3MDG Support to MNCH Service Delivery –
A Strategy for Transition and to Address Sustainability for work being currently financed in Delta and Magway
updated 7 June 2016

This document consists of three main sections. Section 1 provides an overview of all work undertaken to date through the MNCH Component of the Fund whilst Section 2 summarizes ongoing future MNCH work of the Fund through to the Fund’s end in 2017 and beyond. Section 3 describes a Strategy for Transition/Sustainability for Delta/Magway work for the period beyond 3MDG financing availability.

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1. Introduction to the 3MDG Fund’s MNCH programming areas

The programme goal of the Three Millennium Development Goal Fund (3MDG) for maternal, new born and child health is to increase access and availability of essential maternal and child health services for the poorest and most vulnerable populations in townships supported by the Fund.

The following six programming areas for the Fund’s maternal, newborn and child health component were agreed upon by the Fund in 2015 as part of a review undertaken in 2015 of the Fund’s strategy:

1. Scale up of services in conflict-affected areas
2. Support to healthcare in Special Regions
3. Strengthening service delivery both public and private (MRH, CHD, Nutrition, EPI, health promotion)
4. Support to the Ministry of Health’s Human Resources for Health (HRH) Strategy
5. Service quality improvement in MNCH
6. Evidence based for national MNCH strategies

The following is a summary of key activities to date in six program areas:

1.1 Scale up of services in conflict affected areas

In Kayah and Shan States, 3MDG is financing health care in conflict-affected areas to address the health needs of underserved populations. These are areas where challenges have been identified to serve the population through the public health system. In agreement with a diverse group of stakeholders, an implementing partner(s) works with the township health departments, ethnic health organizations and civil society groups that may have access to areas not accessible to basic health staff.

1.2 Support to healthcare in Special Regions

In Shan Special Region 4 and the Wa Special Administrative Zone, 3MDG is providing funding to support the delivery of integrated services for minorities and hard to reach populations. This support addresses the need to expand service coverage and improve the quality of service delivery. The implementing partners act as a bridge between the Ministry of Health and the Special Region health departments to maximize Ministry support.

1.3 Strengthening service delivery both public and private (MRH, CHD, Nutrition, EPI, health promotion)

Across Ayeyarwady and Magway Regions and Chin State, supply and demand side interventions are being used to address the challenges people face in accessing essential services. On the supply side, 3MDG is providing financing and capacity building support to the public sector to strengthen service delivery. An essential part of the approach to improve service provision for hard to reach areas is through enhancing the planning capacity of the township health departments. On the demand side and through the public sector as well as the implementing partners, 3MDG is strengthening community-based health services, the referral of emergency cases and private sector health care services.
1.4 Support to the Ministry of Health’s Human Resources for Health (HRH) Strategy

Nationwide, 3MDG is supporting the Ministry of Health in the strengthening of its health workforce, and is financing the training of midwives and auxiliary midwives. The Ministry of Health’s Department of Public Health and the Department of Medical Science are supported by a significant health system strengthening programme for improved midwifery education in at least 20 midwifery schools from 2014-2016. Further, in support of a national target to deploy at least one trained healthcare volunteer to every village, 3MDG is committed to support the Ministry in the training of over 5,000 auxiliary midwives in nearly 200 townships. This training is enabling auxiliary midwives to provide effective support to midwives in the communities they serve and improve the delivery of antenatal and postnatal care for women and children.

1.5 Service quality improvement for maternal newborn child health

Across Myanmar, there is a need both to optimize the use of limited resources for health and to scale up existing health services to reach more people. The process of improvement and scaling up of services needs to be based upon sound local strategies for quality so that the best possible results are achieved from new investment.

This area of programmatic focus builds upon work already being undertaken by the Fund. Examples of such work include: financing to improve quality of midwifery services; strengthening of township health department supervision and monitoring of services across areas where 3MDG is providing financing support; on-the-job training and capacity building of basic health staff; and strengthening linkages between skilled midwives and auxiliary midwives to enhance quality and strengthen the continuum of care.

1.6 Evidence based national MNCH strategies

The Ministry of Health and 3MDG together are generating evidence to inform national strategies, guidelines and policy by systematically collecting information through routine monitoring systems and targeted operational studies.

Some examples of the work include a maternal death audit system in which the Ministry was supported to develop and publish a comprehensive report; township health planning reviews in which the experiences of different implementing partners in developing township plans were reviewed to establish unit costs for key interventions and the creation of value for money analyses; and work in conflict-affected areas in which a systematic assessment and recording of work is being undertaken to better understand health programming in conflict-affected areas and the application of ‘do no harm’ principles.
2. MNCH in 2017 and beyond

The following six programming areas for the Fund’s maternal, newborn and child health Component have two distinct programmatic end dates. The Delta and Magway work is timetabled to end in 2016 whilst the remainder of the MNCH programmes is timetabled to end in 2017.

Figure 1. Current designated timeline of MNCH programmatic areas

With 3MDG financing support for MNCH service delivery across six townships in the Ayeyarwady Region and five townships in the Magway Region to be concluded in its present form by the end of this year, the implementation of the strategy for transition and to address sustainability across the Delta and Magway will provide critical learning to inform transition and sustainable approaches for MNCH work across other areas of the country which will end in 2017 when the 3MDG Fund concludes.
**Transition:** For the purposes of this document, transition is about deciding upon, defining and undertaking a set of actions whereby critical elements of support to health service planning and provision, currently financed by the 3MDG through to the end of 2016, can be delivered beyond 2016 thereby ensuring the sustainability of gains achieved under 3MDG. In practice this means preparing for how to ensure community-based services, facility-based services/outreach and referral support remain functional beyond 2016.

**Sustainability:** For the purposes of this document, sustainability means the likelihood that levels of service delivery currently supported by 3MDG in Delta and Magway will continue to function effectively after 3MDG support comes to an end in 2016. 3MDG considers that health service provision is sustainable provided it a) continues to function effectively for the foreseeable future, b) has high levels of coverage, and c) is progressively integrated into the national health system and by the end of 2016, is delivered under the full financial and administrative responsibility of the Ministry of Health.

It should be noted that this document outlining the strategy for transition and to address sustainability across the Delta and Magway is a working document, and thus will change and adapt continually as the context of the operating environment and pool of relevant/responsible stakeholders become clearer in the upcoming months.

### 2.1 Financing for MNCH in conflict affected areas & Special Regions through 2017 and beyond

In relation to programmatic areas (1.1) and (1.2) outlined in the introductory chapter, the work in conflict affected areas and Special Regions is relatively newer. Design work began in 2013 and activities commenced in 2014 or 2015 - across all seven townships in Kayah State, seven townships in Shan State and also Monglar Special Region 4 and Wa Self-Administered Region.

Across areas of Myanmar, issues related to ethnicity and conflict impact upon processes for planning the delivery of health services. There are few reliable resources on the status of health in conflict areas of Myanmar, where access is difficult and population statistics are seen as politically sensitive. There has also been little research on the relationship between conflict and health.

3MDG undertook a number of conflict assessments in Kayah and Shan States in 2013 in order to gain a fuller appreciation of preconditions for successful programme delivery. The assessments found a number of factors inhibiting government access in ethnic regions, including a lack of security as well as problems related to transportation and communication. Within many of these areas, the government has limited or no presence at all. In some conflict areas there are parallel health care systems operated by some of the larger ethnic armed opposition groups with separate health departments and clinics (often mobile in areas with active conflict) and staff often trained according to different health protocols. These departments are typically not linked to the national health system and have lesser capacity.

Monitoring visits to track roll out of the Fund’s conflict sensitivity strategy highlight the key role an implementing partner plays in mediating and facilitating between government health structures and ethnic health organizations. They emphasize the need to reinforce this coordination role first,

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1 This implies, in 2017 and beyond, an assumption and risk therefore entailed of entire reliance on non-3MDG resourcing for sustaining service delivery. Alternative scenarios might include for example, reliance on non-3MDG resourcing for all service delivery, with limited funding for targeted technical assistance provided to townships as requested.
before ambitious service delivery targets are set and implemented.

Recognizing that the development of comprehensive township health plans in partially conflict-affected areas would take time in order to ensure the active participation of all stakeholders, implementing partners were granted funds to support priority service delivery activities alongside the planning phase. This allowed partners to immediately support ongoing efforts such as outreach, immunization crash campaigns, emergency referrals, and assessments in addition to supporting the township planning process. Partners work closely with the state health department as well as with local organizations and representatives of active ethnic health organizations in the area. Security conditions vary to a great extent in different townships, and this has resulted in flexible approaches applied to meet the unique context of each township.

Despite the significant challenges identified, the conflict assessments reveal a common theme. Health is seen as shared issue that concerns everyone, around which cooperation and coordination can more easily be built as compared to more politically-sensitive issues such as education and land rights. It was found that most conflict actors and civil society organizations welcome support for healthcare provision, as the needs are great and often even the most basic health services are lacking.

Bringing people together around health could potentially contribute to peacebuilding, provided it is done in a careful way. With the evolving peace process in Myanmar, the work of 3MDG in Kayah, Shan and the Special Regions (with financing available through 2017 when the 3MDG Fund ends) could be taken up by current and emerging development partners/financing mechanisms who are considering leveraging health dividends as an integral part of the peace building process.

2.2 Transitioning MNCH work in Delta and Magway in 2017

In relation to programmatic areas (1.2) and (1.5) outlined the introductory chapter, MNCH work in the Delta and Magway began in 2013 and mid-2014 respectively. It adopts a continuum of care through a range of service providers at township level that is aligned with national strategies for reproductive and child health. It prioritizes high impact, low cost interventions and integrated delivery of services as close to the beneficiaries as possible, for example at primary and community level. This is in order to ensure provision of a package of essential health services that will address the main causes of maternal, new born and child death and illness for poor and vulnerable populations in Myanmar.

3MDG achievements here\(^2\) are most readily considered against three inter-linked and inter-dependent areas which together deliver a continuum of care, namely support to facility-based services and outreach, support to community-based health provision and support to the emergency referrals system.

The strategy detailed in this document focuses on these three areas for transition to ensure that the impact on health provision made to date is sustained after the end of the 3MDG Fund.

\(^2\) Achievements to date through a 3MDG approach of support to strengthen Township health systems and scale up service provision are documented through an earlier JIMNCH Programme Evaluation, the 2014 Strategic Review of the MNCH Component of the 3MDG Fund as well as regular Fund reports, and most recently the January – June 2015 3MDG report.
3. Core Strategy addressing sustainability for transition of support to MNCH service delivery in the 3MDG-supported Delta and Magway townships

The rationale for a need for a strategy for sustaining gains is justified by a) the significant impact that 3MDG is having on health provision within coverage areas, b) the persistent high levels of the under-five mortality rates of children and the maternal mortality rates which have been documented in the 2014 census and c) the deficit in access to health services which would result if transition to sustainability of service provision was not achieved.

A set of actions to maintain high levels of coverage for the foreseeable future under this approach would result in major shifts from the current direction of the programme and would entail within a transition plan, detailing of a set of steps which would need to include and by way of example:

1. **Facility-based/outreach service provision**
   - Sustaining support using Government funds as well as MoH’s IDA loan based Essential Health Services Access Project funds
   - Transition from external financing through to on-budget financing for facility-based/outreach service provision
   - Ministry-led, Ministry-delivered Township planning (as envisaged under the MoH/WB EHSAP)
   - Use of MoH systems, for example, for procurement/supply chain for commodities and flow-of-funds (as envisaged under the MoH/WB EHSAP)
   - Strengthen microplanning and budgeting capacity that maximizes increased resources available in townships and support with community engagement.

2. **Community-based health care provision**
   - Explore options/models for a sustainable community volunteer health system integral to the public health system
   - Operationalizing national strategies for CCM, newborn survival, AMWs and others
   - Full integration with public sector delivery of community-based programming which is currently significantly dependent upon NGO partners; assumption of a normative MoH role in relation to community based service provision, especially around VHCs as well as CHW/AMW - BHS linkages

3. **Emergency referral systems (demand-side financing)**
   - Adopting support for emergency referrals as a national or targeted sub-national policy, agreeing upon a health financing strategy for emergency referrals and implementing a payment modality
   - Create means for financing emergency referrals through a payment mechanism managed by or on behalf of the MoH
   - Financing of and payment for emergency referrals using governmental systems
   - An enabling environment allowing a continuing effort to advance quality of service provision and allied areas of work to increase coverage/quality, including through strengthening of data and information systems.
   - Review of referral eligibility criteria, design of more efficient management mechanisms led and staffed by Township Health Departments.
Table 1. What “transition” would look like and what should be done to make it happen

<table>
<thead>
<tr>
<th>Areas</th>
<th>2015 – Current delivery modalities</th>
<th>2016 – Preparation for 2017 transition</th>
<th>2017 and beyond – Sustainable service delivery</th>
<th>Assumptions, risks and pre-conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facility based services and outreach</strong></td>
<td>3MDG support to planning and financing of BHS meetings, training and outreach. Handling payments, with compliance</td>
<td>a) Township are supported to undertake planning required for future IDA/Govt budget spend. b) Township prioritize essential activities and budget for these so they are funded under increased township health funds.</td>
<td>BHS meetings, training and outreach are included in township plans and budgets and are supported</td>
<td>These activities are prioritised within township resources. There are clear procedures, systems and staff to handle payments.</td>
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<tr>
<td><strong>Community-based health care provision</strong></td>
<td>Through 3MDG financing, INGO support community-based programmes in partnership with THDs (including provision of supplies, supervision, information systems for volunteer services and support to VHCs and VTHCs)</td>
<td>Preparation for operationalising national strategies – CCM, newborn survival, AMW a) working with MoH to agree a refined and manageable geographical coverage approach (CHWs/AMWs) 2017 and beyond, working with MoH to ensure volunteers are equipped, supported, provided with regular supplies and data collected. c) using programme experience and learning as guides to relevantly operationalise national policies. d) Link VHC and VTHCs in planning and reviews</td>
<td>Operationalisation of national community based health programme strategies in Magway and Delta, including community case management, community health aspects of the National Plan of Action for Food and Nutrition, community based newborn care, scale up of AMWs. Agreement has been reached on modalities for disbursing equipment, supplies, supervision of volunteers, quality assurance and information on services provided. These are budgeted. VTHC and VHCs continue to function and contribute to plans</td>
<td>Commitment to, recognition of and prioritisation of the role of community based programming in reducing mortality and morbidity (as shown in global evidence) - Agreement on essential package of services to be delivered by volunteers (AMW/CHW) - Agreement on essential drugs lists for volunteers. - Financing of volunteer equipment and supplies. - Distribution channels in place - Volunteer reporting in place - Supervision of volunteers in place. - BHS have sufficient time &amp; commitment to supporting volunteers.</td>
</tr>
<tr>
<td><strong>Support and financing for emergency referrals</strong></td>
<td>Guidelines in place, defining eligibility and payment modalities and caps Payments disbursed Compliance checks in place</td>
<td>a) Summarize documentation related to 3MDG financing of emergency referrals to date b) Seek position statements/policy commitment from MoH regarding emergency referrals c) 3MDG Fund Board to provide direction as to whether financing to support emergency referrals can be made available via WB or directly to MoH d) Review of eligibility criteria and constitute design process for payment mechanisms for emergency referral support managed by MoH, if prioritised by MoH3.</td>
<td>Funding committed to support emergency referrals. MoH adopts payment mechanism and eligibility criteria.</td>
<td>- Policy commitment forthcoming from MoH regarding emergency referral mechanism - Alternative funding is available to support emergency referrals - THD have designated staff with time and budget available to manage, administer payments with necessary compliance</td>
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</tbody>
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3 Since the November 2015 Fund Board meeting, the FMO has undertaken a review of emergency referral financing under the 3MDG Fund and documented the approach as delivered to date, also summarizing evidence upon impact. Discussions have been held with the MoH as well as the WB and these discussions are summarized in the attached Annex: Emergency Referrals.
3.1 Transition strategic planning area 1: Facilities based services and outreach

Facility based services and outreach support from 3MDG has improved the services readiness of township health facilities, including through the provision of medical equipment as well as renovations to the health facilities. Transportation and financial support has enabled Basic Health Staff to undertake regular outreach visits with an emphasis on increasing access to services across hard to reach areas. This has led to an increased coverage of immunization, especially in remote areas. Support to regular meetings at the rural health center and Township levels has been used to provide on-going medical education to Basic Heath Staff.

3.1.1 Budget and expenditure review of 3MDG MNCH programmes

In a review of Township Health Plans, key activities and major expenditure categories were identified and the largest part of operational costs for the running of Township Health Departments were found to occur in Planning & Coordination (monthly meetings of health staff), outreach sessions (essential for immunization and other health services), management and supervision (covering costs of communication, travel of supervisors), investment (renovation, equipment for health facilities), training of BHS as well as other expenditures.

In 2016, the townships plans for Ayeyarwady and Magway allocated just under $1 per capita for all these categories – these are essential activities supported by 3MDG and relating to this aspect of transition planning – “Operational Costs for THDs”.

The complexity of the process to plan, implement and report activities were also reviewed and the following activities identified as most suitable for the Township Health Departments to implement initially: Planning & Coordination, Supervision & Monitoring, Outreach, and Investment. Activities in these categories contain relatively simple inputs, with many of them standardized and therefore easy to implement and report on. They also deliver the backbone of the services delivered by the Township Health Department.

3.1.2 EHSAP SOP in-depth review

A review has been undertaken of standard operating procedures for financial management that guide the Essential Health Services Access Project (EHSAP) as undertaken by the Ministry of Health with the technical and financial support of the World Bank. This served to establish a link between the standard government budget codes and descriptions, and the activities to be implemented by the Township Health Departments.

The Government budget codes are limited and do not reflect the full needs of health service delivery activities e.g. not every activity can be broken down into inputs linked to government budget codes. However, for a set of essential interventions/limited set of activities likely to be proposed in the initial plans, the codes would be adequate to ensure compliance with Government financial procedures and audit. In summary, budgeting is feasible for activities currently financed by 3MDG but the workload of breaking down activities against a number of budget lines is high. Similarly aggregating individual health facility plans into township plans will have a large attached workload.

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4 For example in Chin townships coverage of immunizations has increased from 30-40% in 2013 to 70-80% in 2014.
5 Note that this excludes expenditures for referrals as well as supplies and support to Community Health Volunteers.
3.1.3 Township planning template

The Fund has been requested by the Ministry of Health to provide support to the township planning process (which is a core element of the EHSAP work) and especially in the area of a Township planning template. The Ministry of Health indicated that it preferred a simple, paper-based planning format.

3MDG has developed a draft template which included selected priority activities and essential interventions for service delivery at the health facility level, e.g. rural health center, station hospital, MCH and township hospital, and cross-referenced those to the government budget.

In principle, this would enable the health facilities to develop a facility plan and submit to the Township Health Department (THD). The THD would then need to compile all these plans into one plan\(^6\) which can be used to request a disbursement from the Central Ministry of Health. The compilation is likely to be a challenge for the THD. A paper based version will require hand computation. There is a considerable risk of calculation mistakes.

The World Bank has agreed to take the further development, training of TMOs / other MOH staff forward. In 3MDG supported townships, current implementing partners of 3MDG will offer assistance. Some TMOs have requested assistance in planning and financial management.

3.1.4 Community participation

The township plan associated disbursement-linked indicator for the World Bank International Development Association (IDA) loan specifies that community participation must form the basis for township planning. The Ministry received technical assistance from the 3MDG and through 3MDG’s Collective Voices partners for this work. In-depth consultations with the Ministry, an MoH agreed training manual on participatory approaches and the training of trainers for MoH staff at State/Region levels has formed the basis for this technical assistance. The Ministry of Health is now implementing the trainings on its own and 20,000 copies of the training manual will be disseminated nationwide before the end of March 2016.

3.1.5 Key questions

A key set of questions need to be answered for timely transitioning and to achieve sustainability of facility-based service provision and outreach beyond the end of financing for programmes. Resolution of these questions would lead to a design and delivery process with transitioning of facility-based service provision and outreach coming into effect in Magway/Delta before the end of 2016 and for the remainder of the MNCH programme coverage areas before the end of 2017.

1. **Planning and budgeting**

   What are the current and essential 3MDG financed activities that must be included within EHSAP in order for transition and sustainability to be possible? Does the MOH Township led planning finance a set of activities as prioritized in the 3MDG financed plans? When can the

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\(^6\) This would include the numbers of RHC + numbers of Station Hospitals + MCH + Township Hospital under the THD’s jurisdiction. It is not entirely clear to the FMO whether there is a need for a separate plan from the Township Hospital that will be reviewed by the Department of Medical Services where as another plan goes to the Department of Public Health.
plans be reviewed in order to address this question and have any gaps been identified? What are the financing requirements to meet this gap? What type of technical assistance might be required in order to advance the transition and is 3MDG able to offer such support e.g. under the RAS? 3MDG will monitor the planning and budgeting phase through monitoring the above.

2. **Programme spend and programme delivery under the EHSAP**
   What operational challenges are being faced by Township Health Departments to implement and report the plans? How could Townships be supported and what will be the role of the 3MDG and the IPs? How will 3MDG monitor the programme delivery?

3. **Financing of any identified gaps**
   Does EHSAP cover all essential operational costs? If a financing gap is demonstrated between essential activities currently financed and activities to be financed under EHSAP, then in principle can donor financing flow through financing channels used for EHSAP – similar to donor top-ups of WB funds in other sectors? When is a position statement possible on this issue? How will the progress of transition be measured at the expenditure level?

4. **Extension of Magway/Delta programming through 2017**
   If roll-out of the EHSAP is delayed and significant programming is likely on in budget year 2017/18, then should the Delta/Magway support be extended? If so, how will this be determined and when will it be known?

5. **Transitional programming** (Refer to Table 2 on following page)
Table 2. Questions for the transition of facilities based services and outreach

<table>
<thead>
<tr>
<th>Planning and budgeting questions</th>
<th>What is the question contingent upon?</th>
<th>What is the likely timeframe for resolution of question?</th>
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<tbody>
<tr>
<td>1.1 What are the current and essential 3MDG financed activities that must be included within EHSAP in order for transition and sustainability to be possible?</td>
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<td>1.3 When can the plans be reviewed in order to address this question and have any gaps been identified?</td>
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<td>1.4 What are the financing requirements to meet this gap?</td>
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<td>1.5 What type of technical assistance might be required in order to advance the transition and is 3MDG able to offer such support eg under the RAS?</td>
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<td>1.6 How will 3MDG monitor the planning and budgeting phase?</td>
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<td>2. Programme spend and programme delivery under the EHSAP</td>
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<td>2.2 How could Townships be supported and what will be the role of the 3MDG and the IPs?</td>
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<td>2.3 How will 3MDG monitor the programme delivery?</td>
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<td>3. Financing of any identified gaps</td>
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<td></td>
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<tr>
<td>3.1 Does EHSAP cover all essential operational costs?</td>
<td>Plans finalized and shared</td>
<td></td>
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<td>3.2 If a financing gap is demonstrated between essential activities currently financed and activities to be financed under EHSAP, then in principle can donor financing flow through financing channels used for EHSAP – similar to donor top-ups of WB funds in other sectors?</td>
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<tr>
<td>3.3 When is a position statement possible on the above issue?</td>
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<tr>
<td>3.4 How will the progress of transition be measured at the expenditure level?</td>
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<td>4. Extension of Magway/Delta programming through 2017</td>
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<tr>
<td>4.2 If so, how will this be determined and when will it be known?</td>
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3.2 Transition strategic planning area 2: Community based healthcare provision

Community based health care provision supports the training, supplies and supervision of auxiliary midwives and community health workers as well as strengthens the effectiveness of Village Health Committees that serve as an essential link between health service providers and communities.

A review of the global evidence on the effectiveness of community based health programmes/workers, as well as the evidence on cadres (auxiliary midwives and community health workers) in the Myanmar context was undertaken in the month of February 2016. The review objective was to provide an overview of current evidence available and rapid assessment of the strength of the available evidence and addressed a number of key questions relating to community based healthcare provision, including:

1. What evidence is there on the effectiveness of community based health intervention packages from different contexts, with a specific focus on MNCH?
2. What evidence is there on the effectiveness of community based health workers (CHWs) from different contexts, with a specific focus on MNCH?
3. What evidence is there on the effectiveness of CHW cadres in supporting MNCH (CHW/AMW) in the Myanmar context to date?
4. What evidence is there on the costs of community based programmes from different contexts/settings, with a specific focus on MNCH?
5. What evidence (case studies/examples) is there on the national scale up of community based health programmes through the Ministry of Health/public health system in Asia/South East Asia context?
6. What evidence is there on the implications for government/MoH of the national scale up of community based programmes (policy/resources required etc)?
7. What evidence is there on the process of scale up in different contexts?

The report presented recommendations to aid discussion and suggested potential actions to take forward the transition of Delta and Magway townships, with the anticipation that the final proposed actions will be determined jointly by the Ministry of Health, the 3MDG Fund and other key stakeholders with an interest in the transition and contributing to the development of community-based programming at this time.

Given the short-time frame available before the Delta and Magway townships are due to transition, it is recommended that these discussions be taken forward at the earliest opportunity to provide time to come to an agreed plan and pilot new guidelines where agreed. An indicative outline of actions and time-frames is presented in the table below. In taking forward these recommendations, it is envisaged that this will be a joint review by the Ministry of Health and the 3MDG Fund, with support, financial and technical, provided by the Fund and development partners.
<table>
<thead>
<tr>
<th>TIME FRAME</th>
<th>OVERALL ACTIVITY</th>
<th>DETAILS OF ACTIVITIES</th>
</tr>
</thead>
</table>
| INITIAL SCOPING – 5 MONTHS, 2016 | Joint review of 3MDG Fund support to community-based health programmes in Delta and Magway | • Review of roles and responsibilities of community cadres against WHO “optimised” guidelines to ensure fully utilised in supporting system/health outcomes  
• Review of the status and financing of community cadres against equity, fairness and sustainability criteria  
• Review of options for sustainability of support to community institutions  
• Assessment of linkages to the wider health system to ensure support and supervision and foster a continuum-of-care. This latter aspect to include governance and management arrangements under Ministry of Health and local authorities |
| DEVELOPMENT OF OPTIONS – 4 MONTHS 2016 | Development and agreement on options to take forward review findings | • Agreement on options to address review findings  
• Costing of options  
• Development of pilots to test options (as agreed)  
• Agreement of options/pilots to be taken forward |
| 10 MONTHS 2017 | Piloting of options | • Pilots initiated in Delta and Magway townships (as agreed)  
• On-going lesson learning and review |
| 3 MONTHS 2017 | Agreement on roll-out/scale up | • Review and prioritisation of lessons from Delta and Magway pilots  
• Recommendations for scale-up to remainder of 3MDG townships/wider community based health programme within health system |
While the issue of transitioning in Delta and Magway is a programmatic issue, it is clear that the process of transition offers a unique opportunity for learning which can be applied to the wider community based health programme within the health system in Myanmar at this time. It is also an opportunity to link with a number of other developments taking place, such as the essential package of interventions to be delivered through the primary health care system, and the Human Resources for Health plan.

In addition, in reviewing the transition of the 3MDG supported programmes there is also an opportunity to assess the opportunities to bring the 3MDG programmes and wider community-based health programme in line with the changing emphasis on broader health interventions needed to meet the burden of disease within the country. The Sustainable Development Goals (SDGs), place emphasis on UHC as a critical strategy to meet Goal 3 for health, as well as highlighting the continuing need to focus on maternal, neonatal and child health issues. Additionally Goal 3 gives recognition to other health conditions, notably NCDs, which are critical to achieving improved health at this time. This is particularly pertinent for Myanmar, with its recognized NCD burden (WHO, 2014).

A review of community based health programming and cadres within the wider health system, with the aim of capitalizing on the opportunities they present, is also in line with WHO’s forthcoming Global Strategy on human resources in health workforce 2030. This strategy recognizes the role that community cadres play alongside skilled and specialist staff in delivering a service that meets everyone’s needs, and maximizes the potential of community and other cadres (Campbell et al, 2015). The strategy is due to be discussed at the 2016 World Health Assembly (WHO, 2015).

The transition of 3MDG programmes in Delta and Magway townships, and a review of the role of community based health programmes and cadres within the health system in Myanmar, therefore provide a timely opportunity to support this important agenda.

References for this section:


For the full paper on the evidence for community based service provision, please contact the 3MDG Fund Management Office.
3.3 Transition strategic planning area 3: Emergency referrals system

Emergency referral systems for mothers and children under 5 years of age are established across all townships, and the uptake of emergency referral services have been significant in all townships supported by the 3MDG. Unit costs per referral remain more or less stable, which reflect the reduced costs from the medicines now available for free in the hospitals. This is offset by the increasing reach to more remote areas with higher transportation costs.

3.3.1 Rationale for continuing the emergency referrals programme

The population benefit of emergency referral financing is summarized as i) it covers costs for transportation and without it, patients in need of emergency healthcare may forego healthcare as they cannot finance transportation even if services are freely provided, ii) it deepens the delivery of a package of essential health services and bridges levels of the health system, iii) it improves predictability of timely accessing of health services by patients, iv) it reduces catastrophic costs associated with some illnesses (dependent on eligibility criteria).

3.3.2 Achievements of the emergency referrals programme

The achievements in emergency referral financing are further detailed through a stand-alone review of results, which is available from the Fund Management Office.

3.3.3 Key questions

A number of key questions will need to be addressed relating to emergency referrals and their sustainability beyond the end of financing for programmes (Delta, Magway – end of 2016) and remaining coverage areas (Shan, Kayah, Chin - end of 2017). Resolution of these questions would lead to a design and delivery process with transitioning of referrals coming into effect in Magway/Delta before the end of 2016 and for the remainder of the MNCH programme coverage areas before the end of 2017.

6. Policy questions
   Is there evidence upon which to base a policy decision? What is the MoH policy position in regards to inclusion of emergency referrals within a “benefits package”? Does the MoH wish such an expanded benefits package including emergency referrals to be adopted as a sub-national or nationwide policy? What is the likely timeframe of adoption of such a policy? If there is no such nationwide policy, does the MoH wish emergency referrals to be continued to be supported in 3MDG coverage areas? What is the 3MDG Fund position in regard to these questions? What actions need to be taken forward in advance of the end of Magway/Delta programming in 2016 and for other parts of the country in 2017?

7. Financing questions for the MoH and the 3MDG
   If the policy is adopted to continue financing for emergency referrals across 3MDG currently supported Delta/Magway Townships beyond the end of 2016, is there financing available to pay for this? If so, from what source? Is financing for nationwide scale-up of emergency referrals likely under the WB loan, Government budget or other financing sources (e.g. GFF)?

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7 2015 3MDG underspend figures will be available in late March 2016 and will give a clear picture of whether financing is available for 2017 to pay for the direct costs of emergency referrals (not the IP associated transitional costs)
Can donor financing flow through financing channels used for EHSAP – similar to donor top-ups of WB funds in other sectors? For other areas of C1 coverage and beyond 2017, how will funds flow in areas of the country where public sector health provision is constrained? When is a position statement possible on this issue? If financing for nationwide scale-up will become available only in 2017 or 2018, should Delta/Magway programming be extended through to the end of the Fund (2017)?

8. **Transitional programming**

If the policy is adopted and financing is available, a design process is required to agree upon eligibility criteria, payment modality and other associated administrative processes. How long would such a process take, who would be tasked with responsibility for taking forward this process? (Refer to Table 3 on the next page)
**Table 3. Questions for the transition of emergency referrals system**

<table>
<thead>
<tr>
<th>Policy - Inclusion of emergency referrals as part of a benefits package</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Is evidence available upon which to take a policy decision re: emergency referrals?</td>
</tr>
<tr>
<td>6.2 What is the MoH policy position in regards to inclusion of emergency referrals within a “benefits package”?</td>
</tr>
<tr>
<td>6.3 Does the MoH wish such an expanded benefits package including emergency referrals to be adopted as a nationwide policy?</td>
</tr>
<tr>
<td>6.4 What is the likely timeframe of adoption of such a policy?</td>
</tr>
<tr>
<td>6.5 If there is no such nationwide policy, does the MoH wish emergency referrals to be continued to be supported in 3MDG coverage areas?</td>
</tr>
<tr>
<td>6.6 What is the position of the 3MDG Fund if the MoH does not include emergency referrals as part of benefits package?</td>
</tr>
</tbody>
</table>

**Financing**

| 7.1 Can donor financing flow through financing channels used for EHSAP – similar to donor top-ups of WB funds in other sectors? When is a position statement possible on this issue? |
| 7.2 If the policy is adopted to continue financing for emergency referrals across 3MDG currently supported Delta/Magway Townships beyond the end of 2016, is there financing available to pay for this? If so, from what source? |
| 7.3 Is financing for nationwide scale-up of emergency referrals likely under the WB loan, Government budget or other financing sources (e.g., GFF)? If so, when will it flow? |
| 7.4 If financing for nationwide scale-up becomes available only in 2017 or 2018, should Delta/Magway programming be extended through to the end of the Fund (2017)? |

**Design and Implementation**

| 8.1 If the policy is adopted and financing is available, a design process is required to agree upon eligibility criteria, payment modality and other associated administrative processes. How long would such a process take, who would be tasked with responsibility for taking forward this process? |
| 8.2 This would be decided through a joint consultation process involving a working group comprised of decision makers from the MoH, WB and 3MDG. Tentatively the duration of the process would take between 9 and 15 months. |
| 8.3 The Minister has endorsed the proposal of a joint working group and is currently reviewing the draft ToR and assigning MoH counterparts to take the work forward in the next 12 months (June 2017). |

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8 2015 3MDG underspend figures will be available in late February 2016 and will give a clear picture of whether financing is available for 2017 to pay for the direct costs of emergency referrals (not the IP associated transitional costs)