  - Improved organization of delivery – including through Integrated Township and State (Region) Health Plans
  - More integration of systems, processes and services => more value-for-money
- Increased collaboration of government and EHOs around health
- Strengthened Health Systems
- Influence policy making through advocacy using knowledge, data and evidence

Outputs

- Better planning, budgeting and coordination of the Health response at all levels
- Better/more on-the job training for basic health staff, outreach, referrals, ANC sessions, HIV testing, needle distribution, malaria testing and treatment, etc.
1.2 Geographies

In line with the analysis undertaken by the Appraisal Mission\textsuperscript{12} the Fund will concentrate its interventions in Rakhine, Kachin, Shan, Kayin, Kayah and Mon – all states affected by latent or active conflict.

Figure 1. Coverage map

The Fund will support activities in Chin, through modalities yet to be defined; the Fund in some instances will also reach out to populations across state/regional borders when there exist a continuum of populations and health situations (e.g. northern Sagaing bordering Kachin, Mandalay bordering Shan, and Mon State bordering Kayin).

The case for prioritizing populations affected by past and current conflict is threefold:

i. Access to health services in conflict-affected areas is low. By focusing on these areas, the Fund will be targeting some of Myanmar’s least equitable access-to-health situations and some of the country’s most vulnerable groups, in places that the government often is not able to reach and support. Health outcomes in conflict areas are generally below the Union-averages:

- Maternal mortality rate in Rakhine is above the Union average (314 against 282 per 100,000 live births) and is the fourth largest in the country, after Chin, Ayeyarwady and Magway (Census, 2014).
- The under-5 mortality rate in Shan is the second and largest in the country (99 vs. 50 per 1,000), after Chin.
- Child stunting rates in Kayah, Rakhine and Kachin are the highest in the country after Chin (40%, 38% and 36% vs. the Union-average of 29%)\textsuperscript{13}
- In Rakhine, Kayin and Kachin the use of modern contraception is below the Union-average, with 37%, 40% and 42% of currently married women aged 15-49 using any modern method of contraception; the national average is 51%.\textsuperscript{14}

\textsuperscript{12} In February 2017, a Joint Appraisal Mission was commissioned by the 3MDG Fund donors. National and international experts were tasked with the design of a successor Fund consistent with the government’s National Health Plan and the 2030 Universal Health Coverage goal. The mission drew lessons from the experience of the 3MDG Fund.

\textsuperscript{13} Myanmar Demographic and Health Survey, 2015-16

\textsuperscript{14} Ibid
ii. Universal Health Coverage – the country’s goal for 2030 – requires access to health for populations throughout the country, and can only be achieved through closer cooperation and coordination with Ethnic Health Organizations and their partners. The recent participation of Ethnic Health Organizations in the definition of the National Health Plan, and their explicit responsibility in the delivery of the Plan, are a promising indication on the role that these organizations can play. The Fund will continue to promote and support such participation.

iii. By intervening in conflict-affected areas, the Fund will contribute to peace-building in Myanmar:

- One of the key contributions of health to the wider peace process in Myanmar is in bringing together actors around concrete shared goals and, through health-related discussions, contributing to building trust for further dialogue and collaboration. Through careful and sensitive interactions, Access can thus help foster mutual respect and dialogue between individuals, with a focus on empowering women to be key stakeholders in this dialogue.

- Health outcomes (for example, increased access to services and improved quality of care) can be experienced by beneficiaries as direct, concrete dividends of Myanmar’s transition towards peace and democracy – thus reinforcing support for such transition.

- The Fund is well positioned to conduct this work. By building on the experience of the 3MDG Fund, Access will continue to promote a conflict-sensitive approach which starts from an understanding of contexts and interests, takes an “honest broker” approach, focuses on improvement to health services for populations, minimizes harm, and builds a bridge to collaboration and mutual understanding.

1.3 Populations

Within and alongside conflict-affected populations, the Appraisal Mission identified the need for the Fund to focus support on populations which, for geographical, poverty, or social reasons are vulnerable and “hard to reach.”

In focusing on vulnerable populations, the Fund will put gender and diversity at the centre of its approach; ensuring service-provision understands and alleviates barriers to women, girls and minority population’s access to health. The Fund will also be guided by a human rights-based approach to health – encompassing support to the availability, accessibility, acceptability, and quality of health services, as well as the principles of non-discrimination, participation, and accountability.

Global evidence shows that making good investments in health can also stimulate economic growth. Improving access to and quality of essential health services is critical to building citizens’ capabilities and enabling them to compete for jobs and opportunities. Lower mortality can be credited with 11 per cent of economic growth in low and middle income countries, according to a Lancet publication15. Improving the health status of the most vulnerable populations reduces their

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catastrophic and impoverishing out-of-pocket spending on health – and in turn contributes to poverty reduction. In particular, research shows that investments into women’s health have ‘ripple effects’ for entire families and communities.\(^{16}\) A strong commitment to address health issues for women, children and minority groups is a critical element of the Access Fund’s ambitions to improving access to and use of health services in Myanmar.

The Fund will continue to emphasize access to health for people with disabilities, taking proactive steps across its programmes to ensure their inclusion in the assessment, design and implementation of services, programmes and outreach. Compared to able-bodied persons, persons living with a disability have less access to information, education,\(^{17}\) poorer health outcomes,\(^{18}\) lower levels of employment, higher poverty rates, and more likely to experience violence. This is further compounded by dimensions of gender discrimination. Globally, 16% of adults and 5% of children worldwide are living with a disability,\(^{19}\) with similar prevalence rates for girls and boys; among adults, 12% of women have at least one severe functional limitation compared to only 8% of men.\(^{20}\) Prevalence of violence among persons living with disabilities is 1.3 times higher among women with disabilities, and 3.86 times higher among people with mental health conditions.\(^{21}\) Girls and women may be at a higher risk for becoming disabled due to harmful practices such as forced childhood marriage.\(^{22}\) Women who do not have a disability are more likely than men to stay home to look after a family member who is disabled, often causing them to stay home from school or leaves them unable to seek paid employment.\(^{23}\) Economic losses related to the exclusion of people with disabilities from productive work ranges from 3 to 7 percent of GDP.\(^{24}\)

In many settings, people with disabilities experience economic and social barriers in accessing the health and rehabilitation services they need.\(^{25}\) The Fund will focus on awareness raising, capacity building, and innovative approaches; it will also work to empower people with disabilities to demand access and participate in decisions related to health service-provision at the community level.

Health is a goal in its own right, yet health investments are also investments in prosperity, social and financial protection, equity, and national security. Better health is a foundation for Myanmar’s social and economic progress.

### 1.4 The Fund’s approach

This section presents some of the values, principles and modalities that guide the Fund’s approach.

#### 1.4.1 Principles: equity, inclusion, accountability, sustainability, and country-ownership

Equity drives the Fund’s actions, in combination with the following principles:

**Inclusion.** Fund activities will promote the participation of all community members, including those with different genders, abilities, languages, religions, identities, and those facing discrimination.


\(^{18}\) [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4956734/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4956734/)


Evidence links women’s participation and improved health-related outcomes; Access will help establish common guidelines and tools on gender and human rights, and support their application across the country.

**Accountability.** The Fund will work to ensure that implementing Partners and health-service providers are accountable in their delivery of responsive, quality services, in particular to vulnerable persons or those whom are “hard to reach,” due to geography, conflict, mobility challenges faced by those with low income and/or those who have low decision-making power over their mobility or health, and those who face other challenges to accessing care due to intimate partner violence and other inter-familial issues.

**Sustainability.** The Fund will strive to build sustainability in every intervention it supports. The Fund will pursue sustainability through an emphasis on Health Systems Strengthening, integration of interventions, focus on delivering the Essential Package of Health Services, building capacity, and seeking innovative ways to deliver services. The Fund will agree with Implementing Partners, Ministry and EHOs on the modalities through which interventions will be continued after the Access Fund’s support ends – and will work to put the agreed mechanisms in place.

**Country Ownership.** The Fund will work to strengthen ownership of programs and interventions by the MOHS and Ethnic Health Organizations/Ethnic Armed Organizations. This will be done through ongoing consultations about interventions and investments, co-design of programs, and an increased role for institutional partners at Township-level as their capacities increase. The Fund will align with and support national priorities and strategies, aiming to (i) deliver the interventions defined in the Essential Package of Health Services and (ii) work at the national level to strengthen policies, strategies and operational plans to advance the coverage of the basic Essential Package of Health Services.

### 1.4.2 Cost-effectiveness and Value-for-money
Relying on evidence and analysis, the Fund will strive to implement its activities in the most efficient and economical way, maximizing results per dollar spent.

### 1.4.3 Integration
Access aims to support the delivery of as much of the Essential Package of Health Services as possible in intervention-areas. By emphasizing integration to the delivery of health services, the Fund (i) increases the availability of health services for beneficiaries and (ii) creates efficiency gains. The Fund will apply a ‘Whole-Township’ approach, looking at overall needs and opportunities for action. To the extent possible, the Fund will follow the principle of ‘one State, one Implementing Partner’ to avoid overlaps and duplications of efforts.

In the Fund’s theory of change, the delivery of the Essential Package of Health Services to underserved and vulnerable people in conflict affected settings (key strategy), with a focus on sexual and reproductive, mother-newborn, child and adolescent health, will lead to increased capacity of public, private, Ethnic Health Organizations providers to deliver the basic health package (output) and to improved health-service coverage for vulnerable populations (outcome). Impact would be measured in reduced maternal, newborn and child mortality, reduced new HIV infections among

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26 Some useful resource links on the 3MDG Fund and gender equality in Myanmar:

- [https://www.3mdg.org/en/about-the-3mdg-fund](https://www.3mdg.org/en/about-the-3mdg-fund)
people who inject drugs, reduced TB and malaria incidence, reduced health disparities, and reduced poverty.

1.4.4 Influence and leverage
An important part of the Fund’s work will be in its ability to influence policies and investment decisions of other players – thus leveraging the Fund’s resources and increasing the pool of resources available for important health interventions. The Access to Health Fund will pursue this in several ways:
- By continuously sharing information, knowledge, and approaches with other health funders, creating coalitions of like-minded actors (the 3MDG Fund has done so, for example, in its approach to supporting the Village-Based Health Workforce);
- By working with the Ministry of Health and Sports to influence approaches, create a momentum, and have the Ministry advocate for others’ participation (this is currently the case, for example, regarding ongoing improvements to the Sittwe General Hospital).
- By working with civil society and the media to build the public’s expectation of access to quality essential health services – and holding service-delivery actors accountable.

1.4.5 Innovation
The Fund will test innovative approaches (e.g. in the areas of health financing, village-level delivery, integration of services) to strengthen the design and management of health services. In order to innovate, the Access to Health Fund will need to explore new avenues for change – including advocacy, pilots, and research. It will need to reach out to non-traditional Partners such as innovators, incubators, and start-ups, to collect ideas and approaches and help take them to scale. This will require new (and sometimes very different) ways of thinking, and new operational approaches within the Fund and its Partners.

The Fund will continue to support engagement with the (for-profit) private sector through the National Health Plan implementation process and the ongoing strategic purchasing pilot grant with general practitioners. The National Health Plan recognizes that MOHS cannot be the only provider of health services; other actors such as NGOs, CSOs and private General Practitioners/clinics play a vital role. These key stakeholders are to constitute a Township Health Working Group that will collaboratively develop and implement Township Health Plans for improved service delivery. In addition, the strategic purchasing pilot with general practitioners in the Yangon Region will provide evidence towards the MOHS’ goal of developing a purchaser-provider split.

It is important to note that even where the Access Fund continues an approach developed by the 3MDG Fund, this does not necessarily mean business as usual. Over the last few years, the 3MDG Fund has been constantly innovating – moving to integrated programming, expanding sexual reproductive health and rights services through the HIV/Harm Reduction grants, piloting referrals and strategic purchasing, engaging with LIFT and the Joint Peace Fund in the areas of nutrition and conflict sensitivity, to cite a few examples. While developing its own methods of work, Access will strive to keep and build on promising approaches established in the previous programming phase.

1.4.6 Working for the next generation
In parallel to supporting the delivery of immediate services, the Fund will strive to work for the long-term, building a health system for the next generation. This includes commitments to strengthening the health system across six key pillars, namely service delivery, human resources, financing, information management, governance and medicines, vaccines and technology, and working to build the capacity of key actors within ethnic health organizations and the MOHS at all levels.
1.5 Thematic areas

The Appraisal Mission set out to identify priority health interventions aligned to an equity-based agenda. Based on the mission’s conclusions and on subsequent discussions with Donors, the Fund has defined a number of intervention areas, described in this section.

1.5.1 Maternal, newborn and child health

**Evidence**

The maternal mortality ratio in Myanmar fell by more than 37% between 1990 and 2015, from 453 per 100,000 live births to 282—yet sharp geographical disparities persist: the ratio ranges from 157 per 100,000 live births in Tanintharyi to 357 in Chin State; it is significantly higher in rural than in urban areas (310 and 193 per 100,000 live births, respectively) and in areas with large proportions of ethnic groups. Utilisation of essential maternal and newborn health services is relatively low, with notable variations among states and regions. For example, based on the recent Myanmar Demographic and Health Survey, 60% percent of births in Myanmar are delivered by a skilled provider, varying from 30% and 36% in Rakhine and Chin to 83% in Yangon region; deliveries in health facilities represent 37% of deliveries in Myanmar as a whole, ranging from 15% and 19% in Chin and Rakhine to 65% in Yangon region.

Myanmar has made substantial progress in reducing the under-five mortality rate (U5MR), which fell from 82 per 1000 live births in the year 2000 to 50 in 2015–16. Yet, the country is falling short of achieving MDG 4’s target of reducing child mortality to below 38 per 1000 live births. Of all children who die before reaching the age of five, 50% die within the first 28 days of life, and 80% within the first year.

Cost-effective interventions that reduce infant and child mortality are known and are part of the draft basic Essential Package of Health Services. To date, their coverage tends to be low, underlining the need for improved plans for service delivery. The average figure of children in Myanmar who are fully immunized is 55%, varying from 34% in Ayeyarwady to 80% and 81% in Kayah and Mandalay. Among children under the age of 5 with symptoms of acute respiratory infection, 58% seek advice or treatment from a health facility or provider (with, again, a gender gap: 65% for boys, compared to 48% for girls); 57.5% boys vs 56.1% girls for fever; and 56% boys vs. 51% girls for diarrhoea.

Violence against women and girls is directly correlated with poor health outcomes for children and infant mortality rates. Women who have experienced sexual or physical abuse from their partners

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27 Census, 2014
30 Myanmar Demographic and Health Survey 2015–16
31 [http://www.searo.who.int/entity/health_situation_trends/data/hsp/kyrgyz_hsp.pdf](http://www.searo.who.int/entity/health_situation_trends/data/hsp/kyrgyz_hsp.pdf)
32 Myanmar Demographic and Health Survey 2015–16
33 UNICEF, country estimates up to 2015; [https://data.unicef.org/topic/child-survival/under-five-mortality/](https://data.unicef.org/topic/child-survival/under-five-mortality/)
35 Lassi, Z.S., et al., Interventions to Improve Neonatal Health and Later Survival: An Overview of Systematic Reviews, EBioMedicine (2015), [http://dx.doi.org/10.1016/j.ebiom.2015.05.023](http://dx.doi.org/10.1016/j.ebiom.2015.05.023)
36 As the EPHS is still in draft form, we are not able to attach it or make a service-by-service comparison. Through work with NIMU and potentially the Myanmar Development Institute (see below under Health Systems Strengthening) the Fund will help prepare policy briefs and white papers to support the evolution of the EPHS and link policy and programs.
37 Myanmar Demographic and Health Survey 2015–2016
are 16% more likely to have a low birth-weight baby, and their children are more likely to experience negative health outcomes, such as lower immunisation, higher rates of diarrhoeal disease, and greater infant mortality rates.\(^{38}\)

Empowered women in Myanmar who participate in more decisions within their households are more likely to have received delivery care for their most recent birth. Married women in Rakhine State are least likely to participate in three selected decisions (48%). For example, 48% of women who participate in no decisions received delivery care for their most recent birth in the last 5 years, compared with 66% of women who participate in all three decisions. Similarly, 65% of women who disagree with all five reasons for wife beating received delivery care for their most recent birth, compared with 51% of women who agree with all five reasons.\(^{39}\)

Child mortality is another demographic indicator that varies by women’s empowerment. For example, under-5 mortality declines from 77 per 1,000 live births in the 5 years preceding the survey among women who participate in 1-2 of the three decisions to 68 among women who participate in all three decisions. However, under-5 mortality declines from 79 per 1,000 live births among women who disagree with all five reasons for wife beating to 65 among women who agree with one or more reasons.\(^{40}\)

The case for investing in maternal, newborn and child health

The return on investments in pregnant women and newborns has been estimated to be as high as US$ 120 for every dollar spent\(^{41}\). Among other benefits, increasing demand for spacing births and delaying adolescent childbearing contributes to reducing maternal and newborn deaths, increases the number of years girls spend in school, and increases future earning capacity.

Proposed approach

Reducing maternal mortality rates, especially in hard-to-reach populations, requires strengthening supply-side services such as ante-natal care, emergency referrals, skilled birth attendance, institutional delivery, and post-natal care; and addressing demand-side barriers to utilization such as cost and trust.

Health programmes / providers have a critical role to play in addressing gender-based violence to improve maternal and child health outcomes. In many contexts, health services are the first port of call for women who have experienced gender-based violence. Health services also present a unique opportunity to identify and start to address the violence that women and girls suffer at home. Health care settings and confidential patient/provider relationships can provide women and girls with safe environments where they can confidentially disclose their experiences and receive a supportive response. Health facilities are also critical to provide women with essential treatment care and support. It is also important to recognise that frontline health workers, especially women, are also often the victims of bullying and abuse in conducting their work.

Failure to address violence against women and girls through and in the health sector can lead to increased risk and harm for service users and poorer overall health outcomes. When health care

\(^{38}\) WHO, the South African Medical Research Council and the London School of Hygiene & Tropical Medicine, (2013) Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: WHO

\(^{39}\) Myanmar Demographic and Health Survey 2015-16

\(^{40}\) Myanmar Demographic and Health Survey 2015-16


providers are not trained in the guiding principles of working with women survivors or those at risk (e.g. when providers do not protect patient informed choice and confidentiality), women and girls may be at risk of additional violence from partners or family members. Untrained health workers may also misdiagnose or fail to provide survivors with the vital medical treatment they need (e.g. post exposure preventative, PEP, kits). In addition, certain categories of women and girls (e.g. sex workers, adolescents, women living with HIV, women with disabilities) may encounter stigma, discrimination, victim-blaming and violence causing them further harm. It is thus important for health programmes to integrate an approach to violence against women and girls to ensure that they “do no harm” as well as, where possible, contributing to preventing gender-based violence.

Social and gender norms form a major barrier to women’s access to contraceptives (especially for unmarried women) and health practices (e.g. immediate breastfeeding after delivery). Health provider personal beliefs may result in stigmatization of women seeking contraceptives, particularly adolescent girls or those who are unmarried. Further, a woman’s ability to control her fertility and use a method of contraception is likely to be affected by her sense of empowerment and her own belief in her ability to control her sexual life and fertility. In Myanmar, women’s use of contraception is related to the two empowerment indicators. For example, 53% of women who participate in the three specified decisions use contraceptives, as compared with 45% of women who do not participate in any of the three decisions. Similarly, contraceptive use among women who do not agree with any reason for wife beating, at 52%, is much higher than contraceptive use among women who agree with all five reasons for wife beating, at 38%. Overall, 51% of women and 49% of men agree that wife beating is justified for at least one of the five reasons. Agreement with wife beating varies greatly by state and region, ranging from 33% in Tanintharyi Region to 70% in Mandalay Region among women and from 14% in Kayah State to 69% in Rakhine State among men.  

A more conducive environment with supportive policies and regulations is needed. The Fund will include approaches to promote more inclusive practices also for people with disabilities, ensuring that they are enabled to equally access services offered to other beneficiaries and that they are viewed as active partners (e.g. as health volunteers and represented in health committees) in the process of enabling inclusion. Furthermore, cooperation between the MOHS, NGOs, Civil Society Organizations, and Ethnic Health Organizations must be strengthened, for better coordination in conflict-affected areas.

The Fund will implement an organizational capacity assessment of these organizations to assess organizational policies, staff attitudes and skills, and health infrastructure/ supplies to adequately identify and address physical, mental, emotional, and social health and support needs of gender based violence survivors, with a particular focus in conflict-affected areas. This will include identification of harmful service provider attitudes or stigmatization of victims of GBV, including intimate partner violence. The Fund will address identified gaps and challenges of providing quality care and services for victims of gender-based violence within delivery of essential health services to improve maternal, infant, and child health outcomes.

Access will aim to contract one Implementing Partner for the delivery of essential health services in each selected State, and maximize geographic coverage and populations reached. As noted, the Fund will also aim at integrating activities, aiming to deliver more of the Essential Package of Health Services with each dollar invested. Integration will be an important part of the Fund’s value for

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42 Myanmar Demographic and Health Survey, 2015-2016
43 In hard-to-reach areas, auxiliary midwives are the main basic health providers, but they are legally not allowed to provide injections or distribute misoprostol for self-administration by women after delivery to prevent post-partum haemorrhage. Midwives, who are often the only staff in rural health centres, cannot at present perform 7 signal functions required for BEmONC. As per the penal code, women who resort to illegal abortions risk a jail sentence.
money proposition. The selection of the best-placed Implementing Partner in each State – based on historical understanding of partners and considerations of performance, value-for-money, and expertise – aims at furthering integration and cost-effectiveness.

Financial support to Township Health Departments will follow the same integrated approach, focusing on the optimal delivery of Essential Package of Health Services by the Basic Health Staff and Implementing Partners. In the area of maternal newborn and child health, this could include (i) outreach support to midwives, (ii) planning at Township Health Department level and below, and (iii) emergency referrals, with government funding gradually taking over (as per ‘sustainability model’ currently under discussion with the MOHS). While the 3MDG Fund was delivering financial support though Implementing Partners (primarily, international NGOs), Access will explore the best and most economical way to provide this funding on a geography-by-geography basis.44

### 1.5.2 Nutrition

**Evidence**

Despite improvements in the nutrition status of women and children in Myanmar, chronic and acute malnutrition remains a critical issue, with significant variations among Townships. According to the Myanmar Demographic and Health Survey, stunting is around 29% and wasting at 7% for children less than five years of age. Micronutrient deficiencies remain a pressing public health issue: 57.4% of under-five children and 46.6% of women of reproductive age are anaemic.45 The main reasons for undernutrition include insufficient food intake (only 16% of children aged 6 to 23 months receive a minimum acceptable diet); limited access to health services; food insecurity and inadequate hygiene and sanitation. Exclusive breastfeeding was practiced by only 51% of mothers in 2015-16.46

**The case for investing in nutrition**

The need for investment in maternal and child nutrition is supported by overwhelming evidence:

(i) Recognition of stunting’s critical link to child development, and the importance of investing in stunting reduction, noting that despite a decline in stunting from around 50% in 1990 to 29.2% in 2016, 1.4 million children under five years of age have been identified as stunted.47

(ii) A greater understanding of the consequences of child undernutrition, especially between inception and a child’s second birthday (the first 1,000 days).

(iii) More sophisticated estimates of the costs and benefits of addressing undernutrition and micronutrient deficiencies at scale during the first 1,000 days.48

(iv) The return-on-investment for malnutrition interventions could be as high as US$ 35 for every dollar invested.49

The issue is now gaining high-level political commitment, with a nutrition-sector Coordination Group recently established under the Development Assistance Coordination Unit (DACU) – and a Multi-Sectoral National Plan of Action for Nutrition (MS-NPAN) under development.

**Proposed approach**

In Access, all Essential Health Service grants will include the nutrition activities set forth in the essential package. Access will continue to partner with LIFT and the Humanitarian Assistance and

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44 At this point in time, the Fund will exclude the option of financing through “on-budget support” to the MOHS or other government bodies.
45 Myanmar Demographic and Health Survey, 2015-2016
46 Ibid
48 UNICEF’s approach to scaling up nutrition for mothers and their children, 2015
Resilience and Programme Facility (HARP Facility) to coordinate nutrition support nationally with the MOHS, including through support to the National Nutrition Centre.

In collaboration with the National Nutrition Centre and other divisions of the MOHS, Access will support the nutrition interventions included in the Essential Package of Health Services: promotion of early and exclusive breastfeeding; educating families about the importance of dietary diversity and complementary feeding; providing iron-folate and other micronutrient supplements for women during pregnancy and children under two years of age; and strengthening prevention and treatment of severe acute malnutrition at facility-level and within the community. The Fund will support Basic Health Staff and Village Based Health Workers, who play a critical role in these interventions. As children with disability may require additional nutrition interventions and may be at increased risk of stigmatization and/or violence within their households, issues of disability will be considered in the Fund’s nutrition services so that malnutrition and disability can be addressed holistically. The Fund will seek other opportunities to fill gaps in the area of nutrition – including through stronger support to nutrition-related Behaviour Change Communication. Recognizing men play a role in decisions made about how family’s income is used, when and how to seek health services, and about women’s mobility in Myanmar, incorporating men into behaviour change communication activities will be essential to success of these interventions.

1.5.3 Sexual and Reproductive Health and Rights

**Evidence and Situation**

Surveys and research into HIV and other sexually transmitted infections among vulnerable populations – adolescents and young people, migrant workers, female sex workers, men who have sex with men, and people who inject drugs and their sexual partners – have revealed important gaps in these populations’ ability to access appropriate services and commodities, sometimes because of discrimination. Most of the unmet need for sexual, reproductive, maternal, newborn and adolescent health services is for pre-pregnancy sexual and reproductive health services such as family planning or screening and management of HIV and other sexually transmitted infections.

Women’s health interventions in Myanmar are overwhelmingly focused on maternal and reproductive health, with little attention to women’s and girls’ sexual health issues beyond maternity and child bearing years. Little attention is paid to emotional health and violence-related health concerns. Sexual and Reproductive Health and Rights (SRHR) services have been reported to

50 This should include appropriate and safe screening for violence/ neglect with support systems in place for families and individuals at risk of violence, neglect, or harm due to disability status.


52 Correlates of HIV Testing Experience among Migrant Workers from Myanmar Residing in Thailand: A Secondary Data Analysis https://doi.org/10.1371/journal.pone.0154669


be insufficiently sensitive to the needs of adolescents, and youth\textsuperscript{57} often fall outside of available interventions.

Gender-based violence impacts on health, emotional and psychological status, communities, and the economy. Sexual violence increases women’s morbidity and mortality, unwanted pregnancy and unsafe abortion, sexually transmitted infections and HIV, psychological trauma, and social stigma and exclusion. Women globally are 55% more likely to be HIV-positive if they have experienced intimate partner violence.\textsuperscript{58} This negatively impacts families, children of gender-based violence survivors/ victims, communities, and nations, both socially and economically. It is estimated that gender-based violence costs the equivalent of 2% global gross domestic product (GDP), or US$1.5 trillion, accounting for direct health and psychosocial services, legal costs, and child welfare services; and indirect cost of lost wages, productivity, and potential.\textsuperscript{59} In Myanmar:\textsuperscript{60}

- Fifteen percent of women have experienced physical violence since age 15, and 3% have ever experienced sexual violence.
- Tanintharyi Region and Rakhine State have the highest percentages of women who have ever experienced physical violence (30% and 27%, respectively). Rakhine State also has the highest percentage of ever-pregnant women who have experienced violence during pregnancy (8%).
- The percentage of women who have ever experienced sexual violence ranges from a high of 10% in Kayah State and 9% in Rakhine State to a low of 1% each in Yangon Region and Mandalay Region.
- Twenty-one percent of women have experienced spousal violence. Spousal violence is most prevalent in Rakhine State (41%) and Tanintharyi Region (40%).
- Among all women age 15-49 who had experienced physical violence since age 15, more than half (55%) reported their current husband and 19% reported a former husband as the perpetrator.
- Only 22% of women who have experienced physical or sexual violence committed by anyone have sought help to stop the violence, and 37% have never told anyone about the violence. Only 9% of women in Rakhine State are who experienced violence report it (9%). Among women who have experienced physical or sexual violence and sought help, the most common source for help was their own family (53%). The second most common source was neighbors (27%). Only 1% of women sought help from the police. This indicates a significant gap in both the judicial and healthcare system to respond appropriately to gender-based violence survivors’ physical and mental health needs.

Early child marriage is a recognized form of gender-based violence; the practice of child marriage is highest within poorer, rural communities and among out-of-school youth without job opportunity.\textsuperscript{61} Girls who marry before they turn 18 are more likely to experience domestic violence and exploitation.\textsuperscript{62} Child marriage is still quite common among Myanmar women, where 19% of women age 20-49 were married before age 18 and 12.6% of girls currently age 15-19 are married.\textsuperscript{63}

Adolescent fertility rate is high, with an average of 33 births per 1,000 women aged 15-19\textsuperscript{64} (59 in Shan).\textsuperscript{65} Childbearing between 15-19 years presents a higher risk to health and survival than

\textsuperscript{57} A National Youth Policy – which includes attention to sexuality – was drafted by the Union Parliament and launched in January 2017 by the Ministry of Social Welfare, Relief and Resettlement (the policy defines “youth” as people aged 15-35 years of age).


http://reliefweb.int/sites/reliefweb.int/files/resources/Counting_the_costofViolence.pdf

Myanmar Demographic and Health Survey, 2015-2016

https://www.equalitynow.org/sites/default/files/Protecting_the_Girl_Child.pdf

https://www.unicef.org/protection/57929_58008.html

Myanmar Demographic and Health Survey, 2015-2016

between 20-24 for both the mother and the child. It also has social and economic implications, reducing the education, future earning capacity and empowerment of women.

While it is still impossible to accurately quantify, the MOHS’ Reproductive Health Strategy notes that unsafe abortions are responsible for 10% of maternal mortality. Unmarried women experience difficulties in accessing contraceptives and have more limited knowledge of the risks associated with sexually-transmitted infections (STIs). The national modern Contraceptive Prevalence Rate (mCPR) is 31.1% for all women. It is 51%, among married women, ranging from 25% in Chin to 60% in Bago and Yangon regions. (NB: The figure was reported as “51% among sexually active women” – but that is probably because 99.7% of unmarried women reported they were not sexually active). Thus while the absolute rate is low, among women who may actually need contraception (those who are sexually active) it is relatively high. Myanmar is around the middle of the table when compared to regional neighbours, with India, Bangladesh and Indonesia higher – while Pakistan, Laos and the Philippines are lower. The situation, however, is dynamic: as economic development, rapid urbanisation, and a modernisation of lifestyles increase, the number of unmarried women who are sexually active is likely to grow, and so will demand for contraception. As part of its commitment to FP2020, the country’s 2020 target for modern Contraceptive Prevalence Rate has been set at 60%. Growth in mCPR is more difficult as a country moves closer to full prevalence because the last populations who need to be reached are often the most marginalized ones. This challenge aligns well with Access’ focus on equity and reaching the unreached.

The case for investing in Sexual Reproductive Health and Rights
The MOHS included adolescent health in its reproductive health strategy for 2014-2018. Due to capacity constraints, reluctance to provide SRHR services and commodities to unmarried young people, and the lack of training in SRHR by health professionals, the implementation of adolescent sexual health interventions remains a challenge for the Ministry. Further consultations and research could help assess where support to services may be most useful; people may indeed prefer to access Sexual and Reproductive Health services through the private sector because of confidentiality and trust issues.

Sexual and reproductive health rights – including access to sexual and reproductive health care and information, as well as autonomy in sexual and reproductive decision-making – are universal human rights that apply to both men and women. There is a clear connection between sexual and reproductive health, human rights and sustainable development. When sexual and reproductive health needs are not met, individuals are deprived of the right to make crucial choices about their own bodies and futures, with a cascading impact on their families’ welfare and future generations. And because women bear children, and also often bear the responsibility for nurturing them, sexual and reproductive health and rights issues cannot be separated from gender equality. Cumulatively, the denial of these rights exacerbates poverty and gender inequality.

The right to exercise control over one’s own sexuality and reproduction is fundamental for all people. Sexual and reproductive health and associated rights extend to the equal opportunities,

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66 The draft Reproductive Health Strategy is currently under finalization by the MOHS with support from PATH, UNFPA and others
68 Myanmar Demographic and Health Survey, 2015-2016
69 Myanmar Demographic and Health Survey, 2015-2016.
70 The Union Government of Myanmar, 2014, Costed implementation plan to meet FP2020 commitments Myanmar 2014, MOHS, Myanmar
rights and conditions of all people to have a safe and satisfying sexual life and to be able to decide over their own bodies without coercion, violence or discrimination.  

Improving sexual and reproductive health is a key effort towards achieving Sustainable Development Goal 3, which calls for good health and well-being. It also advances Goal 5, which calls for gender equality, as well as many of the other goals included in the 2030 Agenda. Sexual and reproductive health is a lifetime concern for both women and men, and rights include access to comprehensive sexuality education and information, family planning, antenatal and safe delivery care, post-natal care, prevention and treatment of sexually transmitted infections (including HIV), and facilitating early diagnosis and treatment of reproductive health illnesses (including breast and cervical cancer). 

Proposed approach
Review and revision of the existing Reproductive Health policy, coordinated by the MOHS, has been in process from 2017. It includes Technical Advisory Group meetings on adolescents’ SRH needs, including rights. Participation includes the Ministries of Education, Social Welfare, Relief and Resettlement, UN agencies and NGOs. There is a recognition and understanding that SRH rights must be included at the policy-level to serve as guiding principles for service delivery. Since early 2018, the 3MDG Fund has been in discussion with the MOHS about supporting this process in the future (development and review of the SRHR policy and strategic framework, and preparation of costed annual operational plans).

Development and application of a more comprehensive national strategic framework for reproductive health (and costed national operational plans), which includes SRHR, will enable expansion of the Fund’s support in this area.

The Fund will endeavour to help map SRHR needs and respond through scale-up of SRHR activities included in the Essential Package of Health Services, and through advocacy to ensure that other essential interventions are also included. In practical terms, it is likely that less sensitive reproductive health services will be included in the Essential Package of Health Services while more sensitive ones, especially those targeting adolescents and unmarried young people, will be delivered through a public-private partnership. The Fund’s SRHR priorities include the following:

- Improved access for young people to sexual and reproductive health information, knowledge and services (including information about the opposite gender, to reduce stigma and discrimination);
- Promotion of young people’s knowledge and skills on SRHR, including comprehensive sexuality education and capacity building on life-skills and gender-based violence;
- Promotion of access to youth-friendly SRH services through training of general practitioners;
- Support for implementation of post-miscarriage care guidelines and standard operating procedures at public sector hospitals; and
- Advocacy to MOHS to include into the EPHS cryotherapy treatment services for cervical cancer, by showing that a ‘one-stop shop’ approach through private sector providers will increase the early detection and treatment of cervical cancer. Cervical cancer screening and

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73 UNFPA website
74 This support to the MOHS can include strengthening the national health policies to better address and integrate issues of gender-based and intimate-partner violence related to SRHH and other health outcomes; and improving response from health care providers to adequately respond and care for victims of gender-based and intimate partner violence.
75 Capacity building on gender-based violence can include enhanced awareness on gender norms, masculinity redefined, for both adolescent girls and boys, and staff capacity building to address cases of gender-based violence in a knowledgeable and respectful way.
referral is part of the Essential Package of Health Services interventions, yet the clinical package under this medical service is currently in development stage.

The Fund will seek to encourage some of its partners through a future Request for Proposals to create a consortium of organizations able to provide (i) clinical SRHR services supported by (ii) trained outreach delivery of appropriate information and community education, (iii) delivery of SRH commodities, and (iv) referral to clinics.

**SRHR and Harm Reduction:** The Maternal and Reproductive Health Division of the MOHS recommends linking SRHR activities to HIV-related activities for Key Affected Populations, and building on the achievements of service-delivery to these populations. The overlap between the most vulnerable and at risk populations for HIV (and other Sexually Transmitted Infections, TB, and Hepatitis C) and those most in need of access to SRHR services is significant, including female sex workers, men who have sex with men, and men and women who use/inject drugs, their intimate partners and children, and their broader communities.

### 1.5.4 Tuberculosis

**Evidence and situation**

Tuberculosis (TB) is a major public health problem in Myanmar and a leading killer of people aged between 15 and 49. With one out of every six cases of TB in the country, Yangon Region is severely affected by the disease.\(^76\) Worse, more than 53 percent of the drug-resistant cases are recorded in the region,\(^77\) though Yangon has approximately 14 percent of the country’s population.\(^78\) Drug-resistant TB (known as MDR-TB) does not respond to first-line drugs normally used to treat tuberculosis. It is dangerous, infectious and deadly.

With 191,000 estimated new and relapse TB cases a year and close to 30,000 TB deaths with or without HIV, Myanmar is one of 30 Global TB high burden countries. In addition, with more than 10,000 HIV positive and more than 3,000 MDR-TB among 140,000 notified cases in recent years, Myanmar also has high TB/HIV co-infection and MDR-TB burdens.

The Fund will advocate for the nationwide adoption of electronic cash-support to MDR-TB patients through the banking system, an initiative started by the 3MDG Fund (in partnership with the National TB Program and a private bank) to support the reduction in catastrophic patient-costs. This program, implemented by trained community outreach providers/volunteers, is contributing to a significant improvement in treatment adherence and successful treatment outcomes in the Yangon Region. Patients appreciate both the psychological and financial support they receive during their 20-month treatment course.

Although Myanmar has been showing steady progress – consistent with the objectives of the National Strategic Plan for TB 2016-2020 – the TB burden remains high. Ongoing TB surveys have identified hot-spots, including communities with extremely high TB burden, with bacteriological positive TB prevalence of more than 2%. Migrants living in congested urban areas including Yangon potentially have higher TB risk, and those migrating for work or being displaced by conflict present a risk of discontinued or interrupted treatment – which would have severe consequences with a chronic diseases such as tuberculosis.

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\(^76\) 2016 National TB Programme annual data.
\(^77\) 2016 National TB Programme annual data.
\(^78\) Myanmar Population and Housing Census, 2014 [https://drive.google.com/file/d/0B067GBlstE5TeULIVi5DsVzWlk/view](https://drive.google.com/file/d/0B067GBlstE5TeULIVi5DsVzWlk/view)
Remote areas with poorer access to regular service also show higher TB prevalence. Irregular treatment of tuberculosis increases the risk of MDR-TB. Bolder approaches to high-risk populations are essential to control TB. Migrants and people affected by conflict are recognized as one of the high risk and hard to reach populations in the NSP 2016-2020. The National Strategic Plan calls for a proactive approach to identifying and serving migrants and conflict-affected populations in collaboration with partners.

Key funding and technical partners including the Global Fund, 3MDG, USAID, MSF, JICA, FIND, and the UNION have been continuously supporting the National TB Programme and its partners.

Proposed approach
In addition to the integrated programs, Access will support the following TB activities:

1. TB Active Case Finding – prioritising conflict-affected and underserved populations that are complementary to Global Fund-supported activities.
2. National TB Program – support nationwide coordination, planning, and service delivery, and continued TB Active Case Finding and MDR-TB case detection within integrated grants and closed settings (prisons and labour camps).
3. Continuing scale-up of MDR-TB treatment enrolment with a focus on patient support in Yangon.

There are gender differences evident in prevalence of tuberculosis and malaria and in access to diagnosis and treatment. Service provision should take into account these differences, for example providing more services via the workplace in areas where men are more severely affected (e.g. for TB, in crowded or dusty factories or mines, or for malaria, when workers stay overnight in the forest). Women are less likely to receive a chest x-ray to test for TB, leading to lower numbers of positive cases. Services were introduced at the maternal-health clinics to rectify the discrepancy. The Access will pay particular attention to gender-disaggregated indicators; responsiveness will be essential to ensuring all people are reached.

1.5.5 HIV prevention, the health consequences of drug use (Harm Reduction) and TB co-infection

Evidence
Myanmar is one of the 30 highest burden TB/HIV countries in the world. In 2015, approximately 60% of TB patients were tested for HIV, and 9% were HIV positive. Included as a “Fast Track” Priority country for targeted interventions by UNAIDS, Myanmar is one of the 35 countries that account for 90% of new HIV infections globally.

Gender inequalities exacerbate women’s and girl’s vulnerability to HIV and accessing HIV-related services. Inequalities, discrimination, and violence that increase risk to HIV are more acute for socially excluded women, including female sex workers, transgender women, women who inject drugs, migrant women, and women with disabilities. Intimate partner violence, inequitable laws and harmful traditional practices reinforce unequal power dynamics between men and women, limiting women’s choices, ability to negotiate for condom use, opportunities and access to

79 3MDG analysis, 2015  
81 TB National Strategic Plan (2016-2020)  
82 HIV National Strategic Plan (2016-2020)  
84 https://papersmart.unmeetings.org/ecosoc/csw/csw59/programme/2nd-meeting/
information, health and social services, education and employment.\(^{85}\) HIV also entrenches gender inequality, leaving women more vulnerable to its impact.

Preventing new HIV transmissions in high-risk groups remains a priority. Significant progress has been made in the fight against HIV, as reflected in the sharp decrease in new HIV transmissions from 35,000 in 2000, to 15,000 in 2010, and 11,000 in 2015. Yet, national-level HIV prevalence is still extremely high in high-risk groups:\(^{86}\) 28.5\% among people who inject drugs,\(^{87}\) 14.6\% among female sex workers, and 11.6\% among men who have sex with men (MSM) (2015).\(^{88}\)

Only 20\% of women and 22\% of men have comprehensive knowledge about the modes of HIV transmission and prevention. Only 8\% of women in Rakhine State and 10\% of women in Chin State have comprehensive knowledge. Men are more likely than women to know that HIV can be prevented by using condoms and limiting sexual intercourse to one uninfected partner; the difference is most prominent in the 20-24 age group (65\% and 52\%, respectively). Women living in Chin State have the least knowledge of the two prevention methods (27\%), followed by women in Shan State (30\%) and Rakhine State (32\%). Women and men living in rural areas (13\% and 16\%, respectively) are less likely than those living in urban areas (36\% and 38\%, respectively) to have comprehensive knowledge of HIV.\(^{89}\)

The HIV epidemic remains high among Key Affected Populations, largely due to a failure to tackle societal and other conditions and factors that increase HIV risk and vulnerability. Some of these factors have not been effectively addressed in Myanmar: criminalisation of risk behaviours for sex workers and people who use drugs; gender inequality and the lack of empowerment of women and girls; discrimination, stigma and social marginalization; and economic inequality. Conflict, displacement, food insecurity, and poverty can contribute to making affected populations more vulnerable to HIV transmission.\(^{90}\)

HIV prevention including Harm Reduction remains largely funded by external resources, leaving a significant funding gap between resource needs and anticipated resources.\(^{91}\) The Global Fund Investment Case 2017-2019 concludes that while Myanmar is on the right side of the tipping point to control HIV, TB and Malaria; renewed investments and effective implementation are needed to use investments more effectively.\(^{92}\) The 3MDG Fund has been providing around US$6 million in annual financing to HIV prevention – predominantly for Harm Reduction/SRHR for Key Affected Populations. Access will be well positioned to provide policy, service, and capacity building support in this area: supporting legal reform and decriminalisation; helping develop a legal framework to guarantee rights and access to services; strengthening health in prisons and prison/community treatment continuity; supporting decentralised State-level operational planning through NIMU and the National AIDS Program; and funding a ‘one-stop’ service-provision of Harm Reduction and SRHR.

The case for investing in HIV prevention and TB co-infection


\(^{86}\) National Department of Disease Control, 2016, National Strategic plan on HIV/AIDS-Myanmar 2016-2020, Department of Disease Control, Myanmar.

\(^{87}\) IBS, 2014

\(^{88}\) AEM model prevalence based on IBBS (PWID 2014, FSW & MSM 2015) and HSS 2014; Myanmar Spectrum, AEM 5.41 (2016)

\(^{89}\) Myanmar Demographic and Health Survey, 2015-2016.


\(^{91}\) Myanmar, HIV & TB Concept Note to the Global Fund, June 2016

\(^{92}\) Global Fund Investment Case; 5\(^{th}\) Replenishment 2017-2019
Access will emphasize the scaling up of SRHR activities targeting people who inject drugs, their intimate partners and children, and the broader population; there will therefore be few standalone Harm Reduction grants but rather integrated delivery of comprehensive programs (HIV, TB, malaria, and SRHR services) responding to the health consequences of drug use. Along with Shan State, a priority focus will be Kachin State, which is one of the few locations in Southeast Asia with a generalized HIV epidemic.

**Proposed approach**

The Fund’s approach is aligned to the *National Strategic Framework on Drug Use and Health Consequences in Myanmar*, which is currently under development (expected completion date: August 2018). The Framework recognizes the need to bring together elements of SRHR and Harm Reduction in order to address vulnerable populations.

Access will continue community-led outreach programs, community advocacy activities, and comprehensive programs for people who use drugs (integrating HIV, TB, malaria, and SRH services). With HIV prevalence higher in women who inject drugs than in men, the Fund will implement gender-sensitive\(^{93}\) Harm Reduction programmes in hard-to-reach and mining areas of Kachin. In close cooperation with township hospitals, projects can provide methadone substitution therapy, HIV and TB testing, commodities, and referral for testing and treatment for a range of sexual reproductive health concerns (HIV, Hepatitis B and C, and TB).

### 1.5.6 Health in prisons

#### Evidence

Prisons in Myanmar are severely overpopulated, understaffed, and under-resourced, with many prisons holding twice to three times the number of people they were designed to accommodate. There are currently over 60,000 men and women incarcerated in the country’s 45 prisons. As the prisons were originally built to house mostly men, the accommodation for women and their young children is extremely limited and overcrowded\(^{94}\). The overcrowding is largely the result of the criminalisation of certain behaviours (sex work, injecting drugs, etc.). Today, 48% of inmates are in prison serving mandatory long sentences for drug-related offences;\(^{95}\) infants and young children of female sex workers spend long periods in prison.

Prisons in Myanmar lack adequate health facilities to address basic health care and targeted HIV and TB care. Vulnerability to transmission of HIV, multi-drug resistant TB (MDR-TB), Hepatitis B and C, and other infections, is extremely high among both prisoners and prison staff, and in communities to which these individuals return.\(^{96}\)

#### The case for investing in health in prisons

People in prisons and labour camps are some of the most vulnerable and discriminated against people in Myanmar. Rather than supported with health services and commodities, which is advised globally, people with the health condition of drug dependence are criminalised.

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\(^{93}\) An example of gender-responsive programming in harm reduction is to support couples’ testing and disclosure in a manner that will minimize the risk of intimate partner violence during the process.


\(^{95}\) Myanmar National Drug Control Policy, Feb, 2018, Page 8

\(^{96}\) See 3MDG Annual Report 2016 for more information.
Access is uniquely positioned to support the Myanmar government to reach a critical point of policy changes in prison health; it will build on the 3MDG Fund’s support to a Project Board bringing together senior officials from the MOHS and the Ministry of Home Affairs (Prison Department) to coordinate priority actions on prison health. In recognition of this unique niche, the MOHS requested the Fund to continue the prison health work along two tracks: support to essential services for incarcerated people; and support in the development of national policies aligned to international best practices. Previous and ongoing actions have included renovation and construction of health facilities in prisons for TB/HIV treatment97 (including Insein for Lower Myanmar and Mandalay for Upper Myanmar); and development Standard Operating Procedures for the delivery of health services in prisons. The 3MDG has been coordinating closely with the Global Fund’s support to prison-based TB/HIV treatment.

Proposed approach
In collaboration with the Ministry of Home Affairs, MOHS, UNODC, UNAIDS, WHO, and the Global Fund, the Fund will aim to support the development of policies and National Strategic and Operational Plans that promote increased access to preventative education, services and commodities.

1.5.7 Malaria

Evidence
Myanmar is among countries in a malaria-elimination phase,98 with a major objective in the National Strategic Plan (2016-2020)99 to reduce the reported incidence to less than 1 case per 1,000 people in all states and regions by 2020. Reduction in 2015 compared to 2012 is visible in malaria cases (61%), malaria-related deaths (91%), and malaria incidence (49%).

The malaria volunteer workforce is the largest volunteer workforce in the country and the cornerstone for the introduction of the Essential Package of Health Services at village-level. Since 2017, the National Malaria Control Program (NMCP) has started using this workforce to provide a more integrated service-package by incorporating health literacy promotion and appropriate referral related to HIV, TB, Dengue, Filariasis and Leprosy in the activities of Integrated Community Malaria Volunteer (ICMV).

The case for investing in malaria
While the 3MDG Fund has been a major contributor to the reduction in the malaria burden in Myanmar and efforts to eliminate falciparum malaria – along with the Global Fund and President’s Malaria Initiative – it is important to continue controlling/eliminating ‘residual malaria transmission.’ The main challenge is in increasing accessibility to diagnosis and treatment, and improving case-detection by Rapid Diagnostic Test (RDT) and effective treatment by Artemisinin combination therapy (which remains more than 95% effective100).

97 From the NSP III (2016-2020), Strategic Direction 1 (Reducing new HIV infections): “90% of priority population including prisoners are to be reached by HIV prevention programs.”

98 World Malaria Report, WHO 2017 (Countries with elimination programs are Bangladesh, Bhutan, Democratic People’s Republic of Korea, India, Indonesia, Myanmar, Nepal and Thailand); see also National Malaria Elimination Plan (2016-2030).

99 Malaria National Strategic Plan, Myanmar (2016-2020)

100 Following deterioration in the efficacy of ACTs in neighbouring countries, the likely emergence of multi-ACT resistance in Myanmar calls for urgent and aggressive measures. Therefore, it warrants the country to be on the path to eliminate *Plasmodium falciparum* malaria by 2025 (Malaria National Strategic Plan, Myanmar, 2016-2020)
This is especially needed among the wide variety of key at-risk populations who, alongside disproportionately low access to prevention and treatment services, are also most at risk of malaria in endemic areas of Myanmar.\footnote{Malaria National Strategic Plan 2016-2020} Malaria during pregnancy deserves special attention.

**Proposed approach**

Access will, resources permitting, continue to provide testing and treatment services to hard-to-reach groups, internally displaced persons in Rakhine and Kachin, migrant workers, and incarcerated populations. The Fund could also continue support important activities not funded by other donors such as replacement of artemisinin monotherapy with quality-assured artemisinin combination therapy through private sector distribution channels.

**1.5.8 Infrastructure**

The Fund will continue supporting the Sittwe General Hospital’s improvement, in accordance with the June 2018 Masterplan and with the overarching aim to promote an inclusive and non-discriminatory approach to service delivery at the hospital.

The Fund will also set aside US$ 2 million for other construction work in areas where a lack of infrastructure is a key obstacle to access to essential health services.

**1.5.9 Health System Strengthening**

**Evidence**

The main goal of the National Health Plan (2017-2021) is to extend access to a Basic Essential Package of Health Services (Basic EPHS)\footnote{A common misconception is that those services not included in the EPHS will not be provided. It only means that those services cannot be guaranteed by MOHS to be provided at that health facility or community. The EPHS is meant to be updated continuously based on various criteria such as burden of disease, cost-effectiveness, affordability and societal values. In addition, services in the Basic EPHS are currently being provided by health facilities nationwide. But the number of services and quality of services are not standardize across State/Regions and Township due to varying service readiness and availability.} by 2020/21. Subsequent National Health Plans will focus on expanding the package from Basic to Intermediate (2025) and Comprehensive (2030).

Through strategic purchasing, risk-pooling mechanisms will guarantee greater financial protection. Simultaneously, the Plan focuses on primary health care delivered at Township level and below, ensuring that these levels are able and resourced to provide the Basic Essential Package of Health Services. This is an important switch to bottom-up, needs-based planning and budgeting.

The evidence-base that supports the Fund's Health Systems Strengthening interventions is the same evidence that supports the National Health Plan and its Annual Operational Plans. The bottlenecks identified by the National Health Plan (2017-2021) and lessons from the 3MDG Fund’s programmatic experience are presented below:

**Human Resources for Health**

The Health Workforce Strategic Plan (2012-2017) outlines human resource challenges including shortages in human resources, inappropriate balance and mix of skills, inequitable distribution, and difficulties in rural retention. More generally, the system suffers from the absence of locally based health workers, integrated in the MOHS, readily available to address common health
problems at community-level.

As of November 2016, there were 1.33 health workers (doctors, nurses and midwives) per 1,000 people, well below the WHO minimum recommended threshold of 2.3; health workers largely concentrated in urban areas; and lack of clear evidence-based recruitment and deployment policies further complicate matters. Additionally, there is limited clarity around roles and responsibilities of the different health cadres at all levels of the system.\(^{103}\)

**Service Delivery**

The current public sector health-service provision focuses on tertiary care, which means that station hospitals and lower-level facilities have received less attention over the past few decades. This underinvestment has led to various shortcomings in service availability, readiness and coverage, especially for people in conflict-affected areas. Government oversight over other service providers (private for-profit providers, NGOs and Ethnic Health Organizations) is limited; and the organization of service delivery needs to be strengthened, with a clear understanding of *the best provider and delivery-platform* for each service.

**Medicines, vaccines, technology**

Existing procurement and supply chain arrangements are fragmented along vertical programs and funding sources, which complicates coordination and creates inefficiencies. Ensuring the availability of quality essential medicines and health commodities at the primary health care level for all persons is a critical component of strengthening the health system and achieving Universal Health Coverage.\(^{104}\)

**Health Financing**

Sustaining progress towards Universal Health Coverage requires ensuring access to quality health services with financial protection – which in turn requires that the Myanmar health-financing system generates sufficient resources. While resources are crucial, they are not sufficient: funds must also be used equitably and efficiently – which means that government funding for health must be directed to priority populations and services, be used efficiently, and achieve outcomes. The National Health Plan takes a path that is explicitly pro-poor.

The public financial management system (the institutions, policies, processes that govern the use of public funds) plays a key role, and needs to be aligned with mechanisms that determine how budgets are formulated, allocated and executed with overall health system objectives.

Currently in Myanmar, out-of-pocket expenditure remains the largest source of financing for health expenditures. The direct and indirect costs of obtaining services exclude persons who because of their income status, cannot access health services, and excessive reliance on out-of-pocket spending pushes people (further) into poverty. The 2015 Myanmar Poverty and Living Conditions Survey (MPLCS) showed that only 48% of individuals seek formal care, and much less among poorer households. Among the 21% of individuals who did nothing or self-medicated in response to sickness, 17.5% cited their inability to afford the treatment (or transport costs) as the main reason for not seeking treatment. The MPLCS found that often, low-income households are unable to finance the health care expenditures they need, and hence do not pursue any medical care. A study funded by 3MDG Fund in 2017 showed that in most cases, care is sought locally first (within the village or ward) with the poorest households often seeking care only locally or not at all.

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\(^{103}\) Ministry of Health and Sports, 2016, Myanmar National Health Plan 2017-2021

\(^{104}\) Ministry of Health and Sports, 2016, Myanmar National Health Plan 2017-2021
Myanmar currently allocates 3.65% percent of its total budget to health, which is low by global and regional standards. Funding from other sources, including from development partners, is largely channelled through parallel systems. This situation makes oversight and coordination challenging, results in inefficiencies, and does not contribute to building the government’s institutional capacity. There is a need for coordinated approaches on planning that includes funding and priority-setting especially at the service delivery level.

**Health Information**

Recent efforts to roll out DHIS2 (District Health Information System) are critical to ensuring the availability and usage of accurate and timely data and information. Particularly, data on population sub-groups – namely women, persons with disabilities and marginalised groups - costs, service coverage, and system-performance need to be improved. Challenges include fragmented processes (both manual and automated) within and across Ministry of Health Departments and partners; separate workflows; and limited integration and interoperability with other systems (e.g. Logistics Management Information Systems, Human Resources Information Systems, etc.). A Health Information System Strategic Plan (2017-2021) has been endorsed by the MOHS and published in 2017. A draft Health Information Policy and draft e-Health Architecture Blueprint are yet to be finalized, which would provide more insights on support needed.

**Governance**

The implementation and monitoring of the National Health Plan will be fundamental steps towards Universal Health Coverage. Currently, each MOHS department contributes to the realization of Universal Health Coverage by working on its own objectives, mandates, and strategies. Although coordination and direction are provided at Ministry-level, the ways activities are carried out by individual departments are more often vertical in nature. A mechanism at Ministry-level providing a common strategic framework is needed to ensure more cohesive work.

The National Health Plan Implementation Monitoring Unit (NIMU) was established to build consensus among various stakeholders on National Health Plan goals and strategies, to facilitate engagement, and to coordinate implementation efforts. Its role is also to support the adoption of evidence-based policies which follow a clear policy cycle.

**The case for investing in Health Systems Strengthening**

The Universal Health Coverage movement in Myanmar has been gaining momentum over the past few years, with strong political support. Universal Health Coverage goals form an integral part of Myanmar’s road to sustainable growth and poverty reduction.

Investments in the health sector to support Universal Health Coverage will boost economic growth in line with Sustainable Development Goal 8 (decent work and economic growth). The WHO report from the High-level Commission on Health Employment and Economic Growth states that the contribution to economic growth can happen through six inter-related pathways:

1. Investment in health which contributes to an increase in life expectancy and healthier workers, contributing to increases in economic productivity.

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107 The Lancet Commission on Investing in Health reported that around one quarter of economic growth between 2000 and 2011 in low- and middle-income countries resulted from the value added by improvements in the health of the
2. Promoting economic output by expanding health care related jobs, infrastructures, and supplies.
3. Enhancing social protection, including through financial protection against loss of income, out-of-pocket payments and catastrophic health expenditures.
4. Enhancing social cohesion. Equal societies are more economically productive societies.
5. Promoting innovation and diversification: scientific and social innovations in the health sector are likely to further support economic growth in the future.
6. Protecting and promoting human security through the detection, prevention and control of infectious disease outbreaks.

Support to governance and policy development: In order to promote evidence-informed decisions, make a sustainable and long-term contribution to the Myanmar health system, and be able to influence other Donors to join the Fund’s equity-focused priorities, Access needs to provide dedicated support to the policy-making process across multiple Ministries and Departments. Such support would span problem identification, stakeholder engagement, policy options, policy analyses, and bridging the gap between evidence and policy-makers.

To take this forward in an organized way, Access will explore supporting a “think tank” on Health Policy and Systems Research, dedicated to strengthening and sustaining institutional capacities to generate evidence and inform policies. The role could be played by the National Health Plan Implementation Monitoring Unit, in collaboration with Policy Institutes such as the Myanmar Development Institute.

Proposed overall approach
To ensure sustainability of health programs in MNCH, SRHR, nutrition, HIV, TB, Malaria, the Fund will invest in Health Systems Strengthening.

The Fund’s overarching vision is to improve access to high-quality services that reach underserved and vulnerable population groups with improved financial protection. In order to achieve this vision, the Fund will focus on four strategic outcomes:

i. Increased financial protection;
ii. Increased EPHS service utilization;
iii. Improved service provision and service quality; and
iv. Equitable access, with low-income, underserved, marginalized and vulnerable people having the same access to essential health services.

To achieve the overarching goal and the four strategic outcomes, the Fund’s HSS activities will be aligned with the National Health Plan framework and successive Annual Operational Plans, as well as with the six core health systems strengthening functions mentioned. This will be done through both discrete projects and through health-strengthening actions under service-delivery grants. Interlinkages and interactions between these functions are critical, as health-system bottlenecks often involve several of these functions – and an appropriate response needs to touch on multiple functions at once.

A critical feature of the Fund will be its flexibility, which should allow it to identify and seize opportunities as they arise during its five-year lifespan – especially as the National Health Plan and population. The estimated return on investment in health from improved economic growth was nine to one. [Jamison DT, Summers LH, Alleyne G, Arrow KJ, Berkley S, Binagwaho A, et al. Global health 2035: a world converging within a generation. Lancet. 2013 Dec 7;382(9908):1898955. http://dx.doi.org/10.1016/S0140-6736(13)62105-4 pmid: 24309475]

108 Adapted from USAID’s Vision for Health Systems Strengthening 2015-2019

109 Human Resources for Health, health finance, governance, health information, medicines, and vaccines and technologies
its Operational Plans evolve. While this Program Description goes into details of interventions (to create a shared understanding of what the Fund could deliver over its five-year lifetime), the following principles and criteria determine which cross-cutting HSS activities the Fund supports:

1. Interventions have cross-cutting benefits beyond a single service delivery intervention.
2. Interventions address identified policy and organizational constraints, and the health system rather than simply support it. (For example, buying generators for health facilities supports the health system, whereas creating a mechanism to conduct regular surveys of facility equipment, together with revised budgeting procedures that include funding for equipment maintenance and replacements, is a health systems strengthening activity).
3. The intervention will provide long-term systemic impact beyond the life of the activity.
4. The interventions are tailored to country-specific constraints and opportunities, with a clear defined role for country institutions.\textsuperscript{110}

With the above caveat, the following is an illustrative list of potential activities per health system function:

<table>
<thead>
<tr>
<th>Health system function</th>
<th>Key objectives in 2019-2023</th>
</tr>
</thead>
</table>
| Human Resources for Health (HRH)    | - Support MOHS to improve health workforce forecasting and to ensure appropriate deployment (an evidence based deployment policy)  
- Support MOHS to increase ‘sanctioned posts’ as required, by working with other institutions such as the Civil Service Board and Ministry of Planning and Finance  
- Develop and implement a rural retention policy  
- Institutionalization and strengthening of Village-Based Health Workforce  
- Advocate for qualified and dedicated financial management and procurement and supply management at all levels |
| Service Delivery                     | - Support the introduction of national planning and budgeting tools and guidelines at State/Region and Township levels, focused on the delivery of the Essential Package of Health Services  
- Support improved capacity of the National Nutrition Center and National TB Program  
- Improve delivery of health services through application of Standard Operating Procedures across the prison system, training for prison health staff, and increased numbers of prison health staff  
- (as above) Institutionalization and strengthening of Village-Based Health Workforce  
- Improve health staff capacity and tools to respectfully and adequately address physical, mental, emotional health of those impacted by gender-based violence, especially intimate partner violence, throughout health service delivery streams |
| Medicines, vaccines, technologies    | - In collaboration with USAID and Procurement and Supply Management (PSM), and provided the Fund Board so decides, Access could provide support to the development and implementation of standardized Logistics Management Information System |
| Health Finance                       | - Support to NIMU to develop the health financing strategy and the financial health protection law, with Technical Assistance from the World Bank and WHO  
- If the Board so decides, continued support to the MOHS on Public Financial Management – building capacity for budget formulation, execution, monitoring, and reporting; and decentralisation of budget to States and Regions. |

\textsuperscript{110} Why differentiating between health system support and health system strengthening is needed. The International Journal of Health Planning and Management, 2013
The fund will support services that improve collection of accurate and timely data and information, and increase data utilization at State and Township levels. (The e-Health Architecture Blueprint process, which coordinates different e-Health initiatives, will be funded by the Global Fund Principal Recipient).

- Continued support through NIMU to improve planning and budgeting at Central, State/Region, and Township levels
- Continued support to Universal Health Coverage and NHP communication strategy
- Create an enabling environment for Universal Health Coverage
- Promote evidence-based policy-making

Other areas of health systems strengthening work include:

Conflict Sensitivity: The Fund will maintain the collaboration initiated by the 3MDG Fund with CDA\(^{111}\) (or a similar organization) to support conflict sensitivity mainstreaming within the Fund’s own staff, Implementing Partners, and national institutions.

Gender Equality: An important part of the Fund’s proposed approach is in ensuring system-strengthening identifies and addresses gender inequalities.\(^ {112}\) This can take three forms: regulatory, organizational, and informational. The **regulatory approach** requires laws/policies that support gender equality and focus on participation of all genders in the public sphere (anti-discrimination legislation, human rights protection, early child marriage prevention, gender-based violence prevention and response, etc.). The **organizational approach** focuses on aspects such as gender mainstreaming, gender-equality outcomes including women’s empowerment and adequate prevention and response to GBV that impacts health outcomes, and gender budgeting (i.e. making explicit the gender impact of budgetary decisions).\(^ {113}\) An **informational approach** prioritizes collecting gender-sensitive indicators to identify key differences between women’s and men’s access to health, linkages of gender equality, women’s empowerment, and GBV to women’s and children’s health outcomes, and supports related policy changes. Throughout its Health Systems Strengthening work, Access will strive to support all three approaches.

Support to Policy development: In order to promote evidence-informed decisions, make a sustainable and long-term contribution to the Myanmar health system, and be able to influence other Donors to join the Fund’s equity-focused priorities, Access needs to provide dedicated support to the policy-making process across multiple Ministries and Departments. Such support would span problem identification, stakeholder engagement, policy options, policy analyses, and bridging the gap between evidence and policy-makers.

To take this forward in an organized way, Access will explore supporting a “think tank” on Health Policy and Systems Research, dedicated to strengthening and sustaining institutional capacities to generate evidence and inform policies. The role could be played by the National Health Plan Implementation Monitoring Unit, in collaboration with Policy Institutes such as the Myanmar Development Institute.

**Linkages between service delivery interventions and health system strengthening efforts**

\(^{111}\) [http://cdacollaborative.org/](http://cdacollaborative.org/)


There are various ways to frame the linkage between health system strengthening and service delivery. WHO regards service delivery as one of the key health system building blocks – at the risk of viewing these blocks in silos and not fully capturing their linkages and interactions. Others argue that service delivery is an output of all inputs into the health system (health workforce, medicines and equipment, health information, and financing).

The following table summarizes the linkages between service delivery grants and health system strengthening efforts:

<table>
<thead>
<tr>
<th>Service delivery interventions</th>
<th>Health system strengthening efforts</th>
</tr>
</thead>
</table>
| EPHS (Maternal, Newborn and Child Health) | - Support the introduction of national planning and budgeting tools and guidelines, focused on Essential Package of Health Services, at State/Region and Township levels  
  - Capacity building of State/Region and Township Health Departments to develop and implement Inclusive Township Health Plans (ITHP)  
  - Support the institutionalization and strengthening of Myanmar’s Village-Based Health Workforce  
  - Support the increase of ‘sanctioned posts’ for midwives; increase recruitment and deployment by working with the Civil Service Commission.  
  - Support the development of a standard Logistics Management Information System.  
  - Support services that improve collection of accurate and timely data and information and increase data utilization especially at State/Region and Township levels. |
| EPHS (Nutrition) | - Support the introduction of national planning and budgeting tools and guidelines, focused on the Essential Package of Health Services at State/Region and Township levels  
  - Strengthen the role and functions of the National Nutrition Centre  
  - Support the increase of ‘sanctioned posts’, recruitment, and deployment for midwives.  
  - Support the institutionalization and strengthening of Myanmar’s Village-Based Health Workforce.  
  - Support the development of a standard Logistics Management Information System.  
  - Support services that improve collection of accurate and timely data and information and increase data utilization at State/Region and below. |
| SRHR (EPHS includes Family Planning and cervical cancer screening) | - Policy and advocacy work around SRHR in Myanmar society  
  - Support the introduction of national planning and budgeting tools and guidelines, focused on Essential Package of Health Services, at State/Region and Township levels |
| Harm Reduction (drug use and health consequences) | - Support to Policy, National Strategic and Operational Plans, and National Strategic Framework development to improve the legal framework dealing with drugs and health consequences |
| EPHS (Tuberculosis) | - Support improved capacity of the National TB Program  
  - Support the introduction of national planning and budgeting tools and guidelines, focused on Essential Package of Health Services, at State/Region and Township levels |
| EPHS (Malaria) | - Support the institutionalization and strengthening of Myanmar’s Village-Based Health Workforce |
- Support the introduction of national planning and budgeting tools and guidelines, focused on Essential Package of Health Services, at State/Region and Township levels

Health in prisons
- Improve prison health facilities
- Improve delivery of health services through application of SOPs across prison system, training for prison health staff, and increased numbers of prison health staff

Overall
- Support the introduction of national planning and budgeting tools and guidelines, focused on Essential Package of Health Services, at State/Region and Township levels
- Integrate gender equality, women’s empowerment, and addressing gender-based violence (including intimate partner violence) within planning, policy-making and health service delivery activities
- Continued support National Health Plan communication strategy
- Create an enabling environment for Universal Health Coverage
- Promote evidence-based policy-making

Interlinkages between components of the health system and the broader context

Building the capacity of State and Township Health Departments to develop and implement Inclusive Township Health Plans (ITHP) will benefit all priority services and interventions – not just one disease or program. Better planning and budgeting improves service delivery through improved governance and oversight, and strengthens other HSS functions such as health financing and public financial management, health workforce, and medicines and equipment. It also provides Health Departments with various tools to promote local ownership and encourage integrated primary care.

Institutionalizing and strengthening Village-Based Health Workers will also benefit various programs by extending services to the communities. The National Health Plan 2017-2021 states that “All health workers (whether community-based or outreach) involved in the delivery of health promotion, prevention and treatment services must be fully recognized and institutionalized within the health system to ensure efficient use of resources, necessary oversight and quality service provision (regardless of whether the health workers are voluntary or salaried).”

Support to a standard Logistics Management Information System will improve the availability of essential medicines and equipment at MOHS health facilities and support the provision of the Basic EPHS. Again, this benefits not just one or two disease program but the overall service-readiness and availability of MOHS health facilities to extend services to their communities.

Support to Health Information Systems will benefit planning, management and decision making at all levels of the health system, which in turn would support service delivery at the community level. Information is also crucial for other system-strengthening components – e.g. Human Resources for Health, drugs and equipment.

Finally, the importance of leadership and governance in building a health system cannot be overstated. It is a cross-cutting team that touches on every other aspect of health systems strengthening.

114 Ministry of Health and Sports, 2016, Myanmar National Health Plan 2017-2021
115 WHO, 2010, Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies
2. CURRENT FUNDING SCENARIO

This proposal develops a Program Description outlining the funding scenario in which four initial Donors are on board, with funds totalling USD 215 million or so over five years:

Expected initial contributions:

<table>
<thead>
<tr>
<th>Description</th>
<th>USD</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Kingdom - DFID</td>
<td>116,951,380</td>
</tr>
<tr>
<td>Sweden - SIDA</td>
<td>51,055,140</td>
</tr>
<tr>
<td>United States - USAID</td>
<td>19,854,559</td>
</tr>
<tr>
<td>Switzerland - SDC</td>
<td>15,000,000</td>
</tr>
<tr>
<td>Expected 3MDG Rollover</td>
<td>12,139,653</td>
</tr>
<tr>
<td><strong>TOTAL CONTRIBUTION</strong></td>
<td>215,000,732</td>
</tr>
</tbody>
</table>

These numbers reflect the planned contribution amounts in USD as of September and are indicative due to: exchange difference fluctuations, changes in donor contribution amounts (two of the four Donors have signed as of the end of October 2018), and rollover funding number will not be finalized until 3MDG implementation is completed.

**Note:** The Fund Management Office (FMO) would like to reiterate that the figures in the Program Description, while getting closer and closer to the final version, are still tentative and pending the ongoing grant negotiations as well as the signing of contracts with Implementing Partners on 15th December, 2018. The FMO recognizes the need to provide the updated allocations to enable progress on donors’ appraisal process however, and is submitting the above figures with this understanding.

2.1 An overview of the Access to Health Fund’s portfolio

This section outlines notional interventions and geographic areas for the Access to Health Fund. In the meantime, the list below should be seen as a first attempt to define interventions on the basis of the criteria as presented in this Programme Description.

1. **Essential Health Services (including Maternal, Newborn and Child Health)**
   a. Support to planning at Township Health Department level
   b. Support to outreach activities
   c. Support to maternal and child referrals
   d. Support to Village-Based Health Workers (supervision, supplies, training) including auxiliary midwives, community health workers, volunteers, and others.
   e. **Health Systems Strengthening:**
      i. Support the institutionalization and strengthening of Myanmar’s Village-Based Health Workforce
      ii. Support the introduction of tools and approaches to planning the provision of the Essential Package of Health Services at State and Township level

2. **Essential Health services (Nutrition)**
   a. Promotion of early and exclusive breastfeeding
   b. Nutrition education
   c. Provision of micronutrient supplements for women during pregnancy and children under two years of age
   d. Strengthening prevention and treatment of severe acute malnutrition at facility-level and within the community
e. **Health Systems Strengthening: strengthening the role and functions of the National Nutrition Centre**

3. **Essential Health services (Sexual Reproductive Health and Rights)**
   a. Clinical SRHR services (e.g. cervical cancer screening and post abortion care)
   b. Referral to clinics and to youth-friendly services
   c. Delivery of SRH commodities
   d. Outreach delivery of SRHR information and community education, with a focus on young people
   e. **Health Systems Strengthening: Policy and advocacy work around SRHR in Myanmar society**

4. **Harm Reduction (Drug use and health consequences)**
   a. Needle distribution and exchange programs (part of Harm Reduction)
   b. Methadone maintenance programs (part of Harm Reduction)
   c. Provision of HIV prevention and SRH services (prevention of sexually transmitted infections) to people who inject drugs, intimate partners, children and broader community
   d. **Health Systems Strengthening: Support to Policy, National Strategic and Operational Plans, and National Strategic Framework development to improve the legal framework dealing with drugs and health consequences**

5. **Tuberculosis (TB)**
   a. Support Active Case-Finding in conflict and remote areas
   b. As part of the TB response, provision of integrated health care services at community level
   c. **Health Systems Strengthening: Support improved capacity of the National TB Program**

6. **Health in prisons**
   a. Improve health services to prisoners and prison staff – in prisons and labour camps – including specific health, TB, and SRHR services to women and children in prisons
   b. Support establishment and strengthening of TB ACF and MDR-TB management and response to co-infection throughout the prison system
   c. **Health Systems Strengthening:**
      i. Policy development
      ii. Improve prison health facilities – renovation and new construction
      iii. Improve delivery of health services through application of SOPs across prison system, training for prison health staff, and increased numbers of prison health staff

7. **Malaria**
   a. Testing and treatment services to hard-to-reach populations
   b. Replacement of artemisinin monotherapy with quality-assured artemisinin combination therapy, through private sector distribution channels
   c. **Health Systems Strengthening: Support the institutionalization and strengthening of Myanmar’s Village-Based Health Workforce.**

8. **Health Systems Strengthening**
   a. Support a Health Systems Strengthening agenda alongside all service-delivery grants
   b. Support the strengthening of Human Resources for Health at all levels:
      i. Work with MOHS on Human Resources for Health systems
ii. With the Civil Service Commission, support the increase of ‘sanctioned posts’ for midwives; increase recruitment and deployment
iii. Support to strengthening of midwifery and medical education
iv. Support operationalization of a comprehensive, institutionalized approach to community health (i.e. Village-Based Health Workers policy development).

c. Support supply chain management
d. Infrastructure work: refurbishment of the Sittwe General Hospital
e. National Health Plan:
   i. Support the strengthening of national planning template and approaches
   ii. Capacity building in support to the National Health Plan implementation
   iii. Support to the National Health Plan Implementation Monitoring Unit (NIMU)
f. Support and streamline Conflict Sensitivity principles
g. Support an enabling legislative and policy environment: Support to development of a policy think tank (see section 1.4.9)

2.2 Regions, areas, and intervention

This section provides an overview of the proposed 2019-2023 program – outlining the types of activities the Fund will be conducting in various geographical areas.

2.2.1 Breakdown by State

<table>
<thead>
<tr>
<th>Description</th>
<th>USD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rakhine</td>
<td>25,000,000</td>
</tr>
<tr>
<td>Chin</td>
<td>11,400,000</td>
</tr>
<tr>
<td>Kachin</td>
<td>30,477,077</td>
</tr>
<tr>
<td>Shan</td>
<td>37,123,764</td>
</tr>
<tr>
<td>Sagaing</td>
<td>3,000,000</td>
</tr>
<tr>
<td>Kayah</td>
<td>11,750,000</td>
</tr>
<tr>
<td>Kayin</td>
<td>7,998,000</td>
</tr>
<tr>
<td>Mon</td>
<td>772,000</td>
</tr>
<tr>
<td>Yangon</td>
<td>7,250,000</td>
</tr>
<tr>
<td>HSS</td>
<td>9,379,891</td>
</tr>
<tr>
<td>Unallocated</td>
<td>13,000,000</td>
</tr>
<tr>
<td>Nation-wide</td>
<td>12,750,000</td>
</tr>
<tr>
<td>MoHS Grants</td>
<td>13,337,374</td>
</tr>
<tr>
<td>MoHS Infrastructure</td>
<td>3,300,000</td>
</tr>
<tr>
<td>Non-grant Support</td>
<td>2,643,000</td>
</tr>
<tr>
<td>UNOPS Fees on Programme Delivery</td>
<td>4,319,626</td>
</tr>
</tbody>
</table>

**PROGRAM EXPENDITURE SUBTOTAL:** 193,500,732

**FMO MANAGEMENT COSTS:** 21,500,000

**TOTAL EXPENDITURE** 215,000,732
### 2.2.2 Breakdown by Thematic Areas

<table>
<thead>
<tr>
<th>Thematic Areas</th>
<th>Budget All Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>MNCH</td>
<td>54,223,846</td>
</tr>
<tr>
<td>SRHR</td>
<td>40,190,100</td>
</tr>
<tr>
<td>Drug Use</td>
<td>13,918,711</td>
</tr>
<tr>
<td>TB/MDR TB</td>
<td>12,527,248</td>
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<tr>
<td>Nutrition</td>
<td>5,942,879</td>
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<tr>
<td>Malaria</td>
<td>4,848,677</td>
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<tr>
<td>Other</td>
<td>68,989</td>
</tr>
<tr>
<td>SRHR (Nationwide)</td>
<td>11,750,000</td>
</tr>
<tr>
<td>Disability and Mental Health Inclusion</td>
<td>1,000,000</td>
</tr>
<tr>
<td>HSS/CSS</td>
<td>2,636,661</td>
</tr>
<tr>
<td>Harm Reduction Policy</td>
<td>2,535,410</td>
</tr>
<tr>
<td>SRHR Policy</td>
<td>1,994,952</td>
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<tr>
<td>Health in Prison</td>
<td>1,763,259</td>
</tr>
<tr>
<td>Technical Support to MOHS</td>
<td>1,000,000</td>
</tr>
<tr>
<td>HRH Management</td>
<td>1,000,000</td>
</tr>
<tr>
<td>Midwifery and Medical Education</td>
<td>1,000,000</td>
</tr>
<tr>
<td>Investment in Technology</td>
<td>500,000</td>
</tr>
<tr>
<td>MoHS Grants</td>
<td>13,337,374</td>
</tr>
<tr>
<td>MoHS Infrastructure</td>
<td>3,300,000</td>
</tr>
<tr>
<td>Non-grant Support</td>
<td>2,643,000</td>
</tr>
<tr>
<td>Unallocated</td>
<td>13,000,000</td>
</tr>
<tr>
<td>UNOPS Fees on Programme Implementation</td>
<td>4,319,626</td>
</tr>
<tr>
<td>FMO, Management Budget</td>
<td>21,500,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>215,000,732</strong></td>
</tr>
</tbody>
</table>

### 2.2.3 Detailed Programme Description

<table>
<thead>
<tr>
<th>Geography</th>
<th>Thematic Area</th>
<th>Budget All Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rakhine</td>
<td>MNCH</td>
<td>13,950,000</td>
</tr>
<tr>
<td></td>
<td>Nutrition</td>
<td>2,830,000</td>
</tr>
<tr>
<td></td>
<td>SRHR</td>
<td>5,810,000</td>
</tr>
<tr>
<td></td>
<td>TB/MDR TB</td>
<td>1,390,000</td>
</tr>
<tr>
<td></td>
<td>Malaria</td>
<td>670,000</td>
</tr>
<tr>
<td></td>
<td>HSS/CSS</td>
<td>350,000</td>
</tr>
<tr>
<td></td>
<td><strong>Sub-Total</strong></td>
<td><strong>25,000,000</strong></td>
</tr>
<tr>
<td>Chin</td>
<td>MNCH</td>
<td>7,676,000</td>
</tr>
<tr>
<td></td>
<td>Nutrition</td>
<td>160,000</td>
</tr>
<tr>
<td></td>
<td>SRHR</td>
<td>3,069,000</td>
</tr>
<tr>
<td></td>
<td>TB/MDR TB</td>
<td>4,000</td>
</tr>
<tr>
<td></td>
<td>Malaria</td>
<td>160,000</td>
</tr>
<tr>
<td></td>
<td>HSS/CSS</td>
<td>331,000</td>
</tr>
<tr>
<td></td>
<td><strong>Sub-Total</strong></td>
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</tr>
<tr>
<td>Kachin</td>
<td>MNCH</td>
<td>7,975,095</td>
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<tr>
<td></td>
<td>Nutrition</td>
<td>893,954</td>
</tr>
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<td></td>
<td>SRHR</td>
<td>12,863,095</td>
</tr>
<tr>
<td>Region</td>
<td>MNCH</td>
<td>Nutrition</td>
</tr>
<tr>
<td>--------------</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>Shan</td>
<td>16,650,958</td>
<td>1,231,306</td>
</tr>
<tr>
<td>Sagaing</td>
<td>822,167</td>
<td>5,119</td>
</tr>
<tr>
<td>Kayah</td>
<td>5,170,000</td>
<td>3,760,000</td>
</tr>
<tr>
<td>Kayin</td>
<td>1,945,561</td>
<td>1,613,704</td>
</tr>
<tr>
<td>Mon</td>
<td>34,065</td>
<td>5,543</td>
</tr>
<tr>
<td>Yangon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nation-wide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability and Mental Health Inclusion</td>
<td>1,000,000</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Sub-Total</td>
<td>12,750,000</td>
<td></td>
</tr>
<tr>
<td>Grand Total A</td>
<td>156,900,732</td>
<td></td>
</tr>
<tr>
<td>Unallocated</td>
<td>13,000,000</td>
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<tr>
<td>MoHS Grants</td>
<td>13,337,374</td>
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</tr>
<tr>
<td>UNOPS Fees on Programme Delivery</td>
<td>4,319,626</td>
<td></td>
</tr>
<tr>
<td>FMO, Management Budget</td>
<td>21,500,000</td>
<td></td>
</tr>
<tr>
<td><strong>Sub Total (Remaining)</strong></td>
<td><strong>58,100,000</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total B</strong></td>
<td><strong>215,000,732</strong></td>
<td></td>
</tr>
</tbody>
</table>

The Access program will be a mix of new activities and the continuation of high-impact support from the previous phase of programming. A timeline in section 3.3 shows when the Fund will issue Calls for Proposals, negotiate and sign awards, and finalize its program portfolio. In the meantime, the above summary tables are only indicative of current thinking at this time.

### 3. SETTING UP THE ACCESS TO HEALTH FUND

The sections above have described investment areas and the outlines of the Fund’s overall portfolio. This section outlines some of the modalities and timelines related to the Fund’s setup.

#### 3.1 Selection of the Fund Manager

In early 2017, in parallel to the Joint Appraisal Mission, 3MDG Donors commissioned an independent benchmarking of direct and indirect costs associated with management of a pooled Fund. The study aimed to assess the strengths and weaknesses of the current mechanism, as managed under UNOPS, and compare it to other possible options.

The report concluded that a continuation of UNOPS as the manager of the follow-on health fund would maximize value for money against the other options, as measured in the “four E’s”:

1. **Economy** – The current human resources for the 3MDG Fund Management Office costs 9.0% of the overall budget, which is low compared to some commercial companies. Potential cost savings of approximately 55% were identified with improved management structure (section 3.6 of this Programme Description addresses cost-reductions in human resources for the Fund). Overall, the Fund Management Office costs were targeted for 10%, which is considered competitive. In relation to pharmaceutical prices, the report noted that UNOPS beats international benchmarks.

2. **Efficiency** – The current Fund Management Office has shown a flexible and responsive approach to changing needs. A strong and sound results-focused monitoring system ensures the performance and efficiency of Implementing Partners. UNOPS has robust systems in place for the management of similar Funds under the UNOPS umbrella. Efficiency gains in staff and shared UNOPS facilities were identified by the Benchmarking Study.

3. **Effectiveness** – UNOPS has effective teams to deliver results on activities supporting service-delivery and strengthening health systems. Looking back on past and current performance, most outcome indicators have met or exceeded expectations. The maturity of the

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116 Funds going to the delivery of products and activities-related outputs  
117 Project support costs, overheads and management
established Fund Management Office also frees up capacity for innovation on new aspects of the programme.

4. **Equity** – The Fund Management Office has extensive contribution to the development of the equity-focused National Health Plan. The Fund moved towards a geographical focus in September 2017, and continues to build on this to deliver an essential package of health services, addressing the National Health Plan’s emphasis on inequalities and priorities. Engagement and relationships with ethnic health organizations are being strengthened in 2018 and will continue.

The report noted that a competitive tender for the Fund Manager would result in “a high risk to continuity of core grant-making and support services ... [and] threaten not only economy and efficiency but risk severe adverse health outcomes in the short and medium terms.”

As UNOPS was found to be an appealing option for maximizing value for money, the continuing Donors to the Fund (United Kingdom, Sweden, United States, and Switzerland,) indicated their choice for UNOPS to manage the Fund. This selection is formalized in the Joint Collaboration Arrangement to be signed by the Donors and UNOPS in June 2018.

It is important to note that, as part of UNOPS, Access will continue to benefit from the same economies of scale currently afforded to the 3MDG Fund. UNOPS-managed Funds have been sharing resources (office space, transportation, Human Resources management) for many years. In the last year UNOPS and the three Funds managed by UNOPS (LIFT, 3MDG and the Joint Peace Fund) have been pushing integration of services more proactively:
- In late 2017, the three Funds brought their distinct Programme Support Units (Contracts, Finance, Admin, Travel) into one Programme Management Office;
- In early 2018, UNOPS brought all Procurement functions (including the 3MDG Procurement Team) under the overall umbrella of a UNOPS-wide Procurement Unit, creating a more streamlined and economical structure.

### 3.2 Governance structure

The governance arrangements for Access will build on the experience of the 3MDG Fund, and the core governance structure will be the Fund Board and the Fund Manager.

The **Fund Board** is the forum where the Donors will meet in order to consult and seek a unanimous position on matters brought to their attention. The Fund Board will provide strategic leadership for and overall guidance in relation to the Fund. The Fund Board will focus on strategic decisions, policy decisions, donor coordination, building relations with the government of Myanmar and overall performance management of the Fund Manager. The Fund Board will review and endorse funding allocations in line with the Fund’s strategy.

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119 The recommendation made in the Benchmarking Study was to continue with UNOPS either for the management of entire portfolio (Option 2) or for the service delivery aspects of the portfolio (Option 4). For reference, the four options were: **Option 1** - continue with the current management provider and modalities for the next phase; **Option 2** - keep the management provider but improve current management modalities ahead of the next phase; **Option 3** - open the management of the next phase to competitive tendering; and **Option 4** - a new form of delivery of the programme, with UNOPS managing improved maternal, newborn, child and adolescent health (MNCAH) outcomes, and improved TB case finding and decreasing transmission of HIV in key populations along with an open tender(s) for strategic purchasing, facilitation of annual operational planning, capacity building of the MOHS, and knowledge generation.
The *Fund Manager* is responsible for effective, transparent and efficient management of Access on behalf of the Fund Board. The Fund Board is kept abreast of implementation plans, grants, and activities, and provides appropriate guidance to the Fund Manager. The Fund Board is responsible for the appointment of UNOPS as the Fund Manager, or any successor.

With Access focusing on conflict affected areas, the Board in the future may want to consider inviting Ethnic Health Organizations and/or Community Based Organization to join the Fund Board, with a mechanism to ensure representation of broader Ethnic Health Organization/Civil Society Organization perspective.

### 3.3 Mode of investment

It is currently envisioned that the Fund will work mainly through grants; other financing approaches (such as prizes, awards, co-financing) will be explored where evidence suggests these would enhance results. The Fund will also mandate projects when relevant to its mission.

The Fund will by design aim to address health issues, vulnerabilities and areas that are not addressed by others; however, this will not preclude the Access Fund (as it did not preclude the 3MDG Fund) from co-investing with other actors in the Health Sector when a joint approach makes sense. As an illustration, in the area of nutrition, the 3MDG Fund and LIFT, together with the HARP Facility, are investing to improve nutrition in Rakhine; in Harm Reduction, the 3MDG Fund and USAID are co-investing in the same partner to increase coverage while increasing cost-efficiency; and the 3MDG Fund and USAID jointly funded the Malaria Consortium to implement a Malaria Indicator Survey.

Implementing Partners will be identified through calls for proposals and selected on a competitive basis. In some cases with Board approval, the Fund may propose retaining an existing Implementing Partner by demonstrating that this partner is in a unique position to continue delivering a specific intervention.

The Fund will operate on a performance-based funding model: Performance will be measured by a program (i) meeting indicator targets, i.e. delivering health services and products to the intended beneficiaries) and (ii) having quality grant-management, which in turn includes program management, financial management, monitoring and evaluation, quality of services, and value for money.

Performance-based funding strengthens the link between grant-performance and investment/funding decisions; incentivises delivery of certain outputs; and contributes to improvements in service delivery, coverage, and quality. Access will work through performance-based funding both in the way it holds Implementing Partners accountable for results, and through systematic assessments of grant-management quality.

The introduction of performance-based funding will require careful consideration, particularly given the Fund’s focus on conflict-affected, weak-capacity areas. Implementing partners may have limited influence on obstacles to performance; face data quality constraints; and find it difficult to commit to high targets in challenging settings. It will be important to ensure that the Fund, true to its focus on equity, does not incentivize access to services for those easiest to reach.

### 3.4 Coordination with other actors in the Health Sector

The proposed design for the Access Fund (increasing access to quality essential health services for underserved and vulnerable people in conflict-affected areas) builds on what other health actors are
doing or intend to do. Access will continue to coordinate and collaborate with the following actors, among many others:

**Government partners:** Access will work in very close collaboration with the MOHS, the Ministry of Social Welfare, and the Ministry of Home Affairs. The MOHS will continue to be a member of the Board.

**Ethnic health organizations** are a key partner in conflict-affected and non-government controlled areas. Access will engage these partners, and support their continued coordination with the Ministry of Health and Sports to ensure coverage of health services for the most vulnerable populations.

The GAVI Alliance and Access share a focus on strengthening Township-level coordination and management capacity – and working with midwives for immunization (GAVI) and outreach (Access Fund).

The Global Fund (managed in Myanmar by UNOPS and Save the Children) and the 3MDG Fund have been coordinating on a weekly basis to ensure complementarity and to avoid duplication. Access will continue this close working relationship (i) at the national level, through the relevant Technical Strategic Groups; (ii) at the level of the State/Region, through the National Health Plan’s ‘Inclusive Health Plans’; and (iii) at the Township level, through the plans prepared by multi-stakeholder Township Health Working Groups.

The World Bank and Access share several common areas of work including nutrition, Township-level support to reaching beneficiaries, piloting and strengthening purchasing entities; promoting policy formulation in support to the National Health Plan; and funding/sharing technical assistance.

United Nations Technical Agencies play an important role in providing technical assistance to the MOHS and supporting the development of national policies, strategies, and guidelines. Access will work closely with these agencies in their normative, guidance, and advice role; and collaborate with them in areas of joint work – nutrition (UNICEF), human resources for health (WHO), and sexual and reproductive health, gender-based violence and gender equality (UNFPA).

LIFT, the Livelihoods and Food Security Trust Fund, will be a major partner Access in the area of nutrition, with collaboration currently under discussion in relation to Community Management of Acute Malnutrition, and support to the National Nutrition Centre. Access will also step up “social behaviour change communication” work to support ongoing (and LIFT-funded) Mother and Child Cash Transfer schemes.

The Joint Peace Fund and Access will collaborate very closely on conflict-sensitivity and working in conflict-affected areas. Discussions are underway with the 3MDG Fund in this respect, and any arrangement will be carried over to Access in 2019.

The Japan International Cooperation Agency (JICA) is a key bilateral donor supporting health system strengthening, including RMNCH, through the provision of technical assistance and the development of infrastructure. In line with the National Health Plan, JICA is now considering a stronger focus on primary health care, which complements the work of Access.

Access will of course collaborate with countless other entities – civil society organizations, NGOs, Implementing Partners, professional associations, private sector partners, and others.
3.5 Risk analysis and management

With a focus on conflict-affected areas, Access will be taking more risk and will be implementing more costly interventions. At the same time, results are likely to decrease compared to 3MDG Fund results, as populations are smaller and harder to reach. Access will work with Ethnic Health Organizations whose governance structures and capacity need greater support as compared to international partners. Programmes will have a high dependency on the ongoing peace process.

The management of risk under Access will be of utmost importance. The Fund will need to track a number of key risks on an ongoing basis, introducing mitigating measures both preventively and reactively.

The Risk Matrix below is proposed as a Draft Zero for the management of risk. It will be modified throughout 2018 to be as relevant as possible to the realities of the Access Fund and its specific portfolio of actions.
<table>
<thead>
<tr>
<th>Risk #</th>
<th>Risk description</th>
<th>Risk type</th>
<th>Action plan (to mitigate risk)</th>
<th>Risk Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Despite the peace/ceasefire process, increased armed conflict and instability affect health service-delivery in areas covered by the 3MDG Fund. The 3MDG Fund significantly strengthened the focus on conflict areas, increasing the proportion of funds invested in conflict-affected Townships.</td>
<td>9 - Political risk</td>
<td>The Fund will continue to: 1. Ensure that IP staff and activities are known, accepted and supported by parties at all levels – from Nay Pyi Taw to local-level. 2. Minimize ‘harm’ through an increased focus on conflict-sensitivity among FMO staff and Implementing Partners. 3. Maximize opportunities for dialogue between all stakeholders to foster trust and joint work (includes dialogue among IPs, Tatmadaw, MoHS, GAD, Non-State Actors, Ethnic Health Organizations, other NGOs, and local communities). Across-Funds - Discussions on an approach to conflict sensitivity across Funds (3MDG, LIFT, and JPF) are underway. Capacity building - FMO staff has completed in-house training to enhance understanding of conflict sensitivity to effectively strategize and adapt to geographical contexts. In addition, CDA (now known as RAFT), an organization specialized in conflict-sensitivity approaches and work in conflict areas, is now on-board to provide tailored assistance to 3MDG partners. For the remainder of 2018, CDA/RAFT will support partners in: articulating current approaches and lessons learned to date; identifying individual needs for developing/enhancing conflict sensitive approaches; and implementing and monitoring these measures. Kachin conflict - Since Jan/Feb 2018, the deteriorating security situation in northern Kachin has caused delays in project implementation in affected and neighboring areas (due to restricted road access and shortage of basic goods). The FMO with guidance from the Fund Board, is looking into developing an appropriate response to the escalating humanitarian emergency.</td>
<td>3 - Medium-high</td>
</tr>
</tbody>
</table>
|   | The situation in Rakhine prevents services from reaching the intended beneficiaries. | 9 - Political risk | The 3MDG Fund is taking the following approach:  
1. Continue to abide by principles of fairness, equal access, and non-discrimination in serving Rakhine State’s Buddhist and Muslim populations in a ‘conflict-sensitive’ manner.  
2. Continue to foster good relationships with the State Public Health Department and Department of Medical Services; engaging and coordinating with the respective authorities at the State level; and continuing consultation and exchange with Township Medical Officers and Basic Health Staff at the Township level. 3MDG is involved in health cluster and coordination meeting at the state/regional led by MoHS and supported by WHO and UNICEF (3MDG partner).  
3. Communicate with Implementing Partners and other Partners on a regular basis around the evolution of the situation, access, programmatic choices, and support opportunities.  
4. Provide feedback and updates to authorities in a transparent manner at the monthly health cluster with all health partners in Rakhine, not only 3MDG partners. This promotes transparency and cross learning.  
5. Maintain flexibility to adjust the program as needed to respond to the changing situation.  

The FMO requested partners in northern Rakhine to monitor on a monthly basis the level of access received by all populations for emergency referrals. A standardized reporting template has been developed jointly by the FMO and Rakhine partners to identify other relevant and feasible metrics that can be tracked. | 3 - Medium-high |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>The National Health Plan process slows down or stalls, reducing the Fund’s capacity to support the Myanmar Health response in a way that is strategic and fully aligned to the MOHS’ priorities.</td>
<td>9 - Political risk</td>
<td>The 3MDG Fund continues to provide extensive support to the National Health Plan Implementation Monitoring Unit (NIMU) and seeks MOHS guidance on ways to better serve key priorities in the national approach.</td>
</tr>
<tr>
<td>4</td>
<td>Changes in the MOHS leave the 3MDG Fund without long-nurtured relationships. Or in the event that priorities of the Myanmar government and bilateral agencies drift apart, tensions arise in their relationships.</td>
<td>9 - Political risk</td>
<td>The 3MDG Fund continues to nurture excellent relationships with the MOHS at all levels. The Fund continues to be one of the strongest supporters of the National Communicable Disease Programs, MCH, Human Resources for Health Division, NIMU, National Nutrition Center (under the Department of Public Health) and other key Ministry Departments. Regular consultations in Nay Pyi Taw (the latest in 22 March August 2018) brought together the 3MDG Fund Senior Management Team and key senior Officials from the MOHS to discuss programs and priorities. Additional consultations with key Ministry officials to finalize the 2019-2023 portfolio are planned for the first half of September, maximizing opportunities for MOHS engagement and ownership.</td>
</tr>
<tr>
<td>5</td>
<td>In 2017-2018, the 3MDG Fund and the MoHS are unable to find solutions to sustain key health interventions beyond the 3MDG’s lifetime.</td>
<td>9 - Political risk</td>
<td>Donors have signalled commitment in a Joint Collaboration Arrangement to continue the work of the 3MDG Fund through the Access to Health Fund. The major risk is to begin implementation on 01 Jan 2019 as planned, however, as the activities required to develop, set up and implement the new phase of programming are expected to be completed in a very tight timeframe. Further, delays from donor on fund commitments may lead to delay in signing of grant agreements as well as create liquidity issues in running FMO. Detailed fund flow analysis to be conducted as well as proactive follow up with donors to continue.</td>
</tr>
<tr>
<td>6</td>
<td>The Fund fails to step out of a silo-m entrality and to integrate programs for maximum value for money.</td>
<td>3 - Substantive (technical) risk</td>
<td>The Fund is now entirely restructured – stepping away from a division by Components and into a more strategic setup. The teams are motivated to work on a regional based approach. With the integrated approach, geographical classification takes precedence over thematic areas. There is a risk that Donor reporting requirements may not be fully met by themes. Expectations need to be managed well with Donors to minimize future misunderstandings. As a mitigation measure, discussions with the M&amp;E and grants teams are underway to ensure that a robust system is set up for the Access Fund on inception.</td>
</tr>
<tr>
<td>7</td>
<td>Delivery of essential services in selected geographies or populations is hampered (i) by capacity issues within the Ministry or Ethnic Health Organizations; or by (ii) lack of coordination between the Ministry and non-Ministry actors in mixed (or non-state) areas.</td>
<td>3 - Substantive (technical) risk</td>
<td>The 3MDG Fund’s model is well suited to address this risk: by working through Implementing Partners in delivering support to Ministry and Ethnic Health Organization structure, the Fund ensures that support is at hand in cases of low capacity. The 3MDG Fund, together with the MOHS Leadership, will continue to explore options to help strengthen the Ministry’s capacity. Ethnic Health Organizations have taken part in the development of the National Health Plan and Annual Operational Plans, and will be represented in relevant Township Health Working Groups. Funding was provided for partners working with Ethnic Health Organizations to convene forums in consultation with NIMU in Shan (21-23 February), Kayah, Kayin, and Nay Pyi Taw (for Wa and Shan Special Regions) in the second quarter of the year. The forums engage Ethnic Health Organizations in the operationalization of the National Health Plan. The 3MDG will continue to plan and support the delivery of services with Ethnic Health Organizations, bringing closer together Ethnic Health Organizations and the MOHS, and maximising opportunities to engage the MOHS at the state level in the planning and review of all services and referrals.</td>
</tr>
<tr>
<td></td>
<td>Plans to establish a semi-autonomous “strategic purchasing” entity are delayed or abandoned.</td>
<td>3 - Substantive (technical) risk</td>
<td>The 3MDG Fund in 2018 supports three pilots in Yangon and Chin (private sector GPs), and Kayin (Ethnic Health Organizations). Learning Briefs 1-5 were developed to provide an overview of ongoing efforts and lessons learned of the pilot project among private GPs. Learning Briefs 6 and 7 on working with EHOs will be disseminated before the end of the year. USAID, in a complementary action, is funding implementation research on strategic purchasing to inform the development of the pilot into a fuller program. Dialogue at the Ministerial level are ongoing. Lessons learned from these pilots will be used in the ongoing work around Health Financing Strategy Development. It is envisaged that the Access Fund will continue the strategic purchasing work on a small scale in 2019 and 2020.</td>
</tr>
<tr>
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</tr>
<tr>
<td>8</td>
<td>Natural disasters, such as epidemics, floods, or landslides, hamper service delivery and prevent programmes from achieving their targets.</td>
<td>6 - Environmental risk</td>
<td>UNOPS’ infrastructure risk-management considers climate-variability impacts and known risks from natural hazards, including seismic loads, wind loads, increasing plinth height in areas prone to floods and situating structures away from landslide areas. A partnership agreement focused around increasing disaster resilience and emergency preparedness of partners was developed between the 3MDG Fund and HARP Facility. Phase 1 was implemented to build capacity of four national partners working in high risk areas, with the training provided by HARP. In Phase 2, additional partners will be trained and more in-depth training provided to the previous partners, in particular on how to secure and manage rapid humanitarian funding from the HARP Rapid Response Fund (RRF).</td>
</tr>
</tbody>
</table>
| 10 | Poor financial management practices of key stakeholders lead to loss of funds. | 1 - Financial risk | The 3MDG Fund continues to maintain strong mechanisms to prevent fraud through the following: stipulating provisions on liability, obligations, and audit clauses in partners’ grant agreements; providing standard operational guidelines for all partners; and adhering to a global UNOPS policy to address fiduciary risk and fraud. Specifically, 3MDG prevents and monitors fraud risks through the following measures:

   a. Monitoring field activities – Findings from regular field visits are catalogued. Delays, deviations and reported weaknesses in project management will trigger discussions to address the issues with partners.

   b. Commodity tracking and review – Partners are required to have functioning and transparent supply chain management and commodity tracking systems. Regular reviews with partners ensure commodities procured are used according to agreements between 3MDG and partners. Spot checks are conducted to make sure commodities are provided free of charge to beneficiaries.

   c. External IP audits – Partners are audited annually by an independent audit firm for effective, efficient and economical use of resources; reliability of reporting; safeguarding of assets; and compliance with applicable legislation.

   d. Audits of the FMO – The 3MDG Fund is audited by the Internal Audit and Investigations Group (IAIG) which produces an audited financial statement to give assurance on the use of donor funds. This is published on UNOPS’ public website in the Accountability section. |

| 11 | Programs managed by the Fund have beneficiaries who are heavily disempowered and vulnerable, leading to opportunities for abuse and misconduct by partners or UNOPS staff. | 4 - Ethical risk | UNOPS Myanmar and the 3MDG Fund reviewed mechanisms in place to prevent and report on cases related to sexual exploitation and abuse. The safeguarding checks on Implementing Partners occur at multiple points in the grant management process: from the stage of receiving proposals; contracting and assessment; implementation (operational guidelines); and through an overall accountability equity and inclusion strategy to ensure service-provider accountability towards beneficiaries. | 2 - Low-medium |
3.6 The Fund Management Office

This section presents the proposed structure of the Access Fund including Human Resources and other costs. Broadly, the structure of the Fund (see organigram on the next page) retains the current 3MDG matrix structure:

**Fund Directors Office/Board/Communications (6 people):**
- The Fund is led by an International Fund Director, who has one Assistant.
- The Communications team is led by an international Team Lead, who will also manage Board Relations and the Fund Directors Office. They will be supported by two national Communications Analysts and a national Fund Board Liaison Officer.

**Programme Team:**
- The team is managed by a Head of Programme.
- The Programme Team is divided into geographies to support more integrated programming and better collaboration with the critical state/regional level of the Ministry of Health and Sports, as well as Ethnic Health Organizations. There are four geographies: (i) Rakhine, (ii) Kachin and Shan, (iii) Kayin, Kayah and Ethnic Health Organizations, (iv) Yangon and Chin.
- Each geography has one lead focal point (Programme Officer). They are each supported by two Programme Analysts.
- There are four Programme Officers, and seven Programme Analysts in total.

**Strategy Team:**
- The team is led by the Head of Strategy.
- There are three separate sub-teams: Health, Health Systems Strengthening, and Health for all/Communities grants. Each team has a Team Leader (Programme Officer) and one Programme Analyst. For the Health for All/Communities team, this Programme Analyst is a Gender and Social Inclusion Specialist.
- There are three Programme Officers, and three Programme Analysts in total.

**Monitoring and Evaluation:**
- The Monitoring and Evaluation team is led by an international Team Lead. It has two M&E Specialists, two M&E Analysts, and one Information Systems Analyst.
Programme Management Office (PMO):
For programme support, a percentage of overall costs for five key roles in the UNOPS Programme Management Office will be paid (between 30% - 40%); these roles are shared with two other UNOPS-managed Funds, LIFT and the Joint Peace Fund (these roles will be supported by 13 full-time support roles (two in finance, four in grants, and three in admin). They are:
- PMO Lead (international)
- Finance Lead
- Contracts Lead (international)
- Oversight Lead (international)
- Administration Lead

Support services:
A number of shared services areas do not appear on the Access Fund organigram, including human resources, procurement, admin and logistics support. Costs are covered by locally managed direct cost (LMDC) and appear in the budget document.

Personnel (31 full time in FMO + 18 in the PMO) = 49 total people *(Not all full-time roles)*

<table>
<thead>
<tr>
<th></th>
<th>2012-2018</th>
<th>2019-2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fund budget</td>
<td>330 million</td>
<td>200 million</td>
</tr>
<tr>
<td>FMO costs</td>
<td>Human resource + travel + consultancies + etc. (and % of total Fund amount)</td>
<td>33 million (10%)</td>
</tr>
<tr>
<td>HR Budget</td>
<td>Total amount allocated to Human Resources (and % of total Fund amount)</td>
<td>18 million (5%)</td>
</tr>
</tbody>
</table>

*Again, please note that USD 200 million is an evolving figure as additional support and resources are identified for the Access to Health Fund.*

### 3.3 Timeline for the establishment of the Access to Health Fund

The following timeline is provided to align processes and expectations towards the establishment of Access:

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-Mar</td>
<td>Develop Programme Description document for the Access to Health Fund</td>
</tr>
<tr>
<td>15-Mar</td>
<td>Develop budget (HR, Closure, etc.)</td>
</tr>
<tr>
<td>15-Mar</td>
<td>Draft Programme Description for two scenarios</td>
</tr>
<tr>
<td>22-Mar</td>
<td>Consultation with stakeholders to discuss programming (with MOHS)</td>
</tr>
<tr>
<td>30-Mar</td>
<td>Consultation with stakeholders to discuss programming (with Implementing Partners including Ethnic Health Organizations)</td>
</tr>
<tr>
<td>02-Apr</td>
<td>Assess performance of existing grants and management capacities of IP to provide inputs in IP selection</td>
</tr>
<tr>
<td>27-Apr</td>
<td>Communications and Branding presented to the Board (initial names will be presented to the Board at the March 28 Board Meeting)</td>
</tr>
<tr>
<td>30-Apr</td>
<td>Finalized Description of Action and Programme Description</td>
</tr>
<tr>
<td>30-Apr</td>
<td>Finalized Joint Collaboration Arrangement</td>
</tr>
<tr>
<td>28-May</td>
<td>Review and clearance of business case by UNOPS HQ (UNOPS HQ need at least 3 weeks to review the package)</td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>31 May</td>
<td>Switzerland, USA and UNOPS sign Joint Collaboration Arrangement</td>
</tr>
<tr>
<td>11 -12 Jun</td>
<td>Consultation with MOHS, including the Minister, on the Access to Health strategy</td>
</tr>
<tr>
<td>15 June</td>
<td>Fund Board meeting with MOHS, Donors, and Independent Expert representatives to discuss the ongoing developments of the 3MDG and Access Funds</td>
</tr>
<tr>
<td>25 Jun</td>
<td>Consultation with MOHS, including national and state level Ministry officials on the Call for Proposal process</td>
</tr>
<tr>
<td>27-Jun</td>
<td>Update the Programme Description to reflect Gender Analysis and Anti-Corruption reviews in the Access Fund’s strategy and design</td>
</tr>
<tr>
<td>02-Jul</td>
<td>Launch Call for Proposals</td>
</tr>
<tr>
<td>02-Jul</td>
<td>Agree upon monitoring modalities for the Access Fund grants based on risks and available staff</td>
</tr>
<tr>
<td>Jul</td>
<td>Policies and processes - finalize operational guidelines, budgeting and reporting templates for 2019</td>
</tr>
<tr>
<td>13 Aug</td>
<td>Deadline for proposal submissions from partners</td>
</tr>
<tr>
<td>30-Jul</td>
<td>Development of templates (GSA, narrative, budget, log frame, work plan) to be used in Access Fund</td>
</tr>
<tr>
<td>30-Jul</td>
<td>Procurement decisions/budget + warehouse</td>
</tr>
<tr>
<td>14-Aug-13 Sep</td>
<td>Evaluation of Proposals received through Calls for Proposals, selection of partners, request to submit full set of documents. The Evaluation Panel will comprise of UNOPS, MOHS and Fund Board representatives.</td>
</tr>
<tr>
<td>Sep</td>
<td>Fund Board meeting to be held on 14 September to determine the overall portfolio of Access. Thereafter, selected Implementing Partners will be informed.</td>
</tr>
<tr>
<td>Oct</td>
<td>Finalize log frame in parallel with IP log frames.</td>
</tr>
<tr>
<td>03-Dec</td>
<td>Partners submit full set of grant documentation (work plan, budget, log frame)</td>
</tr>
<tr>
<td>Dec</td>
<td>Finalize grant negotiation with partners</td>
</tr>
<tr>
<td>Dec</td>
<td>Financial Capacity Assessments for new Grants</td>
</tr>
<tr>
<td>Dec</td>
<td>Requests for awards</td>
</tr>
<tr>
<td>31-Dec</td>
<td>Sign Grants Support Agreements with Implementing Partners for 2019</td>
</tr>
</tbody>
</table>

**2019**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>09-Jan</td>
<td>Call for proposals/expression of interests up for new SRHR projects</td>
</tr>
<tr>
<td>23-Jan</td>
<td>Deadline for submissions for partners</td>
</tr>
<tr>
<td>11-Feb</td>
<td>Evaluation of Calls for Proposals / Expression of Interest, Selection of Partners, Request to submit full set of proposals for new SRHR projects</td>
</tr>
<tr>
<td>11-Mar</td>
<td>Partners submit full set of proposal documents</td>
</tr>
<tr>
<td>May</td>
<td>Grant negotiation with partners</td>
</tr>
<tr>
<td>10-Jun</td>
<td>Financial Capacity Assessments for new Grants</td>
</tr>
<tr>
<td>Jun</td>
<td>Requests for awards</td>
</tr>
<tr>
<td>01-Jul</td>
<td>Finalize all SRHR contracts and disbursements</td>
</tr>
</tbody>
</table>

### 4. Coverage, Objectives, and Expected Results

Implementation challenges in hard-to-reach and conflict-affected areas could include a wide range of issues, from political sensitivity to capacity constraints and active conflict. This could impact both provision and demand for services. In addition to service outputs and outcomes, the M&E system will need to be flexible and adaptable, and include process indicators, contextual factors and

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120 For example, measuring stakeholder engagement
121 E.g. number of armed conflicts in project areas; access restriction by local authorities, etc.
interaction between programme and context. Monitoring missions conducted by the FMO may need to systematically engage both the Government and Ethnic Health Organization partners, in addition to Implementing Partner teams.

Based on the program description in section 1 and the portfolio outlined in section 2, the following tables provide an overview of the expected coverage, results, outcomes, and impact of the Fund. At this conception stage of the Access Fund, this description is by definition general, lacking the specific indicators and targets that will follow detailed calls for proposals, grant negotiations, and the establishment of defined programs. A result-oriented M&E framework will be finalized after grant negotiations with Implementing Partners; the framework will allow the collection and analysis of data and its use in support of strategic decision-making.

In order to progress the design of the program, an analysis at the State/Region level, combined with stakeholder consultations (MOHS, Implementing Partners, EHOs) will be carried out. The analysis will aim to gage the specific and diverse population needs in program geographies, and to identify appropriate and effective interventions to deliver the outcomes under the two scenarios. The theory of change (next section) and program indicators will be revised in line with forthcoming discussions.

For the majority of indicators under MNCH, SRHR, and Nutrition, results are based on the national HMIS data as the Fund will be supporting Township-wide outreach, planning, and commodity supplies to health volunteers. For harm reduction, Tuberculosis and malaria, funding represents around 80% of the 3MDG Fund’s 2018 levels in scenario one (and around 30% in scenario 2); targets have therefore been set at around 80% of 2018 levels (20% under scenario 2).

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122 For example, “Coordination meeting on health”; “exchange visit between government and Ethnic Health Organizations”
123 First consultation completed March 26, 2018; subsequent consultations at the Minister and State/Region levels are to follow in the second quarter of 2018.
124 Nutrition is frequently included in MNCH in global literature. As this is a new area of interventions, hereby it is indicated separately.
<table>
<thead>
<tr>
<th>Indicators</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and % of women attended at least 4 times during pregnancy by skilled health personnel</td>
<td>67% (232,000 pregnant women (PW))</td>
</tr>
<tr>
<td>Number and % of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)</td>
<td>64% (221,000 births)</td>
</tr>
<tr>
<td>Number and percentage of mothers and newborns who received postnatal care visit within three days of childbirth</td>
<td>79% (325,213 Newborn)</td>
</tr>
<tr>
<td>Number and % of children under one immunized with Penta3</td>
<td>94% (322,000 children)</td>
</tr>
<tr>
<td>Total number of appropriate EmOC referrals supported</td>
<td>10% (44,000 PW)</td>
</tr>
<tr>
<td>Total number of ECC referrals supported</td>
<td>2% (36,000 children)</td>
</tr>
<tr>
<td>(Family Planning) Modern Contraceptive Prevalence Rate (MCPR) among married women</td>
<td>TBD</td>
</tr>
<tr>
<td>(Family Planning) Number of young people (aged 10 to 24) reached by SRHR education via interpersonal communication approach</td>
<td>172,000</td>
</tr>
<tr>
<td>Number of post-abortion care services provided to women through public sector service providers</td>
<td>15,000</td>
</tr>
</tbody>
</table>

- Coverage area:
  - Scenario 1: 10 Townships in Rakhine, 9 in Chin, 7 in Shan, 7 in Kayah
  - Scenario 2: 10 in Rakhine, 4 in Shan (North)
- Coverage percentages reflect coverage of interventions by the end of Year 5 of the Access Fund (2023)

- Coverage area: same as above
- A notable reduction is projected from 2017 results (which were 17% for EmoC and 3% for ECC). The Access Fund, in coordination with MOHS, will adjust eligibility criteria for referral support to prioritise the most vulnerable populations.

- Coverage area (number of Townships covered):
  - Scenario 1: same as in 2018 (53 townships)
  - Scenario 2: 80% of areas in Scenario 1

- Coverage area (number of Townships covered):
  - Scenario 1: continuing activities in Bago at the same pace as in 2018.
  - Scenario 2: 20% reduction of scenario 1 targets in line with SRHR budget reduction.
- Additional results from conflict-affected areas will be estimated during grant negotiations.

125 Bago region has the highest proportion of abortion cases seeking treatment in the public sector (75%)
<table>
<thead>
<tr>
<th>Indicators</th>
<th>Assumptions</th>
</tr>
</thead>
</table>
| Number of women who received cervical cancer screening service (part of the EPHS) | - Scenario 1: 10,500 women screened annually  
- Scenario 2: 20% reduction to scenario 1, in line with SRHR budget reduction          |
| Number and % of newborn with initiated immediate breastfeeding within 1 hour after birth | - Coverage area (number of Townships covered):  
  - Scenario 1: 10 in Rakhine, 9 in Chin, 7 in Shan, 7 in Kayah  
  - Scenario 2: 10 in Rakhine  
- This will be reported based on HMIS data                                       |
| # of micronutrient powder distributed through health facility (part of the EPHS) | - Coverage area (number of Townships covered):  
  - Scenario 1: 10 in Rakhine, 9 in Chin, 7 in Shan, 7 in Kayah  
  - Scenario 2: 10 in Rakhine  
- Population: at least 50% of all children aged 6-36 months  
- Data collection system to be established                             |
| Number of people who inject drugs (PWID) reached with HIV prevention programmes | - Coverage area: in both scenarios – covering high burden townships in Kachin, Shan and bordering regions with high rates of injecting drug use.  
- Population coverage:  
  - Scenario 1 - 40% of national PWID estimates  
  - Scenario 2 - 30% of national PWID estimates |
| Percentage of people who inject drugs who received an HIV test and known the result | - Coverage area as above: in both scenarios – covering high burden townships in Kachin, Shan and bordering regions with high rates of injecting drug use.  
- Population coverage: half of PWIDs reached                             |
| Number and percentage of PWID tested who have a positive result | -                                                                               |
| Number of sterile injecting equipment distributed to people who inject drugs | - Coverage area as above: in both scenarios – covering high burden townships in Kachin, Shan and bordering regions with high rates of injecting drug use.  
- Population coverage:  
  - Scenario 1 - 40% of national PWID estimates  
  - Scenario 2 - 30% of national PWID estimates  
- Distribution of 350 needles/syringes per PWID per year                |
<p>| % PWID who used sterile injecting equipment at last injection | - The baseline will be established based on the IBBS 2017 results (once available) and targets will be set accordingly. |</p>
<table>
<thead>
<tr>
<th>Indicators</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of notified cases of all forms of tuberculosis</td>
<td>- Coverage area:</td>
</tr>
<tr>
<td></td>
<td>o Scenario 1: Community-based TB case finding in Rakhine, Kachin, Shan, Kayah, Kayin, Chin, Mon, and case finding by mobile NTP teams (limited support nationwide)</td>
</tr>
<tr>
<td></td>
<td>o Scenario 2: Community-based case finding in Rakhine, Kachin, Kayin, Mon and case finding by mobile NTP teams (limited support nationwide).</td>
</tr>
<tr>
<td>Number of rapid diagnostic tests taken and read</td>
<td>60,000</td>
</tr>
<tr>
<td></td>
<td>- Coverage area:</td>
</tr>
<tr>
<td></td>
<td>o Scenario 1: Community-based diagnosis and treatment of malaria in Rakhine, Kachin, Shan, Kayah, Kayin, Chin and Mon.</td>
</tr>
<tr>
<td></td>
<td>o Scenario 2: Community-based diagnosis and treatment in Rakhine, Kachin, Kayin, Mon and very high-burden Paletwa township of Chin.</td>
</tr>
<tr>
<td></td>
<td>- Steady testing rate each year. The approach may be adapted depending on the Myanmar elimination agenda.</td>
</tr>
<tr>
<td>Number of confirmed malaria cases treated in accordance with national</td>
<td>1.5 million</td>
</tr>
<tr>
<td>malaria treatment guideline</td>
<td>- Coverage area: as immediately above:</td>
</tr>
<tr>
<td></td>
<td>o Scenario 1: Community-based diagnosis and treatment of malaria in Rakhine, Kachin, Shan, Kayah, Kayin, Chin and Mon.</td>
</tr>
<tr>
<td></td>
<td>o Scenario 2: Community-based diagnosis and treatment in Rakhine, Kachin, Kayin, Mon and very high-burden Paletwa township of Chin.</td>
</tr>
<tr>
<td></td>
<td>- Projected decline of test positivity rates by 30% per year</td>
</tr>
<tr>
<td>Number of prisoners reached with HIV prevention programmes</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td>To be developed. In 2018, 3MDG is supporting around 1,600 prisoners reached with HIV prevention programmes as a pilot by AHRN. The coverage for the Access Fund is to be worked out.</td>
</tr>
<tr>
<td>Number of prisoners who received an HIV test and known the result</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Number of prisoners who received treatment for sexually transmitted</td>
<td>TBD</td>
</tr>
<tr>
<td>infections (STIs)</td>
<td>-</td>
</tr>
<tr>
<td>Indicators</td>
<td>Assumptions</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Health Systems Strengthening</strong></td>
<td>Indicators on Health Systems Strengthening will be added when the Access to Health Fund’s HSS portfolio is better defined</td>
</tr>
<tr>
<td>Number of forums facilitated by the Access to Health Fund at which EHOs and the MOHS get an opportunity to coordinate their action on Health</td>
<td>4</td>
</tr>
<tr>
<td>Joint initiatives implemented by the MOHS and an EHO with the Fund’s facilitation</td>
<td>5</td>
</tr>
</tbody>
</table>

- Other gender equality, women’s empowerment, and gender-based violence (GBV) indicators for consideration depending on final portfolio:
  - # of GBV cases identified through health systems and referred for appropriate care (categorized by GBV-IMS type)
  - # and % of policies, plans, and operational procedures that integrate GBV actions and targets throughout health service delivery
  - # and % of health care providers trained on GBV warning signs and case management

If M&E Plan includes surveys of affected population:
- DHS indicators on women’s decision-making
- DHS indicators on women’s and men’s acceptance of wife beating

If quality assurance or exit interviews are conducted as part of patient satisfaction:
- # of women/ men (disaggregated by age, disability status) who report satisfaction with quality of care received (scale of 1-5)
- # of women/ men (disaggregated by age, disability status) who report satisfaction with respect received from health care provider (scale of 1-5)