



Photo: John Rae/UNOPS

# Reasons for Optimism

## 3MDG ANNUAL REPORT 2016



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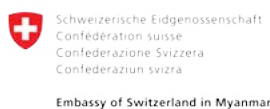


The Three Millennium Development Goal Fund  
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# 3MDG ANNUAL REPORT

## JANUARY - DECEMBER 2016



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# 1. EXECUTIVE SUMMARY

Investing in health reduces the burden of preventable disease, increases life expectancy and enables people to exercise their rights. Global evidence shows that making good investments in health can also stimulate economic growth.

In 2016, alongside important challenges, Myanmar's health system showed real reasons for optimism. There has been a marked increase in public spending on health and a reaffirmed commitment from the government to realizing universal health coverage. The newly launched National Health Plan sets a road map for improving health for all people in the country.

## Building equity

A focus on health equity helps concentrate efforts on the most vulnerable. It involves strengthening the health system at all levels, ensuring that medicines, supplies and infrastructure are available when needed. It also means ensuring health services are in place, and people are able to access those services when they need to.

To build a stronger health system in Myanmar, the Three Millennium Development Goal Fund (3MDG) supports the Ministry of Health and Sports to strengthen its technical capacity, improve approaches for more efficiency, and support the development of an enabling environment. Interventions are targeted at central, state, and township levels and focus on infrastructure, supply chain, human resources, financing, governance, and evidence-based policy-making. 3MDG also supports ethnic health organizations, local authorities and civil society organizations to build stronger systems.

To build equity in access to health services, 3MDG maternal, newborn and child health services are targeted to areas which are remote or affected by

*Photo: John Rae/UNOPS*



Daw Mana Kee Pai, from Chin State, gave birth to her child safely with the help of a 3MDG emergency referral to the hospital.

conflict. Tuberculosis (TB) active case detection activities prioritize people in prisons and those who live in urban slums, and malaria interventions target endemic areas. 3MDG’s HIV Harm Reduction programme brings services to people who inject drugs. They may be highly vulnerable and face criminalization and stigmatization. Locations for infrastructure projects are chosen based on difficulty of access to existing services.

Even when health services are in place, people can face barriers in reaching them. These include distance, cost, embedded beliefs about health services, lack of trust, stigma, and discrimination. As part of the Collective Voices initiative, 25 local civil society organizations held more than 500 community meetings across six states and regions in 2016, uncovering the causes of limited access to healthcare using language and conceptual frameworks familiar to the communities they are working with.

3MDG’s support to emergency referrals helps overcome barriers of distance, cost and lack of knowledge about available health services, by training health workers to detect and refer pregnant women and children under five who need emergency care. Transportation, food and other costs are reimbursed.

### Our approach

The 3MDG approach – building on equity, the reinforcement of health systems, and the delivery of key services – is aligned to the priorities of the Ministry of Health and Sports as described in the National Health Plan 2017 - 2021. The plan is explicitly inclusive and pro-poor, seeking to provide access to all populations, including the most disadvantaged ones, to a basic package of health services. 3MDG supports health systems that put people at the centre, by understanding their needs and hearing their voices.

### Results in 2016

In 2016, 3MDG programmes were running at full speed and results across most indicators were meeting or exceeding targets. For maternal, newborn and child health services, results across the country were strong. In townships that 3MDG supports, women are now more likely to access skilled care before, during and after their pregnancy. Women and children under five are better able to access emergency care when it is needed.

These overall figures can hide geographic disparities. For example, more than 413,000 married couples were able to access contraceptives, representing 66 percent of all couples in 3MDG townships. However, in Chin State, only 27 percent of couples accessed these services. Disparities were also evident for other indicators (*see Chapter 9.3 Maternal, newborn and child health results*), which calls for continuing commitment to hard-to-reach areas and populations.

## FUND STATUS

As one of the largest contributors of external assistance for health in the country, 3MDG combines the resources of seven donors - Australia, Denmark, the European Union, Sweden, Switzerland, the United Kingdom, and the United States of America – to provide around USD 284 million in the period 2012–2017. By bringing key donors together in a single fund, 3MDG increases efficiency, achieves scale, pools risks, and provides co-ordinated support to government priorities. It is managed by the United Nations Office for Project Services (UNOPS).

3MDG's HIV Harm Reduction programme is performing extremely well across all indicators and making a significant contribution to national targets. The distribution of needles and syringes, at 13 million in 2016, represents 43 percent of the national target.

The World Health Organization recommends at least 200 clean needles and syringes per person who injects drugs in one year to reduce HIV transmission via this route.<sup>1</sup> Higher targets are appropriate where prevalence of disease is higher.<sup>2</sup> In 2016, 3MDG was able to provide 342 items per person.

The National AIDS Programme also set a target to reach 76,000 people who inject drugs with prevention programmes. 3MDG was able to reach 40,000 people, which is 53 percent of this target and 96 percent of people who inject drugs in the coverage area. 3MDG was able to reach such a large number of people because they are concentrated in a small number of geographic areas, and through the use of a combination of facility-based services and trained peer outreach to reach a population that is in part mobile.

The number of people enrolled on treatment for multi-drug resistant tuberculosis – at 2,054 – is also a significant proportion of the national burden. Active case detection through mobile clinics continues to be an important way to reach those people living in urban slums, prisons and worksites, where tuberculosis is prevalent.

3MDG continues to meet testing targets for malaria, with more than 444,000 people tested in 2016. However, as prevalence across the country continues to fall, the detection of cases is also dropping. This represents a great success for Myanmar, however, efforts must continue towards supporting those living in drug-resistant areas and ultimately, towards elimination of the disease.

In 2016, 22 midwifery schools and one Lady Health Visitor school were upgraded and 44 new rural and sub-rural health centres were constructed. Including those centres completed in 2015, 61 centres have been handed

## **SINCE THE START OF THE FUND (2013 - 2016):**

**4.5 million people covered by maternal, newborn and child health services** in 34 townships, including people in remote and conflict-affected areas

**150,000 pregnant women** accessed skilled care for childbirth

**45,000 emergency referrals** used by pregnant women

**220,000 children received the Penta 3 vaccination** against five common childhood diseases

**36 million syringes distributed** to people who inject drugs

**2 million malaria tests** taken and read

**39,000 cases of tuberculosis** (all forms) detected and notified

**86,000 referrals for TB testing** by community health workers and volunteers

**22 midwifery schools** and one lady health visitor school upgraded for more hands-on learning

**77,500 children received micro-nutrient powders** to improve nutritional status

**3,609 health facilities** across Ayeryawady, Bago, and Magway are submitting monthly consumption reports using a standardized stock book

Support to the development of the National Health Plan 2017-2021



over to the Ministry of Health and Sports and cover a population of about 365,000 people. By early 2018, 82 centres will be completed.

3MDG supported the development and launch of the National Health Plan and the set-up of its monitoring unit; as well as improvement of the cold-chain through a partnership with UNICEF that has allowed the introduction of pneumococcal vaccine nationwide.

In conflict-affected and hard-to-reach areas, partners also work closely with ethnic health organizations, local authorities and non-state actors to support delivery of health services. 3MDG supports the organizational capacity development of these partners, whose work is particularly important in order to extend reach into these areas. Working to improve co-ordination in conflict areas also makes an important contribution beyond health, creating opportunities for people to come together around health.

A strong health information system is critical to a well-functioning health system. In 2016, with 3MDG support, significant steps were taken in improving this system with the roll-out of two tools: the electronic District Health Information System (DHIS 2) and the Volunteer Recording System.

## Lessons Learned

From its inception, the 3MDG Fund has been a learning organization. Projects and approaches require monitoring and adjustments to make sure they are responsive to the needs of the population. Overall lessons shape the future actions of 3MDG (*see Chapter 10: Lessons Learned*), any Successor Fund (*see Chapter 12: Moving Forward*) and all health actors in Myanmar.

3MDG has learned important lessons about promoting integration, working in conflict-affected areas, and improving co-ordination with the Ministry of Health and Sports. 3MDG has remained flexible in a changing environment,

A mother and child attend a mobile TB clinic in Yangon.



and this has been valuable. For example, an increased role for government was reinforced by a reconstitution of the Fund Board in 2015 to include representatives from the Government of Myanmar.

Starting in 2015, 3MDG launched the Collective Voices initiative, in recognition of the critical role that civil society organizations play in healthcare, due to their unique insights into the issues communities face and how they can be solved. For example, civil society organizations have been able to uncover key reasons why people were not travelling to health facilities, such as language barriers or cultural beliefs about travelling on certain days. As a result, outreach visits have been increased on those days and more local staff who speak the same language as the community have been employed.

## Moving forward

3MDG has adopted three broad strategies which aim to ensure sustainability is built into the work of the Fund: strengthening the health system; building the capacity of key stakeholders in the health sector; and ensuring sustained health benefits, including through institutionalizing services and activities. The long-term goal is to achieve institutional and financial sustainability of public sector health services and government stewardship of the wider health sector. Work being undertaken under the Fund's health system strengthening portfolio, such as the strengthening of public financial management, supply chains and planning processes, help to prepare national systems.

Two key examples from 2016 demonstrate this commitment to transition and sustainability. The first is the 3MDG's work to institutionalize the emergency referral programme. Further detail can be found in *Box: Institutionalization of emergency referrals in Chapter 7: Building Equity*. Meetings to discuss the way forward were held in 2016, and this work will continue in 2017.



Opening of a 3MDG-funded caretaker quarters for TB patients in Mandalay.



Secondly, 3MDG is working with the Ministry of Health and Sports to institutionalize the role of the community health workforce (*See Box: Institutionalizing the role of the community health workforce, Chapter 7: Building equity*). In 2016, this included advocacy and meetings to discuss the potential for integration of volunteer roles and the challenges faced.

The National Health Plan 2017-2021 is a strong framework for Myanmar's progression towards universal health coverage. With renewed Ministry leadership and a clear roadmap for the delivery of an Essential Package of Health Services to the entire population, the time is right for continued investment in and support to health in the country.

In 2017, 3MDG has the opportunity to work more closely with the Ministry of Health and Sports and development partners to address the constraints that need to be overcome and the policies required for the scale-up in healthcare that is required if the country is to achieve universal health coverage. Engagement of all stakeholders will continue to be a priority. 3MDG will also make internal changes to foster better integration of our support within Myanmar's health response.

Several bilateral donors are currently exploring the establishment of a follow-on mechanism that will allow them – and possibly other development partners – to continue pooling resources in support of the Myanmar health sector, sustain the gains achieved by the 3MDG Fund, and continue to promote equity in access to health. This 'Successor Fund,' with an estimated USD 150 million for a period of five years, will contribute to improving equity and inclusiveness, aligned with and in support of the National Health Plan and the Ministry of Health and Sports.

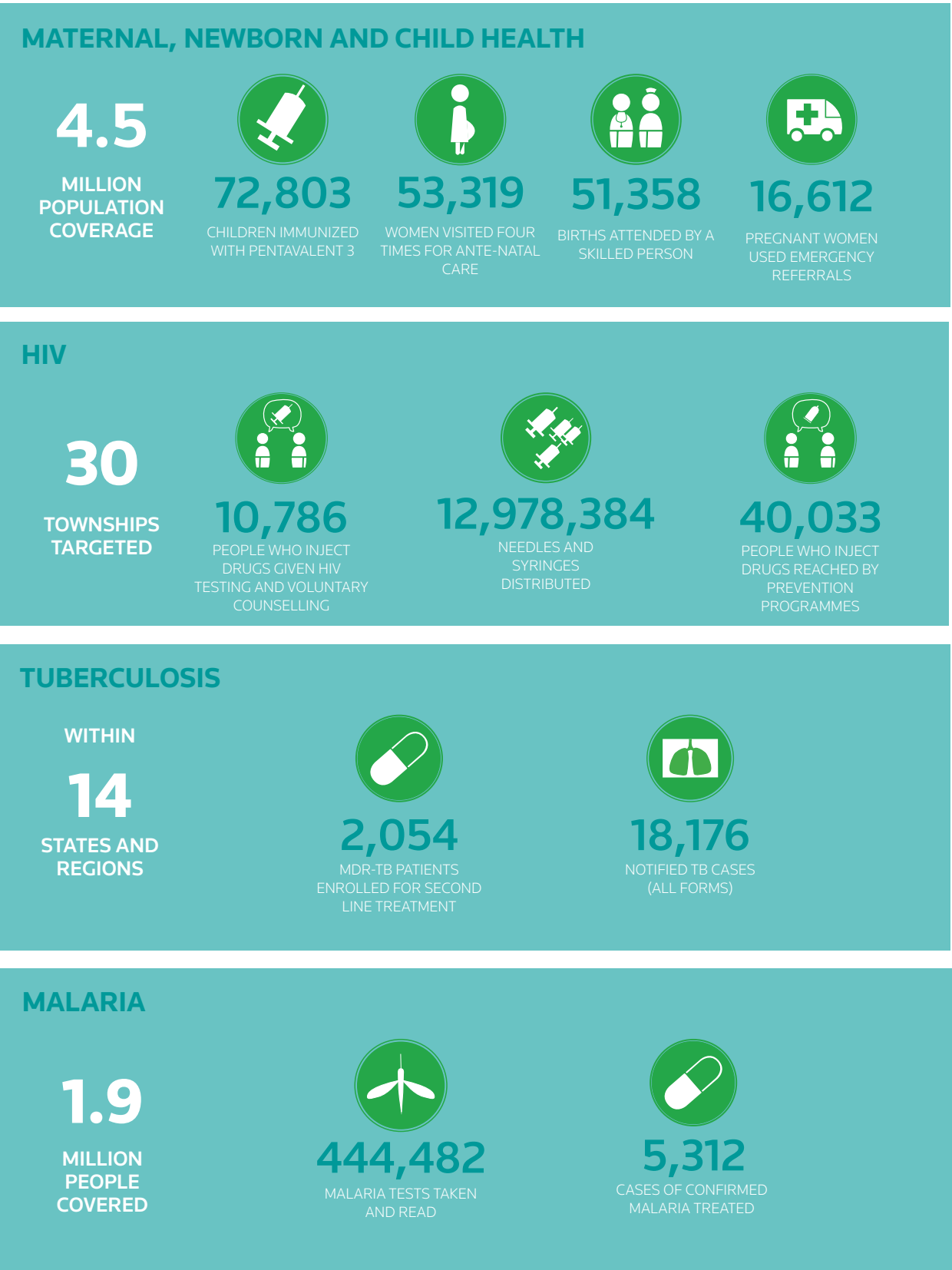
Local mothers at the health centre where they gave birth to their babies in Kone Thar Village, Ngape Township, Magway Region.





# 2. RESULTS AT A GLANCE

From January 2016 to December 2016



## MEASURING PERFORMANCE AGAINST TARGET (% of target achieved)



# 3. COVERAGE MAP

## HEALTH SERVICES COVERAGE FINANCED BY 3MDG

December2016

### NATIONWIDE ACTIVITIES

In addition to this service coverage map, 3MDG funds nationwide projects.

#### 22 MIDWIFERY SCHOOLS + 1 LADY HEALTH VISITOR SCHOOL



Supported by the Midwifery Education and Training Strengthening Programme, through a partnership with MoHS and Jhpiego

#### 321 TOWNSHIPS



Covered by TB Active Case Finding, implemented by the MoHS National TB Programme

#### 82 HEALTH CENTRES



Being constructed to provide healthcare to poor and vulnerable communities in remote areas

#### PUBLIC FINANCIAL MANAGEMENT



Training of MoHS staff at central, state/region and township levels, in partnership with the World Bank

#### PROCUREMENT



Contraceptives procured and distributed nationwide in partnership with Population Services International (PSI)

#### COLD CHAIN SYSTEM



Strengthening cold chain, through partnership with MoHS and UNICEF, to enable introduction of pneumococcal vaccine

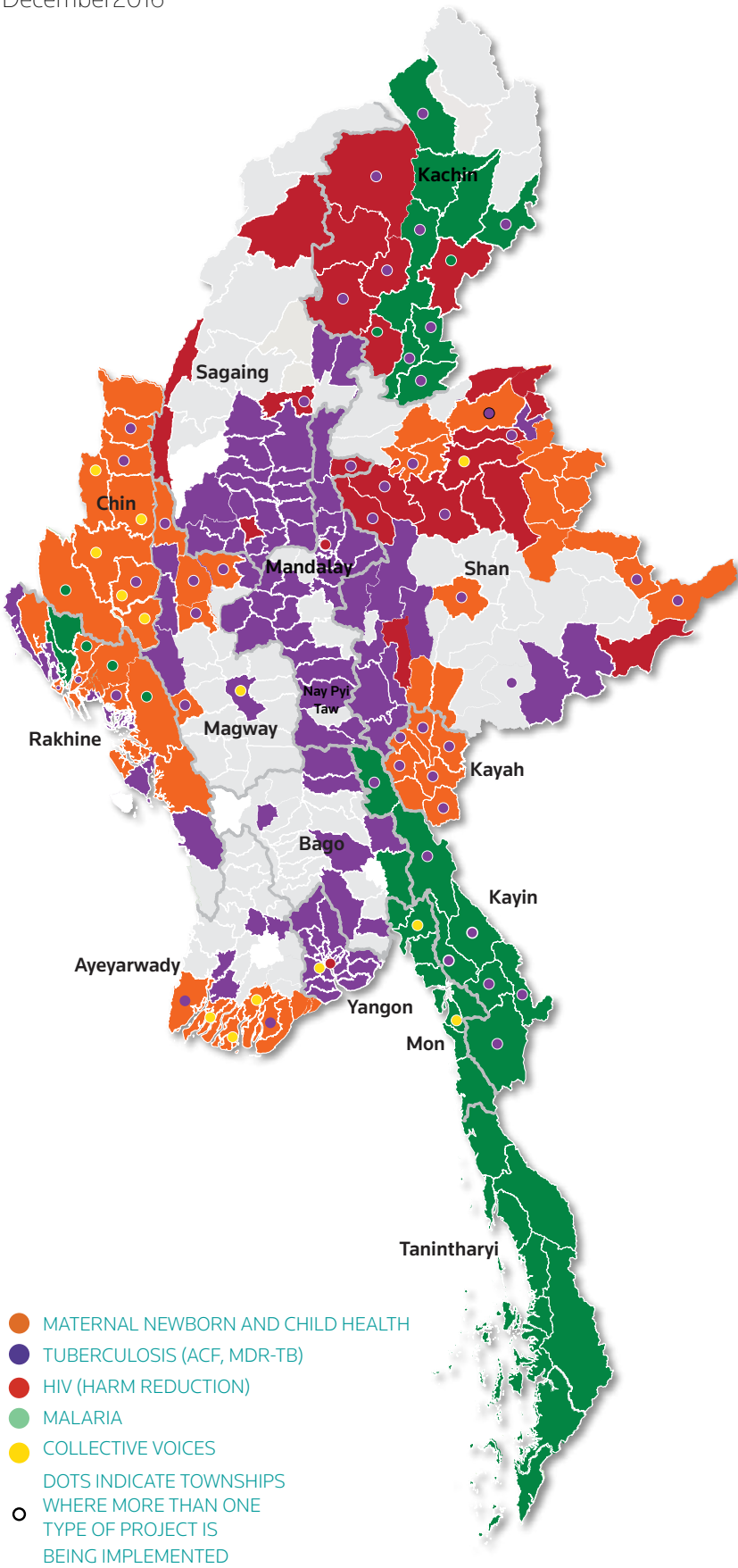
#### SUPPLY CHAIN MANAGEMENT

Helping to ensure essential medicines and health commodities are available when needed

#### NATIONAL HEALTH INFORMATION SYSTEMS



District Health Information System 2; development of MDR-TB patient management system; design of health information system strategy



# 4. REASONS FOR OPTIMISM

Looking at developments in 2016, there are many reasons to feel optimistic about health in Myanmar.

Public spending on health has grown significantly during the past five years, from 94 million USD in 2012 to 850 million USD in 2016/17.<sup>3</sup> The majority of the increase has been used to directly finance the delivery of health services and the expansion of existing coverage. That means the health needs of more people, in more places, are being met. With this increase in funding, there are already early signs that **out-of-pocket** spending on health has been reduced,<sup>4</sup> though more time will be needed to confirm this.

Myanmar is going through a major political transition. After more than 50 years of military rule, the first democratically-elected government took office in March 2016. The transition, alongside a complex peace process, presents opportunities for improvements in health: a country at peace, with a stable democracy, can make great inroads into tackling the health challenges it faces.<sup>5</sup>

This has been accompanied by rapid economic development, with the rate of economic growth expected to exceed eight percent in the coming years<sup>6</sup> - among the highest in the world. Also noteworthy are the developments in information and communication technology, reflected in the rapid uptake of mobile technology throughout the country – and which will no doubt provide further opportunities for the health sector.

Cementing the opportunity for these developments to make an impact on the ground, there is renewed commitment from the Government of Myanmar to confront and overcome the issues which currently face Myanmar's health system. In his first year, the new Minister for Health and Sports His Excellency Dr. Myint Htwe has set an ambitious direction for the Ministry, building on the former political leadership's promise - that all people can access quality health services they need at a price they can afford. The government has reaffirmed its commitment to reaching this state, known as **Universal Health Coverage (UHC)**, by 2030. This is also in line with the third Sustainable Development Goal.

**Out-of-pocket** expenses are those that households have to pay themselves. Out-of-pocket payments for health can cause households to incur catastrophic expenditures, which in turn can push them into or further into poverty.  
*Source: World Health Organization*

The goal of **Universal Health Coverage (UHC)** is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them.  
*Source: World Health Organization*

**Pro-poor** policy processes are those that allow poor people to be directly involved in the policy process, or that by their nature and structure lead to pro-poor outcomes. The Civil Society Partnership Programme says 'the aim of pro-poor policies is to improve the assets and capabilities of the poor'.  
*Source: ODI*

## THE NATIONAL HEALTH PLAN 2017 – 2021

The National Health Plan 2017-2021 aims to strengthen the country's health system and pave the way towards universal health coverage by 2030, by choosing a path that is explicitly **pro-poor**. The main goal of the plan is to extend access to a Basic **Essential Package of Health Services** (essential package) to the entire population by 2020 while increasing financial protection.

The plan was developed in an inclusive and transparent manner, involving key stakeholders such as ethnic health organizations, civil society organizations, the private sector, non-government organizations, donors, United Nations agencies, professional councils and associations, state and regional health departments, township health departments and state and regional social ministries.

The five-year plan will be translated into annual operational plans that will elaborate on implementation details. The first operational plan will focus on:

- the finalization of the basic essential package of health services
- investments to expand capacity to deliver these basic services in the first 70 townships,



This is outlined in the National Health Plan (see Box: *The National Health Plan 2017 – 2021*), which structures the health response by laying out the steps needed to reach universal health coverage by 2030. It emphasizes inclusion and encourages collaboration, which is critical for a health plan in such a diverse country, especially one facing tough challenges.

An **Essential Package of Health Services** is the package of services that the government is providing or is aspiring to provide to its citizens in an equitable manner.  
*Source: World Health Organization*

One of the most critical first steps towards universal health coverage in the National Health Plan is the development of the **Essential Package of Health Services** (essential package). This approach will ensure the universal readiness and availability of a basic set of services. Services in the package are chosen based on criteria developed through a series of consultations over two years. The ‘package’ will be expanded over time, starting with a ‘Basic Essential Package’ by 2020, an ‘Intermediate Essential Package’ by 2025, and a ‘Comprehensive Essential Package’ by 2030. The plan also includes new goals for co-ordination and alignment within the health sector to avoid duplication and overlap and to ensure there are no gaps.

The new direction was made clear in the Minister’s first speech, and the priorities identified have now been cemented in the National Health Plan. 3MDG’s efforts support these priorities, including the expansion of primary healthcare coverage and support to rural and under-served populations. See *Chapter 8: Our Approach*, for a description of how 3MDG work aligns to the Ministry of Health and Sports priorities.

*“The overall goal of the National Health Plan 2017 – 2021 is to provide basic essential health services to every citizen by 2020; especially to those residing in the rural and hard to reach areas. This plan has been formulated with the aim of improving access to health services in these communities.”*

**Daw Aung San Suu Kyi, Launch of the National Health Plan**

- strengthening the health system itself to support effective delivery of the basic essential package
- developing an enabling environment
- the initiation of a bottom-up inclusive planning process
- the monitoring of the National Health Plan

The Ministry of Health and Sports has established a specific implementation monitoring unit for the National Health Plan, to ensure implementation remains on track. The implementation itself will be the responsibility of all relevant stakeholders.

With the leadership of the Ministry of Health and Sports and in collaboration with other development partners, the 3MDG Fund has supported the formulation of the National Health Plan and the first Annual Operational Plan since August 2016. Support for the implementation of the plan will continue under the guidance of the Ministry’s monitoring unit.

# 5. CHALLENGES

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The Ministry of Health and Sports is showing renewed leadership in pushing forward the Universal Health Coverage agenda. Yet health problems in the country are significant, with Myanmar recording some of the poorest health indicators in the region (*See Box: Health in Myanmar on this page*).

Decades of armed conflict and neglect across ethnic states in Myanmar have had negative impacts on the health system and health outcomes, as well as on the mental and physical health of communities in conflict areas.<sup>7</sup> The effects of long-lasting armed conflict on the security and governance situation, health infrastructure, and the relationship between ethnic armed organizations, ethnic communities and the government all have deep implications for the strengthening of healthcare systems in conflict-affected areas.<sup>8</sup>

Though investment in health has improved since being the lowest in the world in 2009, it is still limited (slightly over one percent of GDP in 2014). Myanmar currently allocates only 3.65 percent of its total budget to health, which is low by global and regional standards. This is equivalent to about USD two per capita per year. Combined with past political isolation, poor economic management and internal conflicts, these limited resources have translated into poor levels of basic health services.

Though they are possibly decreasing, out-of-pocket payments for health as a proportion of total health spending are among the highest in the world, at almost 80 percent in 2011-12. This remains the dominant source of health financing.

Financial barriers to access, combined with other barriers such as geographical remoteness, conflict and cultural practices have led to considerable inequities in the use and access to health services, with rural and hard-to-reach areas of the country being the most deprived.

In a health emergency, these barriers mean families can be faced with a difficult choice. By seeking care – which can be expensive or a long distance away – families can be thrown into poverty, and those already struggling can sink deeper. Some families will hope that the situation improves with traditional remedies or on its own, meaning care seeking may be delayed

## HEALTH IN MYANMAR

Myanmar has among the lowest life expectancies of any country in the region, at only 66.8 years.<sup>9</sup> However, due to increased investment in health, there have been significant declines in infant and under-five mortality, suggesting that child health services are increasingly reaching many of those in need.

The maternal mortality ratio is 282 per 100,000 live births.<sup>10</sup> This is the highest in the Association of Southeast Asian Nations,<sup>11</sup> but it has improved. Decreases in these mortality rates are consistent with changes in key determinants, including an increasing age at marriage, higher contraceptive use, lower fertility, better immunization coverage, and good coverage of ante-natal and post-natal care.

Hidden behind national figures, however, are wide geographic, ethnic and socioeconomic disparities. For example, the under-five mortality rate is twice as high in Chin State (104 deaths for 1000 live births) as in Yangon (46 deaths per 1000 live births).<sup>12</sup> In urban areas, 84 percent of women reported receiving four or more antenatal care visits, while only half the women received four visits in rural areas.<sup>13</sup>

**Basic Emergency Obstetric and Newborn Care (BEmONC)**

is critical to reducing maternal and neonatal death. In Myanmar the care provided with skilled staff in health centres, large or small, includes the capabilities for administering antibiotics, uterotonics, use of magnesium sulphate to address eclampsia followed by referral and basic neonatal resuscitation care. *Source: UNFPA*

The bacteria that cause tuberculosis (TB) can develop resistance to the antimicrobial drugs used to cure the disease. **Multi-drug-resistant TB (MDR-TB)** is TB that does not respond to (at least) the two most powerful anti-TB drugs. Multi-drug resistance continues to emerge and spread primarily due to mismanagement of TB treatment and person-to-person transmission. *Source: World Health Organization*

until the issue is more severe and more difficult to treat. If the barriers are too great then care may never be sought.

Across the country, the quality of roads and transport for patients and staff is inadequate. This means that people cannot get to the health facilities they need in a reliable or affordable way.

When people do seek care, they may be faced with more challenges. The coverage and condition of health infrastructure is poor, with public hospitals sometimes lacking basic facilities and equipment.<sup>14</sup> A recent health facility assessment showed that only seven percent of rural health centres and sub-centres – which are most readily accessible by the rural majority – provide **Basic Emergency Obstetric and Newborn Care (BEmONC)**.<sup>15</sup>

Drugs and supplies often run out or are otherwise not available, particularly at the township level. Coverage of critical child health interventions tends to be low and only 55 percent of children are fully immunized.<sup>16</sup> There is a shortage of medical and paramedical staff, as well as volunteers, in nearly all areas and professions. The training that health staff receive before they start their careers can be inadequate, and on-the-job training – primarily provided through projects rather than the government – is poorly co-ordinated.<sup>17</sup>

There are significant gaps in health data from the community level and especially from hard-to-reach areas. Health information may be incomplete or unreliable, but efforts are underway to address this – such as the roll-out and use of two health information tools in the majority of 3MDG townships, and broader Ministry efforts.

Among the wealthier households, 77 percent of children had all basic vaccinations, compared to 41 percent among the poor. Delivery by a skilled provider is nearly universal (97 percent) among wealthier households, while among the poorest households, less than 37 percent gave birth with a skilled provider.<sup>18</sup>

The nutritional status of children under five needs to be improved with nearly three in ten children stunted and one in five underweight. Only about half (55 percent) of children aged 12-23 months have received all of the recommended basic vaccinations.

The country has a high burden of HIV, tuberculosis (TB) and malaria. Significant progress has been made in the fight against HIV/AIDS, reflected in the sharp decrease in new HIV transmission from 35,000 in 2000 to 11,000 in 2015.<sup>19</sup> Yet, national level HIV prevalence is still extremely high in high-risk groups: 28 percent among people who inject drugs, 23 percent among female sex workers, and 12 percent among men who have sex with men.<sup>20</sup>

Myanmar is one of the 30 high TB/HIV burden countries in the world. WHO estimates show a reduction in TB prevalence from 922 per 100,000 people per year in 1990 to 457 in 2014. The death rate declined from 133 per 100,000 people to 53 in the same period. TB detection has accelerated in remote areas through mobile clinics. In 2014, 3,495 cases of **multi-drug resistant-TB** were recorded.<sup>24</sup> In 2014, 40 percent of TB patients were tested for HIV, and 11 percent were HIV positive.<sup>25</sup>

With more than two-thirds of the country’s population living in areas of malaria risk, malaria continues to present health risks in Myanmar.<sup>26</sup> Great strides have been made in reducing morbidity and mortality over the last decade. For example, from 2012 there has been a 49 percent reduction in malaria cases and deaths have reduced from 1,707 in 2005 to just 37 in 2015.<sup>27</sup> The use of bed nets remains low (16 percent of the population, 19 percent of children under five), despite high overall ownership of a regular mosquito net at 97 percent, although only 27 percent owned an insecticide treated net.<sup>28</sup>



Services are often not available or affordable, and even when they are, they may not be known in the community or people may not feel comfortable accessing them. This is shown in the relatively low usage of maternal and newborn health services. For instance, only 60 percent of the births in the five years preceding the Myanmar Demographic and Health Survey were delivered by a skilled provider and only 37 percent were delivered in a health facility.<sup>21</sup> For children under five with symptoms of acute respiratory infection, advice or treatment from a health provider was only sought in 58 percent of cases.<sup>22</sup> Geographic disparities are considerable.<sup>23</sup>



A grandmother takes care of one of her daughter's children as her daughter recovers from childbirth in Chin State. The birth took place in the hospital with referral support from 3MDC.



A midwife works at a mobile TB clinic. Though the focus is TB, the clinics serve many community health needs.

# 6. THE CASE FOR HEALTH

Health is a goal in its own right. It is central to human happiness and well-being, critical for people to enjoy fulfilling lives. Investing in health reduces the burden of preventable disease, increases life expectancy and enables people to fulfill their potential.

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 all citizens' capabilities and enabling them to compete for jobs and opportunities generated through inclusive and sustainable development. In fact, lower mortality can be credited with 11 per cent of economic growth in low or middle income countries, according to a Lancet publication.<sup>29</sup>

The return on investment in pregnant women and newborns has been estimated to be as high as USD 120 for every US dollar spent.<sup>30</sup> Increasing demand for spacing births and delaying adolescent childbearing contributes to reducing maternal and newborn deaths and increased female education and future earning capacity.<sup>31</sup>

**Conflict sensitivity** is the ability of an organization to understand the context in which it operates; understand the interaction between its intervention and the context, and; act upon the understanding of this interaction, in order to avoid negative impacts and maximize positive impacts.  
*Source: Saferworld et al*

In conflict-affected areas, health interventions are able to make immediate and long-term impacts on the health of the people who live there, with the potential to do even more. That is, to be **conflict sensitive** in this context does not only mean ensuring better health, but also creating opportunities to bring people together around health, when possible. The principles of conflict sensitivity guide 3MDG interventions in conflict-affected areas. Such interventions are only possible because of improved co-ordination and collaboration between the Ministry of Health and Sports, ethnic health organizations and other 3MDG implementing partners. *For more on 3MDG's contribution to peace building through bringing people together around health, please see Box: Working in conflict-affected areas on page 50.*

Investment in health is an investment in prosperity, social and financial protection, equity and national security. Better health is a foundation for Myanmar's social and economic progress. Families are protected from being forced into poverty by healthcare costs. Healthy children achieve more in education; healthy adults are more productive, better able to look after their families and to contribute to their communities.

*“The National Health Plan is important not only for the improvement of health but also for the advancement in peace and development of the country”*  
**Daw Aung San Suu Kyi at the Launch of the National Health Plan (2017- 2021)**

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## 7. BUILDING EQUITY

The Constitution of Myanmar says that every citizen shall have the “right to health care.” This is true no matter where they are born, their gender or ethnicity, or how much money they have. This can only be guaranteed through **health equity**, which is only realized when each individual has a fair opportunity to enjoy a healthy life. A focus on health equity helps concentrate efforts on those who are most vulnerable, most distant and most hidden.

It is populations beyond the reach of the government who are often most in need. The 3MDG Fund has a unique role to play in building health equity, aligned to the priorities of the Ministry of Health and Sports and the National Health Plan. 3MDG is able to complement their efforts by filling challenging gaps in health service delivery and helping to ensure the health system is truly universal.

This means working on some of the most complex issues in Myanmar’s health response: extending access to health services in remote areas; working with vulnerable, criminalized and stigmatized population groups, such as people with drug dependence; tackling health issues that impact the poor and marginalized; and working in areas affected by conflict. For example, the 3MDG Harm Reduction programme reached more than 40,000 people who inject drugs with prevention programmes, which is 96 percent of the people who inject drugs in the coverage area.

To reach people in under-served and remote areas, 44 new rural and sub rural health centres were constructed in 2016 as part of a bigger USD 12 million project to build 82 new centres across the country. Locations were chosen based on accessibility, local needs, and lack of existing services

By focusing on collaboration and co-ordination, 3MDG’s approach helps to build trust and facilitate enhanced dialogue between key stakeholders, including the Ministry of Health and Sports, ethnic health organizations, private providers, non-government organizations and civil society. This engagement makes an important difference to the health of people living in these areas. For example, in 2016, work has continued in seven townships of Kayah State thanks to strong relationships between implementing partners and ethnic health organizations. At the end of the year, 87 percent of mothers

To achieve **health equity**, we must eliminate avoidable health inequities and health disparities.

**Health inequities** are differences in health that are avoidable, unfair, and unjust. Health inequities are affected by social, economic, and environmental conditions.

**Health disparities** describe the differences in health outcomes among groups of people.

**Health equity** is therefore the attainment of the highest level of health for all people. It means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

*Source: Health Equity Institute*

### PUBLIC FINANCIAL MANAGEMENT

Public financial management involves all of a country’s processes relating to financial management, from revenue capture and management, to budgeting and planning, reporting, audit and oversight. It is essential for good, sustainable governance and vital for the achievement of policy objectives. Without a robust public financial management system, service delivery is compromised.

Throughout 2016, 3MDG worked closely with the World Bank to strengthen the public financial management system at central, state and regional, and township levels. The team assessed bottlenecks in the system at the central level, and identified key areas for improvement. The assessment has recommended improving the planning and budgeting process, the introduction of electronic systems for timely data recording, better collaboration with other ministries and strengthening the standard operating systems.

Training sessions were conducted and hands-on mentoring was provided to all states and regions and 50 townships in order to improve: budget executing and tracking, public sector accounting, and understanding of the rules that affect health spending. In 2017, new tools will be introduced for budgeting and planning will be better linked to budgeting. Community involvement will be increased to strengthen public financial management accountability.



and newborns in the coverage area received postnatal care within three days of childbirth and 78 percent of births were attended by skilled health personnel.

## 7.1 STRENGTHENING THE HEALTH SYSTEM

Technological and medical advances mean that we have many of the interventions that are needed to prevent and cure diseases and help people live longer with improved quality of life. However, health gaps persist. Currently in Myanmar, the health system is not robust enough to deliver services to the people who need them most. A responsive, resilient and people-centered health system is critical so that everyone’s health needs can be met, and gains that have been made are sustainable.

**A Lady Health Visitor** is a diploma level midwife who has had at least three years of work experience. She is interviewed in a national selection process and if she passes, she attends a nine month course. This post is equivalent to a diploma level nurse.

For people to enjoy good health, recover from illness and feel confident in the public health system, all parts and all levels of the system need to be strong and they need to work well together. This means interventions need to be targeted at the functions of the health system – infrastructure, supply chain, human resources, health financing, governance and ensuring evidence-based policy making – at all levels, including central, state and regional, township and community.

What does a well-functioning health system look like? It has effective procurement and distribution systems that deliver equipment and medications to those in need. People are able to access quality health services regardless of their ability to pay. This means geographical proximity to a health centre that is equipped with staff with the right skills, motivation and tools to do their job.

### HUMAN RESOURCES FOR HEALTH

Human resources are a building block of any health system, ensuring that the right staff are available where they are needed. In Myanmar, it is estimated that a high proportion of sanctioned posts remain unfilled, and issues persist with management, planning, recruitment, retention and performance. Strengthening human resources for health is a key objective of the National Health Plan 2017 – 2021, and an area where 3MDG continues to work closely with the government and partners.

Jhpiego, a Johns Hopkins-affiliated non-profit organization, and 3MDG are helping change the way that midwives are trained in Myanmar’s 22 midwifery schools and one **Lady Health Visitor** school. Completed in 2016, skills labs have been built in all schools to encourage hands-on practice and refresher trainings ensure skills are maintained throughout a midwife’s career. Faculty capacity is being built through clinical standardization, effective teaching and performance assessment skills.

With 3MDG support, Jhpiego has worked with the Myanmar Nursing and Midwifery Council to develop the legislative framework to support midwifery training standards and accreditation of training schools. In 2016, Jhpiego and the Ministry of Health and Sports also developed the first strategy for nationwide refresher skills-based training of health providers on basic emergency obstetric and newborn care (BEmONC). At present, the role of the midwife does not cover all seven signal life-saving functions considered internationally to comprise BEmONC. However 3MDG, World Health Organization, UNFPA and Jhpiego continue to advocate to expand this, and individual modules for these additional functions can be added to the curriculum once permission is received.

3MDG recently designed a project with the Ministry to strengthen human resource management for the entire health workforce. Jhpiego will help the Ministry strengthen systems in planning, production, deployment, retention and support of high-quality professionals at all levels of service delivery. 3MDG is supporting the development of a strategic approach to human resources for health with the World Health Organization. The focus is on strengthening frontline providers’ technical skills, developing an enabling environment, particularly in hard to reach and rural areas, and improving support to village health workers.

Patients are aware of the services available, and when visiting the centre, the patient receives the information and the medication they need to get better. Financing systems are sustainable, inclusive, and fair, ensuring healthcare costs do not force impoverished households even deeper into poverty.

Government health facilities are just one part of the equation – it is also about access to quality providers in the private system, who are critical partners in health service delivery. That includes pharmacies, pharmaceutical providers, private sector clinics and other health providers. Strengthening these elements of the system requires governance, regulation, subsidies and other ways of ensuring equitable access.

At all levels of health system strengthening, 3MDG invests in people to strengthen the technical capacity of the Ministry, civil society, and other stakeholders; improves approaches to promote efficiency; and builds an enabling environment for frontline staff by ensuring medicines, supplies and infrastructure are available when needed.

## Central level

Increasing moves towards decentralization are changing the role of central level health systems around the world. New demands are being placed on local actors for service delivery, and the central role is moving largely to a focus on good governance and effective stewardship.

3MDG supports the Ministry of Health and Sports in their role in providing centralized oversight, co-ordination, regulation, strategic direction, and creating an environment conducive to health interventions. For example, 3MDG provides technical assistance to improve the governance of the health system, helps to develop plans, policies and strategies based on evidence, as well as generating evidence that is relevant for policy, and helps to establish an effective monitoring system to assess progress.

3MDG support also includes public financial management training (*see Box: Public Financial Management on page 20*), strengthening the supply chain for essential medicines, and improving the **cold chain** to extend access to vaccines nationally. In 2016, 80 percent of 3MDG supported townships had functional cold chain equipment and adequate storage space compared to a target of 60 percent.

**Cold chain** refers to a network of refrigerators, cold stores, freezers and cold boxes organized and maintained so that vaccines are kept at the right temperature to remain potent during vaccine transportation, storage and distribution from factory to the point of use.

*Source: World Health Organization*

## KEY TUBERCULOSIS INFRASTRUCTURE

In 2016, construction began on the four storey Yangon TB Outpatient Department (OPD). It is a one-stop service centre for patient diagnosis and treatment, featuring a laboratory, medical dispensary, and x-ray, counselling and emergency rooms. A similar OPD is also being built in Mandalay.

Two other facilities are being constructed as part of the same USD 3.1 million 3MDG project being implemented by UNOPS Infrastructure Unit. This includes a caretaker quarters at Patheingyi TB Hospital in Mandalay which was opened in 2016 and a two level Biosafety Level 3 National TB Reference Laboratory in Yangon. This facility is equipped to perform confirmation tests for drug resistant TB, including molecular testing and drug sensitivity testing.

This laboratory is also an example of integration between Principal Recipient of the Global Fund (PRGF) and 3MDG, who are both managed by UNOPS. To draft the requirements for the laboratory, 3MDG and the PRGF worked together, and PRGF will fund the lab equipment.

Locations for all facilities were chosen based on demographics, disease prevalence and need.

3MDG focuses resources on improving human resources for health in Myanmar. *For more on this, see Box: Human Resources for Health on page 21.* 3MDG has also worked with the Maternal Health Department and the Child Health Department and other stakeholders to formulate strategies to decrease maternal and child mortality, including the development and roll out of Maternal and Child Death Surveillance Reporting Systems.

**Harm reduction** refers to policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs. The Harm Reduction approach to drugs is based on a strong commitment to public health and human rights, understanding drug dependence as a health condition. *Source: Harm Reduction International*

3MDG helps to create an enabling environment for health through nationwide efforts to address social, legal and structural barriers to HIV prevention and **Harm Reduction**. This includes addressing criminalization of the activities of key affected populations and removing legal obstacles to the distribution of safe injecting equipment, which reduces transmission of HIV and other diseases, such as hepatitis and TB co-infection.

3MDG works with the National Malaria Control Programme, National TB Programme and National AIDS Programme. This means supporting the provision of key commodities including pharmaceuticals and long life insecticide nets, the development of electronic database and patient support systems, support to outreach activities and high tech equipment and vehicles to extend access to vulnerable populations, and upgrading of key infrastructure (*see Box: Key Tuberculosis Infrastructure on page 22*).

### Decentralized levels

State and regional level, township level, and ethnic health organizations play the most substantial operational role in healthcare in Myanmar. A great deal of 3MDG’s support is at this decentralized level, in particular the township level. The support varies according to context: it is more operationally focused the closer it is to vulnerable and priority populations.

## WORKING WITH THE STATE HEALTH DEPARTMENT IN RAKHINE

Rakhine State is one of Myanmar’s most vulnerable states. It is characterized by widespread poverty, under-investment in infrastructure, healthcare, education and human capital, a lack of economic and social development, and high population density. It is battered by regular natural disasters, home to thousands of internally displaced persons and characterized by a deeply-rooted conflict between Buddhist and Muslim communities.

3MDG’s strategy is comprised of two pillars. First, the health system strengthening pillar provides technical assistance to the State Health Department through UNICEF. This statewide programme is an opportunity to improve maternal, newborn and child health by enhancing capacity in financial management, human resources for health, supply and stock management, the health management information system, as well as in the co-ordination of health services.

The second pillar focuses on support to township health departments to improve maternal, newborn and child health work. Guided by 3MDG’s conflict sensitivity approach, this work aims to remove barriers to accessing health services for all groups and all populations. The program includes outreach activities such as immunization, emergency referrals for pregnant women and children under five years, preventive, promotive and curative services, and enhancing the availability of quality services in rural and sub-rural health centres. This pillar is being implemented by International Rescue Committee, International Organization for Migration, Myanmar Health Assistant Association and Relief International in nine selected townships.

The active role of the Ministry of Health and Sports on the 3MDG Fund Board provides an opportunity for discussions on the most appropriate support to the Ministry in Rakhine State.

## State and regional level

At the state and regional level, and township level, 3MDG works with the national health programmes of the Ministry of Health and Sports and their decentralized staff to help with the actual implementation of strategic decisions, including regular planning and co-ordination meetings.

In 2016, 3MDG invested in several health system strengthening initiatives at the state and regional level which support the capacity development of the health departments. In Bago, Magway and Ayeyarwady regions, 3MDG supported regional health departments to implement a logistic management information system that provides timely access to consumption data. In Rakhine State, 3MDG engaged UNICEF to support the State Health Department on a broad spectrum of health system strengthening activities, including planning, supply chain, human resources for health and health information systems. *See Box: Working with the State Health Department in Rakhine State on page 23 for more.*

## Ethnic health organizations and local authorities

3MDG partners with a range of ethnic health organizations and **local authorities** in special regions. They are critical health providers for areas and populations beyond the reach of public health services and facilities. Through partners, 3MDG supports the development of delivery capacity and service improvement within these organizations, as well as their closer co-ordination with Ministry of Health and Sports at all levels.

For maternal, newborn and child health services in Kayah State and seven townships in Northern and Southern Shan State, 3MDG adopts a township wide approach. International Rescue Committee and International Organization for Migration work with Community Development and Health Network in a consortium. Relief International also deliver healthcare services.

**Local authorities** are the leaders of the self-administered areas, such as the special regions, in Myanmar.

**Sun Quality Network** was launched by Population Services International in Myanmar in 2001. It is a franchise of licensed private sector general practitioners and community healthcare workers that serve low-income clients. The goal of the Sun Network is to provide high-quality health services and products to low-income communities by leveraging the country's existing private sector general practitioners.

*Source: Population Services International*

**Capitation payments** are the system of paying a physician or group of physicians a set amount for each enrolled person assigned to them, whether or not that person seeks care, for a set period of time.

## HEALTH FINANCING INNOVATION: PROVIDER PAYMENTS

Population Services International (PSI) Myanmar is piloting a government-supported project to demonstrate the capacity of private general practitioners to offer a basic package of primary care services. Services are being delivered through the **Sun Quality Health network**, which has been a part of PSI's programming for a number of years. This is supported by 3MDG and other donors, and is a key study for the National Health Plan. It will help inform the Government's long-term universal health coverage plan by testing a different strategic purchasing mechanism. Instead of fee-for-service payments, this pilot will implement **capitation payments** and a pay-for-performance bonus. The project will assess whether increasing the range of services private practitioners can offer decreases out-of-pocket payments among low-income households, increases service utilization from quality providers and decreases the time it takes clients to seek treatment from the onset of symptoms.

In 2016, PSI completed the project design - including defining the package of health services covered and modelling the anticipated disease burden in target areas - identified providers and began mapping out low income households.

Beginning in the first quarter of 2017, approximately 2,000 low-income households in two townships in Yangon region were screened and issued with a health card. This entitles household members to a defined benefit package provided by members of the Sun Quality Health network. All household members undergo a baseline health check on vital signs and nutritional status, and data is being collected on their socioeconomic status.

Preliminary findings will be shared with Ministry of Health and Sports and stakeholders by December 2017, and full report will be available by early 2018. It is anticipated that the pilot will help shape the Ministry's plans to reform payment mechanisms to providers.



For the detection and treatment of malaria through clinic and community-based approaches, 3MDG works through Community Partners International and actors in Kachin, Kayin, Mon, Kayah States and Tanintharyi Region.

3MDG also supports an integrated healthcare model in parts in Wa and Special Region 4 through Health Poverty Action. This means that a host of services are offered - maternal, newborn and child health, including emergency maternal and child referrals; and HIV and TB services. This work is delivered through local authority and Ministry of Health and Sports facilities and by community health staff, such as village health volunteers, trained traditional birth attendants and some newly trained auxiliary midwives.

**Township level**

Township health departments are critical in the provision of health services, and are in a good position to respond to local needs. They are supported by 3MDG in planning of essential health outreach and services, monthly co-ordination meetings, and supervision visits. For example, at the end of each month the township health department meets with basic health staff to plan the next month and reimburse money for the previous month’s activities. This is also used as an opportunity for continuous medical education.

3MDG’s work in maternal, newborn and child health is conducted through implementing partners who work directly with the township health departments. Basic health staff are supported to conduct critical outreach activities including vaccination, ante- and post-natal care and newborn care. Outreach services are particularly important as they allow people in hard-to-reach locations to access health services.

In 2016, nearly 2,000 doctors, nurses and midwives attended at least one mother, newborn and child health training in 3MDG supported townships. This is 62 percent of total eligible basic health staff in these areas. Partners also give assistance to township health departments and rural health centre staff to supervise and monitor health facilities. Community health volunteers

The township medical officer of Dagon Seikkan Township consults with a community member at the mobile team visit.



Photo: John Rae/UNOPS

are provided with initial and refresher training, supplies and supervision by partners and basic health staff.

3MDG also works closely with township health departments to implement HIV, TB and malaria activities. For example, mobile teams who travel into communities to detect and refer cases of TB work closely with township health departments to choose locations, co-ordinate schedules and make announcements about the visits. If TB is detected, patients are immediately referred to the township health department for confirmation and treatment initiation. In 2016, mobile TB units conducted 227 visits to 131 townships.

### Communities

Communities are an important level of the health system, with an important role to play in their own health. 3MDG supports community systems strengthening in a number of ways. For instance, 3MDG finances community governance structures such as village health committees and village health funds. Village health committees are trained to work alongside health staff to support referrals, and mobilize better health seeking practices (see Box: Preventing needless deaths through village health funds on page 39.)

As explored in Chapter 7.2.1 *Knowing the problem*, engagement with communities is important to understanding problems and needs, as well as drive project improvements. 3MDG interventions in this area help to make township health systems responsive, holistic and inclusive.

To ensure that people are able to make good health choices and are aware of the services available to them, 3MDG supports health education and promotion. This is delivered through basic health staff and community health workforce, as well as volunteers through the **Collective Voices** initiative. This is further explained in Chapter 7.2.3 *Removing the barriers*.

3MDG’s innovative USD 1.5 million initiative, **Collective Voices**: Understanding Community Health Experiences partners with 25 local civil society organizations (CSOs) to uncover, and then address, barriers to health access



3MDG supports the Ministry of Health and Sports to strengthen its human resources for health, focusing on quality improvement. Here, a nurse receives training on BEmONC.

## 7.2 IMPROVING SERVICE DELIVERY

Many people in Myanmar cannot access the healthcare they need. Those services may not be available, or may be unreachable because of distance, cost or lack of health service knowledge. People may be reluctant to seek healthcare because of stigma and discrimination, lack of trust in the system, or alternative health seeking practices in particular communities (*see Box: Making the link between informal and formal health services in Chin State*).

Health equity is only possible if the health system is strong, and **everyone** can access the services they need. Apart from health system strengthening, addressed in the previous chapter, 3MDG efforts to help achieve health equity and universal health coverage in Myanmar focus on those populations that face extra difficulties when accessing or affording quality care, or are vulnerable to poor health status.

For example, to improve healthcare for people in prisons, a particularly vulnerable group, in 2016 3MDG supported the development of assessment and action plans by the Ministries of Health and Sports and Home Affairs, and the Department of Prisons. Priority interventions were identified and the development of a long-term plan for improving prison health was initiated.

Maternal, newborn and child health interventions are focused on areas where existing services are weakest, due to conflict or remoteness. For example, Chin State has the poorest health outcomes of any state in Myanmar, as evidenced in the latest Myanmar Demographic and Health Survey. 3MDG work began there in 2013.

About 7,600 cases of pneumonia in children under five were treated by volunteer health workers in 2016 in Chin State, and good vaccination coverage for both measles (94 percent coverage for children under one year) and **DPT/ Pentavalent 3** (Penta 3) (93 percent) has been reported. Figures for post-natal care (82 percent of pregnant mothers) are also positive. However, the contraceptive prevalence rate remains low (27 percent of married couples) and investigation into these figures is ongoing.

**Pentavalent 3** vaccine is a vaccine that contains five antigens (diphtheria, pertussis, tetanus, and hepatitis B and Haemophilus influenzae type b) and protects from common childhood diseases.

**DPT** refers to a class of combination vaccines against three infectious diseases in humans: diphtheria, pertussis (whooping cough), and tetanus.

### MAKING THE LINK BETWEEN FORMAL AND INFORMAL HEALTH PRACTITIONERS IN CHIN STATE

In rural and hard-to-reach areas, community members’ reliance on traditional and informal health practitioners can lead to delayed attendance at health centres and inappropriate treatment. In Chin State, one of the poorest states in Myanmar, 72 per cent of people in Thantlang villages and 54 per cent in Hakha villages said they first turn to an informal practitioner in a health emergency.<sup>32</sup> Having often lived their entire lives in their village, informal practitioners are trusted by community members. They are available when needed, and sometimes offer delayed payment for their services.

Ensuring these practitioners can identify when a patient needs to be referred on to further medical care can make a crucial difference in health outcomes, even the difference between life and death in some cases. 3MDG, in collaboration with the State Public Health Department, organized a conference which brought together formal and informal healthcare providers from 19 villages in Thantlang and Hakha. Trainings focused on helping providers know when to refer their patients for further care. They also learned more about typical health problems, helping to dispel misinformation about health at the village level. This conference was part of the 3MDG’s broader efforts to improve health equity in Myanmar, through a responsible, fair and inclusive health sector.



In Ayeyarwady and Magway regions, 3MDG serves populations with maternal and child mortality rates amongst the three highest in the country (alongside Chin State). 3MDG also works in the conflict-affected areas – Kayah, Northern and Southern Shan and the two special regions of Wa and Special Region 4. In all of these areas, 3MDG provides emergency referral support to help mothers and young children get to the hospital, which may be otherwise out-of-reach due to their inability to afford transport.

To ensure 3MDG interventions are consistently working towards health equity, there must be a thorough understanding of the issues that are faced. Work in this area is found under *Chapter 7.2.1, Knowing the problem*. What follows are dual sets of initiatives to put the needed services in place (7.2.2) and remove the barriers that stand in the way of accessing care (7.2.3). Throughout this work, 3MDG emphasizes strengthening the ability of the community to fulfill their role in the health system.

## 7.2.1 KNOWING THE PROBLEM

### Gathering evidence to uncover the health problems faced by different groups across Myanmar.

To ensure health needs are met, the first step must be to understand what those needs are and which barriers to health exist for different communities. These may differ from place to place, and for different population groups, calling for localized and contextual solutions.

### Basing interventions on data and evidence

Building an evidence base forms an important pillar of the 3MDG approach. This is done through improving the quality of data collected through routine systems, encouraging data utilization, supporting research and getting community inputs. *Find more on our approach in Chapter 8.4 Building an evidence base.*



Civil society organizations attend the community scorecard training.



## Learning from communities

What we can learn from communities cannot be overstated; they are critical actors in their own health. Speaking with community members can grow our understanding of needs, problems, barriers, and potential solutions. After projects begin, community feedback can be drawn on to make improvements.

### Uncovering barriers

The **social determinants of health** play a major role in people’s ability to access health and health outcomes. Barriers to healthcare access are one type of social determinant, and can include factors like education, poverty, language, gender and culture. Communities are in the best position to help understand what these barriers might be.

As part of the 3MDG Collective Voices initiative, 25 local civil society organizations held more than 500 community meetings across six states and regions in 2016. Using their own language and conceptual framework, they were able to uncover the causes of limited access to healthcare, even for poor and marginalized groups who may otherwise be excluded.

From this work, a report was compiled and launched in August 2016. At its launch event, government and civil society representatives came together to discuss how community voices can be used to inform health policy-making and programming at every level. Addressing these barriers may require fundamental changes in healthcare and the relationships between providers and the communities they serve. 3MDG partners are now working to overcome these barriers, detailed in *Chapter 7.2.3 Removing the barriers*.

### Informing interventions and services

The unique skills, strengths and knowledge of communities can, and should, be engaged to inform health policies, interventions and services. For example, when choosing locations for the construction of 82 health centres across the country, the UNOPS infrastructure team, who are building the 3MDG-funded centres, consulted with the community. This ensured that the locations were on neutral grounds, were easily accessible (even in the wet season) and were available for use.

#### Social determinants of health

are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

Source: World Health Organization

## BEING RESPONSIVE TO THE COMMUNITY

Dr Sandar Lin, Project Manager of Save the Children in Thantlang, outlines the benefits of the community feedback mechanism:

*“In 2016, the communities in Thantlang, Tonzang, Hakha, Falam and Tedim townships told us that in their villages water is scarce in the dry season, and cases of diarrhoea increase a lot. The township medical officers also asked us to do something about it – diarrhoea was the number one cause of referral for children under five.*

*“We planned the donation and installation of water filters in five selected villages in each of the five townships where cases of diarrhoea were especially high, along with the provision of clean containers to transport and store the water. The community was very happy, and as a result, the cases of the diarrhoea went down – it was a big success. The benefits of the feedback mechanism were so clear, so the communities became even more invested in it.”*

On behalf of 3MDG, Save the Children has been implementing a maternal health project in Northern Chin State since 2014, in collaboration with the township health departments in that area.

### Shaping project improvements

All projects and interventions should be continually improving to be more effective. Community feedback mechanisms help implementing partners understand how their interventions are perceived and received by the people they serve, allowing them to make adjustments based on the suggestions they get.

In 2016, more than 7,500 pieces of feedback were received from communities, and 66 percent has already been addressed. Important changes have been made from this feedback, including improving accessibility of drop-in centres and adjusting reimbursement costs for referrals from hard-to-reach areas.

Social accountability and the use of data for informed decision-making is still in its infancy, largely due to a tradition of extremely hierarchical processes. Continuing to shift towards more supportive and collaborative decision-making will encourage communities to openly share constructive feedback.

## 7.2.2 PUTTING SERVICES IN PLACE

### Helping to put quality, affordable services where they need to be so everyone can access them.

Primary healthcare services are critical to saving and improving lives. These interventions are both preventative, such as immunizations and ante-natal care, and curative, such as treatment for common diseases. This work is supported by health system strengthening interventions at all levels. At the same time as helping to make these services available, 3MDG works to remove barriers which might restrict access to available services (*see Chapter 7.2.3 'Removing the barriers'*).

From maternal health services delivered via outreach, to malaria services focused to endemic areas through volunteers, 3MDG service delivery across



Stigma and discrimination impact access to health for LGBT people. 3MDG supported an event in Yangon on the International Day against Homophobia and Transphobia that aimed to raise awareness.

the Fund works to meet the needs of focused priority populations, across different geographic areas and often with different models of implementation.

Communities are a critical element in how services are made available. The next section explores 3MDG support to community-based healthcare, before the report moves on to outline how services are delivered in maternal, newborn and child health, TB, malaria and HIV Harm Reduction.

### Improving the community health response

Long periods of conflict, international sanctions and limited investment in public health have left significant populations and parts of the country largely beyond the reach of health facilities and services. The community health workforce, community-based organizations and national non-government organizations have emerged to support under-served and geographically remote populations, alongside critical work from ethnic health organizations.

#### Community health workforce

Many of the interventions financed by 3MDG are conducted by workers at the community level. They are known alternately as the ‘community health workforce’ and the ‘village health workforce.’ Due to their significant role in Myanmar’s health system, their institutionalization is being explored at the central level (see *Box: Institutionalizing the Community Health Workforce.*)

In 2016, there were nearly 44,000 referrals of suspected TB to the township health department or health centres by community health workers and volunteers. They have a unique ability to provide basic health services to marginalized communities or those beyond the reach of health facilities because of their close ties to these communities.

3MDG has invested in training, capacity building, supply and supervision and for volunteers, as well as data collection on the services they deliver. This includes community health workers and auxiliary midwives, who work in support to midwives, and volunteer health workers who provide health education, support community mobilization for immunization, identify and treat some diseases, and refer patients.

## INSTITUTIONALIZING THE COMMUNITY HEALTH WORKFORCE

Myanmar is committed to training and deploying community based health volunteers in public health and disease control programmes. Rosalind McCollum, a researcher from the Liverpool School of Tropical Medicine, studied Myanmar’s community health system in 2016.<sup>33</sup> She concluded that the introduction of community health worker programmes did increase uptake of services across factors like gender, disability and socioeconomic status, and contributed toward a more equitable health system.

However, challenges remain for the integration of these volunteers into a successful programme that provides the appropriate support needed in terms of policies and strategies around remuneration, supervision and supply, among others. There are different incentive packages and training requirements depending on the volunteer’s area of work and as yet, the Ministry of Health and Sports has not committed to a universal system. For instance, community health workers receive 28 days of training and their work is completely voluntary, whereas disease control volunteers receive only five days of training and receive incentives. In a particular village, one person may fill both roles or different people may fill the roles.

3MDG continues to work closely with the Ministry of Health and Sports to strengthen this workforce.



### **Building the capacity of community based organizations**

3MDG supports the development of informed, capable and co-ordinated communities and community-based organizations, groups and structures. An important element of this partnership is the provision of longer term organizational capacity development to help strengthen their systems and functionality. Pact Myanmar is financed to conduct training in administration, logistics, planning and human resources for local organizations. In 2016, 19 partners including six ethnic health organizations received this support.

This support can extend to private organizations at community level. For example, pharmacies have received training in the distribution of safe injecting equipment to reduce the transmission of HIV and other blood-borne diseases.

3MDG also works to support civil society, who can also help to make services available by filling gaps, increasing demand, building trust in the health system and improving health knowledge. Empowered communities, in an enabling environment, can also help to develop the structures and support, such as village health committees and health funds, to overcome barriers to health access. This work is explored in *Chapter 7.2.3, Removing the barriers*.

### **Maternal, newborn and child health**

Every year in Myanmar around 2,800 pregnant women and over 70,000 children die from largely preventable causes, according to the 2014 census. The country has higher maternal and child mortality rates than most Southeast Asian countries.

The Myanmar Demographic and Health Survey shows that only 60 percent of women had their deliveries assisted by skilled attendants and only 37 percent of all deliveries were in health facilities. This indicates a lack of skilled care around the labour and delivery period, which is where the largest number of maternal and child deaths take place. Women in rural, remote or conflict-affected areas are particularly disadvantaged, and often interventions are not adequate, available or affordable.

## **INSTITUTIONALIZATION OF EMERGENCY REFERRALS**

The Emergency Referral Programme has shown evidence of a reduction in case fatality alongside a growing usage of emergency referrals. Costings show the intervention to be good value for money.<sup>39</sup> The global strategy for ending preventable maternal and newborn deaths emphasizes the promotion of facility-based deliveries. A Lancet paper in the Maternal Series 3<sup>40</sup> reviewed evidence from the millennium development goal-era and finds that the remarkable increase in skilled birth attendance is not accompanied by a proportional decrease in maternal mortality.

This metric does not reveal the content of the care that women receive, in particular whether Basic Emergency Care was available (supplies, skills, attitude) and whether the woman has access to Comprehensive Emergency Obstetric services through timely referral to an appropriate hospital.

Emergency referrals are critical while the health system makes progress to service readiness and better health facility distribution. 3MDG experiences will be used to discuss and advocate for a model of a scale-up of the programme to become institutionalized as part of the Ministry of Health and Sports work.<sup>41</sup> Meetings have been held with this aim. A way forward will present a major opportunity for extending timely access to lifesaving interventions and addressing the country's existing commitments to bring down rates of avoidable maternal and under-five mortality.

Interventions must cover prevention, such as immunizations for pregnant women and children, ante-natal, postnatal and newborn care, and access to appropriate delivery care and treatment, including emergency referrals. Promotive healthcare, such as health education in nutrition or family planning is important to ensure communities are able to make informed choices about their own health. The capacity of government and ethnic health organizations must be built so that access to healthcare is increased and needs can be met on an ongoing basis.

3MDG provides support to townships as well as health system strengthening interventions that improve immunization services, the cold chain and midwifery skills. Public and private sector actors are now better able to deliver health services, work to build evidence continues and human resources for health are being strengthened with a new programme launched in 2016.

In areas where communities are out-of-reach of government services, health outcomes can suffer. Ethnic health organizations and local authorities have been supported to provide basic services. Improved co-ordination and collaboration between the Ministry of Health and Sports, ethnic health organizations, local authorities and 3MDG partners has led to better trained staff and higher quality and more reliable services.

Together, this ensures essential maternal, newborn and child health services for a population of 4.5 million who live in remote and hard-to-reach areas in Magway, Kayah, Ayeyarwady, Chin State, Shan State, Wa Special Region 2, and Special Region 4. The 3MDG focus areas were chosen in agreement with the Ministry of Health and Sports based on health needs and demographic data with regards to poverty. For example, 3MDG efforts to improve maternal, newborn and child health started in Ayeyarwady Region in 2013, in the six townships worst affected by Cyclone Nargis. This work was continued after the 2014 census showed the region had among the worst mortality rates for children and mothers in Myanmar.

A **skilled attendant at birth**, post and ante-natal care, immunizations and support to emergency maternal and young child referrals to the nearest appropriate hospital have resulted in improvements in health indicators

A **Skilled Birth Attendant** is an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.

## WORKING TOGETHER ON NUTRITION WITH THE LIFT FUND

3MDG works closely with the Livelihoods and Food Security Trust Fund (LIFT) for nutrition interventions within the maternal, newborn and child health programme. LIFT, like 3MDG, is managed by the United Nations Office for Project Services (UNOPS). This creates significant opportunities for integration. For example, the funds are currently working towards a joint strategy for nutrition and work is co-ordinated where possible.

One example of this is the Save the Children project Bright SUN that is funded by LIFT in the Delta. The project delivers maternal cash transfers and behaviour change communication, and is integrated with Save the Children’s existing 3MDG project. Health workers of the rural health centers are engaged to distribute these cash transfers, which promote improved nutrition and hygiene practices. Community health worker capacity is also improved to deliver nutrition actions alongside primary health care.

In the future, 3MDG will continue to work with LIFT for its activities in nutrition, sharing expertise and guided by LIFT experiences. *For more on integration within UNOPS, see Chapter 11: Fund Status.*

in Ayeyarwady that have continued in 2016. For example, immediate breastfeeding was initiated within one hour of birth for 85 percent of total live births, and 84 percent of mothers and newborns received post-natal care. Contraceptive coverage for the region is good, with use by 77 percent of married couples in the region. *See 9.3 Maternal, newborn and child health and Annex I: Results Matrix for more results.*

## Communicable diseases

Communicable diseases are still a major public health issue in Myanmar. Though they can affect anyone, the effects are particularly debilitating for populations that are already vulnerable. These groups may have difficulty in accessing services because they are living in rural, remote or conflict-affected areas; engaged in criminalized or highly stigmatized activities; part of migrant or mobile populations, or facing incarceration in prisons or labour camps. To achieve health equity, focus must be on reaching these groups. 3MDG does this through outreach and mobile teams, HIV Harm Reduction and patient support.

### Tuberculosis (TB)

The latest national TB prevalence survey suggests that late or advanced cases are detected more often in remote, hard-to-reach, mobile or migrant populations and in urban slum areas compared to stable urban populations who have ready and easy access to health facilities.<sup>34</sup> Detecting TB cases early improves the chance of cure, reduces the risk of transmission, and helps prevent the development of drug resistant TB. In response, the National TB Programme adopted an active case detection strategy.

Nine mobile teams operate strategically throughout Myanmar to improve access to diagnosis and early treatment. Their focus is the most vulnerable populations, including prisoners, people who use drugs, HIV co-infected



A mother and her baby attend a health education session in Yangon.



patients, and migrant populations. However, mobile clinics are open to everyone because the disease can affect anyone, symptoms can be mild and stigma can mean some sufferers are hidden.

For a week, mobile teams move to different locations within a township. They advertise widely to inform the community. If TB is suspected, patients are given a chest x-ray. If tests are positive, treatment begins immediately. Patients are also referred to the township health department for further testing and for registration and follow-up. The teams introduced by the active case detection component have detected three times as many TB cases as previously.<sup>35</sup>

**TB case holding** is a World Health Organization technical term which refers to the broadest possible parameters within which all services are included, such as clinical management and patient and adherence support.

At the village level, treatment is supported by community volunteers. They have been trained to observe daily treatment, provide moral support to patients, and help the National TB Programme in **TB case holding**. This is essential for preventing multi-drug resistant TB (MDR-TB), the name given to TB that does not respond to first line medications. Myanmar is one of the 30 MDR-TB high burden countries globally, with the highest prevalence in the country in Yangon and Mandalay regions. It has a significantly higher mortality rate than TB.

The National TB Programme and its partners have prioritized the detection of missing MDR-TB cases and rapidly enrolling them into treatment. Free treatment for twenty months is provided by the government, accompanied by a package of patient support provided by 3MDG. This includes provision of a nutrition package, moral support, cash payment (30 USD per month), and daily visits to assist with treatment. This community-based model is administered by trained volunteers, and significantly improves patient treatment adherence and outcomes by helping to overcome barriers such as cost and side effects.

Artemisinin-based combination therapies (ACTs) are recommended by WHO as the first-line treatment for uncomplicated malaria. In patients who are infected with **artemisinin-resistant** strains of malaria, the artemisinin compound is less effective in clearing all parasites within this 3-day period.  
*Source: World Health Organization*

**Malaria**

Malaria incidence has significantly declined over the past two to three years. To sustain these improvements, investments in malaria testing and treatment remain a public health priority. 3MDG’s contribution has been towards the containment of **artemisinin-resistant** malaria and pre-elimination. Interventions are sometimes conducted in conjunction with TB detection work. Together they target conflict-affected populations in co-ordination with ethnic health organizations, as well as other hard-to-reach groups, including internally displaced people, and construction and mine workers. In 2016, about 444,000 malaria tests were taken and read.

**PRISON HEALTH**

A high proportion of the national prison population, estimated to be anywhere between 20 percent and 70 percent in some prisons in Kachin State, are imprisoned for drug-related crimes. This is a result of long mandatory prison sentences for people with drug dependence convicted for possession of illicit drugs. Low investment in public health facilities and services, especially in closed settings like prisons and labour camps, leads to severe overcrowding, limited health facilities and services, under deployment of health staff and lack of infection control. This creates conditions that are harmful to the health of people in these closed settings – prisoners and staff.

In partnership with United Nations organizations, international non-government organizations, the Ministries of Health and Sports, and the Home Affairs/Prison Department, 3MDG is working to assess priority actions to strengthen health facilities and services for people in closed settings. This includes the construction of new health facilities, the development of standard operating procedures governing health service provision, the training of health staff and improved co-ordination between closed settings and source communities.

Malaria services include diagnostic facilities and standard treatment through a trained community volunteer network. Directly Observed Treatment (DOT) volunteers ensure that patients take their initial treatment immediately and explain how to complete the rest of the course. Treatment adherence is key to cure, preventing drug resistance and the overall success of the programme.

3MDG has supported recent moves by the Ministry of Health and Sports towards the integration and multi-tasking of malaria volunteers. Integration of TB and malaria service provision can bring about significant reductions in cost. *See Chapter 9.4.3, Box: Expanding coverage from volunteer worker to read about a pilot programme underway in Sagaing Region.*

Looking to the future, the focus is shifting towards the elimination of **plasmodium falciparum malaria** in line with global and regional planning. Malaria elimination is targeted in all states and regions by 2030. This will require strengthening of the case surveillance system, improving access to diagnosis and treatment and improving preventive interventions to prevent parasites being carried from place to place.

**Plasmodium falciparum (p.f.) malaria**, the most serious form of malaria, is a life-threatening disease. It is a protozoan parasite, one of the species of Plasmodium that cause malaria in humans.

*Source: World Health Organization*

### **HIV Harm Reduction**

Poverty and underemployment create conditions conducive to drug dependence, which is particularly high in areas of opium and illicit drug production and transport routes. Being born into a family or community with prevalent drug dependence increases the likelihood of further dependence.

Unsafe drug use – especially injecting drug use and associated risky behaviours, such as unprotected sex – is an efficient mode of transmission for sexually transmitted diseases. More than a quarter of new HIV infections (28 percent) in Myanmar were among people who inject drugs. Higher levels of co-infection of sexually transmitted infections, HIV, Hepatitis C and TB are also prevalent for this group.<sup>37</sup>

‘Harm Reduction’ is an effective global response to reduce the negative consequences associated with drug use (see box). In support to the National HIV and AIDS Strategy, 3MDG finances Harm Reduction services in 30 townships in Shan and Kachin states, and Mandalay, Sagaing and Yangon regions. Activities are prioritized in areas with large numbers of people who inject drugs, and include drop-in centres, needle and syringe exchange programmes, regular testing and treatment, prevention and advocacy.

## **GLOBAL EVIDENCE HIGHLIGHTS SUCCESS OF ‘HARM REDUCTION’ SERVICES FOR PEOPLE WHO INJECT DRUGS**

Support services for people who use drugs have been shown internationally to reduce transmission of HIV and hepatitis, reduce health costs and reduce crime in the community. These interventions are built on respect for the rights of people who use drugs, and emphasize a non-judgmental and inclusive approach. Known as Harm Reduction services, this type of support is based on the concept that drug use is a part of society, and we must do all we can to reduce the harm it causes, rather than focus on elimination.

According to the World Health Organization (WHO), in Baltimore – where heroin use has been the highest in the United States of America – drug use decreased by 20 percent for those enrolled in a harm reduction programme. Studies have also shown sustained effects on lowering HIV contraction, as well as criminality, after similar programmes were introduced.<sup>36</sup>

As a result of the complex and multi-faceted nature of HIV transmission, prevention programmes must address many factors. These can be categorized into behaviour, structural and biomedical interventions. Prevention programmes should consider setting-specific factors, such as levels of infrastructure, culture and traditions as well key affected populations.<sup>38</sup>

3MDG works with local partners who are able to contextualize their approach and have a good knowledge of affected populations. In 2016 they were able to reach 96 percent of the target population (people who inject drugs) with prevention, which included distribution of needles and condoms, education and testing. Prevention work also includes a programme to reduce community stigma and discrimination, launched in 2016, and continued advocacy for the decriminalization of low level drug use.

### 7.2.3 REMOVING THE BARRIERS

#### Removing barriers to healthcare access and helping communities drive change from within.

Even when health services are in place, people can face enormous barriers in reaching them. These include practical issues, like distance and cost, but also embedded beliefs about health services, lack of trust, stigma and discrimination. Removing these barriers is critical to achieving universal access.

##### Distance

Myanmar has a large rural population and difficult topography and weather patterns. Distance, challenging travelling conditions and insufficient transport options can make it especially difficult to reach healthcare. For example, mountainous parts of Chin State can be inaccessible except on foot, especially in bad weather, and during the rainy season in Ayeyarwady Region entire roads can be washed out and waterways became dangerous.

A person with multi-drug resistant tuberculosis is visited by the volunteer for the evening dosage. Patients are attended daily by the basic health staff and volunteers to ensure treatment adherence.



Responding effectively to the health needs of populations beyond the reach of health facilities and services requires early diagnosis and treatment. This is supported by a combination of locally available village health volunteers, mobile clinics and effective and timely referral to health facilities. Outreach allows health staff to reach people that may have very limited access to care.

3MDG is also bringing health services closer to the community with the construction of 82 rural and sub-rural health centres in eight states and regions. To find the best possible locations, the Ministry of Health and Sports, UNOPS Infrastructure Unit, 3MDG and local communities considered population coverage, accessibility, security and lack of existing services, among other factors. They were strategically located to reduce walking distance for community members.

### **Cost**

The affordability of healthcare is another significant factor which limits access to health services. In some cases, 'perceived cost' can be as great an issue as the cost itself. Believing the price of health services to be out-of-reach, many people choose to delay care, seek care from informal practitioners or not to access healthcare at all. *See page 44 for 'health service promotion.'*

Out-of-pocket costs for health in Myanmar are amongst the highest in the world<sup>42</sup> and falling sick can mean a choice between further impoverishment or foregoing care all together. Interventions supported by 3MDG aim to reduce this financial barrier through demand-side financing for emergency mother and child referrals which might be achieved in some townships through support to village health financing structures.

#### ***i. Emergency Referrals***

Most maternal and newborn deaths occur in the first 48 hours from the start of labour. Half of all child deaths in Myanmar are amongst newborn babies. To save these lives, access to basic and comprehensive obstetric care and early newborn care is needed. Children under the age of five are also particularly vulnerable to rapid deterioration in their health. While preventative care and early treatment of illnesses such as diarrhea, pneumonia and fever can prevent serious complications, a certain proportion of very ill children will need timely access to emergency care, which is often lacking in Myanmar.

In response, the 3MDG emergency referral programme was developed. For maternal referrals, the target has been set at 15 percent of all pregnant women, in recognition of the global evidence that about 15 – 20 percent of pregnant women globally will experience an unpredictable obstetric emergency that will need an intervention. For children, there is less available evidence for target-setting, but 3MDG aims to refer four percent of all children. These are potentially lifesaving interventions, and in 2016, about 16,600 pregnant mothers used these services, along with nearly 14,600 children.

Though healthcare for pregnant women and children at public hospitals is free-of-charge, the distance to hospitals and the cost of transport and food costs incurred while in the hospital are still major impediments. 3MDG support helps to ensure that:

- Basic health staff and community health workers are able to recognize the danger signs for seriously ill patients
- Established criteria for referral and when to refer exist
- Transport is made available and its cost is covered



- The cost for food is available for the patients and one attendant during the period of hospitalization

*ii. Strengthening village health structures*

Village-based structures can support good health outcomes. For instance, village health committees have been set up to identify and address specific village health needs and issues. Partners assist with governance and sometimes provide financing for specific interventions, such as improved sanitation or bed nets.

Many village health committees have set up village health funds to make sure people can pay for the healthcare they need. When there is a health emergency, money can be borrowed from the fund and repaid at a low or zero interest rate. When the emergency patient is a pregnant woman or young child in a 3MDG supported township, the money can be reimbursed via the emergency referral programme. The funds are a locally-owned way of giving people in hard-to-reach areas access to healthcare services and creating critical linkages between different parts of the health sector.

**Gender and decision-making**

Gender norms and a lack of decision-making power impact women’s access to health services. The 3MDG Collective Voices initiative and other experiences on the ground show that in many cases, men have a higher status in the community and usually make the decisions for their family when it comes to income and health. Women may also not be able to finance the health services they need.

3MDG has financed a number of trainings to try overcome this imbalance. The participants in these trainings are nearly always women, which is important for better health education, more informed health decisions and more balance in relationships. However, it does not tackle head-on the lack of

*“I don’t want to have children anymore. But there are no boys among my seven children. I have to bear another child until I get a boy. I want to practice birth control, but my husband does not agree to do it. Not only has my husband forbid me, but also all his relatives forbid me to practice birth control.” - **Mother of seven children, Chin State***

**PREVENTING NEEDLESS DEATHS THROUGH VILLAGE FUNDS**

People in Pan Par Village, Mindat Township, Chin State, faced health problems for years, including malaria, diarrhoea, skin infections, and post-delivery deaths. The nearest hospital is more than a day away by foot, and transport is expensive. A village health committee was started in 1997 to try to tackle these issues and reduce the spread of disease.

“Because we got clean water, clean toilets and mosquito nets, and people followed the lessons from the health education sessions, there was a reduction in the amount of disease,” said U Ling Law Ha, chairman of the Village Health Committee. The committee worked with a number of organizations to put these interventions in place.

However, in emergency situations, patients still did not have enough money to get to the hospital. In response, the committee established a village health fund. The fund money, which is collected monthly from households, is available for supporting health emergencies of all residents, including the ones that cannot afford a contribution. Some of the start-up money, as well as support with governance and planning, is provided by 3MDG implementing partners.

“Poor quality roads and access to care were the biggest healthcare obstacles in the region. By addressing these issues, the fund has made a difference,” said U Ling Law Ha.

male engagement in health issues, though they are often the final decision-makers. In 2016, 3MDG financed training sessions that aim to make space for men and women to make shared decisions about the healthcare of their families, acknowledging that changes in behaviour take time. These sessions increase men's awareness of gender equality and their role in facilitating access to healthcare.

### **Stigma and discrimination**

*"A major social barrier to health according to LGBT people, transgender people and people living with HIV is stigma and discrimination from families and society towards them."*

**- Collective Voices Report, 2016**

Stigma and discrimination against population groups and particular health issues can make people reluctant to seek services, or can influence the decisions they make about their health. The 3MDG Collective Voices report revealed how community stigma can influence decision-making. For example, a woman from Chin State explained that she felt uncomfortable seeking family planning services, because of the stigma from her community. She explained that she felt that other couples wanted many children, so she would be looked down upon if she wanted something different.

3MDG partners, via community health workers and volunteers, share principles of gender equality with community members. They share information about family planning, and work with religious and community leaders to improve understanding and acceptance of these services. See *Chapter 9.3, Box: Family planning in Chin State*.

Marginalized or criminalized population groups, such as people with drug dependence or people living with HIV, also find it difficult to seek healthcare. 3MDG works to minimize this by bringing services to people, for example through mobile clinics for TB and malaria. Peer educators play a critical



A person with multi-drug resistant tuberculosis is attended by the nurse on her daily rounds.

role in sharing information about HIV Harm Reduction services, which is important because as former or current people with drug dependence, they are trusted in this community.

Building trust

Reports of insensitivity or judgmental treatment by health staff towards patients, together with cultural norms, can contribute to a lack of trust in the health system, and health seeking behaviour can be subsequently delayed. In Mon State, 3MDG partners have found that prolonged conflict between ethnic Mon militants and the government army has led to a reduced trust in the government health system. In conflict-affected areas, ethnic groups can feel marginalized and discriminated against, which can lead to a preference for informal health practitioners in these areas.

Community scorecards are a simple tool administered by neutral third parties to open a dialogue between health providers and community members. They help to identify the challenges in access and delivery of healthcare.

In 2016, implementing partners conducted about 2,750 events and meetings that facilitated participation and engagement between healthcare providers and target communities. This enhances understanding of local needs and experiences in accessing services and helps to build trust and relationships. Community scorecards were also introduced to build relationships between health providers and communities. The tool is able to open a dialogue between providers and communities to identify challenges facing both access and delivery of healthcare. Based on the feedback, health staff and the community are able to develop an action plan to improve the delivery of health services.

Feedback from the scorecards has been used to adjust working hours to better suit community schedules, for example, and the scorecards also help to build understanding of the challenges for healthcare providers. This can help manage community expectations. However, it must be noted that these scorecards are only relevant in specific settings. People in closed settings, such as prison and labour camps, and people who are discriminated against and criminalized may not have access to such mechanisms.

Building community acceptance of Harm Reduction services

High rates of drug use in Kachin State are accompanied by frustration from communities, who have at times shown violent behaviour towards drug users.

“I would hate to think women are not going to hospital for financial reasons”

“My name is Ma Hnin. I am a pregnant mother from Ngar Pyan Taung. A lot of migrants live here. I only just arrived, and I work at the rubber plantation. Because it is so remote, we don’t really see any health staff at the plantation. But luckily for me a staff member from Bright Future found out that I was pregnant on one of his outreach visits. He informed the midwife responsible for our area, and arranged for me to get ante-natal care.

When I went into labour, I had a lot of pain. The health staff referred me to Mudon Hospital. Because of Bright Future’s advocacy work with the Township Health Department, the health staff are more understanding of the needs of migrants. They greeted me warmly, and I delivered my beautiful baby –it went well!

Before I went to the hospital, I thought it would cost a lot of money so I dared not go. But I was wrong. Bright Future staff told me everything was free at the hospital, except the travel and food. I would hate to think women are not going to hospital for financial reasons. If you need it, you can even get help with the travel and food costs.”

Bright Future is a 3MDG Collective Voices partner, working to uncover and address barriers to healthcare in Mon State. In 2016, they helped Ma Hnin access the services she needed to give birth safely.



This makes it difficult for people with drug dependence to access services. In 2016, 3MDG launched a new project in response to the urgent need to reduce stigma and discrimination and raise community understanding of the benefits of Harm Reduction. The project is being implemented by a local partner already engaged in community development, Metta Development Foundation, alongside a technical partner, Medecins du Monde.

As a project of this nature is a long-term exercise it will take time before results are seen. In 2016, Metta conducted advocacy sessions with the community and targeted groups. Technical support provided to Metta has also allowed them to make progress in setting up drop-in centres to provide further services to people who inject drugs and those vulnerable to drug use, and to recruit and employ doctors and nurses to provide clinic support.

### **Health knowledge and behaviour change**

Health knowledge in Myanmar can be limited, and there can be misinformation about health and healthcare. This is especially true in rural and remote areas, where there are information gaps between the information being provided by the health sector and the messages being received by communities. Many communities are not aware of where and how they can access healthcare, and there can be a lack of information about schedules for routine outreach.

There are also embedded beliefs about health, or which can impact health. For example, in Chin State, there are beliefs that travelling on particular days of the month is unlucky. Many people avoid travelling to the hospital on these days. Ancestral medical practices and superstitions can also play a role in how communities access healthcare. Ill-health can be thought to be the result of evil spirits, and remedies are spiritual rather than medical.

When people do receive formal care, they are often not informed about the treatment they are receiving. This is disempowering and does not allow people to control their own health outcomes. For example, people living with HIV can sometimes receive additional medication on top of their ante-retroviral drugs which is not explained to them. Counselling services offered at drop-in centres funded by 3MDG can help to clear up these misunderstandings, which can sometimes be a result of language or limited basic health knowledge.

### **“The participants were empowered”**

Moh Moh Darli, 21, joined the Social Care Volunteer Group (SCVG) in 2016.

*“I found out about village volunteers in a community meeting. I wanted to raise awareness about gender and health issues, especially TB, one of the biggest problems of this village. I thought joining SCGV was a great opportunity to do so.”*

*“As a volunteer, I also contribute to improving the knowledge of the village on gender and health, which is extremely low. Mobilizing people can be very difficult sometimes; they don't show an interest in health. I try to do one-on-one visits to overcome that challenge, and it's working.”*

*“Once I gave a session to 15 women in a neighbouring village. Women from rural areas don't understand their rights and are subject to their husbands' decisions in health. After the training, the participants were empowered and changed their situation at home. This job is so rewarding, I hope I can be a volunteer for a long time.”*

Social Care Volunteer Group is one of 25 local organizations supported by 3MDG as part of the Collective Voices initiative.

Health literacy can be a better predictor of health outcomes than other factors, including age or income.<sup>43</sup> When people are informed and empowered, they can play an active role in improving their own health. 3MDG works to make that happen in two main ways, health education and health promotion.

*i. Health education*

Health education is integrated across the work of the Fund. During ante and post-natal visits, midwives share information with pregnant women and their families about nutrition for themselves and their babies during and after pregnancy, how to care for their babies and warning signs for when further care is needed. In 2016, 3MDG worked with the Department of Nutrition to develop an interactive package of essential nutrition actions for the first thousand days of a child’s life.

3MDG Collective Voices partners share health knowledge with innovative games and other outreach activities. This is particularly targeted at vulnerable groups, such as migrant and mobile populations in Mon State. Volunteer malaria workers undergo training to learn more about health issues for their communities, which they share as they screen for malaria.

In Myanmar, there are more than 130 ethnic groups and more than 100 different languages. This can mean that health providers and communities do not speak the same language, so to overcome these issues 3MDG partners have employed local staff in many areas. General health education can also be limited, with high levels of water-related diseases in the rainy seasons. These diseases are related to sanitation and hygiene, suggesting that at the community level more information and understanding is needed on good practices and how diseases are transmitted.

In 2016, partners reported that nearly 90,000 community members (57 percent women) received health education and accountability, equity and inclusion awareness training. Of these, about half were conducted by partners working in maternal, newborn and child health, nearly 40,000



A health education session at a mobile TB clinic in Yangon Region.

attended sessions held by Collective Voices partners and nearly 8,000 by HIV/AIDS, tuberculosis and malaria partners.

## *ii. Health service promotion*

People need to know what services are available to them and at what cost. Health volunteers and staff mobilize people to use health services through one-on-one visits, information sessions and outreach activities. For example, announcements about mobile TB clinics are made in crowded spaces so people know when and where they will be held, and that they are free-of-charge. Midwives and their support staff also regularly visit villages to conduct immunizations and detect and treat illnesses. They are also able to find out if any women are pregnant in the area, so they can let them know about nutrition, pregnancy care services and emergency referrals.

In Saint Sin village in Chin State, community members report an increase in their use of formal healthcare services and more regular vaccinations. Local field staff and auxiliary midwives have clearly explained the benefits of appropriate health seeking behaviour. One mother explained that when she was a child, she was hidden by her parents in the forest during the vaccination period due to their cultural beliefs and fear of the fever that can happen after immunization. Villagers have the right information now.

Health education and promotion are necessary for uptake of family planning services and preferred contraceptive methods for women and couples. This is essential to securing the well-being and autonomy of women, while supporting the health and development of communities. For 3MDG, this has been done both in the public health sector through townships and in the private sector.

At the township level, 3MDG supports the operational costs of this work, allowing increased outreach visits for basic health staff to meet with mothers and married couples and share information about contraceptive use. 3MDG's partnership with the private sector includes services provided by Population Services International and Marie Stopes International. For both public and private sectors, the use of services is further improved by sharing principles of gender equality and providing spaces for women to express choices over their reproductive health.

## **WHY FAMILY PLANNING?**

A woman's ability to choose - if and when to become pregnant - has a direct impact on her health and well-being. Along with allowing the spacing of pregnancies for all women, family planning allows women at increased risk of health problems and death from early childbearing to delay pregnancy. Family planning also prevents unintended pregnancies, including those of older women who face increased risks related to pregnancy, and enables women who wish to limit the size of their families to do so.

Further evidence suggests that women who have more than four children are at increased risk of maternal mortality. Infants of mothers who die as a result of giving birth also have a greater risk of death and poor health. Birth spacing has also been shown to have positive effects on the well-being of the mother and increase the likelihood that her babies are born at a good weight. It also allows the mother to breastfeed her child for a full two years with all its related benefits. The Myanmar Demographic Health Survey shows that babies born with a birth interval of two years or less, or if they are the fourth or more child, have significantly higher mortality rates.



# 8. OUR APPROACH

3MDG is aligned to the Ministry of Health and Sports priorities and operational plans. This includes the National Health Plan, which moving forward will be the umbrella under which 3MDG aligns its work. It reflects the priorities of the new Ministry of Health and Sports, which took office in early 2016, and which have guided 3MDG’s work through the year.

Investments in communicable disease, TB, HIV/Harm Reduction and malaria, are guided by national strategic operation plans, which are costed and prioritized. They are reviewed and adapted at mid-term and end term. The World Health Organization’s global clinical and disease specific guidelines also guide national responses to most health concerns and are reflected within national frameworks. Similarly, investments in maternal, newborn and child health and health system strengthening are directed by policies, guidelines and plans within national health programmes.

Within this framework, 3MDG is committed to increasing equity in health and improving access to affordable, quality healthcare, especially in rural and hard-to-reach areas and among poor and vulnerable groups in Myanmar. 3MDG is guided by a rights-based approach, supporting health systems that put people at the centre, by understanding their needs and hearing their voices. Interventions are based on evidence and with consideration of value for money principles.

## 8.1 ALIGNING TO THE MINISTRY OF HEALTH AND SPORTS

3MDG programmes are consistently aligned to the direction of the Ministry of Health and Sports. The new direction was made clear in the Minister’s first speech where he outlined priorities, which have now been cemented in the National Health Plan.

A midwife with mothers who she helped with childbirth at the 3MDG-supported rural health centre in Kone Thar village, Ngape Township, Magway region.





3MDG aligns to the Ministry of Health and Sports and the National Health Plan both in principle and in specific areas of implementation. These principles include inclusiveness, integration and better co-ordination among partners. 3MDG works on service prioritization, critical to the development of the Essential Package of Health Services, planning at township level in maternal, newborn and child health; systems building; an enabling environment and community engagement. With equity as a guiding principle, 3MDG is well-placed to support the Ministry in their goal to reach people in underserved, remote and border areas, including conflict-affected areas.

In areas of implementation, 3MDG is similarly aligned. This includes the expansion of primary healthcare, with the aim of driving down maternal and child mortality, and the prevention and control of communicable diseases, co-ordinated with national programmes. Much of this work supports the implementation activities of the government, such as outreach activities and capacity development of government health staff, particularly those working in rural areas and support to the Ministry to improve the supply and cold chains, public financial management and data collection and use.

3MDG supported the Ministry on the development of their annual operational plan for 2017-2018, a process which has further supported alignment, and the National League for Democracy Programme of Health Reform. This is in direct support to the aim of reaching everyone with essential health services towards universal health coverage in 2030.

3MDG reviewed the investment portfolio to ensure all projects are in-line with the priorities outlined in the National Health Plan. This includes streamlining the logistic management information system, supporting the development of the human resources for health information management system, and supporting the finalization of the essential package of services.

## LISTENING TO VOICES

For the first time in Myanmar, a new emphasis has been placed on hearing the community as they express their own health needs. Elevation of community voices and feedback is reflected in the National Health Plan. At the launch event for the formulation of the plan, the Minister of Health and Sports said: *"I would like to hear the voices of those working at the ground level. We must include these voices and perspectives...we want a holistic perspective of what is happening in the country."*

In 2016, 3MDG was well-placed to support this through community feedback mechanisms, the Collective Voices initiative and participatory township health planning. During the year 3MDG held a launch event for the report *"Collective Voices: Understanding Community Health Experiences,"* which uncovered key barriers to healthcare based on more than 500 community meetings.

3MDG encourages implementing partners to listen to the voices of people living in the community. 'Listening' can be conducted in formal or informal ways, depending on the context. It helps staff and organizations to understand the social factors that limit access to healthcare, be more accountable, increases awareness of how much people know about their project and correct minor mistakes and manage risks.

Local health and other authorities are able to be more involved, and trust between organizations and communities increases. Through this community-based approach, the planning and use of resources can be improved as they are based on community needs, and staff and communities are encouraged to participate as their voices really matter.

## 8.2 ‘HEALTH FOR ALL.’ A RIGHTS BASED APPROACH TO HEALTH

3MDG’s rights-based approach is underpinned by the principles of responsibility, fairness, inclusion and ‘do no harm.’ The four principles form the basis of the 3MDG Accountability, Equity and Inclusion Strategic Framework (see Figure 3), and are also reflected in the Fund’s financing decisions, which target resources to those who cannot otherwise access services or afford healthcare, including women and children, people living with HIV, and those in conflict-affected areas. These principles have guided the work of the Fund since its inception, and in 2015, these principles were aligned under the banner of ‘Health for All’ (see Chapter 9.2 Health for All results).

### Responsibility

3MDG has supported training and resources to help implementing partners improve their approaches to participation and community feedback. This helps to create health accountability and responsibility amongst providers because when people know what they should expect, they are in a position to demand it, and they are able to voice their health needs and concerns.

### Fairness

To create more fairness in the health sector, ensuring that all people, no matter their gender or sexual identity, are able to access the health services they need, 3MDG supported activities that improved understanding of how needs may be different, increased access and provided essential services and enhanced women’s representation and voice. In 2016, a total of 107 women were on township health committees (28 percent), and 44 percent of the members of village health committees were women.

### Inclusion

3MDG provides services to ensure the inclusion of a wide range of population groups who are considered vulnerable. Partners receive training on the

FIGURE 3: 3MDG PRINCIPLES



inclusion of different groups, including women and young children, people with disabilities, people living with HIV and those most at risk, such as people who inject drugs. For example, in 2016 Marie Stopes International worked with people with disabilities to support their involvement in village health committees and health education sessions.

In rubber plantations, Bright Future co-ordinates with migrant workers to ensure they receive immunization and maternal, newborn and child health services. In 2016, outreach services were organized together with basic health staff, and during these trips health education sessions and individual counselling were also available.

Inclusion is also about ensuring that language barriers do not stand in the way of accessing health services. 3MDG partners employ local staff to help grow awareness of available health services, understanding of health education sessions, and help people communicate with health staff.

For example, in 2016 in Shan State, difficulties with trust due to conflict, and language barriers meant that children were not always receiving proper immunizations. To overcome this, village leaders and partner staff have been used effectively as translators between health staff and the community. Due to their position, they are also able to encourage villagers to have their children immunized.

## **‘Do no harm’**

The principle ‘do no harm’ forms the basis of 3MDG’s strategy to operate in conflict areas. It requires an in-depth understanding of the context of these operations to ensure health activities do not create or worsen conflict, and involves stakeholders at all stages, among other principles.

## **WORKING IN CONFLICT-AFFECTED AREAS**

The peace process has allowed for increased cooperation and communication between Ministry of Health and Sports, local authorities and ethnic health organizations. The willingness of the Ministry to engage and recognize these organizations has provided hope for future effective and context-appropriate healthcare arrangements.

3MDG-funded implementing partners have facilitated coordination between key stakeholders in the health sector, such as Ministry of Health and Sports, local authorities, ethnic health organizations and civil society organizations. This is particularly true where access to health has been limited. In many cases, they have been able to bring people together around health. Continued support from international actors through sensible action (i.e., through the creation of a space for dialogue) will foster mutual respect and long-term sustainability.

In conflict-affected and hard-to-reach areas, partners also work closely with ethnic health organizations, local authorities and non-state actors to support delivery of health services. 3MDG supports the organizational capacity development of these partners, whose work is particularly important in order to extend reach into these areas through services, as well as to help ensure timely referral in the event of a medical emergency which requires further care.

3MDG-supported project implementation in conflict-affected areas has been guided by a conflict sensitivity strategy. The strategy adheres to international best practices related to ‘do no harm’, including conflict sensitivity principles and a clear strategy to engage in conflict-affected areas.

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

8.3 VALUE FOR MONEY

By pooling the contributions of seven bilateral donors - Australia, Denmark, the European Union, Sweden, Switzerland, the United Kingdom and the United States of America - 3MDG promotes the efficient and effective use of development funds. 3MDG is managed by the United Nations Office for Project Services (UNOPS), which results in increased efficiencies and economies of scale through shared services in procurement, human resources, finance and other support services. *For more on this, see Chapter 11: Fund Status.*

3MDG is also guided by evidence and best practice, and in ensuring that the money with which we are entrusted is well-spent. For example, a value for money assessment conducted in 2016 by Hera (based on 2015 data)<sup>44</sup> showed that interventions to improve maternal, newborn and child health are cost effective and therefore good value for money. If maximal effectiveness is assumed, these interventions are highly cost effective. If interventions are only 50 percent effective, these interventions are still cost-effective, according to the study.

Choosing to provide emergency referrals, alongside other maternal, newborn and child health interventions, is based on global evidence that shows that it is during the period of labour and delivery that the most maternal and infant

Villagers in eastern Kayah State, which is conflict-affected. 3MDG provides support to this area and works with ethnic health organizations and the Ministry of Health and Sports.





lives can be saved with the delivery and access to basic and comprehensive obstetric and newborn care. The assessment also looked at support to emergency maternal and child referrals and found this highly cost-effective.

The 3MDG HIV Harm Reduction programme has showed an improvement in its cost effectiveness over the past three years. Measuring the cost based on **disability adjusted life year** (DALY) averted also shows good value for money. The World Bank Group cost-effectiveness analyses recommend an average cost per DALY of USD 102.<sup>45</sup> 3MDG's interventions have been calculated to be 52 USD per DALY.

The unit cost of treatment per tuberculosis case detected has also decreased each year from 2014, showing that 3MDG has become more efficient over time. They are calculated to be 44 USD per DALY, which falls within the recommended range indicated in the 3MDG Inception Report (38-46 USD). This has also improved from 2014, when it was more than double at 102 USD.

The unit cost per case of multi-drug resistant tuberculosis is higher because of the more intensive nature of the treatment and support package. In Yangon, this cost is about 800 USD per year, and in Mandalay it is more than 2500 USD per year. This is because of the high cost of delivering specialized TB services outside of Yangon. Though these figures are significant, responding to the health concern presented by the drug resistant form of TB is critical.

For malaria, the unit cost per case treated has actually increased from 2014, to be 421 USD in 2016. This is due to the declining prevalence of the disease. This means that there are significantly more tests conducted for fewer cases detected. The cost for one DALY-averted is 2,558 USD.<sup>46</sup> The cost-effectiveness of this is difficult to calculate due to limited cost-analysis research.

Looking ahead, 3MDG is also supporting a review of the cost-effectiveness and rationale for active case detection for tuberculosis in 2017. Active case detection is used because it helps improve access to health for vulnerable,

A **disability adjusted life year' (DALY)** can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability.

*Source: World Health Organization*

## VOLUNTEER RECORDING SYSTEM

The volunteer recording system developed by 3MDG and its partners has been rolled out in 27 out of a total of 34 townships. Through the system, information can be collected about the services provided by community health workers and auxiliary midwives, stock and supplies, and other health information. Progress around this is shared with the Ministry of Health and Sports regularly.

Out of a total of 7,000 volunteers, 79 percent were trained in the recording system. Of these, 87 percent reported at least once during 2016. Admittedly, this first dataset gives only a partial reflection of the situation and results of community health activities due to existing challenges such as under reporting and data quality issues. Efforts are under way to improve and encourage data use at the local level.

However, despite challenges, there were significant results extracted from the reports. For example, it was found that on average around 19 people can be reached by each volunteer health worker through village level health education sessions each month.

Over 74,000 nutrition assessments were done for under five children in 2016. The overall finding was 11 percent moderate wasting and 1.8 percent severe wasting. Findings differ among the townships. *For more on the 3MDG Volunteer Recording System, see Annex III.*

difficult-to-reach, stigmatized and criminalized populations. Continued research into its effectiveness and value for money is an important legacy and contribution from 3MDG to the wider health sector in Myanmar.

### 8.4 BUILDING AN EVIDENCE BASE

Basing health policy on actual evidence connects the needs and priorities on the ground with interventions at all levels. This helps policy-makers to understand which intervention responds best to which population need, allowing for differences in implementation according to location and other factors. Basing healthcare improvements on evidence helps use money effectively and ensure the most critical activities are prioritized. An evidence base enables programme performance assessments and can indicate a need for changes in programme design or for specific corrective actions.

In order to provide more and better evidence, reliable data is critical. 3MDG uses data from both the national health information system and additional systems established by its implementing partners. 3MDG continues to help strengthen the national health information system and build the evidence base through:

- The use of the District Health Information System 2 (DHIS2) in 32 townships
- Inputs to the Health Information System assessment and the National Strategic Plan
- The recent roll-out of the volunteer recording system
- Financing research into the work of the Fund

In 2016, 3MDG supported the production and dissemination of 17 operational research studies and case studies. This included a regional supply chain assessment study and based on the findings, the government agreed to revise the stock ledger book and introduced an electronic system to improve tracking of essential health commodities.

In 2015, two studies - the review of private health sector regulations and the first health in transition report - were used as evidence for the preparation of the National Health Plan, released in 2016. The Myanmar Demographic and Health Survey, released in early 2017, and the upcoming micro-nutrient survey will also feed into the planning process for each state and region's implementation of the plan. Also in 2016, 3MDG results were presented and discussed in 50 policy dialogues and technical and strategic forums.

Continuous improvement of the evidence base is dependent on many factors, including but not limited to availability, training and supervision of the personnel involved in data collection and reporting, robust systems and processes and prioritization of needs for new evidence generation.

# 9. RESULTS

## 9.1 HEALTH SYSTEM STRENGTHENING

**44** **Health centres built** in Myanmar in 2016. 17 in Sagaing, 13 in Ayeyarwady, 7 in Shan South, 3 in Kayah, 2 in Shan East, 1 in Chin and 1 in Mandalay

**1,985** **Doctors, nurses and midwives** who participated in at least one mother, newborn and child health training, including delivery and emergency obstetric care in 3MDG-supported townships (62% of total eligible basic health staff)<sup>47</sup>

**80%** **3MDG-supported townships** with functional cold chain equipment and adequate storage space (compared to a target of 60%)

Tangible results were seen in 3MDG's health system strengthening work in 2016, and 3MDG made important contributions to government progress. The Ministry of Health and Sports formalized its commitment to achieve universal health coverage by 2030. This was made plain in the launch of the National Health Plan (2017-2021) Executive Summary in December 2016, followed up by the full report and operational plan in early 2017. 3MDG provided financial and practical support to the development of the plan and the associated annual operational plan for the first year of implementation.

In early 2017, the Ministry of Health and Sports released the findings from the Myanmar Demographic and Health Survey, which was implemented by the Ministry with funding from the USAID and 3MDG. The survey provides important input for the Ministry's future planning, policies, strategies and guidelines, including at state level. 3MDG will also use the survey for 2018 planning.

Through a total grant value of USD 2.8 million provided to the World Bank, 3MDG supported a two-year effort to design and cost the Essential Package of Health Services (Essential Package) alongside other interventions. The

## INFRASTRUCTURE

Since 2015, 3MDG has been financing the construction of health facilities across the country. By the completion of the project in early 2018, 82 new rural and sub-rural health centres will be serving community health needs. In 2016, 44 of the health centres were completed, bringing the total completed since the project began to 61. During the year, 32 of the centres were formally handed over to the Ministry of Health of Sports, with the remaining 12 handed over in the beginning of 2017.

By building the centres, 3MDG aims to increase access to care for some of the hardest-to-reach people in the country. Locations were chosen based on lack of existing facilities, accessibility and population coverage. The 44 centres completed in 2016 improve access to care for about 270,000 people. When all 82 centres are completed, the number of people covered will increase to 440,500. Based on the project cost of USD 12 million, the investment per person is 27 USD.

Staff in the centres will focus on maternal, newborn and child health, because of disparities between rural and urban settings in health indicators related to maternal and child mortality. However, they will serve all community health needs and can treat up to 50 patients per day. The centres include delivery, emergency and waiting rooms, solar panels, examination rooms, water tanks, incinerator and placenta pit, onsite accommodation for staff, and drug storage facilities.

The construction of the centres has been managed by the UNOPS Infrastructure Unit. The team has also managed the construction of tuberculosis treatment and testing facilities in Yangon and Mandalay. A facility for family and attendants to stay when caring for patients was opened in Mandalay in November 2016 and two outpatient departments and a laboratory will open in 2017. *For more information on these facilities, see Chapter 7.1, Box: Key Tuberculosis Infrastructure.*

World Bank held several rounds of consultations and conducted an analysis of the amount and type of financing available for health (fiscal space analysis); highlighting which services are affordable for the government to provide. A phased approach was then designed which will ensure all population groups have access to a package of health services by 2030. In principle, the Essential Package has been accepted by the Ministry and the content will be further reviewed and defined in 2017. In particular, the costing of the package needs further review. 3MDG will continue to support the Ministry in this effort in 2017.

Information gathered from analytical work in 2016, including the Demographic Health Survey, an out-of-pocket expenditure study, a regional supply chain study, and a rapid health system strengthening assessment in Rakhine, is shaping policy dialogue on critical issues. Discussions have included the prioritization of the Ministry’s limited resources, how to fix health system bottlenecks at state level, and addressing drivers of catastrophic spending in health.

Data aggregation tools have been introduced in a number of townships, which has contributed to the increased use of data in planning. For the three regions that are currently piloting a new approach in supply chain management, regional health directors will be able to forecast requirements for supplies and commodities based on consumption needs.

Across the country, all 22 midwifery schools, and one school for Lady Health Visitors, have been strengthened to include skills labs for hands-on practice and assessment. A midterm assessment of midwifery student skill competency has shown a more than 20 percent increase compared to the baseline. The training of 268 master mentors has continued.

3MDG’s partner in this work, Jhpiego, is also working with the Departments of Medical Service and Human Resources for Health to identify, upgrade and standardize the clinical practicum sites for all midwifery skills. Together with UNFPA, the Ministry of Health and Sports, and midwifery and nursing school principals, the curriculum of the diploma course in midwifery is being revised and further developed for the Bachelor’s degree in Midwifery.

Midwife trainees studying for their final exam at Pyay Midwifery School, Bago Region.



Photo: Jhpiego



## 9.2 'HEALTH FOR ALL'

**76%** Of implementing partners (19 out of 25) included participation and engagement between health care providers and target communities in their activities

**7,673** Pieces of feedback received by implementing partners from community members  
66% of this feedback has already been addressed

**1,644** Women attended the annual review workshop on the comprehensive township health plans. This is 79% of all attendees

**107** Women on township health committees  
This is 28% of all members, 3MDG target is 20%

**15,242** Women on village health committees  
This is 44% of all members, 3MDG target is 30%

**3,192** Staff trained in accountability, equity, inclusion and conflict sensitivity\*

*\* Staff from the Ministry of Health and Sports, implementing partners, local non-governmental organizations, and community-based organizations (at central, regional and township level)*

3MDG's 'Health for All' strategy is aligned to the guiding principles of the Ministry of Health and Sports, reflected in the Myanmar National Health Plan 2017-2021. These include equity, inclusiveness, accountability, efficiency, sustainability and quality. 3MDG has worked on this critical area since 2013.

A review of the strategy in December 2016 identified good practices to date, including the use of existing structures and opportunities for engagement, such as township and village health committee meetings and mobile clinics. These create spaces for sharing information and listening to people's voices, and can bring about significant project adjustments. The review also praised 3MDG's focus on participation and inclusion, and information-sharing to reduce stigma and discrimination.

### "I focus on what the community needs"

Daw Aye Aye Thein has been working as a midwife at Song Khwar rural health centre in Hakha in Chin State for three years. After she attended a 3MDG-supported training, she saw a lot of changes.

*"In the rural health centres in our area, there were vacant staff positions for a long time. We tried to cover their communities as well, but we got a lot of complaints because we couldn't provide the health services they needed. Along with staff shortages, there were also landslides and floods, and expensive motorbike fees which meant we had to travel by foot.*

*"When 3MDG starting supporting our outreach visits, we could make them more regularly and provide more health services, including immunization.*

*"When I attended training on Health for All in Hakha, things really changed for me. I had never heard of them before, but I found the principles of accountability, equity, inclusion and conflict sensitivity useful for my work and also for my life. Now, I focus on what the community needs rather than job accomplishments. I really appreciate the participation of the community in health activities, and now they recognize my job more and participate more too. Their knowledge has improved, and preventable diseases have decreased because of this knowledge and because of immunization."*

For example, to reduce the stigma around women with drug dependence, 3MDG implementing partner Substance Abuse Research Association (SARA) organized a number of community meetings to raise awareness and host discussions. Family members were particularly appreciative of their involvement in activities which helped them understand the importance of their support to people who use drugs.

Recommendations and an action plan will drive improvements where needed and inform the future positioning of this type of work.

### 9.2.1 Accountability, equity and inclusion, and conflict sensitivity and capacity building

Throughout 2016, 3MDG and implementing partners promoted accountability, equity, inclusion and conflict sensitivity (AEI&CS) in their work. Progress reports from the township level demonstrated good mainstreaming of these principles into programme and project management for all partners, exceeding expectations in 2016.

According to reports received from implementing partners, more space has been created for engagement with communities and at township level.



A panel session at the launch of the Collective Voices report, attended by the Minister for Health and Sports, representatives from government and parliament and civil society.

*"I would like to hear the voices of those working at the ground level. We must include these voices and perspectives if we want a holistic perspective of what is happening in the country."*  
**H.E. Dr. Myint Htwe, Minister for Health and Sports, Launch of the Collective Voices report.**

Feedback is shaping project activities, and listening to people's voices is becoming more central. Flexibility in budgeting has allowed partners to respond better to changes in local context. Out of 19 implementing partners, 18 completed the AEI&CS assessment in 2016.

#### *AEI&CS for health staff*

In total in 2016, 3,192 health staff from central, regional and township levels were trained in accountability, equity, inclusion and conflict sensitivity. There were 1,477 people trained from the Ministry of Health and Sports, 950 from 3MDG implementing partners and 765 people from local non-government and community-based organizations. The total number includes 1,856 women and 1,336 men.

#### *AEI&CS for implementing partners*

A number of trainings and workshops were organized throughout the year, both by Pact Myanmar and by 3MDG. In total in 2016, there were 470 attendees from implementing partners at the sessions. Topics included information-sharing, universal health coverage, the social determinants of health, ethnic diversity, sexual and reproductive rights and men's engagement.

Some trainings aimed to increase the involvement of women, including sessions in participation and feedback mechanisms to reach women and girls; and promoting and monitoring women's participation in health planning and decision-making bodies. As a result of these efforts, more women than previous years (1,644 women, 79 percent of all attendees) attended annual meetings in 3MDG-supported areas, including midwives, Lady Health Visitors and nurses.

There were five sharing sessions amongst AEI focal points and four in conflict sensitivity. Five exchange visits between partners aimed to enhance the capacities of partner organizations and create stronger linkages across different health areas.

#### *Capacity development of partners*

3MDG provides technical and capacity building support for its partners' through Pact Myanmar. Based on the needs of each partner, this is done through training sessions, workshops and forums, technical assistance, and organizational capacity development services. Topics include financial and human resources management, administration and logistics, advocacy and fundraising, strategic planning, monitoring and evaluation and programme management. There were 19 partners in total supported, including six ethnic health organizations.

## **9.2.2 Community feedback and response**

To promote accountability and ensure interventions meet the needs of the community, 3MDG partners collect feedback directly from community members. In total, 7,673 pieces of feedback were collected, and 66 percent of this feedback was addressed. Of these, 4,300 were positive, 490 were negative, 1898 were suggestions and 985 were classified as 'other.'

Changes have been implemented as a result. For example, after a request to improve the accessibility of drop-in centres for women with drug dependence, partners began to open the centres on the weekend and arranged outreach services to reach those who could not access them. When reports were received about needles and syringes in public places, volunteers were quickly mobilized to collect them.

The amount of referral support was adjusted in response to feedback that it did not reflect actual costs for people travelling from hard to reach villages. More topics were added for health education sessions in response to community requests, and current information was modified to be more clear and understandable.

### 9.2.3 Support to village-level health structures

Village health committees held health education sessions and trainings on gender equality. 3MDG partner organizations helped to set up village health funds to help overcome a common barrier to health, cost.

More women participated in community health education sessions and village health committees than in previous years. In 2016, there were 107 women on township health committees, representing 28 percent of the total members (up from 19 percent in 2014). In comparison, 44 percent - or 15,242 - of village health committee representatives were women.

### 9.2.4 Collective Voices

The Collective Voices project grant furthers the 3MDG Fund’s contribution to a responsible, fair and inclusive health sector, with a focus on community engagement, to achieve better health for all in Myanmar.

Collective Voices partners now have a major role in health education and social mobilization campaigns, reaching out to vulnerable communities, migrants and diverse ethnic groups. This project is able to strengthen beneficiary accountability and responsiveness by listening to the voices of the community.

## LOOKING TO THE FUTURE FOR COLLECTIVE VOICES

Local civil society and community based organizations have a critical role to play in achieving universal health coverage and to support the implementation of the Essential Package of Health Services. It is critical that they are integrated across all areas of the Fund to address the social determinants of health, improve health-seeking behaviour, empower citizens, strengthen health services accountability and responsiveness and foster an enabling environment between healthcare providers and communities.

While many agencies are supporting the Ministry of Health and Sports, 3MDG has played a unique role in connecting the Ministry with communities and local organizations through work on the social determinants of health. Following the early success of the Collective Voices initiative, it would be beneficial to continue (or ideally expand) funding support for local civil society organizations to play an important role in a people-centred health system. The new National Health Plan also offers potential opportunities as the plan states explicitly that civil society organizations have an important role to play in accountability.



Specific activities include health education for hard-to-reach communities, co-ordination with village elders to facilitate health activities, social mobilization, support to immunization campaigns and informing the midwife or township medical officer when there are cases or outbreaks of disease.

Partners co-ordinate with different public sectors, including education. They work with township education officers and headmasters to organize health education sessions for school children in primary healthcare, hand washing, nutrition and adolescent sexual health. Partners also hold game show type competitions and quizzes in local languages to improve community knowledge about health and rights. Their impact is significant because they are able to share and multiply information about health and about health services to hard-to-reach communities.

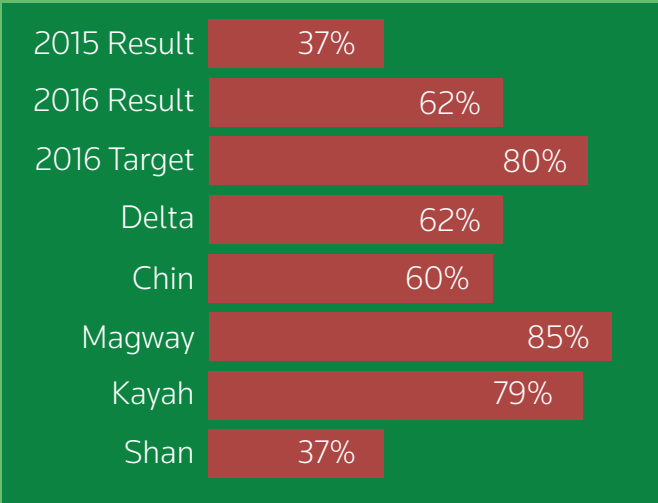
Within a relatively short period of time, the Collective Voices project has been able to uncover knowledge on the barriers to healthcare and create spaces for constructive engagement with health service providers and policy-makers. The Collective Voices report released in 2016 has also influenced health policy. The report was launched by the Minister, and community engagement is included in the National Health Plan. The strength of the Collective Voices

A midwife is able to provide **supervision** for volunteer health workers. She is able to instruct them on how to provide treatment correctly. **Monitoring** is the assessment of whether the services are being provided regularly.

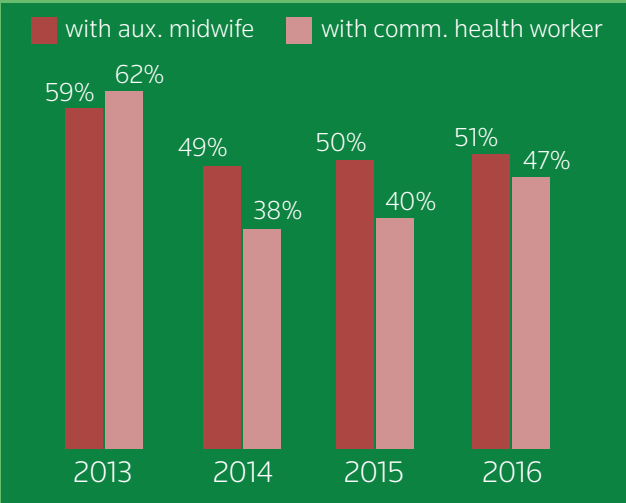
## SUPERVISION OF THE COMMUNITY HEALTH WORKFORCE

In the area of supervision and monitoring, there was significant improvement in 2016 but with some work to be done to reach targets. **Supervision** refers to the work done by a midwife to ensure volunteers are administering treatment correctly, and **monitoring** ensures that it happens regularly. Previously, this was done without a checklist, but in 2015 the 3MDG monitoring and evaluation team developed a checklist that is now used by basic health staff and implementing partner staff. It may take place at quarterly rural health centre meetings or while the midwife is conducting outreach visits to villages.

GRAPH 1: Average percentage of auxiliary midwives, community health workers receiving quarterly supervision in 2016



GRAPH 2: Percentage of hard-to-reach villages with an auxiliary midwife, community health worker (2013-2016)\*



\*The expansion of 3MDG services into new townships each year means the total number of villages is not comparable and as such is not included. The result for 2013 is only for six townships in the Delta, as support to these townships was carried on from preceding work by an earlier fund.

approach has been the ability of community based organizations to engage directly with government health service providers, share grassroots evidence of the barriers to health, and use dialogue to work with providers to address these issues.

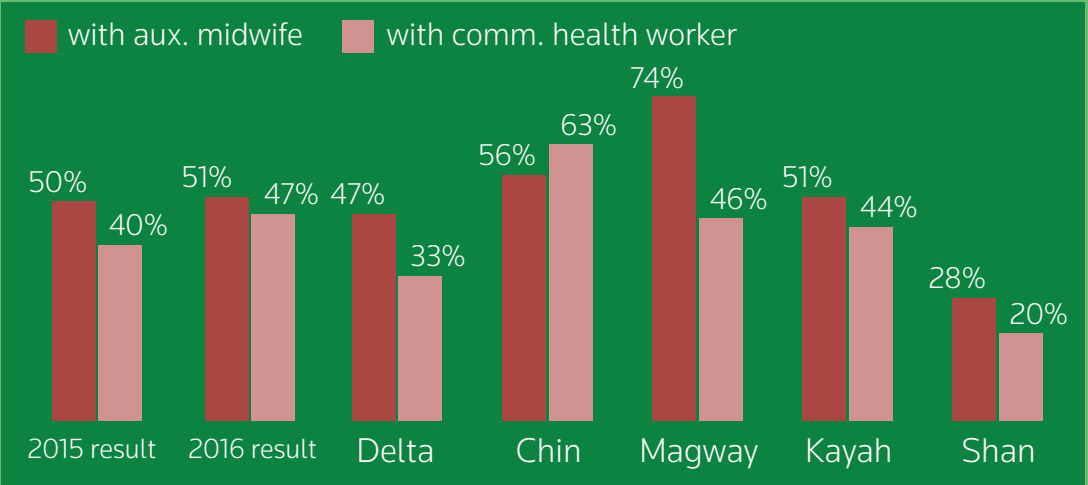
### 9.2.5 The community health workforce

Across the work of the Fund, significant resources are dedicated to improving the community health workforce and how the community can be empowered and supported to respond to its own health needs. This includes auxiliary midwives and community health workers. They may be trained in child health, first aid, sanitation advice, or provide treatment and counselling for malaria, tuberculosis and HIV. Health staff at the village level are often the first, sometimes the only, health service available to villagers – particular in hard-to-reach areas. Improving the ability of these staff to meet immediate needs, ensuring they have the right training and equipment, the right supervision, and that they know when to refer, is a priority of the Fund’s work. *See the Box below for more on the supervision of this workforce.*

*Graph 1* highlights geographical disparities for quarterly supervision and monitoring for auxiliary midwives and community health workers. For instance, though there is 85 percent coverage in Magway Region, there was only 37 percent coverage in Shan State. This can be explained by an escalation in conflict in Northern Shan townships, which has resulted in limited access for staff.

Another important measure of the strength of the community workforce is how well they are able to reach people living in rural and remote areas. As shown in *Graph 3*, In 2016, 51 percent of hard-to-reach villages had an auxiliary midwife, and 47 percent had a community health worker. This has shown small improvements each year. Again, geographical disparities persist, and again Shan State has the lowest coverage for auxiliary midwives and community health workers, with Magway again performing well.

**GRAPH 3: Hard-to-reach villages with auxiliary midwife, community health worker by state and region in 2016\***



*Note as this is not in the 3MDG logframe, there is no target for this indicator.*

9.3 MATERNAL, NEWBORN AND CHILD HEALTH



There has been good progress in the delivery of essential maternal, newborn and child health services in 2016, across 34 townships in Ayeyarwady, Magway, Chin, Shan and Kayah and the special regions of Wa and Special Region 4. Preparation for support to nine townships in Rakhine was finalized in October 2016, meaning that the reporting period covers what is essentially the start-up phase of this programme.

There was improvement in a number of health indicators across all townships, except those in Northern Shan because of higher levels of conflict in 2016. Almost all measures are meeting 3MDG targets. There was an increase in the number of women who received four or more ante-natal visits, from 68 percent in 2015 to 71 percent in 2016. There was also a small increase in the

FIGURE 4: Key maternal, newborn and child health indicators in 2016

	Number of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife) in 3MDG-supported townships	Number of women attended at least four times during pregnancy by skilled health personnel in 3MDG-supported townships	Number of mothers and newborns who received postnatal care visit within three days of childbirth in 3MDG-supported townships	Number of children under one immunized with DPT3/Penta3 in 3MDG-supported townships	Number of children under one immunized against measles in 3MDG-supported townships	Number and percentage of appropriate maternal referrals in 3MDG-supported townships
2016 TARGET	72%	73%	80%	95%	95%	11,800
2016 RESULT	51,358 68%	53,319 71%	60,734 82%	72,803 95%	73,650 96%	16,612* (19% of expected pregnancies)
CUMULATIVE RESULT	149,368	155,947	173,812	219,352	219,718	44,730

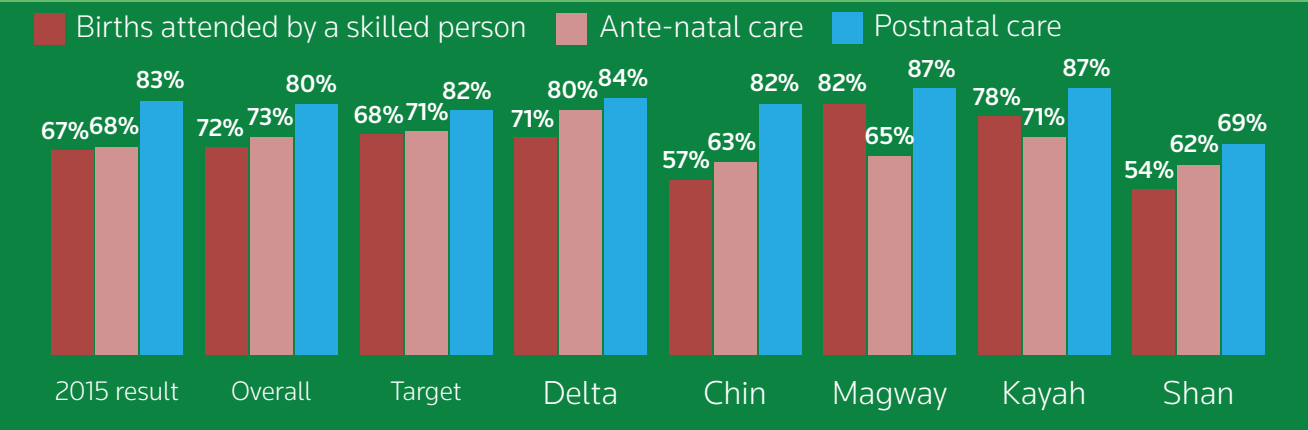
This only includes 34 townships, not including 194 maternal referrals from Rakhine and an additional contribution of 336 cases from the ethnic health organization/s and Health Poverty Action

number of deliveries that were assisted by skilled birth attendants, from 67 percent in 2015 to 68 percent in 2016. *Graph 4* shows a comparison across different states and regions.

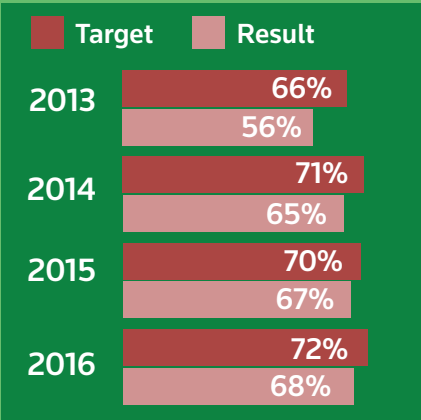
*Graphs 5, 6 and 7* show the yearly percentages for skilled health personnel and immunizations from when the Fund began delivering services. For example, for the percentage of births that had a skilled attendant, this has improved 12 percent since the start of the Fund. Since 2014, growth in coverage has been consistent with three percent total improvement. This is despite significant number of unfilled midwife positions in some areas that 3MDG supports, especially in conflict-affected areas. This presents challenges to increasing access to skilled care.

The number of children receiving vaccinations remains high in 3MDG-supported townships in 2016, with 95 percent coverage for all three doses of Penta 3 vaccine and 96 percent for the measles vaccine. It also remains a solid performer across the years of the Fund. *For more information on yearly trends, please see Annex V.*

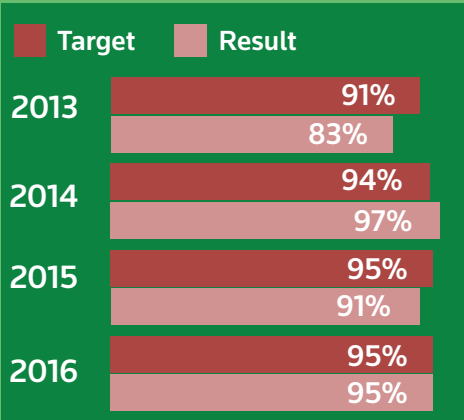
GRAPH 4: Key maternal, newborn and child health indicators in states and regions in 2016



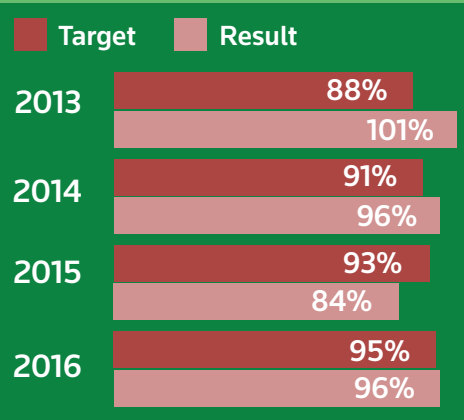
GRAPH 5: Percentage of births attended by skilled health personnel in 3MDG townships (2013-2016)



GRAPH 6: Percentage of children under one immunized with Penta 3 in 3MDG townships (2013-2016)



GRAPH 7: Percentage of children under one immunized against measles in 3MDG townships (2013-2016)





Maternal and child referrals

Women were better able to access emergency care during pregnancy and childbirth. In 2016, 16,612 women (about 19 percent of all pregnant women in 3MDG townships) were referred to a secondary care centre when it was needed. Nearly 14,600 of children under five (four percent of all under five children) were also referred when they were unwell.

This intervention addresses the critical period of labour and delivery where the majority of maternal and infant deaths can be prevented. Referrals are primarily made by midwives based on established criteria outlined in the 3MDG guidelines. Volunteers are also trained to look for danger signs.

In two townships in the Ayeyarwady Region – Dedaye and Ngapudaw – more than 30 percent of expected pregnancies were referred to the hospital. The number in Dedaye is very high, at 37 percent, because the doctor there refers all first-time pregnancies for mothers who live in villages far away from the hospital. There also may be people coming from nearby townships to receive

**Crash services** are used in hard to reach areas where access is not always possible through the year. Children are immunized every month for three consecutive months when access is possible.

FIGURE 5: Maternal referral disaggregated by state or region for 2016

	Maternal cases	Expected pregnancy	Percent referral of expected pregnancy
Ayeyarwady	9,747	36,995	26%
Chin	1,524	13,724	11%
Magway	2,967	13,310	22%
Kayah	883	6,951	13%
Shan	1,491	15,404	10%

FIGURE 6: Child referral disaggregated by state or region for 2016

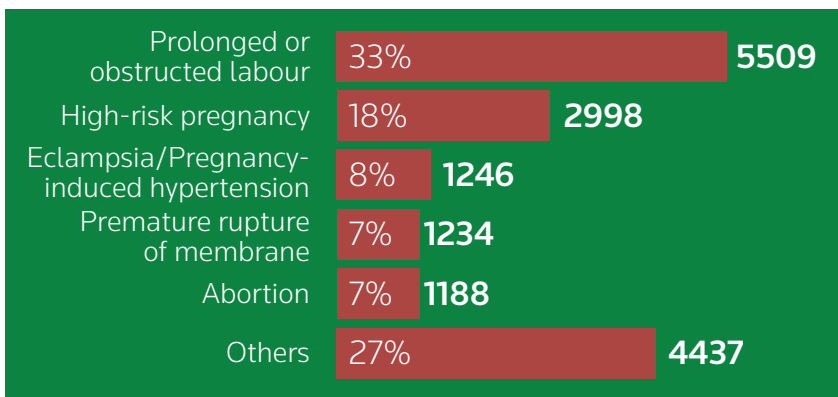
	Under five child cases	Under five children	Percent referral of under-five
Delta	5,977	162,936	4%
Chin	2,339	61,655	4%
Magway	3,751	57,344	7%
Kayah	985	32,072	3%
Shan	1,534	61,742	2%

WORKING WITH ETHNIC HEALTH ORGANIZATIONS

In one conflict-affected area, a network of ethnic health organizations is collaborating well with both the State Health Department and 3MDG implementing partners. After receiving training from the state immunization team, providers were able to provide ‘crash’ services in 37 villages in a township where the Ministry of Health and Sports has no access. More regular and frequent outreach by mobile teams because of increased support and better co-ordination with the public sector and Ministry of Health and Sports has improved the delivery of preventive and promotive services and improved the equity of healthcare provision and access.

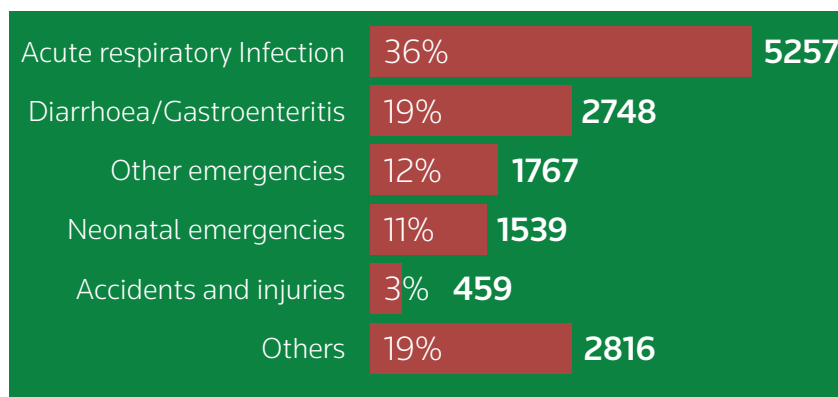
In Shan State, all of the ethnic health organizations and the health departments of local authorities working with 3MDG attended regular state co-ordination meetings, strengthening their collaboration with the Ministry of Health and Sports. In three Southern Shan townships, Relief International also provides support to and accompanies township staff in visits to villages serviced by ethic health organizations, resulting in better access to preventative services, as ethnic health staff mainly provide curative services.

**GRAPH 8: Top five causes of maternal referrals in 2016 (based on 16,612 3MDG referrals)**



*\*As prolonged and obstructed labour are not disaggregated by the township health department in their data collection, they are presented together in this graph.*

**GRAPH 9: Top five causes of referral for children under five in 2016 (based on 14,586 3MDG referrals)**



referrals. In both townships, it is also believed that increased community awareness is driving up the figures, which in turn raises the average across the entire region, leading to the high figure of 26 percent in Ayeyarwady.

Results in 2016 show consistent improvement across important health interventions, and mean that women in townships that 3MDG supports are more likely to have the assistance they need throughout their pregnancy and

## FAMILY PLANNING IN CHIN STATE

Chin State is a mountainous region, with poor transport and road infrastructure. Access to healthcare services can be difficult for many reasons. This has a serious impact on important indicators like child and maternal mortality, and Chin State is one of the worst performing states or regions for these figures in the country. It also has the highest fertility rates, highlighting the importance of access to family planning, contraception and other healthcare.

Resistance from churches to family planning added a layer of complexity for the 3MDG partner in this area, Marie Stopes International (MSI). However, the appointment of Chin staff with the role of building relationships with churches has achieved increased acceptance of contraception amongst their parish members. This has allowed for awareness-raising and behaviour change sessions, however, there is still work to do to increase historically low levels of contraceptive use (see Graph 12 on page 68).

Ms. Elizabeth Kim\* (not her real name) comes from a hard-to-reach village about 70 km from Hakha in Chin State. All of her children were delivered by a traditional birth attendant. “I didn’t want to have another baby, but I didn’t know much about contraception,” she says. When Marie Stopes visited her village to conduct a session on sexual and reproductive health, Elizabeth decided she wanted to use a long term family planning method. This was the first time in her life she used contraception. She said: “I am so happy to be using contraception now. I cannot stop saying thank you.”

childbirth. Women and men have better access to the tools they need to plan their families, and children have increasingly better chances to avoid disease and enjoy healthy childhoods.

Overall numbers, however, can obscure state and regional figures, which show more varied degrees of improvement and overall coverage. For instance, though Magway is performing very well across almost all indicators, results in the four Northern Shan townships actually show a decreased achievement against 2015. Heightened conflict resulted in lack of access to certain parts of the townships by health and partner staff.

There is gradual improvement in data collection and analysis in 3MDG townships. For example, the District Health Information System (DHIS 2) was implemented in 26 townships (rising to 32 townships as of April 2017) and this allows the use of real time data to identify challenges and formulate solutions in low-performing areas as the system allows disaggregated analysis.

Volunteers at the village level also report via the ‘volunteer recording system.’ Though reporting figures are only at about 50 percent, the information it provides will aid in discussions with the Ministry of Health and Sports on the institutionalization of the community-based health programme. *For more on results from the volunteer recording system, see Chapter 8.4 Building an evidence base and Annex III.*

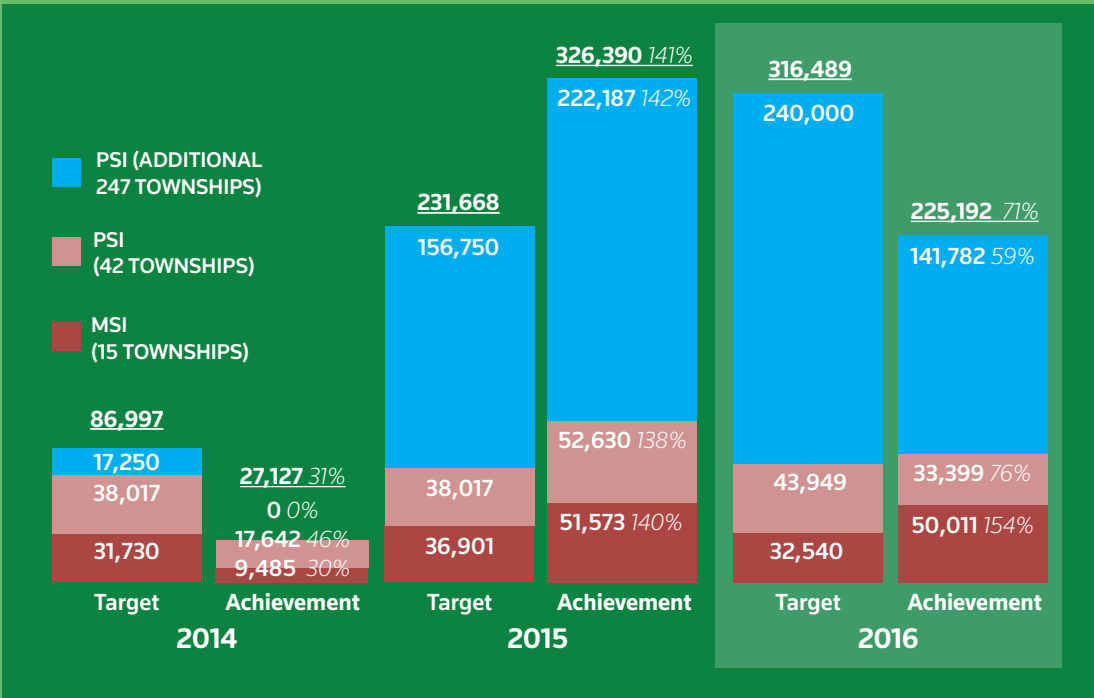
Family planning and access to contraceptives

**Disability adjusted live years (DALYs)-averted** and **Couple Years of Protection** are indicators which can improve based on the quantities of contraceptives distributed and used over a period of time. CYPs are an output measure of how many couples will be protected for one year using those

A ‘disability adjusted life year’ (DALY) can be thought of as one lost year of ‘healthy’ life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability.  
*Source: World Health Organization*

**Couple Years of Protection (CYP)** is the estimated number of couples who are protected from getting pregnant in one year. Each pregnancy carries a risk of death and disability and the Maternal Mortality Ratio is an indicator of that risk.  
*Source: World Health Organization*

PUBLIC AND PRIVATE SECTOR: COUPLE YEARS OF PROTECTION



GRAPH 10:  
Total number  
of Couple Years  
of Protection  
(CYPs) delivered  
through public  
sector services  
and private sector  
channels

contraceptives. DALYs-averted by the use of contraceptives is an indicator of how much death and disability can be prevented by this intervention.

In the graphs below, we can see steady improvement in achievement of CYPs and DALYs-averted (except for the 2016 achievement in additional townships, which is explained below). This work is delivered by Marie Stopes International Myanmar and Population Services International. Contraceptives are also delivered in the public sector, which 3MDG supports through provision of operational and outreach costs.

Marie Stopes International Myanmar provides family planning and contraceptive services through static and mobile clinics. For Population Services International these contraceptives and other family planning services are offered through different modes.

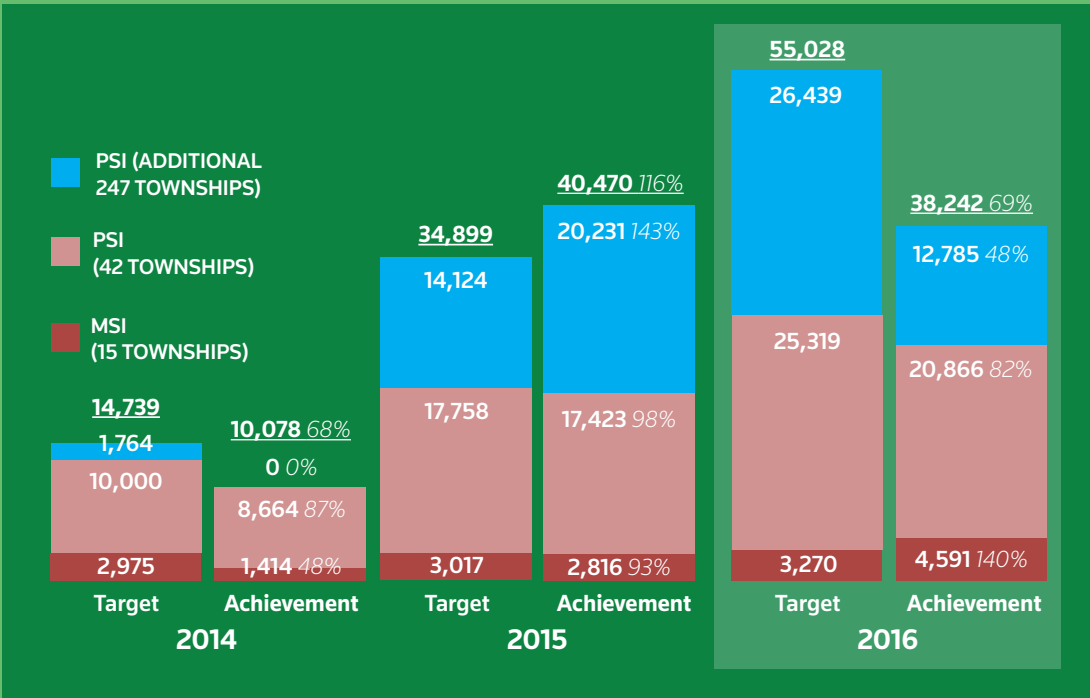
The Sun Quality Franchise is a network of general practitioners who are trained to use and offer the health products that are marketed at agreed prices. The Sun Primary Health care network uses community health workers to deliver health education and distribute contraceptives and other health products at the village level. The Win Win Service is a micro-franchising system, working on a model similar to Avon ladies. Women in the franchise build relationships with local leaders and community members to ensure acceptance and understanding of family planning and contraception, as well as providing health promotion activities.

Both partners also market contraceptives and other health products through drug and non-drug retail outlets.

In 2016, Marie Stopes International was able to distribute more contraceptive than they had planned and therefore achieved more than their target for

## PUBLIC AND PRIVATE SECTOR: DISABILITY ADJUSTED LIFE YEARS

**GRAPH 11:**  
Disability-adjusted life years delivered through public sector services and private sector channels

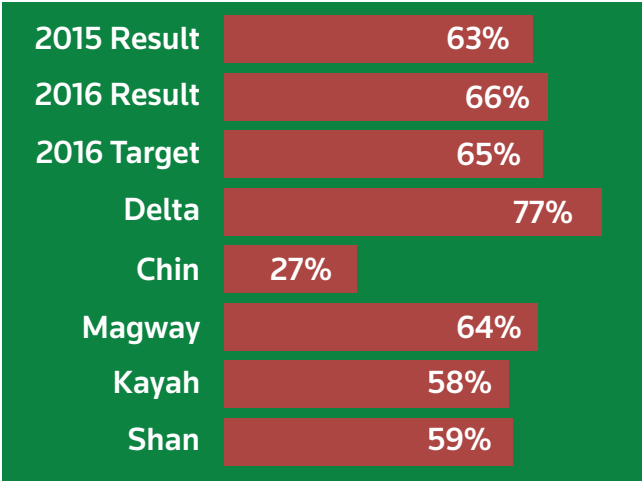




CYPs. Population Services International (PSI) did not meet the 2016 targets for CYPs. An even pattern of distribution over two years was projected, but over-achievement in 2015 left limited commodities to distribute in 2016 which resulted in under-achievement in 2016. Overall, PSI met their targets over the two-year period.

Overall, the **contraceptive prevalence rate** continues to improve, rising to 66 percent from 63 percent in 2015. However, there are significant geographic disparities in the pace of change – for example, in Kayah it improved from 48 percent in 2015 to 58 percent, whereas in Chin it remained unchanged (27 percent). This is based on Myanmar Health Management Information System (HMIS) data, and includes oral contraceptives, emergency contraceptives injectables and implants among other methods.

**GRAPH 12: Contraceptive prevalence rate in 3MDG townships by state and region in 2016**



**The contraceptive prevalence rate** is determined based on demographic information collected annually by basic health staff. It shows the percentage of couples who are practicing birth spacing out of couples where the wife’s age is between 15 and 49.

**Areas for improvement**

Alongside the decreased performance in Northern Shan (explained above) there were some other indicators that did not show the expected progress. The number of volunteers receiving quarterly supervision showed only moderate progress against the target, though it was still a significant improvement from 2015. This can be explained by difficulties in travel, especially during the wet season, and high workload of government health staff.

Only 32 percent of volunteers reported no stock-outs, which is low. The reported stock-outs are also exacerbated by incomplete reporting. With this being the first year of use for the volunteer recording system, difficulties were experienced by volunteers in filling out this section of the report. This section will be reviewed with all stakeholders and revised to make it clearer and more user-friendly. *For more areas for improvement, see the Chapter 10: Lessons Learned.*

# “We can plan to have as many children as we want”



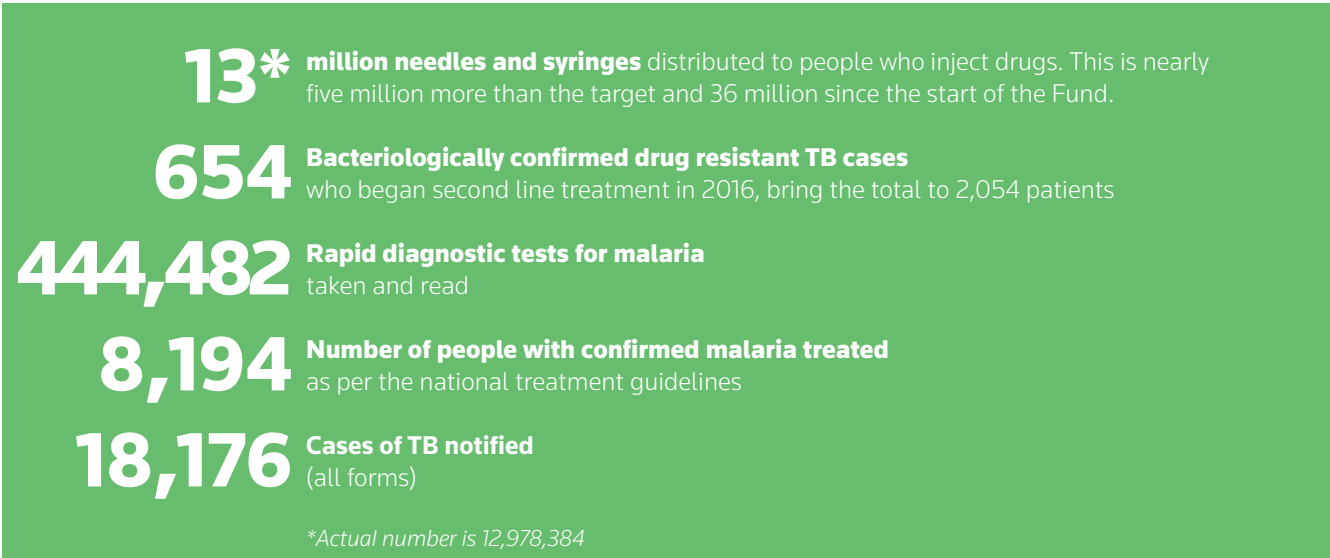
Daw Thin Thin, 28, and her husband received birth control from their midwife so they can plan their family's future.

“I gave birth to my first child nine months ago. During an ante-natal visit, the midwife noticed that my legs were swollen. She decided to refer me to the hospital. In the tenth month, I gave birth to a healthy daughter by Caesarean section. I felt so happy after the baby was born, but I was in a bit of pain too. Fortunately, I received a lot of support and care from the midwife. I also went back to the hospital for a check-up 45 days after giving birth.

“Just a few days ago my baby had a fever, so I went to see the midwife again. After getting the treatment, she quickly recovered.

“Our lives have changed so much since the baby was born. Before our house was very quiet, but now it's noisy and entertaining. Everyone is really happy that she is with us. But, I think one child is enough for us – she needs a lot of attention. The midwife has given me birth control so we can plan to have as many children as we want, when we want.”

9.4 HIV, TB AND MALARIA



9.4.1 HIV HARM REDUCTION

The Harm Reduction programme was boosted with the launch of a new project with Medecins du Monde and Metta Development Foundation in Kachin, which aims to increase community understanding and acceptance of harm reduction services (see Chapter 7.2.3 Removing the barriers). This community-led approach will also contribute to a stronger, more supportive enabling environment for Harm Reduction in Kachin State.

The Myanmar Anti-Narcotic Association and the Asian Harm Reduction Network have extended their Harm Reduction service coverage to different parts of Sagaing Region, where the movement of illicit drugs and their low cost availability continue to create problems for people vulnerable to drug dependence.

Nearly 13 million needles and syringes distributed in 2016 represented 43 percent of the national target, an increase from 40 percent in 2015. More than

FIGURE 5: Key HIV Harm Reduction indicators in 2016

	People who inject drugs (PWID) reached by prevention programmes	Needles and syringes distributed	People who inject drugs given voluntary confidential counselling and testing for HIV
2016 targets	29,050*	8,000,000	9,714
2016 achievements	40,033**	12,978,384	10,786

\*It was estimated that 41,500 PWID exist in programme area. 3MDG targeted to cover 70% of PWID in programme area, which is equivalent to 29,050 PWID (annual target).

\*\*96% of PWID in the target area

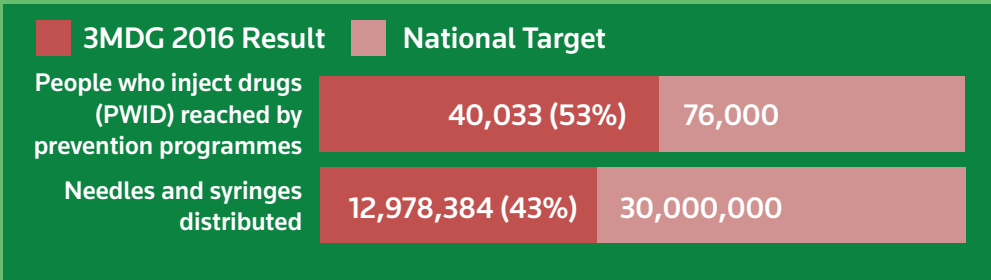
Note: Cumulative targets are not included because they can count twice the same person accessing the services each year.

40,000 people who inject drugs were reached by prevention programmes. This represents 53 percent of the national target, up ten percent from 2015, and is 96 percent of people who inject drugs in the target area. The WHO standard is at least 200 needles per person who inject drugs per year. In 2016, 3MDG distributed 324 to each person. This is critical work.

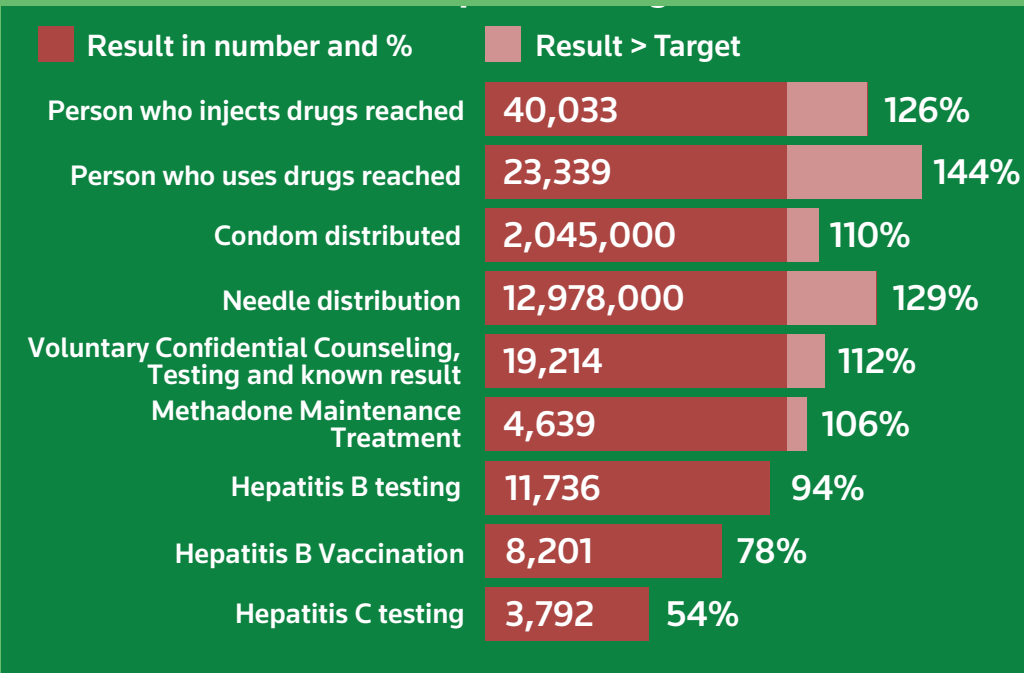
The cold chain was strengthened with ice-lined refrigerators. This caused a delay in the procurement of Hepatitis B and C test kits and Hepatitis B vaccines until the correct protective equipment was in place. Since the test kits and vaccines did not arrive until late 2016, implementing partners have had to catch up and reach 2016 targets retroactively.

Coverage for voluntary confidential counselling and testing (see Graph 14) remains low across the country, though 3MDG is meeting its targets. This has been historically weak due to restrictions on who has been previously

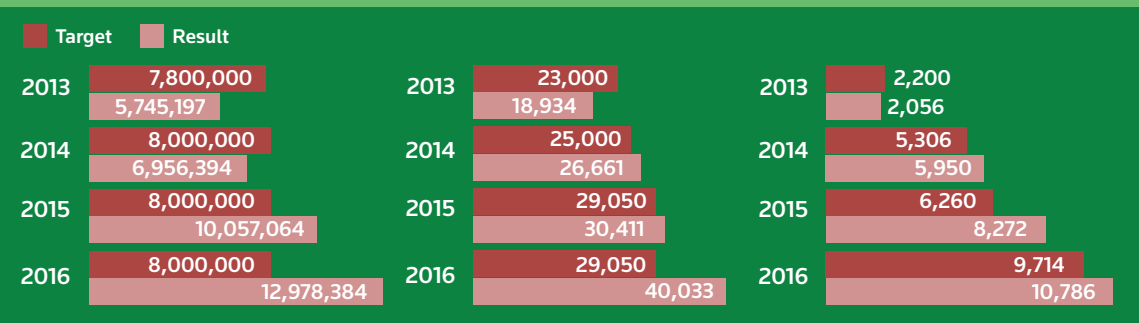
GRAPH 13:  
Harm Reduction  
contribution to  
national targets



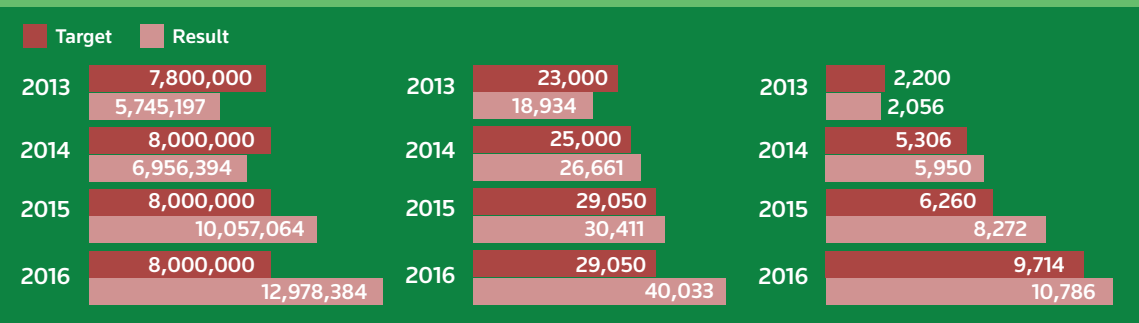
GRAPH 14:  
Harm Reduction  
contribution to  
national targets



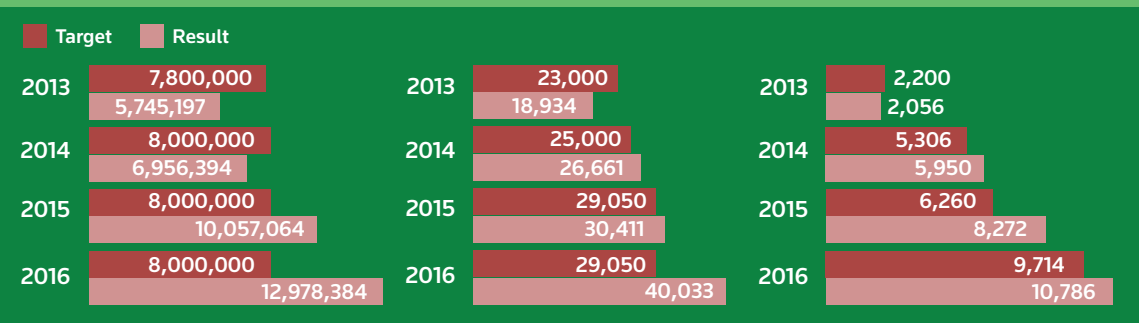
Lower line (L-R)  
GRAPH 15:  
Number of  
needles and  
syringes  
distributed  
(2013-2016)



GRAPH 16:  
People who  
inject drugs  
reached by  
prevention  
programmes  
(2013-2016)



GRAPH 17: People  
who inject  
drugs given  
counselling and  
testing for HIV  
(2013-2016)





authorized to provide these services, as well as discrimination from health service providers towards key affected populations.

Across the critical indicators of the Harm Reduction programme, 3MDG partners have shown steady improvement year on year (see *Graphs 15, 16 and 17, page 69*). For example, in 2013 nearly 19,000 people who inject drugs were reached by prevention programmes. This has more than doubled in the three years since, reaching 96 percent of target population in the coverage area. Similar improvements can be seen in needle and syringe distribution and access to testing and counselling. *For more yearly comparisons, see Annex V.*

## **“I want to make change and build a peaceful society”**



Sut Nau works as a programme coordinator in Kachin State for a 3MDG-funded Harm Reduction project.

*“My name is Sut Nau and I am a programme coordinator of the Metta Development Foundation community-led harm reduction programme in Kachin State.”*

*“When I joined Metta in 2006, I started working together with communities to make changes and build a peaceful society. A year later my uncle passed away, after having AIDS for three years. He did not get antiretroviral (ART) treatment as it was very difficult to access it. He had gotten HIV by injecting drugs. Some of my close friends have also died of HIV.”*

Sut Nau has personally experienced the consequences of the stigma of HIV. Now, he works in Harm Reduction-related activities at the community level. Through his job, he improves the conditions of people dependent on drugs, helping them to avoid HIV and enabling their reintegration in the society.

*“Working with the communities can be tricky sometimes. At the beginning, they did not accept Harm Reduction, particularly methadone treatment and needle syringe exchange programme. People thought that would encourage people to use more drugs. After advocacy meetings, trainings and workshops in the communities, they came to know the real meaning of harm reduction and what it stands for. Attitudes changed. But still, some communities outside our project areas continue to be strongly against the approach.”*

### 9.4.2 TUBERCULOSIS (TB)

FIGURE 6: Key TB indicators in 2016

	Notified TB cases (all forms)	Number of MDR-TB patients enrolled for second line of treatment	Number of referrals to TB centres by community health workers/volunteers
2014-2016 cumulative targets	62,503	2,000	110,024
Cumulative achievements	39,405	2,054	85,975
2016 targets	25,872	600	44,523
2016 achievements	18,176	654	43,449

#### Active Case Detection

National TB Programme active case detection activities were strengthened over the year, with testing and referral becoming more routinely available within closed settings, such as prisons and labour camps, as well as within camps for Internally Displaced People (IDPs) in both Rakhine and Kachin States. In total, 227 visits to 131 townships across the country were conducted by the mobile teams in 2016.

In previous years, targets set for the detection rate have been revealed to be unrealistic, for a number of reasons including: a lack of baseline data, the newness of the active case detection approach, and the complexity of decisions around which specific populations to prioritize and the timing of mobile team visits. To better understand this context, 3MDG is supporting a review of the cost-effectiveness and rationale for active case detection to be conducted in 2017. *For more results which compare year-to-year delivery, see Graphs 18, 19 and 20 on the next page, and Annex V.*

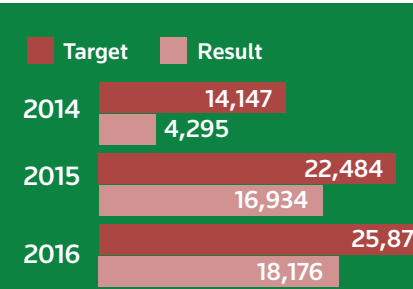
### PROGRESS IN PRISON HEALTH

Low investment in public health facilities and services, especially in closed settings like prisons and labour camps, leads to severe overcrowding, limited health facilities and services, under deployment of health staff and lack of infection control. Health indicators in these facilities are very poor, with high levels of communicable disease among other problems.

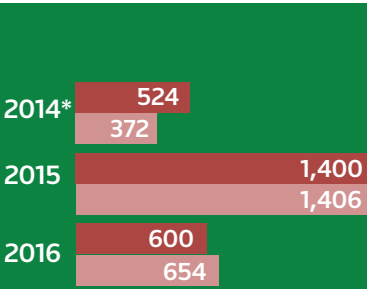
Every person in Myanmar has the right to healthcare. Prisoners are not able to access that care on their own, due to their detention. To ensure they can exercise this right, there was agreement from the Ministry of Health and Sports and the Ministry of Home Affairs for 3MDG support for strengthening prison health facilities and services.

The Ministries of Health and Sports and Home Affairs, and the Department of Prisons approved carrying out an assessment of health facilities, services and needs in Lashio and Myitkyina Prisons. This was technically supported by a 3MDG prison health expert and contributed to development of an action plan responding to the recommendations of the assessment. This was followed by a high level planning meeting, bringing together officials from the Prison Department and the Ministry of Health and Sports. They identified priority interventions and initiated the development of a long term plan for improving prison health.

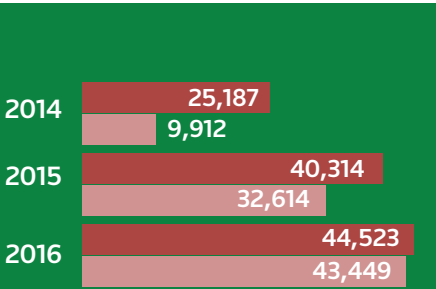
GRAPH 18: *Notified* cases for TB (all forms) (2014-2016)



GRAPH 19: Number of MDR-TB patients enrolled for nutritional support/treatment (2014-2016)



GRAPH 20: Number of referrals to TB departments by community health workers/volunteers (2014-2016)



*\*Note that 2014 is only nutritional support*

Overall, 3MDG’s contribution to the national achievement for testing and treatment of all forms of TB was 13 percent, and for bacteriological confirmed TB, it was eight percent. Considering the number of organizations providing TB testing and treatment, this represents a significant proportion.

Construction of new TB infrastructure progressed, with the caregiver accommodation in Patheingyi Hospital in Mandalay being handed over to Ministry of Health and Sports in November 2016. Construction also began for two outpatient departments in Yangon and Mandalay, and the Bio Safety Level 3 National TB Reference Laboratory in Yangon, to be finished in 2017.

The term **notified** means that TB is diagnosed in a patient and is reported within the national surveillance system, and then on to the World Health Organization  
*Source: World Health Organization*

Multi-drug resistant TB (MDR-TB)

2016 was a year of achievement for the National MDR-TB Programme, with the number of 3MDG-supported patients enrolled in second line treatment reaching 2,054 in Yangon and Mandalay, above 3MDG’s target of 2,000.



A man receives a x-ray to check if he has tuberculosis at a mobile clinic. Nine teams operate around the country.

Photo: John Rae/UNOPS



The MDR-TB database has been further developed in health facilities in Yangon, Mandalay and at the central level for the National TB Programme in Nay Pyi Taw. Having an up-to-date database improves treatment adherence by facilitating better follow-up with patients. The real-time data also helps the National TB Programme understand the scale of the problem and helps to support decision-making, such as where to place staff and resources.

## “We were so happy, we danced”



Photo: John Rae/UNOPS

Hlaing Hlaing Htet shares her experiences. She is now cured of TB, after receiving treatment for six months.

*“When I was in seventh grade I had to drop out of school because of my joint pain. Instead, I helped my family at their grocery store. I have a big family, we are nine in total. My other siblings are working in factories or are still at school.”*

*“At some point I started coughing and sweating a lot at night. I was always ill during the evening. After two months with symptoms my parents thought it could be TB, but we didn’t think we had enough money to go to the hospital.”*

*“One day my father told me about the mobile TB clinic and we decided to go. Doctors checked my x-ray and said I had TB. Everyone there was very kind and supportive of me, and they explained to me all about TB, but I only wanted to cry.”*

*“I started the treatment right away. I never experienced bad symptoms, but everyone was scared of contracting TB when being around me. I used to cry a lot, I felt weak and ashamed.*

*“When I went to the hospital six months later, the nurse said I was cured. My family and I were so happy, we danced.”*

Hlaing Hlaing Htet is from Yangon Region, and received support from the Ministry of Health and Sports and 3MDG via mobile clinics. She was cured of TB in 2016.



### 9.4.3 MALARIA

FIGURE 7: Key malaria indicators in 2016

	Number of malaria tests taken and read	Number of confirmed malaria cases treated	Number of confirmed malaria treated within 24 hours of onset of fever
2013-2016 cumulative targets	2,013,623	324,000	117,700
2013-2016 cumulative achievements	1,921,850	129,418	61,426
2016 targets	415,000	9,000	5,400
2016 achievements	444,482	8,194	5,312

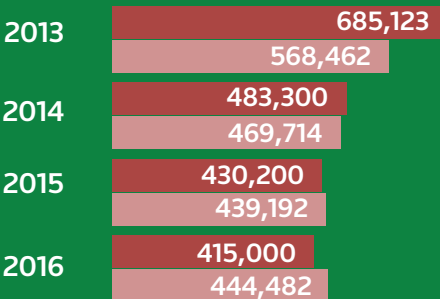
All donors and implementing partners have maintained strong achievements against testing targets, the impact of which is a continuing decline in malaria prevalence and a gradual move towards malaria elimination. Viewed in this context, the apparent failure to reach treatment targets should be seen as a reflection of this success rather than under-performance, and indicates the difficulty in setting realistic treatment targets during a period of rapid decline in prevalence.

Graph 21, 22 and 23 illustrate this over the years of delivery for the Fund. Graph 21 shows a steady number of malaria tests taken and read, in line with targets, while Graph 22 and 23 show markedly decreasing number of confirmed cases treated. For more results which compare year-to-year delivery, see Annex 5.

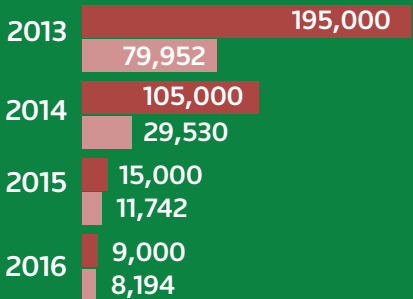
3MDG results for malaria made a significant contribution to the national achievement, with 15 percent contribution for testing and nine percent for treatment. Support to the National Malaria Control Programme also included a major additional procurement activity to buy two million long lasting insecticidal nets. A distribution plan was developed to benefit

GRAPH 21: Number of malaria tests taken and read (2013-2016)

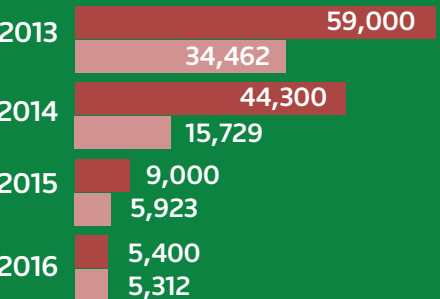
■ Target ■ Result



GRAPH 22: Number of people treated for confirmed malaria (2013-2016)



GRAPH 23: Number of confirmed malaria cases treated within 24 hours of fever



vulnerable migrant and mobile populations and prisoners working in labour camps. Testing and treatment was extended to malaria endemic villages in Paletwa Township in Southern Chin State, an area which contributes a great proportion of reported cases.

Findings of the Malaria Indicator Survey jointly funded by the Presidential Malaria Initiative/USAID and 3MDG were disseminated in December, contributing to the knowledge base supporting implementation of the national response to malaria. To support integrated service delivery, TB and malaria volunteers in Rakhine and Chin were trained to support testing and referral and treatment of both diseases.

“I have close ties to my community...they trust me”



Ko Nwet Linn (third from right) with his family in Kyan Thar village.

Ko Nwet Linn lives in Kyan Thar in Sagaing Region, a village with a population of over 1,500 people. There are no health providers in his village, and it is 35 miles from the nearest hospital.

The Malaria Consortium offered Ko Nwet Linn training as part of a pilot programme that aims to assess how feasible it is to use volunteers to diagnose, treat and refer childhood illnesses. There are 29 other volunteers in the programme and some of those are already volunteers for other health areas. It is run in partnership with the Ministry of Health and Sports, and financed by 3MDG, the Malaria Consortium and other sources.

Ko Nwet Linn didn't have any volunteer experience before he attended the eight day training session last summer but since then he has already made a big difference to his community. So far, of the 90 children he has seen, he has been able to confidently diagnose 85 of them, thanks to the support and training he has received. This includes supervision from basic health staff and personnel from Malaria Consortium.

During his training, he learned that children under five are particularly vulnerable to serious health situations. Early diagnosis and treatment and early referral to hospital can make all the difference. Many of the children he diagnosed needed treatment for pneumonia and diarrhoea, which can be dangerous conditions if left untreated, and some were even referred to the hospital. Ko Nwet Linn was also able to identify and treat two positive malaria cases coming from a nearby mine site.

Ko Nwet Linn is in a unique position to help: “I have close ties to my community, and I know them well. That makes it easier to improve their health and well-being and they trust me.”

## 9.5 PROCUREMENT

In 2016, the total amount purchased by the 3MDG Procurement Unit reached almost USD four million. Of this, 65 percent was purchased under Long Term Agreements (LTAs) from UNOPS or other United Nations agencies. This allowed access to the economies of scale of larger entities and reduced the transactional costs due to faster and simpler processes.

UNOPS operates two warehouses for the storage of health supplies to be prepositioned in country and then distributed to partners. One warehouse is for bulk commodities and the other is an environmentally-controlled warehouse for the storage of temperature-sensitive commodities such as pharmaceuticals and rapid diagnostic test kits. Stock totalling USD 1.15 million was distributed from the warehouses to support volunteer health staff working in maternal, newborn and child health.

At the end of 2016, there was a Commodity Tracking Systems Review for all partners who operate supply chains containing 3MDG-funded commodities. This assessment validates whether supplies are adequately protected in the supply chain and whether adequate measures are in place to ensure proper storage conditions and mitigate risks such as fraud and theft. Although some minor issues were detected, the overall result of the review was satisfactory for all partners.

### DELAYS IN DELIVERING SUPPLIES

Delays in procurement in 2016 can be explained by the following factors:

- Introduction of a new Enterprise Resource System on 1st January 2016 for UNOPS worldwide caused delays for up to three months for processing certain purchase orders, as the system did not function correctly.
- The Foreign Economic Relations Department changed their procedures for requesting a tax exemption, causing delays of up to two months for clearing consignments through customs.
- The sudden introduction of a new requirement from the Customs Department, that all pharmaceuticals to be imported had to be registered with the Myanmar Food and Drug Administration. This requirement was eventually withdrawn, but not until several consignments had already been delayed in their arrival.

The delays resulted in stock-outs in the two 3MDG warehouses for internationally purchased items and longer delivery lead times for partners receiving supplies directly from suppliers.

Two custom-made mobile TB screening units were ordered from a supplier in the Netherlands. The units were manufactured in Dubai by a subcontractor, with part of the work being further subcontracted. This part of the work was not delivered as promised due to a financial dispute between subcontractors, resulting in a major delay in the delivery of the units. They were expected to be delivered around May 2016, but arrived in April 2017. Ten percent of the total price will be deducted in accordance with the liquidated damages clause in 3MDG's terms and conditions.

## 9.6 MONITORING AND EVALUATION

A strong health information system is critical to a well-functioning health system. Policies, guidelines, projects and interventions can be built on evidence and an in-depth understanding of the issues faced and the country’s health profile. In 2016, with 3MDG support, significant steps forward were taken in strengthening this system, with the roll-out and utilization of two systems:

- The electronic District Health Information System (DHIS) 2 in 26 townships (with six more added at the beginning of 2017) ;
- The volunteer recording system, which is a community health information system developed by the 3MDG and implementing partners in 27 townships (*see Box: Volunteer recording system in Chapter 8.4 Building an evidence base and Annex III for more.*)

The introduction of new systems is frequently associated with challenges, in this case some missing reports, delayed reporting and occasional issues of data quality. Supportive supervision along with refresher training and provision of feedback helped to address these issues.

Improvements in the timeliness of DHIS 2 reporting have already been observed in the second half of 2016. An implementation review jointly undertaken by 3MDG and the Ministry of Health and Sports’ Health Management Information Systems unit has helped identify strengths and weaknesses, and contributed to improving functionality before the system is scaled up to additional townships.

The data quality and use needs to be strengthened, especially in townships and rural health centres. These are priorities for 2017. In the medium to long term, these systems will help create a stronger evidence base by improving the timeliness and quality of data, and through built-in tools for decision-making support.

As part of monitoring grant activities and verifying results, in 2016, 3MDG conducted 75 programme monitoring visits including 44 routine data quality assessments. There were 19 organizations that underwent these assessments in 12 states and regions (Ayeyarwady, Chin, Kachin, Kayah, Kayin, Magway, Mandalay, Mon, Sagaing, Shan, Tanintharyi and Yangon).

The Independent Evaluation Group conducted an annual data quality assessment of the 3MDG Monitoring and Evaluation (M&E) system and shared its findings and recommendations in June 2016. The assessment included verification of 3MDG reporting against partner reports for 2015, a review of M&E systems and data at the implementing partner level for maternal, newborn and child health, HIV and tuberculosis grants, and a follow-up on the previous year’s recommendations. The assessment has concluded that the 3MDG’s M&E system is functional, and the audited data is of good quality.



# 10. LESSONS LEARNED

The 3MDG Fund strives to be a learning organization, constantly adjusting to make sure its work is responsive to people's needs. Lessons learned inform ongoing adjustments, future work, the design of a **Successor Fund** to the 3MDG, and the overall response to health challenges in Myanmar.

**Successor Fund** is the name given to the fund which will come after the closure of the 3MDG Fund. *For more detail, see Chapter 12 Moving Forward.*

## 10.1 PROGRAMME DESIGN

### Closer linkages with the Ministry of Health and Sports

The context for health in Myanmar was significantly different when the Fund was designed and set up in 2011-2012. There were fewer opportunities to work with the Government of Myanmar and an urgent need to expand access to health services. This meant that some parallel systems, including Fund-specific approaches and tools, were developed. Though necessary in the short term, in the longer term these systems need to be joined back together with the national response.

In 2015, in response to a changing context and deeper relationship with the Government of Myanmar, the 3MDG Fund Board was reconstituted to include the Ministry of Health and Sports alongside donors and independent experts. This has had positive results.

For example, the Department of Human Resources for Health has been involved from the very start in the development of a new 3MDG programme to strengthen management of the Ministry workforce: program design, call for proposal, and selection of implementing partners. This resulted in greater ownership of the project by the Ministry, a closer relationship between the implementing partner and its Ministry of Health and Sports counterparts, and overall a better, stronger program.

## 10.2 CONFLICT SENSITIVITY

Myanmar is at a significant juncture in the peace process – with the second Union Peace Conference planned for August 2017, and yet a recent increased number of armed clashes. Adopting and adhering to a strong conflict sensitivity framework has benefits for the delivery of health services but also beyond the health sector. 3MDG principles such as an in-depth understanding of the context, meaningful involvement and participation of civil society organizations, flexibility, cooperation and coordination, are all essential to delivery.

In 2016, some implementing partners operating in active conflict areas increased their project coverage by enhancing their co-ordination with other organizations in the area as well as their capacity to map, analyze and understand the conflict.

In other areas, where key stakeholders had difficulties in co-operating with each other as a result of the long history of conflict, 3MDG also helped facilitate dialogue through organizing workshops focused on better co-ordinated service delivery. In one session, a group of participants identified one village that was not covered by any actor discuss potential solutions, and find joint solutions.

Moving forward, and learning the lessons of the past, the 3MDG's thinking on conflict sensitivity is along three lines:

1. The ultimate goal is to bring more and better health services to populations living in conflict areas while not creating further 'harm' and – when and where possible – contributing to maximizing the positive/peace building.

Further adjustments could be made in the design of the Successor Fund to ensure better co-ordination and alignment to the Ministry of Health and Sports as the Fund looks to fill critical gaps identified as difficult for the government, such as working in conflict areas and targeting vulnerable or criminalized populations. The potential for the context to rapidly change means there is great value in building flexibility into the design and operation of the Fund.

### National and civil society organizations

Other elements of the 3MDG model are also undergoing adaptation. The Fund – like 3 Diseases Fund before it – was based on short term goals and targets, with a focus on delivery by international non-government organizations. This model, while well suited for delivery in difficult contexts, is less sustainable and more expensive. The 3MDG Fund is currently transitioning to an approach wherein national organizations play a bigger, more direct role in implementation.

In making this transition, 3MDG can build on its experience through the Collective Voices initiative (*see Chapter 7.2.1 Knowing the problem*), as well as through implementation by local non-government organizations in other programmes. One of the principles driving this work is an understanding of how beneficial it is to work directly with local civil society and community-based organizations. As they work so closely with communities, they have unique insights into the issues communities face and how they can be solved.

For example, health staff in Lal Hla village were having a difficult time communicating with villagers to understand their health needs. Local staff were employed who speak the same language and are sensitive to cultural practices and needs. They were able to come up with innovative solutions in challenging circumstances.

2. 3MDG Fund thus far has gone about this through a combination of broad, high-level ‘conflict analysis’ and an attempt to increase conflict sensitivity capacity within the Fund, with implementing partners, and with Ministry and ethnic health organizations’ and local authority staff. Training to implementing partners could be further leveraged.

3. The 3MDG Fund and a possible Successor Fund are in a unique position to leverage conflict sensitivity work with the Ministry of Health and Sports and ethnic health organizations – and achieve exponentially greater results.

The focus of the 3MDG Fund in 2017 and 2018 – and a possible focus for the Successor Fund thereafter – will be to create a space for dialogue and exchange among ethnic health organizations (allowing them to share best practices and approaches to health in conflict) as well as – when possible – between ethnic health organizations and the Ministry of Health and Sports.

One of the key contributions of health to the wider peace process in Myanmar could be in bringing together actors around specific, result-oriented discussions on which there is a shared agenda; and through these discussions and actions, build trust for further dialogue and collaboration. Trust-building will be a function of more than these discussions (or shared results) alone; but if through careful action, the Successor Fund can foster mutual respect, mutual assistance, and conversations that are a dialogue between like-minded equals, the contribution to improved relationships would be tangible.

That was evident in 2016, when it was discovered that people were not travelling to the health clinic on particular days due to fear of travel on particular days of the month. This was communicated to the basic health staff member, who was then able to perform outreach visits on these days. This fact was only discovered because the local partners were embedded within, and understanding of, the community that they serve.

Another example of the benefits of working with local organizations comes from implementation in Northern Shan State in 2016. When conflict worsened in the area, international non-governmental organizations, working under strict safety and security rules, were required to leave the area. Local organizations were able to continue working, though in some cases they lacked the capacity to adequately deliver healthcare services. To ensure continuous care can be offered in these challenging environments, 3MDG emphasizes working with and building the capacity of local organizations as a priority. To facilitate this, Pact Myanmar has been engaged to provide organizational capacity development, work which will continue.

Into the future, 3MDG recommends a hybrid, community-based approach which combines the capacity and experience of international non-government organizations in co-ordination and advisory roles, alongside local organizations and the government. The Successor Fund should continue to engage with the Ministry of Health and Sports, ethnic health organizations and local authorities, and should pursue the 3MDG's commitment to effective capacity building and organizational development.

### **10.3 THE NEED FOR CLOSER INTEGRATION**

The 3MDG Fund has to date been organized in a predominately vertical, disease-focused structure – which has historically served the Fund well. With the changing health landscape, and the call for a primary healthcare approach and a more holistic strategy, the Fund now has the opportunity to become more integrated and more efficient.

For example, as prevalence and incidence of malaria across the country declines, staff working in this area will not find as many cases. This has the potential to affect their motivation and incentives, and their skills are not being put to the best use. In 2016, a pilot programme was introduced to overcome this, called integrated Community Case Management, or iCCM. Community-based health volunteers received training to broaden their knowledge, so they are now able to diagnose, treat and refer childhood illness, such as pneumonia and diarrhoea, in addition to malaria (*see example in Chapter 9.4.3 Malaria results*).

So far, the pilot has had good results, and offers support to a vulnerable sector of the population, especially in rural areas. To build on its success, 3MDG has been working with the Ministry of Health and Sports to standardize the role of the community health worker.

### **10.4 ACCOUNTABILITY, EQUITY AND INCLUSION**

Accountability, equity and inclusion (AEI) is a workstream whereby the 3MDG Fund works with its implementing partners to ensure health service delivery

is consistent with a rights-based approach and advances gender equality, builds capacity and strengthens adherence to the principles of ownership, alignment and accountability. This is done through workshops, trainings and organizational capacity development.

Lessons from past implementation show that this workstream has been most impactful and beneficial when integrated into programme delivery and seen by implementing partners as a long-term undertaking with full support by senior management to the AEI and conflict sensitivity officer. For example, the AEI focal point in Burnet Institute is the Monitoring and Evaluation Manager, who is well supported by the Senior Management Team and project field staff. This has been the result of awareness-raising sessions about the importance of AEI and conflict sensitivity, based on global evidence.



A community volunteer helping measure a child’s weight at the mobile team activity in Dagon Seikkan Township.



A malaria volunteer providing rapid diagnosis test to mine workers in Shwegyin Township, Bago region.



With limited time and resources, it can be difficult to get AEI on the agenda. In response, 3MDG has advocated for an extra day of training for health staff at the township level and in 2016, this was included in the compulsory training for health staff. Attendees learn how to be sensitive to the needs and inclusion of different groups through hands-on exercises and practical advice.

## 10.5 IMPROVED CO-ORDINATION

While the 3MDG's relationship with the Ministry of Health and Sports continues to deepen, a critical lesson in 2016 has been that in a decentralized health system, it is important that relationships are built at all levels, not just the central level. There are a number of examples and lessons which highlight this.

In 2016, work began on the Rakhine State programme. To help foster ownership and accountability, the initial idea of the partner in charge of the health systems strengthening component was to transfer funds directly into the Rakhine Department of Public Health's account. This was discussed at length with the State Health Department, and it was agreed that this would help build their capacity to manage funds. Unfortunately, this was not properly co-ordinated with the central level and was not possible due to banking process issues and a lack of decentralized decision-making authority which would be required to make this possible.

This issue was caused, in part, by a lack of co-ordination by 3MDG between the state level and central level Ministry. 3MDG has learned that it is critical to maintain lines of communication and strong relationships between all levels of government. This needs to happen in tandem, not separately. Ethnic health organizations must be included as well.

This is also clear from the Fund's work in prison healthcare. In order to reach this vulnerable population, 3MDG submitted a proposal in 2014 based on an assessment which was perceived by the government as a criticism. And it is



H.E. Dr. Myint Htwe, the Minister of Health and Sports with UNOPS representatives and state authorities at the rural health centre handover ceremony in Southern Shan State.

true that the relevant ministry – the Ministry of Home Affairs – was already making a number of improvements to the prison system. The proposal was revised and resubmitted in 2015, but still could not find any traction until the change in government in 2016.

At the central level, 3MDG continued to advocate for the merits of the proposal. When the government changed, 3MDG tried a new approach – working more closely with United Nations Office on Drugs and Crime, who have stronger ties with the Ministry of Home Affairs, and building trust through a different part of the Ministry – the Central Committee for Drug Abuse Control. Ultimately, this was successful and in 2016 the programme began.

However, throughout this nearly three-year process, and although work on the overall comprehensive health plan had stalled, 3MDG was still able to support lifesaving mobile teams working on malaria and tuberculosis in prisons. This was because of the relationships that had been built with state, regional and township governments, as well as the strong relationships between 3MDG and the national disease programmes. The time that had been invested in these relationships meant that immediate health impacts were possible, despite slower progress at central level.

10.6 HUMAN RESOURCES

Challenges affecting human resources for health in Myanmar include difficulties in recruitment, retention, deployment, technical and general capacity, motivation, remuneration, supervision, management and direction.

3MDG is currently working with the Ministry of Health and Sports and other partners on a number of long-term initiatives to improve Myanmar’s human resources for health. Ultimately, improvements in this area need to come from within the Ministry and the government more broadly. However, lessons have been learned through implementation that are interesting to share.

The State Counsellor Daw Aung San Su Kyi visiting the display booths at the launch of National Health Plan in Nay Pyi Taw in March 2017.





Attracting staff in remote or conflict areas can be particularly challenging. 3MDG and the government have tried to introduce pay incentivization to encourage more staff to work in these locations. However, the approach has not been particularly successful – highlighting that the problem is not only about remuneration. Other factors include lack of adequate supervision and fear of being placed in a location and ‘forgotten’ there. This needs careful thought from the Ministry.

Staff availability is also critical to the effectiveness of 3MDG-financed rural health centres, being built in some of the most hard-to-reach locations in the country. 3MDG has done this in two ways. First, before construction commences, a written commitment is received from the Ministry of Health and Sports that staff will be available. Second, the facilities include high quality accommodation for staff onsite, ensuring they do not have to worry about housing, transport or security in their new placement.

Low capacity and high turnover within implementing partners can also be a problem, making it difficult to implement projects, particularly those which are more complex – such as in conflict areas – or take a township-wide approach. For example, during the Rakhine State programme design phase, the goal was to select one local organization and build its capacity through the other partners. Unfortunately, though the organization has some experience, it lacked technical expertise in managing and designing a whole township approach – and the other partners did not have the capacity, human resources or time to supervise an additional partner.

However, over time this has improved significantly. Implementing partners have developed a better understanding of the township-wide approach and maternal, newborn and child health activities, and how to support the township health department in ensuring people have basic healthcare. Nevertheless, 3MDG and donors should keep in mind that appointing civil society and community based organizations, for example in any Successor Fund, will require time to show results and the same level of achievements compared to well-established international non-government organizations.



A doctor checks an x-ray for TB at a mobile clinic.

## Volunteer health workforce

Myanmar’s health system relies to a significant extent on volunteer staff. Volunteers do not fit under one standardized model – they can be employed by the government, or by non-government, community based and civil society organizations. For many of them, they are only trained to do very specific things – and do not have skills across the health sector. This means they are not able to meet all the health needs of the community, and in cases like malaria, may lack motivation because of a rapidly reducing prevalence.

The 3MDG Fund is engaged in discussions with the Ministry of Health to help improve the supervision, supply, training, and retention of village volunteers.

## 10.7 DATA AND REPORTING

Effective projects and programmes need reliable data and evidence to build upon. In Myanmar, the reporting of this data can be unreliable and inconsistent. Through the roll-out of the District Health Information System (DHIS 2) and the volunteer recording system, 3MDG has learned that a lack of quality data can be a result of unmanageable workload for health staff who do not have time to record data, may not be accustomed to using computers, and face complicated data collecting systems.

To try to overcome this, 3MDG has introduced more training, with a focus on hands-on skills and improving computer literacy. Forms have also been simplified for use in 2017. However, improvements have been modest. To concurrently approach the issue from another angle, 3MDG has been in discussion with the Ministry to increase the demand for data by showing how it can be useful. Trainings will be held at township level, with the provision of simple tools for analyzing, using and synthesizing the data. It is hoped that showing its usefulness will drive demand and incentive for data collection.

With **in-kind donations** goods are provided directly instead of funds required to purchase the goods.

## 10.8 PROCUREMENT

In the last few years the 3MDG Fund has been ‘prepositioning stocks’ – buying commodities that it knows implementing partners will need down the line, so they are ready for distribution as soon as requested. This approach creates flexibility but less precision about quantities, which can lead to overstocks and increased cost (because of the need for storing facilities and human resources to manage them).

The 3MDG Fund is working on increasing the Procurement Unit’s involvement when Memoranda of Agreement are developed, to ensure optimal estimation, planning of procurement and delivery. If prepositioning remains one of the way supplies are to be provided, then information-sharing between programme management and procurement needs to improve.

Lastly, partners do not currently report their stocks level and expiry dates of health commodities to the Fund. Supply management can be improved, reducing losses and wastage, by enforcing regular reporting on stock status to the 3MDG, which opens up opportunities for sharing stocks and more accurate stock replenishment.



# 11. FUND STATUS

## 11.1 GOVERNANCE AND ALIGNMENT

Following a strategic review in 2014, the 3MDG Fund reconstituted its Fund Board to include the Ministry of Health and Sports in addition to donors and independent experts. This has strengthened governance and stewardship of the health sector, made the 3MDG Fund more relevant and accelerated delivery of the work of the Fund.

New opportunities arose in 2016, including the identification of health priorities by the newly elected government. 3MDG’s current and planned focus areas are well-aligned with these priorities. The Fund is operating to scale and is well positioned to provide co-ordinated donor funding to support the government to improve the health of the people of Myanmar.

## 11.2 FINANCIAL STATUS

By pooling the contributions of seven bilateral donors – Australia, Denmark, the European Union, Sweden, Switzerland, the United Kingdom and the United States of America - 3MDG Fund promotes the efficient and effective use of development funds. The Fund is managed by the United Nations Office for Project Services (UNOPS). UNOPS also manages the Livelihoods and Food Security Trust Fund, the Joint Peace Fund and is Principal Recipient for The Global Fund to Fight Aids, Tuberculosis and Malaria.

**FIGURE 8: Donor contribution ratio to 3MDG (including ear-marked top ups)**

	OVERALL COMMITMENTS (MILLION USD)	OVERALL COMMITMENTS (PERCENTAGE)	DISBURSEMENTS RECEIVED (MILLION USD, JUNE 2012-DECEMBER 2016)	DISBURSEMENTS RECEIVED (PERCENTAGE, JUNE 2012-DECEMBER 2016)
THE UNITED KINGDOM (THROUGH THE DEPARTMENT FOR INTERNATIONAL DEVELOPMENT - DFID)	147.2	52%	147.2	54%
AUSTRALIA (THROUGH THE DEPARTMENT OF FOREIGN AFFAIRS AND TRADE - DFAT)	48.2	17%	48.2	18%
THE EUROPEAN UNION (EU)	31.4	11%	30.9	11%
SWEDEN	27.0	10%	17.7	6%
DENMARK	9.2	3%	9.2	3%
SWITZERLAND (THROUGH THE SWISS AGENCY FOR DEVELOPMENT AND COOPERATION - SDC)	7.2	3%	7.2	3%
THE UNITED STATES (THROUGH THE AGENCY FOR INTERNATIONAL DEVELOPMENT - USAID)	6.7	2%	6.7	2%
ROLL OVER FROM 3DF	5.4	2%	5.4	2%
ROLL OVER FROM JIMNCH	1.6	1%	1.6	1%
TOTAL	283.9	100%	274.1	100%

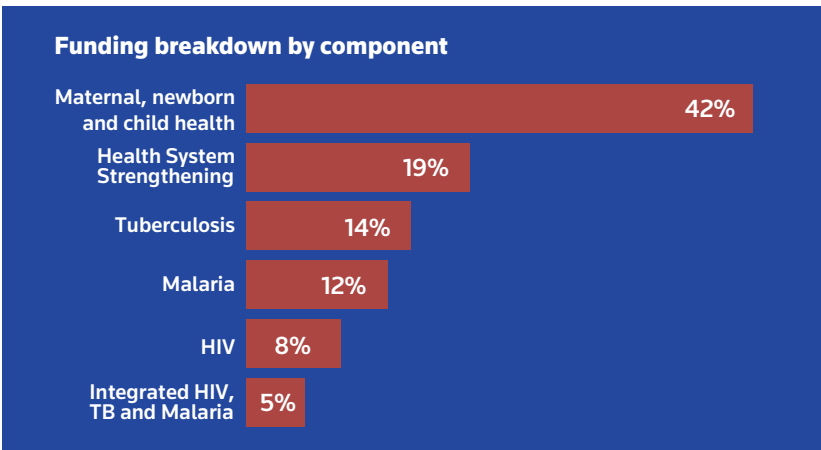
*Note: Donor commitments not yet disbursed to the 3MDG Fund are subject to exchange rate fluctuations, hence the total value of the Fund varies over time until all commitments are met and disbursed.*

By managing all four funds, aid effectiveness, efficiency and quality, and value for money are increased. Risks are lowered through increased knowledge, standardized procedures and greater transparency. The four funds are now based in the same building, sharing facilities, procedures and standards. At the same time, comprehensive monitoring and financial controls ensure transparency in charging for shared services.

The total volume of resources committed to the 3MDG Fund as of December 2016 stands at USD 283.9 million. The Fund has received USD 274.1 million in disbursements from contributing donors since its inception. 3MDG's Fund Manager disbursed USD 213.7 million on behalf of the Fund Board by December 2016, with USD 192.5 million for programme activities, and USD 21.2 million for programme management, governance, monitoring, evaluation, and fund management overhead costs.

The 3MDG Fund's programme delivery in 2016 accounts for the total of USD 49.2 million, representing 23 percent of the 2013-2016 total delivery. Since the Fund's inception a total of 98 grants have been awarded to 56 implementing partners. In 2016, the Fund has added a total of 11 new grants and two new partners, for a combined amount of USD 6.9 million in the new 2016 grants.

GRAPH 24: Funding breakdown by component



Graph 24 shows the funding breakdown by component as legally committed in grants under the 3MDG Fund (2012 – 2016).

## ANNUAL AUDIT FOR THE 2015 FINANCIAL YEAR

As a custodian of public funding, 3MDG adheres to international best practices in transparency and accountability, using strongly defined anti-fraud and anti-corruption policies, monitoring missions and capacity assessments.

An annual audit of expenditure for the 2015 financial year was conducted by external auditors on the fund manager and all partners. Every US dollar spent from 3MDG funds is audited.

The audit report for the Fund Manager listed four medium-priority audit recommendations on the functional areas of procurement and supply chain, and general administration (travel) for the Fund. These have been implemented already.

The 2015 audit reports for implementing partners raised a total of 276 recommendations, of which 17 were high priority, 181 were medium priority, and 78 were low priority.

The five recommendations from the 2013 Fund Manager Audit report and the one recommendation from the 2014 Fund Manager Audit report were not rated as high priority and have all been addressed through improved processes and subsequently closed. All Fund Manager audit reports are published on the UNOPS website<sup>48</sup> and are accessible to the public.

# 12. MOVING FORWARD

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The time is right for continued support for health in Myanmar. The National Health Plan 2017 – 2021 outlines a framework for stakeholders to line-up behind. The Ministry of Health and Sports has demonstrated a commitment to tackling the challenges that the country faces. Universal health coverage is a challenging but achievable goal; the Essential Package of Health Services a practical way of moving towards that goal.

The evidence-base for efficient and effective interventions is slowly growing and becoming more reliable. Understanding of complex health issues is growing, especially for the more vulnerable population groups. Communities have the opportunity to have a real role in project implementation and are supported to step forward and demand health services they are entitled to.

Support must continue so that important gains that have been made are not lost.

The 3MDG Fund has made impressive contributions to improving health for hard-to-reach populations. Yet, the health and nutrition status of women and children in Myanmar is still poor, with large disparities between states and regions and different population groups. Considerable investments from the Government of Myanmar and its development partners are needed to address health inequities and achieve the health-related Sustainable Development Goal 3 by 2030.

Into 2017 and beyond, the 3MDG Fund will take into account the lessons that have been learned (*see Chapter 10: Lessons Learned*) and the direction laid out in the National Health Plan, to better meet the country's health needs within a rapidly changing context.

In 2017, 3MDG will make internal changes to foster better integration for our work. 3MDG will continue to advocate for the institutionalization of important interventions at the central level, such as emergency referrals and standardization of volunteer health workers, whilst maintaining our engagement with all stakeholders.

## PROPOSED STRUCTURE OF THE SUCCESSOR FUND

**Component 1** - Focus on increasing health service coverage and financial protection in under-served areas and for vulnerable populations. Contribute to improving overall health outcomes, particularly among vulnerable populations, and to reducing impoverishing expenditures through ensuring better access to services.

**Component 2** - Build the capacity of Ministry of Health and Sports to ensure delivery of basic services countrywide through a strengthened health system, and ensure that basic systems strengthening on both supply and demand side is the main objective.

## 12.1 BEYOND THE 3MDG FUND

With the 3MDG Fund coming to an end, several bilateral donors are exploring the establishment of a follow-on mechanism that will allow them and possibly other development partners to continue pooling resources in support of the Myanmar health sector, sustain the gains achieved by the 3MDG Fund, and continue to promote equity in access to health.

This Successor Fund, with an estimated USD 150 million for a period of five years, will support Myanmar’s efforts to move towards universal health coverage. It will contribute to improving equity and inclusiveness; enhance accountability and responsiveness by focusing on the health needs of hard-to-reach populations in a conflict-sensitive manner, and continue to support national efforts to strengthen the Myanmar health system in line with the National Health Plan.

Not all areas of the country and population groups can be reached by the Ministry of Health and Sports. By focusing its support on those areas and population groups that are hard-to-reach, the Successor Fund will complement government efforts. It will save lives among the most vulnerable groups and contribute to addressing important health disparities. It will build trust and facilitate enhanced dialogue and collaboration between key stakeholders, including the Ministry of Health and Sports, ethnic health organizations, local authorities, private providers and civil society.

The Successor Fund will adopt a more integrated approach than the 3MDG Fund. While the 3MDG Fund, through its two first components, was structured around specific health areas, the Successor Fund will, wherever suitable, support the delivery of the basic essential package of health services, which is at the core of the National Health Plan and which is seen as a way to reduce inequalities, address fragmentation, and enhance efficiency.

A local midwife at her health centre in Kyit Sone Pway village, Ngape township, Magway Region.





# 13. FOOTNOTES

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1. See the WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision [http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf?ua=1)
2. IAVI Report (2006) 'Injection of Hope: Needle and syringe programs can lower HIV infection rates and provide important outreach to injection drug users' <http://www.iavireport.org/vol-10-no-4-july-aug-2006/1107-injection-of-hope>
3. Ministry of Health and Sports (communications)
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