

The Three Millennium Development Goal Fund
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PROGRESS REPORT

January to June 2016



Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Embassy of Switzerland in Myanmar



SWEDEN



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The Three Millennium Development Goal Fund

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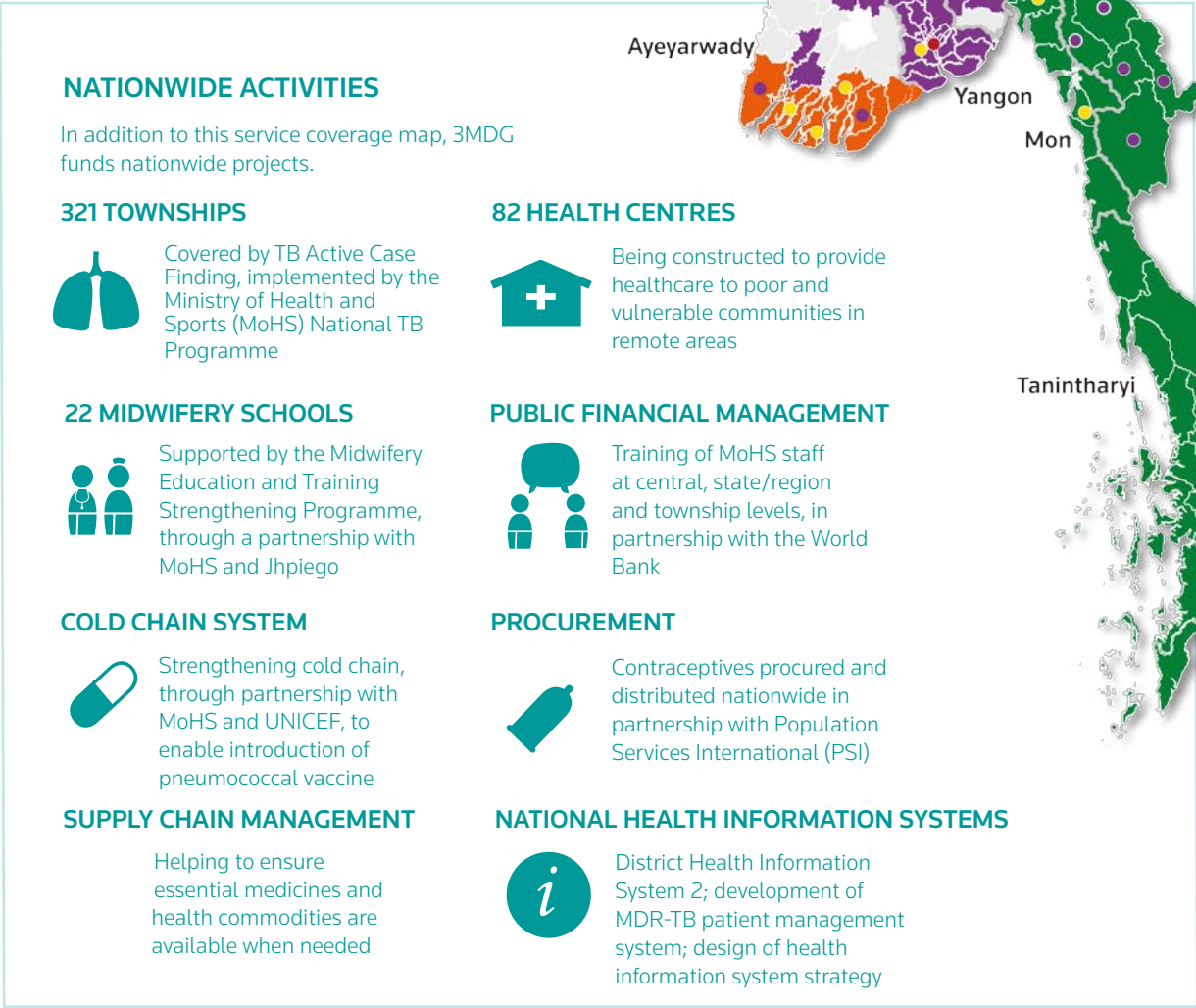
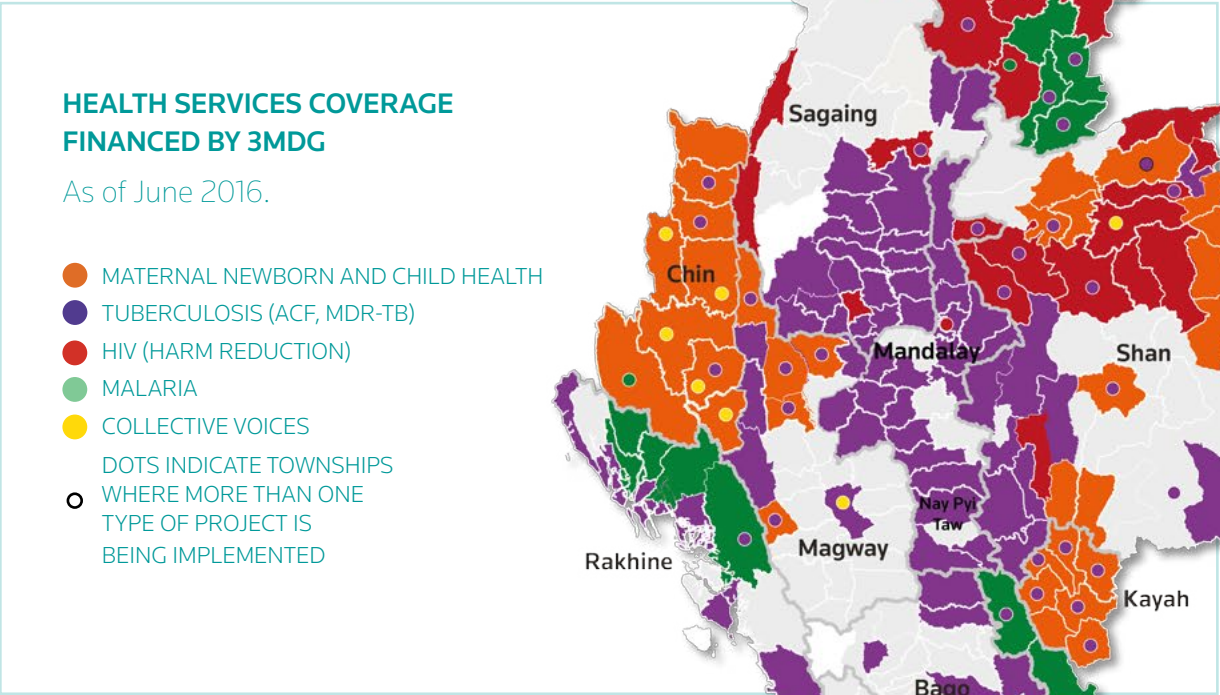
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COVERAGE MAP

As of June 2016.



RESULTS AT A GLANCE

From January 2016 to June 2016.

MATERNAL, NEWBORN AND CHILD HEALTH



35,384

CHILDREN IMMUNIZED
WITH PENTAVALENT 3



25,855

WOMEN VISITED FOUR
TIMES FOR ANTE-NATAL
CARE



24,941

BIRTHS ATTENDED BY A
SKILLED PERSON



7,653

PREGNANT WOMEN
USED EMERGENCY
REFERRALS

4.5
MILLION
POPULATION
COVERAGE

HIV



5,112

PEOPLE WHO INJECT
DRUGS GIVEN HIV
TESTING AND VOLUNTARY
COUNSELLING



6,398,565

NEEDLES AND
SYRINGES
DISTRIBUTED



24,231

PEOPLE WHO INJECT
DRUGS REACHED BY
PREVENTION
PROGRAMMES

29
TOWNSHIPS
TARGETED

TUBERCULOSIS



2,054

MDR-TB PATIENTS
ENROLLED FOR SECOND
LINE TREATMENT



8,123

NOTIFIED TB CASES
(ALL FORMS)



78,871

PEOPLE SCREENED FOR
TUBERCULOSIS

WITHIN
14
STATES AND
REGIONS

MEASURING PERFORMANCE AGAINST TARGET

- Meeting or exceeding expectation
- Moderate achievement (60-90% of the target achieved)
- Weak but potential demonstrated (between 30-59% of the target achieved)
- Substantially not meeting expectations (below 30% of the target achieved)

MALARIA



194,209

MALARIA TESTS TAKEN
AND READ



3,424

CASES OF CONFIRMED
MALARIA TREATED

1.9
MILLION
PEOPLE
COVERED

PROGRAMMATIC AREAS

MATERNAL, NEWBORN AND CHILD HEALTH

STRENGTHENING SERVICE DELIVERY IN PUBLIC AND PRIVATE SECTORS USD 69.0 million

Services being delivered in Ayeyarwady and Magway Region and Chin State

Support to increasing community knowledge and demand for services, for public and private sectors

SCALE-UP OF SERVICES IN CONFLICT-AFFECTED AREAS USD 17.4 million

State-wide approach across Kayah State, seven townships in Northern and Southern Shan State

Guided by conflict sensitivity strategy

EVIDENCE BASE FOR NATIONAL MNCH STRATEGIES USD 3.2 million

Support to standardizing national guidelines

Support to improved township health planning

Conducting research and generating evidence for work being undertaken across Myanmar

SUPPORT TO HEALTHCARE IN SPECIAL REGIONS USD 7.5 million

Health service coverage in Wa Special Region and Shan Special Region 4 (Mongla)

SUPPORT TO THE MOHS' HUMAN RESOURCES FOR HEALTH STRATEGY* USD 9.2 million

Support to the MoHS for midwifery strengthening activities nationwide

HIV, TUBERCULOSIS AND MALARIA

SUPPORT TO THE NATIONAL STRATEGIC PLAN ON HIV AND AIDS (HARM REDUCTION) USD 31.1 million

Priority populations are people who inject drugs, men who have sex with men, sex workers, transgender persons

Support to scale up and sensitization of Harm Reduction, removing legal obstacles

SUPPORT TO THE NATIONAL MALARIA STRATEGY USD 27.1 million

Malaria testing, including asymptomatic cases in drug resistant containment areas
Support to Malaria Indicator Survey

SUPPORT TO THE NATIONAL TB STRATEGY (TB-ACF & MDR-TB) USD 30.8 million

MoHS Technical Support
scale up of TB Active Case Finding TB (TB-ACF) nationwide

Multi Drug Resistant-TB (MDR-TB) in Mandalay and Yangon Regions

Support to priority MDR-TB infrastructure

Establishment of national database for patient support

STRENGTHENING PRISON HEALTH CARE USD 1.8 million

TB prevention and treatment
Improved health infrastructure

HEALTH SYSTEMS STRENGTHENING

GOVERNANCE AND STEWARDSHIP USD 4.8 million

Technical assistance to the MoHS to support decision making and oversight of external assistance

Strengthen public financial management for the health sector

Capacity building at central and state/region level and through scholarships and short programmes

COMMUNITY ENGAGEMENT USD 4.7 million

Collective voices: community health experiences and capacity development of Community Based Organizations and Civil Society Organizations

Technical Assistance for Fund - health service accountability, 'do no harm' approaches

SUPPORT TO EVIDENCE BASED STRATEGY AND POLICY USD 3.2 million

A health financing policy for universal health coverage

Policy and strategy for Essential Package of Health Services (EPHS)

Private sector regulation, including Public Private Partnerships (PPP)

SYSTEMS SUPPORT USD 17.3 million

Strengthening of the national supply chain management systems

Expanding vaccine cold chain nationwide

Contraceptive procurement nationwide

Construction of rural health centres

HUMAN RESOURCES FOR HEALTH USD 9.2 million

Support to implementation of health workforce strategic plan
Transform midwifery education

QUALITY IMPROVED

Quality improved is an overarching investment priority across all components with funding allocation in each grant. Includes support to national strategies for improvement of care and skills and competency based standards and training.





Ministry of Health and Sports and JHPIEGO conduct midwifery training, supported by 3MDG. Photo: Jhpiego

EXECUTIVE SUMMARY

Millions of people in Myanmar face difficulties in accessing affordable, quality healthcare. This is especially true in rural and hard-to-reach areas, those areas affected by conflict and among the most poor and vulnerable populations. Despite increased investment in health in recent years, levels of maternal and child mortality remain high. Indeed, according to the 2014 census, the maternal mortality ratio is the second-highest in ASEAN, with 282 deaths per 100,000 live births. About one in ten deaths among women of reproductive age is a maternal death.

The country has a high burden of communicable diseases with HIV, tuberculosis (TB) and malaria among the leading causes of death. Limitations in the health system undermine the capacity of the public sector to deliver basic healthcare. Inequalities in the health of men and women, boys and girls in different population groups persist.

Health is a goal in its own right for people to enjoy fulfilling and satisfying lives. Investing in health reduces the burden of preventable disease, increases life expectancy and enables people to exercise their rights. It is also an investment in prosperity, social and financial protection, equity and national security.

Better health is a foundation for Myanmar’s social and economic progress. Healthy children achieve more in education, healthy adults are more productive, better able to look after their families and to contribute to their communities. Research shows that lower mortality accounted for eleven percent of economic growth in low or middle income countries¹.

In partnership with the Ministry of Health and Sports, Three Millennium Development Goal Fund (3MDG) is committed to improving access to quality health services, to ensure that citizens of Myanmar are healthier and enjoy a better and more productive life.

1- Jamison et al (2013). *Global Health 2035: A world converging within a generation*. The Lancet 382(9908): 1898–1955

Launched in 2012, 3MDG aims to have a significant, timely and nationwide impact, improving maternal, newborn and child health, and combating HIV and AIDS, TB and malaria. It strengthens the structures and institutions that deliver sustainable, efficient and responsive healthcare across Myanmar, extending access for poor and vulnerable populations to quality health services.

From the start 3MDG has worked with the Ministry of Health and Sports to expand critical maternal, newborn and child health services to a population of 4.5 million people. It has contributed to enabling more than 120,000 pregnant women to access skilled care for childbirth, and more than 180,000 children to receive the crucial Penta 3 vaccination against five common childhood diseases.

In the first half of 2016, over 25,000 women were able to access ante-natal care four times during their pregnancy, and nearly 25,000 births were attended by a skilled person. More than 7,500 mothers and about 5,800 young children received support for emergency referral to the nearest hospital for potentially life-threatening complications. More than 35,000 children under one year of age were covered by the Penta 3 vaccination.

In the same period, 3MDG-funded HIV Harm Reduction services meant that 24,000 people who inject drugs were reached by prevention programmes, 32 percent of the national target. More than six million syringes were distributed to facilitate safe injecting.

From the beginning of 2015 to June 2016, 3MDG has enrolled more than 2,000 patients on treatment for multi-drug resistant tuberculosis, a significant contribution to the national annual target. From the start of the Fund, nearly 1.7 million people have been tested for malaria.

3MDG's investment in health systems strengthening focuses on transforming approaches to human resources for health management, improving supply chain system with the aim of reducing stock outs of essential

medicines and strengthening public financial management, and building a platform to improve community engagement.

Results from the first half of 2016 include the upgrading of six midwifery schools, bringing the total upgraded to 16; and improvement of the cold chain through a partnership with UNICEF, which has allowed the introduction of pneumococcal vaccine nationwide.

3MDG also supports community systems strengthening, an approach that supports the development of informed, capable and coordinated communities and community-based organizations, groups and structures.

3MDG has strong partnerships with the Ministry of Health and Sports at all levels. In line with government priorities, the Fund has increased its focus on national level maternal, newborn and child health and health system strengthening, improved support to the Ministry of Health and Sports' township plans, and increased access to health services in conflict-affected and hard-to-reach areas. Co-ordination of 3MDG implementing partners is managed through partnership with the national programmes of the Ministry of Health and Sports, within the context of strategic and operational plans for each area.

In conflict-affected and hard-to-reach areas, partners also work closely with ethnic health organizations 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 and to help ensure timely referral in the event of a medical emergency.

In the first six months of 2016, 3MDG continued to make progress towards expanding the provision of quality healthcare. Myanmar is a country undergoing transformational change, creating real opportunities for millions of people to improve their lives. A healthier population is best placed to grasp these opportunities.



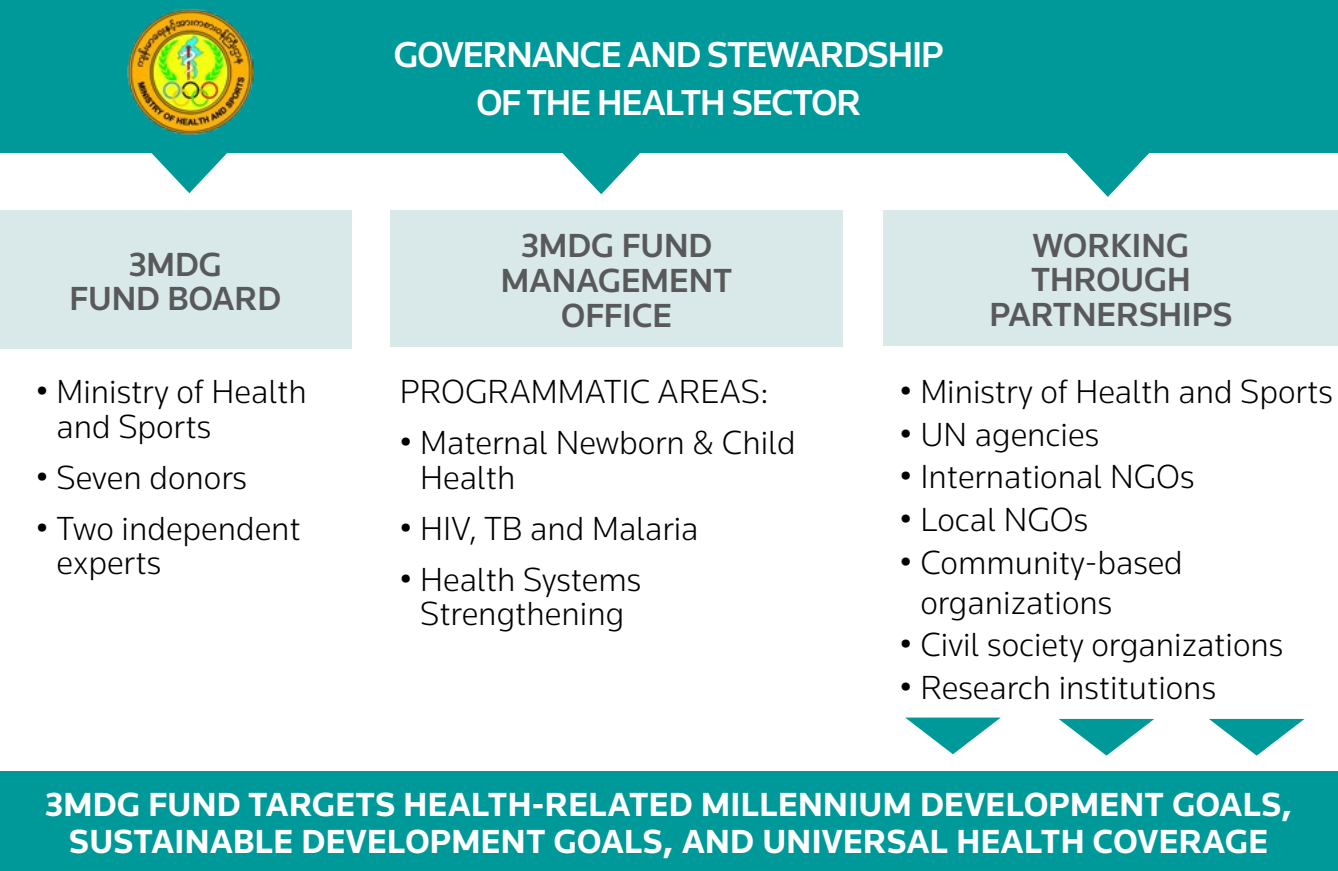
Health workers help to combat malaria and other diseases at a clinic in Ka Toe Hta village, Kayin State.

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 have arisen 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. In 2016, the Fund is operating to scale and is well positioned to provide coordinated donor funding to support the government to improve the health of the people of Myanmar.

FIGURE 1: GOVERNANCE AND STEWARDSHIP OF THE HEALTH SECTOR



APPROACH AND PRINCIPLES

3MDG communicates its vision for a rights-based approach to health underpinned by the four principles of responsibility, fairness, inclusion, and ‘do no harm.’ The vision is contained within the Fund’s ‘Health for All’ approach and through it, 3MDG is working to promote the set of positive changes needed in the health sector. This involves supporting key stakeholders to adopt improved health policies and deliver better health services in a more responsible, fair and inclusive way.

The focus is on working to ensure equitable access to health services for the most vulnerable, enhancing the participation of communities in health planning, decision-making and implementation, and including the voices of women, minorities and other marginalized groups, such as conflict-affected populations and people living with and affected by HIV, TB and malaria. These changes are required in order to address the substantial inequities in access to healthcare services and health outcomes that challenge Myanmar. It is supported by substantial work to generate learning, evidence and enhanced awareness as well as capacity to address gender-based inequities.



FIGURE 2: 3MDG PRINCIPLES

INCLUSION

- Ensure all people are considered in health planning and decision-making
- Understand diverse experiences and needs, and foster mutual respect and tolerance
- Engage communities to plan and deliver quality health services

DO NO HARM

- Understand the context in which 3MDG partners operate
- Ensure health activities do not create or worsen conflict
- Where possible, use health activities to improve opportunities for peace

RESPONSIBILITY

- Promote good governance and accountability
- Empower and inform users about health and how to access services
- Listen and respond to the voices of users

FAIRNESS

- Be fair and just to all people who use health services regardless of gender, age, ethnicity and location
- Recognize the needs of women and girls in accessing health care
- Take actions to address discrimination



A mother holding her child in Dedaye, Ayeyarwady region. Support from the Ministry of Health and Sports, and 3MDG and its partners mean that mothers, newborns and young children now have a better chance of good health.

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. Ante-natal care, skilled care at birth, post-natal care, emergency care in childbirth and treatment of acute severe illness

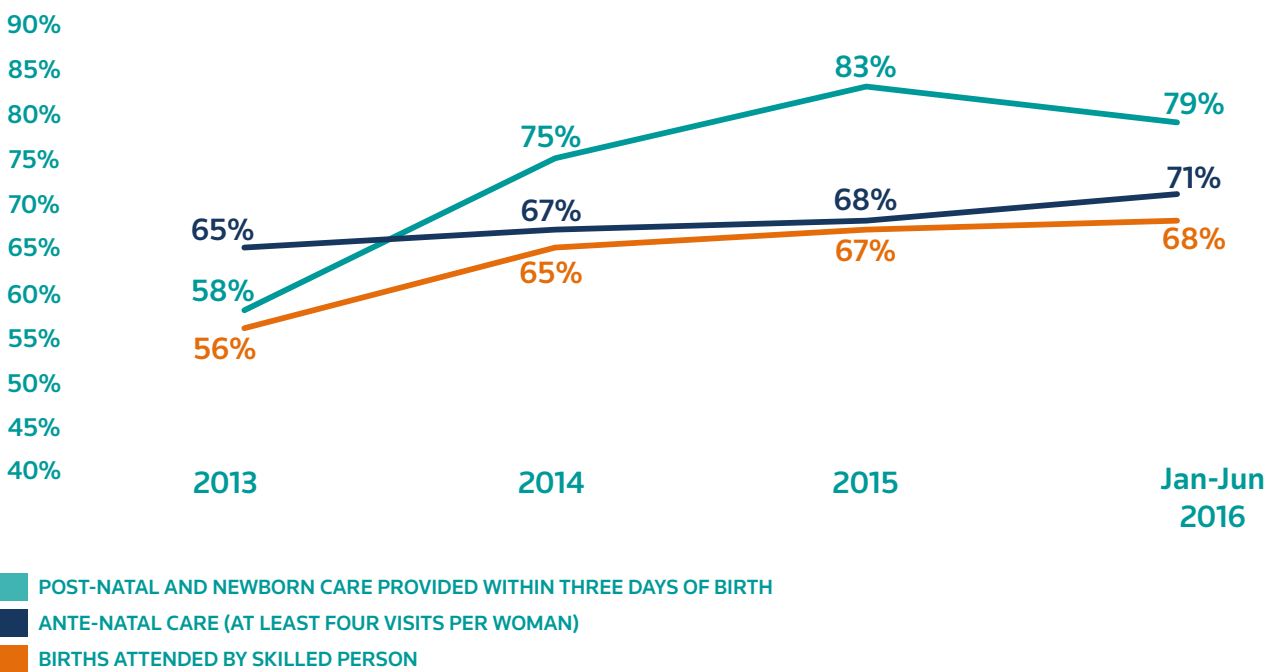
in young children are often not adequate, accessible or affordable. According to the 2014 *Study on causes of under-five death*, undertaken by the Ministry of Health and Sports, the leading causes of death in under-five children are prematurity/low

TABLE 1: RESULTS AND TARGETS AS OF JUNE 2016*

	ANTE-NATAL CARE: 4 VISITS PER WOMAN	BIRTHS ATTENDED BY SKILLED PERSON	POST-NATAL AND NEWBORN CARE PROVIDED LESS THAN 3 DAYS AFTER BIRTH	REFERRALS FOR EMERGENCY OBSTETRIC CARE	CHILDREN IMMUNIZED WITH PENTA 3	DIARRHOEA TREATED WITH ORAL REHYDRATION THERAPY
ACHIEVEMENTS (JAN-JUN 2016)	71% (25,855)	68% (24,941)	79% (28,596)	7,653	90% (35,384)	23,092
TARGETS (JAN-JUN 2016)	73%	72%	80%	5,900*	95%	14,450**
PROJECT-TO-DATE ACHIEVEMENTS (JAN 2013 TO JUN 2016)	128,483	122,951	141,674	35,771	181,933	81,037
PROJECT-TO-DATE TARGETS (JAN 2013 TO JUN 2016)	73% (of coverage area)	72%	80%	30,606*	95%	69,537**

* Estimated targets are based on estimates of expected pregnancies.
 ** Estimated targets are based on health management information system (HMIS) reported diarrhoea cases which reached a health facility.

FIGURE 3: YEARLY CHANGES IN THREE MNCH INDICATORS



birth weight, birth asphyxia, acute respiratory infection/pneumonia, and diarrhea.

For newborns, prematurity/low birth weight and birth asphyxia cause more than 60 percent of all deaths in the first 28 days, with neonatal jaundice and neonatal sepsis accounting for another 27 percent.

3MDG supports access to services for women, newborns and children under five in these programmatic areas:

- Scale-up of services in conflict-affected areas
- Support to health care in Special Regions
- Strengthening service delivery in public and private sectors
- Support to Ministry of Health and Sports human resources for health strategy
- Evidence base for national maternal, newborn and child health strategies

COVERAGE AREAS

3MDG support ensures access to essential maternal, newborn and child health services for a population of 4.5 million who live in remote and hard-to-reach areas in:



A mother with her child, visiting a health clinic in Ka Toe Hta village, Kayin State.

- Magway Region
- Kayah State
- Ayeyarwady Region
- Chin State
- Shan State
- Wa Special Region 2
- Mongla Special Region 4

Across all supported areas, supply side and demand side interventions are being used to address the challenges people face in accessing essential healthcare.

On the supply side, 3MDG is providing financial and capacity building support to the public sector in order to strengthen service delivery in 34 townships and two Special Regions.

On the demand side, and through public as well as private sector work, 3MDG supports the strengthening of community-based health services, the referral of maternal and young child emergencies and private sector reproductive health care services.

RESULTS

In the first half of 2016, around 25,000 pregnant women, 68 percent of total deliveries within the defined coverage areas, were able to access skilled care for childbirth, bringing the total since the Fund began to over 120,000. More than 25,000 women received ante-natal care at least four times during their pregnancy.

3MDG supported over 7,600 referrals for emergency obstetric care, which is 18 percent of all expected pregnancies. This brings the total since the Fund began to over 35,000.

After childbirth, nearly 29,000 women and newborns received post-natal care within the first three days, giving babies a better start to life, and providing mothers with better counselling, support and early detection and treatment of any complications.

Figure 3 shows a consistent improvement over time of most indicators, with a significant increase from the start of the Fund in 2013. Support to township activities, including outreach, supervision, training and support to

FIGURE 4: TOP FIVE CAUSES OF MATERNAL REFERRALS

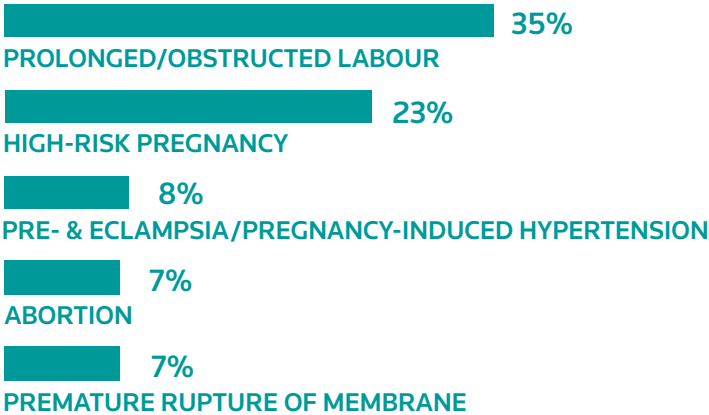


FIGURE 5: TOP FIVE CAUSES OF REFERRALS FOR CHILDREN UNDER FIVE YEARS OF AGE

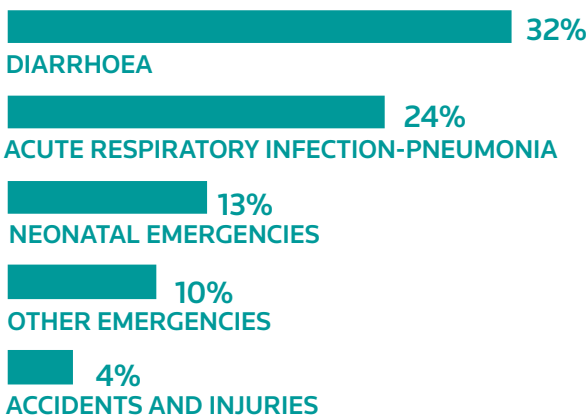


FIGURE 6: TYPE OF DELIVERY IN REFERRALS OF EMERGENCY OBSTETRIC CARE

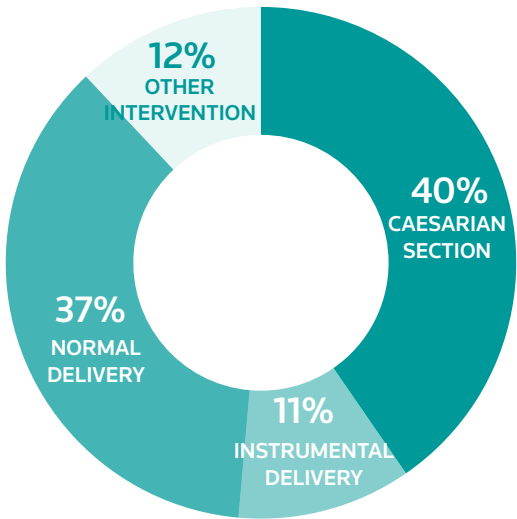




TABLE 2: DALYS* AVERTED BY PRIVATE SECTOR IP

	JAN-JUN 2016		CUMULATIVE (2014 TO JAN-JUN 2016)	
	TARGET	ACHIEVED	TARGET	ACHIEVED
MSI (15 TOWNSHIPS)	1,962	3,439	7,954	7,669
PSI (34 TOWNSHIPS)	10,128	10,078	37,886	36,165
PSI (ADDITIONAL 247 TOWNSHIPS)**	13,220	6,574	29,108	26,805
TOTAL	25,310	20,091	74,948	70,639

*The disability-adjusted life year (DALY) is a measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death.

**This indicator was significantly overachieved in 2015 (ahead of original time), therefore the DALY in Jan-Jun 2016 is lower than targeted.

TABLE 3: CYP* ACHIEVED BY PRIVATE SECTOR IP

	JAN-JUN 2016		CUMULATIVE (2014 TO JAN-JUN 2016)	
	TARGET	ACHIEVED	TARGET	ACHIEVED
MSI (15 TOWNSHIPS)	19,635	26,739	88,266	87,797
PSI (34 TOWNSHIPS)**	18,500	10,134	94,534	80,406
PSI (ADDITIONAL 247 TOWNSHIPS)**	120,000	72,893	294,000	295,080
TOTAL	158,135	109,766	476,800	463,283

*Couple-Years of Protection (CYP) is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period.

**This indicator was significantly overachieved in 2015 (ahead of original time), therefore the CYP in Jan-Jun 2016 is lower than targeted.



Local women in Ayeyarwady Region attend a health education session. 3MDG is working to reduce maternal mortality in the region.

emergency referrals contribute heavily to these improvements. There is a slight decrease in post-natal care coverage, but as this is a half-yearly report, it could improve by year-end.

In the first six months of 2016, over 35,000 or 90 percent of children under one year of age in Myanmar were covered by the Penta 3 vaccination, which protects children from five common childhood diseases.

This brings the total number of children protected since the Fund began to more than 180,000. 3MDG's contribution is largely through support to planning and implementation of outreach activities, including either transport or transport costs. To combat diarrhoea and dehydration, more than 23,000 children were treated with oral rehydration therapy.

3MDG has improved the lives of women by increasing access to modern contraception through partnerships with the private sector, including services provided by Population Services International (PSI) and Marie Stopes International (MSI) (see Tables 2 and 3).

MSI provides short term and long term contraceptives through fixed and mobile clinics and social marketing in 15 townships in Ayeyarwady, Magway and Chin.

PSI provides long and short term contraceptives through Sun Quality GP network, Sun Primary Healthcare Network of community health workers, and social marketing to all 34 townships. There is an additional PSI grant to provide support to the provision of the birth

control injection (depo provera), and oral contraceptives to 247 other townships.

As a result of the work of the Ministry of Health and Sports, 3MDG and other partners, a pregnant woman now has a better chance to survive birth complications in townships that 3MDG supports, as evidenced in the decreasing case fatality rates of mothers and young children who have received support for emergency referrals. She now has a better chance of accessing professional care during and after her pregnancy, and delivering at a facility or at home with a skilled birth attendant. Her baby has a better chance to be born healthy, be fully vaccinated when they are older, and receive emergency care if they need it.

Delivering healthcare in Ayeyarwady Region

The 2014 census showed that Ayeyarwady Region had among the worst mortality rates for children and mothers in Myanmar. 3MDG efforts to improve maternal, newborn and child health started in the region in 2013, with a particular focus on reaching poor and vulnerable people in remote locations in the six townships worst affected by Cyclone Nargis. These efforts have resulted in improvements in health indicators that have continued in the first half of 2016.

The percentage of deliveries conducted by a skilled birth attendant was 70 percent, which has steadily increased from 56 percent coverage in 2013. Facility based delivery has shown even greater improvement, with coverage more than doubling from 2013 (21 percent) to June 2016 (47 percent).

TABLE 4: EMERGENCY REFERRALS BY STATE/REGION

STATE/REGION	NO. OF REFERRAL: CHILDREN UNDER 5 YEARS OLD	PERCENTAGE OF CHILDREN < 5 YEARS OLD*	NO. OF REFERRAL: PREGNANT WOMEN	PERCENTAGE OF PREGNANT WOMEN**
AYEYARWADY	2,424	3%	4,395	24%
CHIN	923	3%	711	11%
MAGWAY	1,319	5%	1,439	20%
KAYAH	515	3%	441	13%
SHAN	631	2%	667	9%
Total	5,812	3%	7,653	18%

* Based on estimated number of under five years old population by using half of 2015 reported figures as proxy.
** Based on expected pregnancies for Jan-June 2016.
Note: Target for maternal referrals = 15% - 20% of expected births. Target for young child referrals = 5% of all children under five.



More than 4,300 women were supported with referral services in emergency situations in pregnancy and childbirth, which is on track to outperform 2013 and 2014 yearly figures. About 79 percent of women were able to access ante-natal care at least four times during their pregnancy, and 81 percent of mothers and newborns received post-natal care within three days of childbirth. Both of these figures have also shown improvement since the start of the Fund, where coverage was 65 percent and 58 percent respectively.

More than 2,400 children were supported with emergency referrals. Penta 3 vaccination reached 90 percent of the estimated children in the first half of the year, and measles vaccination reached 93 percent, also meeting targets. Though an improvement has been demonstrated since 2013 for the Penta 3 vaccination (83 percent), the measles vaccination has decreased from 101 percent. However, the indicator is showing a slight improvement from 2015 when it was 92 percent.

Delivering healthcare in conflict-affected areas and Special Regions

3MDG support in conflict-affected areas, including Shan and Kayah states, as well as in Wa and Special Region 4, has increased and expanded access to maternal, newborn and child health services in these areas.

In Shan and Kayah states, this has included more than 1,100 emergency referrals for children under five, and more than 1,100 referrals for pregnant women (*See Table 4*). Results for ante-natal care, skilled care at birth and post-natal care are similarly strong, with improvements in both Kayah and Shan State from 2015 to the June 2016.

In Kayah State, 2,403 women visited ante-natal care at least four times, which is an improvement of five percent (67 percent - 72 percent) coverage from 2015.

A total of 2,610 women accessed skilled care at birth, (78 percent coverage) and 2,917 women and newborns received post-natal care within three days of delivery (88 percent coverage). Both represent improvements in coverage from 2015.

In Shan State, 3,785 women accessed ante-natal care at least four times (65 percent

coverage), 3,313 women were attended by a skilled person during childbirth (57 percent coverage), and 4,244 received post-natal care within three days of birth (74 percent coverage). Both ante-natal and post-natal care represent improvements from 2015, with a slight dip of one percent for skilled birth care.

In Kayah State, 98 percent of children have been immunized with Penta 3 and 95 percent against measles, which represents improvement compared to 2015 numbers - 94 percent for Penta 3 and 78 percent for measles.

In Wa and Special Region 4, a total of 2,000 children have been immunized against measles, and 1,300 with the Penta 3 vaccination. Without 3MDG support, these children would not have been able to access these services. Access to HIV and TB services in the Special Regions has also increased.

Improved co-ordination and collaboration between the Ministry of Health and Sports, ethnic health organizations and 3MDG partners has enabled increased outreach services, and improved ante and post-natal care, access to immunization, health education, emergency referrals and training of the ethnic health organization workforce.

Ethnic health organizations provide basic services, which include curative, preventive and promotive activities in areas where the Ministry of Health and Sports has no access. Working with them allows immunization to be done by midwives in these areas.

Work is underpinned by the 'do no harm' approach, principles and partnerships with Ministry of Health and Sports and ethnic health organizations outlined in the 3MDG strategy for working in conflict areas.

CHALLENGES AND LESSONS LEARNED

Human resources for health

Closer partnership with the Ministry of Health and Sports has made it possible to roll-out harmonized trainings in 2015 and 2016 across all areas. However, human resource challenges within the Ministry of Health and Sports remain.

For instance, there are many unfilled sanctioned posts, especially in the conflict-affected areas; there is a large dropout rate of volunteers; and a high number of transfers of key township health

department staff. Staff may also be challenged by competing priorities at the central level.

Shortages of manpower, lack of surgical capacity, different staff capacity in the ethnic health organizations and Special Regions, combined with different languages, pose difficulties for increasing access to health services and improving planning and analysis.

Townships have also uniformly faced challenges in working with the World Bank International Development Association (IDA) funds, which are combined with the Ministry of Health and Sports funds.

For instance, rules and guidelines which govern how the money can be spent can restrict flexible and contextually planned expenditure and activities. Funds did not flow until late 2015; and when they did, funds were disbursed to rural health centres earlier than hospitals. This meant they could not be used for supervision, planning or meeting activities at township level.

Finally, government regulation that does not allow travel allowances for distances less than five miles mitigated against the use of the funds for outreach and mobile activities.

Governance and Leadership

Adjustment time has been needed for the division of the Ministry of Health and Sports in mid-2015 into two different departments, Medical Services and Public Health. Initial challenges have included issues of co-ordination and duplication, management of budgets, issues in human resources for health - such as limited manpower and staff capacity - and infrastructure - such as appropriate storage spaces for vaccines and adequate office space.

These challenges are also reflected in the delays in disbursement of funds from the World Bank, because the systems of disbursement had to be reformulated following the division.

Electronic platform for District Health Information System (DHIS2)

To support the implementation of DHIS2, 3MDG partners provide support for data entry and analysis to all 26 townships where it is being rolled out. A review conducted by the Ministry of Health and Sports and 3MDG has resulted in some modifications of the tools being used, as well as revealing important lessons learnt for the strengthening and scale-up of DHIS2 to



A young child sits with her mother during a health education session in Ayeyarwady Region.

nearly 200 townships. This will be done with the support of the Global Fund.

However, challenges in computer literacy, human resources, and connectivity remain, and townships use of up-to-date data for decision-making still needs to be strengthened.

Community-Based Health Programme

The Volunteer Reporting System developed by 3MDG and its partners is being 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.

Alongside challenges of roll-out in Kayah State, the first six months show incomplete reporting and operational challenges across the board. The programme will be reviewed for further strengthening after a year of reporting at the end of 2016.

Application of referral criteria

Criteria for emergency referrals are clear and agreed with the Ministry of Health and Sports. However, at township level there is sometimes variability in how they are applied. Additionally, since a certain number of women are referred as high risk, but with no existing complication, there is a certain percentage of normal deliveries to be expected. Given transport and access difficulties, this is likely to continue for some time.

Building capacity of international non-government organizations (INGOs) and civil society organizations (CSOs)

As a result of 3MDG support to townships through its partners, a large number of Myanmar health professionals from INGO's and CSOs have developed a better understanding of primary health care and how to support the Ministry of Health and Sports and townships in their goal of ensuring people have basic healthcare.

3MDG extends work in Rakhine State

3MDG currently supports efforts to improve healthcare provision in Rakhine as part of existing nationwide programmes. This includes strengthening of midwifery services through support to the midwifery school in Sittwe; conducting training in public financial management; increasing cold chain capacity, which has allowed for the introduction of the pneumococcal vaccine; TB active case finding through mobile team activities, as well as malaria testing and treatment programmes.

Over the next 18 months, 3MDG investments in Rakhine will increase with the addition of new grants. At the state level, 3MDG will support strengthening the management capacity of the State Health Department. Focus areas will include planning, financial management, health information system and human resources for health. At the township level, 3MDG's support will include emergency referrals for mothers and young children, capacity building to ensure quality obstetric and newborn care, and an increase in outreach activities and access to services to all populations.



3MDG efforts in Rakhine State will expand over the next 18 months to include further support to strengthening the health system alongside existing programmes.

MIDWIVES' VOICES

Myanmar's red angels helping to save mothers and babies

Voices

Saving a mother's life: "I just knew what to do"

My name is Daw Ling Gei Pai. I am 26 years old, and I have been working as a midwife in Mindat Township, Southern Chin State, since 2012. Right now I work in Nga Shawng sub-rural health centre. I regularly undergo trainings to maintain and improve my skills, such as a training in Basic Emergency and Obstetric and Newborn Care in January 2016.

Part of my duties is to provide immunization and other health services to villages in the surrounding areas, and in April I went on a routine visit to Chawk Yo village. When I arrived, I received word that a baby had been born the night before, delivered by a traditional birth attendant. I went to visit and I was happy to find a healthy baby, but for the mother, it was more complicated.

I noted that she was pale and had low blood pressure, so I diagnosed a postpartum haemorrhage. I knew this is the most common



cause of maternal death, and when I saw three blood-soaked longyis, I knew we had to act fast.

Remembering my training, I began to administer emergency care – medication, intravenous infusion, uterine massage and aortic compression to stop the bleeding. After thirty minutes, the bleeding had stopped.

I was so happy to help this mother, remembering all I had learnt. Practicing on the resuscitation doll at the training in January made a huge difference in an emergency situation. I just knew what to do.

"I wouldn't have been able to save the baby without the training"

My name is Sui Khen and I am 59 years old. I am from Thantlang Township, Chin State, and have served as a midwife in township health department for many years.

Some time ago a pregnant woman, Ngun Kip Thluai, 36, came to me for ante-natal care. After investigating the fetal position, I found that it was abnormal and spoke with her about high risk pregnancies. I referred her to the Hakha Hospital for an ultrasound scan and further treatment.

However, she did not go there. She understood the danger signs and visited the township medical officer once for ante-natal care, but I could not



Ngun Kip Thluai was not allowed to go to the hospital for treatment. Photo: Save the Children

convince her to seek further help. I tried to find out why, and she revealed that her mother was the key decision maker in the family and would not allow her to go to the hospital. She wanted Ngun Kip Thluai to deliver at home, as she had done with her other children.

“Trusting relationships are crucial”

My name is Ngu War, and I am a midwife at Mine Mu sub-rural health centre in Namtu Township. Before the 3MDG programme, we had a lot of difficulties in vaccinating people in our township, with disagreements over the meeting point and challenges in mobilizing people. For example, if the gathering point was a monastery, people from other religions didn't come. Sometimes, even though I had informed people of the meeting point, no one came. They were afraid that children would get sick after they are vaccinated.

The 3MDG programme, which is implemented by CESVI, increased understanding of the importance of vaccination, and other health interventions, with health education. The sessions were attended by everyone, young and old. Villagers participated in a mobile clinic, and started their own village health committee. Language barriers that were a big issue before have been reduced by collaborating with health workers, who were recruited and trained by this project.

After discussion with the health committee members and the village leader, a meeting point was created in the middle of the village with no religious, ethnic or logistic limitation, and now everyone can participate. For those patients



Ngu War taking care of members of the community, including sharing health information with children from Namtu Township. Photo: CESVI

who are not able to make it there, I visit them at their homes. With all these changes we have successfully reached our targets for vaccinations.

With these visits, we are building positive, trusting relationships that are crucial between communities and health workers, and health service continues to improve.

When she went into labor, a whole night passed without any progress, and at 5am they called me to come. I knew the delivery would be difficult, as the baby was in breech position and it had already taken too long. Finally after a few hours and some difficulties we were able to deliver the baby, but it was not breathing.

Calling on my skills from the Ministry of Health and Sports Basic Emergency and Obstetric and Newborn Care training, which was supported by Save the Children and financed by 3MDG, I successfully revived the baby and restored breathing through neonatal resuscitation.

I was so happy to help, and looking back, I realize the advantages of the trainings we have undertaken. It can save many lives. I freely confess that I would not have been able to save this baby without that training, as I previously had no experience with effective resuscitation.



Now, the mother and the baby are in good health and the family is so grateful. I shared my achievement with other midwives, and feel even more confident that I can use this knowledge in other cases too.



HIV, TUBERCULOSIS AND MALARIA

According to the World Health Organization, HIV, TB and malaria are among the leading causes of death and illness for people in Myanmar. There are significant inequalities in health status and in access to affordable, quality healthcare. 3MDC funds partners who provide HIV, tuberculosis (TB) and malaria related services to vulnerable groups, often in remote locations, or urban areas across Myanmar. To deliver these services, partnerships with national non-government organizations and ethnic health organizations are crucial. This includes organizational capacity development to strengthen systems and staff capacities, as well as the way they interact with and respond to the health and other needs of local communities.

TABLE 5: RESULTS AND TARGETS AS OF JUNE 2016

	PEOPLE WHO INJECT DRUGS REACHED BY PREVENTION PROGRAMS	NEEDLES AND SYRINGES DISTRIBUTED	PEOPLE WHO INJECT DRUGS GIVEN VOLUNTARY CONFIDENTIAL COUNSELLING AND TESTING FOR HIV
ACHIEVEMENTS (JAN-JUN 2016)	24,231	6,398,565	5,112
TARGETS (JAN-JUN 2016)	29,050*	4,000,000	5,653
PROJECT-TO-DATE ACHIEVEMENTS (JAN 2013 TO JUN 2016)	30,411	29,157,220	8,272
PROJECT-TO-DATE TARGETS* (JAN 2013 TO JUN 2016)	29,050*	27,800,000	9,714**

*It was estimated that 41,500 People who inject drugs (PWID) exist in programme area, 3MDG targeted to cover 70% of PWID in programme area equivalent to 29,050 PWID (Annual Target).
** Annual Cumulative Target

COVERAGE AREAS

Harm Reduction services are being financed in 29 townships in Shan and Kachin states, and Mandalay, Sagaing and Yangon regions. Although the United Nations Office for Drugs and Crime (UNODC) project closed at the end of 2015, a well-managed handover process to other Harm Reduction partners ensured continued service delivery in these townships.

The programme prioritizes activities in areas with large numbers of people who inject drugs. 3MDG also continues to support nationwide efforts to address social, legal and structural barriers to Harm Reduction and HIV prevention. This includes removing legal obstacles to the distribution of safe injecting equipment, which is a critical element of Harm Reduction.

RESULTS

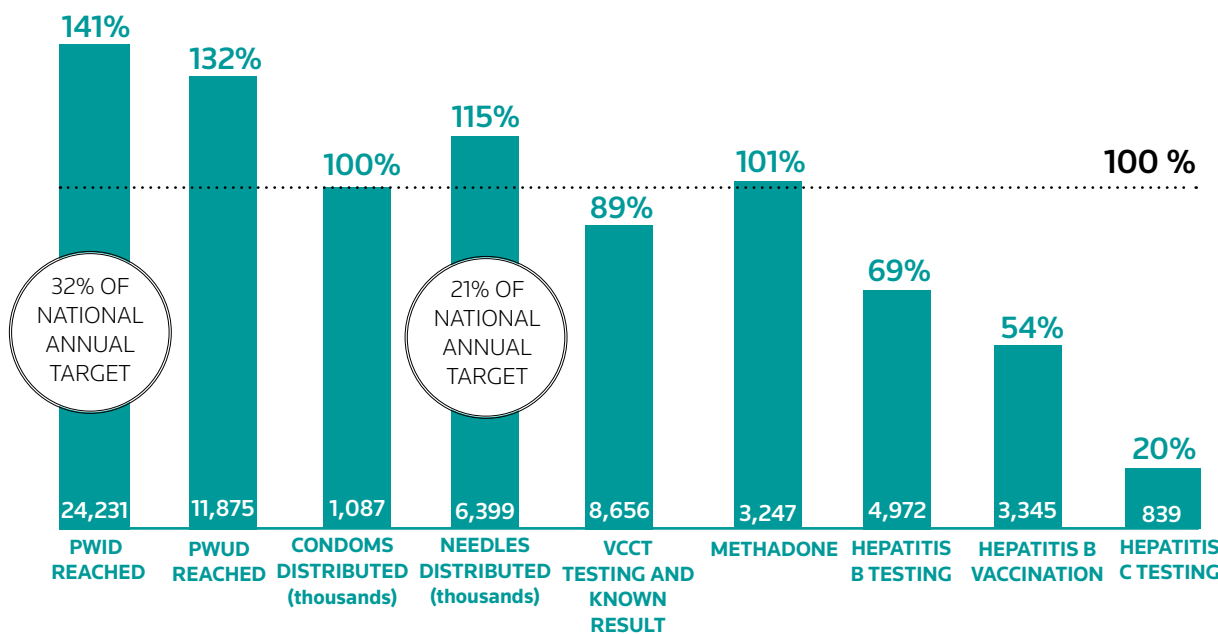
In the first half of 2016, 3MDG and implementing partners reached over 24,000 people who inject drugs, a contribution of more than 32 percent to the national annual target. A total of more than six million pieces of sterile injecting equipment to facilitate safe injecting conditions were distributed to reduce the risk of infection, which represents a 21 percent contribution to the national annual target, expected to reach an approximate 40-45 percent contribution by year-end.

In early 2016, the Metta Development Foundation and Médecins du Monde launched a 3MDG-financed programme that aims to reduce HIV, Hepatitis B and C and tuberculosis prevalence among people who inject drugs (PWID) through increasing the acceptance and the use of Harm Reduction services in targeted locations in Kachin State.

The programme, consisting of community-led Harm Reduction interventions, has started a number of key activities in its inception phase. Advocacy and coordination meetings have taken place with a wide range of stakeholders from state and township to community levels, including police, village and religious leaders, volunteer drug eradication group Pat Jasan, and faith-based organizations. This multi-sectoral approach is critical to address community concerns about drug issues, and reducing stigma and discrimination against people who use drugs.

Population Service International’s (PSI) Low Dead Space Syringe (LDSS) project has extended its technical assistance to Harm Reduction partners in Kachin, Northern Shan and Mandalay. LDSSs retain less blood between uses, which reduces the chance of disease transmission. In these areas, PSI conducted assessments on users’ preference for syringe use and provided trainings for field staff, resulting in increased LDSS distribution.

FIGURE 7: HIV SERVICES ACHIEVED VERSUS PARTNER TARGETS (FROM JANUARY TO JUNE 2016)



In this reporting period, there was underachievement in all three of the Hepatitis indicators (see Figure 7). This was a result of delayed procurement of testing kits, which had an impact on both vaccination and testing results, as those who are found negative during testing are subsequently vaccinated.

HIV and TB co-infection is a significant health issue in Myanmar and the co-infection rate is known to be high among people who inject drugs. 3MDG HIV partners provide services for TB-HIV co-infection, as well as referring patients to the National TB Programme for confirmed cases. In particular, Asian Harm Reduction Network provides comprehensive services at its TB screening facility.

UNAIDS continued to provide substantial contributions to addressing policy, legal and social barriers to HIV prevention, care and treatment. These efforts are outlined below:

- Factsheets and policy briefs on the HIV response amongst key populations were developed to support advocacy efforts towards new government members. These were provided as reference tools to be used during and after the United Nations General Assembly Special Session on Drugs (UNGASS) and 2016 High-Level Meeting on Ending AIDS in New York.
- A total of 234 operational law enforcement staff were trained on HIV and drug use-related challenges faced by key populations in five high HIV burden townships in Kachin,



Northern Shan and Sagaing. The trainings provided knowledge on a human rights-based Harm Reduction approach among police and contributed to creating a climate of mutual understanding between affected and local communities, people with drug dependence and local authorities and law enforcement officers. Positive feedback was received from implementing partners regarding the trainings, including fewer difficulties in going through check points for outreach activities or transporting patients.

- As a result of UNAIDS and UNODC joint efforts to increase acceptance and coverage of Harm Reductions services, the Ministry of Home Affairs/Coordinating Committee for Drug Abuse Control agreed to form Harm Reduction Township Steering Committees in areas with a high burden of HIV. To support this decision, UNAIDS and UNODC conducted joint advocacy visits in Kachin State and Sagaing Division. The first Steering Committee meetings will be launched early in the second half of 2016.

FIGURE 8: 3MDG CONTRIBUTION TO NATIONAL TARGET



CHALLENGES AND LESSONS LEARNED

Police crackdowns

Police crackdowns against people who use drugs remain intense due to lack of clear differentiation in the current 1993 drug law between people who use drugs and small-scale dealers, and major traffickers in drugs. This

“My recovery is helping others”

My name is Zau H pang. I am a peer educator for the Metta Harm Reduction Centre, where I help people who use drugs to recover and educate communities about HIV.

In my village there were a lot of sign boards about HIV saying the disease could not be cured. This created a lot of fear in the community. But even though we were afraid to get the disease, we didn't know how it was contracted. The general belief was that people who had HIV were bad people.

Through working with Metta, I came to learn anyone could be infected, including mother to child transmission. I realized that stigma and discrimination mean that drug users and sex-workers are marginalized, and this can affect how they seek medical care.

When people find out that I am HIV positive, I have to explain to them that being infected doesn't make me a bad person. We can suffer a lot, and if I don't take my medicine, I can't walk



and my immune system is poor, which makes it hard to work.

I can see in society that opinions are changing and people are learning more. But still, despite everything that I know from working with Metta, sometimes when I am open about my status, I feel inferior.

Through my work, I want to change the stigma that people suffer from, including myself. I know that my involvement in community education and my recovery convinces others to seek treatment. I believe that Metta's Harm Reduction campaign is reducing marginalization.

Voices

results in arbitrary arrests and raises concerns regarding the proportionality of sentencing.

Advocacy activities

Due to government transition, key advocacy activities have been restarted at the central level in order to ensure all relevant stakeholders are involved and engaged in the process. Though this has presented minor delays, 3MDG looks forward to continued progress in these activities.

Hepatitis C co-infection

People who inject drugs are at major risk of contracting HIV, TB, Hepatitis B and C. The 2015 nationwide viral hepatitis survey found that eight out of ten people who inject drugs and are living with HIV are co-infected with Hepatitis C. Despite the global availability of a new efficient treatment for Hepatitis C, with pricing options available for lower income countries, there is a continued lack of financing from major donors and the Ministry of Health and Sports to support its use for people who inject drugs in Myanmar.

Delayed procurement of testing kits presented an additional hurdle to testing and vaccination for all forms of Hepatitis. This challenge has highlighted a need to strengthen the cold chain to ensure the integrity of testing kits during transport and storage.

Importance of phasing Harm Reduction activities

Providing effective responses to communities that are affected by long-term violence, crime and conflict, and also have significant livelihood concerns requires careful analysis and planned activities over time. Given the sensitivities in these communities and their incomplete understanding of the health context of drug dependence, public information and the activities of Harm Reduction need to be carefully phased.

Accessing HIV testing and Antiretroviral Therapy (ART) services

At this time, most of the Harm Reduction project sites are far away from ART services and are difficult for people who inject drugs (PWID) to access. This discourages PWID from being tested for HIV. In response, 3MDG and its partners have discussed ways to increase the use of testing and ART services, including introducing testing enhancement protocol, mobile testing units in mid-2016 and the reallocation of budgets to cover ART referral services. This will help work towards the goal set in the National Strategic Plan to provide asymptomatic HIV positive people with early testing and improved access to treatment.



TUBERCULOSIS

TABLE 6: RESULTS AND TARGETS AS OF JUNE 2016

	NOTIFIED TB CASES (ALL FORMS)	NUMBER OF MDR-TB PATIENTS ENROLLED FOR SECOND LINE TREATMENT	NUMBER OF REFERRALS TO TB CENTRES BY COMMUNITY HEALTH WORKER/VOLUNTEER
ACHIEVEMENTS (JAN-JUN 2016)	8,123	654	19,457
TARGETS (JAN-JUN 2016)	12,768	600	21,776
PROJECT-TO-DATE ACHIEVEMENTS (JAN 2014 TO JUN 2016)	29,319	2,054*	61,983
PROJECT-TO-DATE TARGETS (JAN 2014 TO JUN 2016)	49,382	2,000	87,277

* Of those enrolled patients, some patients were transferred out to their native regions/towns, some died and some defaulted. Only 1,788 patients are currently under treatment and receive patient support package during this reporting period.

COVERAGE AREAS

Multi-drug resistant tuberculosis (MDR-TB)

Yangon and Mandalay Regions have the highest reported MDR-TB prevalence in Myanmar with nearly half of the total MDR-TB patients currently on treatment. The National TB Programme (NTP) is providing MDR-TB treatment with 3MDG support in all townships in Yangon Region and 13 townships in Mandalay Region, while our partners ensure regular patient support activities. This includes provision of evening dosage of drugs to the patients throughout the treatment period, as well as financial and nutritional support.

Tuberculosis (Active Case Finding)

Deploying mobile teams to actively find new cases of tuberculosis helps to address the epidemic amongst urban poor and migrant populations, hard-to-reach locations and amongst other underserved populations. Outreach locations include prisons, worksites and mines.

RESULTS

Multi-drug resistant tuberculosis (MDR-TB)

3MDG supports Myanmar’s MDR-TB programme with US\$ 19 million. During the first half of 2016, 848 MDR-TB cases were detected, which is 141 percent of the NTP’s set target

under the 3MDG grant for the period of January to June 2016.

A total of 654 MDR-TB patients were enrolled on treatment, achieving 109 percent of the NTP set target for the same period. The gap between detected and enrolled patients is explained by lack of readiness for treatment, loss of contact or death.

By the end of June 2016, a cumulative total of 1,788 patients are still undergoing treatment on the 3MDG-financed second line TB treatment in Mandalay and Yangon.

To support treatment adherence, four implementing partners were financed to provide community healthcare, including nutritional and financial support to the patients during their treatment for at least 20 months. Nearly 100 percent of enrolled MDR-TB patients under 3MDG partners receive cash support of US\$ 30 per month, available via ATMs or cash payment.

A joint monitoring and supervision visit was carried out by NTP officers and 3MDG in Mandalay Region in June 2016, providing better understanding of ways to improve implementation and contributing to more effective coordination between NTP and partners. This was a critical mechanism to bring together perspectives and implementing approaches of a range of local health facilities and donor implementing partners.



Testing MDR-TB patients in the 3MDG supported Aung San TB Hospital, Yangon.

Tuberculosis (Active Case Finding)

In this reporting period, a total of 109 mobile visits were carried out; 34 in urban poor areas, 62 in hard-to-reach areas, 12 visits to prisons/ worksites and one visit to a mine. The number of mobile team visits significantly increased compared to the previous reporting period, especially to prisons.

In January to June 2016, nearly 79,000 presumptive TB cases were screened, bringing the total number of screened cases to nearly 290,000 since the start of the programme. Of the 79,000, nearly 20,000 were referred by trained volunteers in community settings. This forms a crucial part of the work of community volunteers, and an achievement of 89 percent of that target.

However, the number of cases screened in total represents a significant underachievement of the target. This is explained primarily by a disparity between the number of people with TB symptoms actually identified by mobile teams compared to the number that was predicted based on population and case detection rate at target-setting. This meant that there were not as many suspected TB cases to screen as originally anticipated.

A total of 8,123 drug sensitive cases were diagnosed and enrolled in treatment, which represents 64 percent of NTP and 3MDG TB partners' targets for this reporting period, which is 12,768. This is also shown below in *Figure 9*. Significant logistical challenges in conflict-

Voices

"My treatment can save someone else's life"

My name is Daw Mya Than and I am 50 years old. I live in a small house in Zee Pin Village at Thanatpin Township, Bago Region, with my eight family members. We live very close together – our house isn't big enough for all of us.

In October 2015 I started feeling very tired and found it difficult to work anymore. I started having



Daw Mya Than shares her experiences with a health worker in her village.

chest pains and at the same time my youngest son, who is 8 years old, became ill.

One day a community health volunteer working for Myanmar Health Assistant Association held an education session in our village. He told us about the symptoms of tuberculosis, how the disease is curable, and how preventive measures are important, especially in protecting other family members and the whole community.

The volunteer referred me and my son to the township health centre, as we both had symptoms of tuberculosis. We both tested positive and began the treatment, but my son had difficulties with the side effects. It helped when community health volunteers visited our house and stressed the importance of continuing the treatment.

Now I am a healthy woman again. I can work, I don't feel tired, and I have a good appetite. I have also shared my experiences with my neighbours in the village. Mostly, I am proud that I underwent treatment and overcame the disease – now I know that this can save the life of another villager too.

affected areas and difficulties associated with beginning work in new areas also contribute to this underperformance.

A significant achievement of this reporting period was the completion of the TB patient catastrophic cost survey. Myanmar is the first country in the world to use the standardized tools and methodology developed by the World Health Organization for the survey, and the manuscript is now under review. In line with the End TB strategy, this assessment is an essential contribution to the National Strategic Plan, and ensuring that no family is burdened with catastrophic expenses due to TB.

3MDG has actively participated in development of the new National Strategic Plan (2016-2020), including supporting an international technical mission in February 2016 that worked on the epidemiological data review. The new National Strategic Plan was finalized in early 2016.

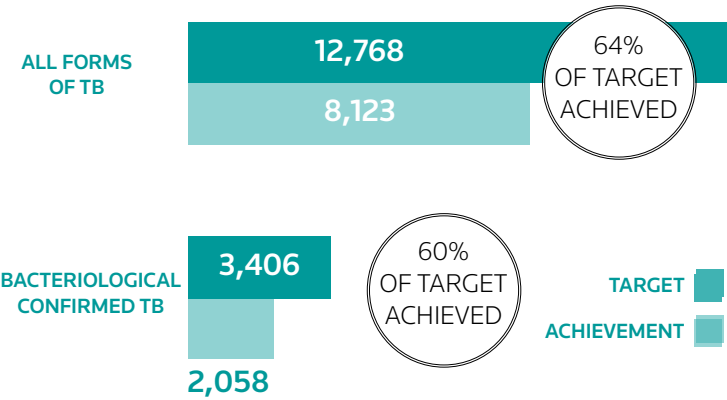
Activities supported by 3MDG have also contributed significantly to implementation of active case detection, operational research, and the development of childhood TB guidelines.

CHALLENGES AND LESSONS LEARNED

High staff turn-over and lack of technical staff

TB active case finding activities rely heavily on the smooth referral systems and diagnostic facilities of township health departments. Finding skilled staff, including laboratory technicians, X-ray technicians and trained medical officers, and high staff turnover in remote townships are continuing challenges.

FIGURE 9: ACHIEVEMENTS OF 3MDG FUNDED ACTIVE TB CASE FINDING PROGRAMME



UNITE TO → END TB

In early 2016, the National TB Programme, the Central Health Education Bureau of the Ministry of Health and Sports and 3MDG developed a nationwide mass media programme to improve public awareness of TB and MDR-TB, free treatment, and the benefits of early detection.

This campaign was successfully launched before the World TB Day on 24th of March, and included television commercials, events, pamphlets and other materials, and participation in a concert with more than 10,000 attendees.





Rory Stewart, the UK Minister of State at the United Kingdom Department for International Development, visiting 3MDG's tuberculosis activities in Yangon.

To address these issues, 3MDG has discussed the issue of staff replacement with the National TB Programme, and supports training in the reading of chest x-rays for township medical officers, TB team leaders, and mobile team medical doctors, who work at township and station hospitals. 3MDG also supports training of newly recruited laboratory technicians to fill gaps at field level.

Irregular reporting

Six Public-Private Mix (PPM) hospitals provide TB screening at routine outpatient units, as well as referral for the confirmation of diagnosis and provision of treatment. However, irregular reporting is a challenge for NTP due to shortage of hospital staff and increasing workload. After discussion with National TB Programme team, it was agreed to drop this activity in favour of strengthening the patient referral system between public hospitals and local TB centres. This is more cost effective and less time consuming work.

Shelter and high referral costs

As guest houses and landlords sometimes refuse to rent to TB patients, it can be challenging for patients to find a place to stay before their treatment starts. Providing temporary patient shelter at the decentralized sites and remote townships, currently in part organized and supported by 3MDG partners, is critical.

The cost of referral can also be an issue for patients, particularly in more remote locations that have higher transport costs. Coordination of referrals between partners and township health departments can also be challenging for staff working in townships that are far away from each other, especially in Kachin State due to the difficult terrain, lack of access roads and continuing conflict.

Improving co-ordination

Co-ordinating the planning of the National TB Programme and the Global Fund-supported work has encouraged a more comprehensive, efficient and effective process, which streamlined use of resources and implementation of activities.

Furthermore, a co-ordination meeting between National TB Programme local staff and partners, organized by 3MDG, has resulted in better co-ordination and communication for patients enrolled in MDR-TB treatment, regardless of the funding source of this treatment. However, as the enrollment is led by the National TB Programme, and the support is led by the partners, more improvement could be achieved by further aligning the two plans.

Finally, it was noted in the first half of 2016 that improvements in quality of field implementation can be achieved through supportive joint supervision and monitoring trips.

MALARIA

TABLE 7: MALARIA RESULTS AND TARGETS AS OF JUNE 2016

	NUMBER OF PEOPLE TESTED FOR MALARIA	NUMBER OF PEOPLE TREATED FOR CONFIRMED MALARIA	NUMBER OF CONFIRMED MALARIA TREATED WITHIN 24 HOURS OF ONSET OF FEVER
ACHIEVEMENTS (JAN-JUN 2016)	194,209	3,424	1,984
TARGETS (JAN-JUN 2016)	207,500	4,500	2,700
PROJECT-TO-DATE ACHIEVEMENTS (JAN 2013 TO JUN 2016)	1,671,577	124,648	58,098
PROJECT-TO-DATE TARGETS (2013 TO JUN 2016)	1,806,123	319,500	115,000

COVERAGE AREAS

Myanmar’s National Strategic Plan for malaria identifies the disease as a leading cause of illness, especially when there is delayed or no treatment. 3MDG supports nationwide efforts to understand the scope of the problem, including the National Malaria Indicator Survey.

Through support to the national response, 3MDG remains focused on the 50 priority townships in the Myanmar Artemisinin Resistance Containment area of East Bago, Kayin, Kayah and Mon States and Thanintharyi Region, as well as expanding and becoming increasingly active in supporting testing and treatment in malaria endemic populations in Rakhine and Southern Chin States.

Expansion of services in all areas is focused on engaging migrant populations, ethnic minorities and populations who were previously not sufficiently covered by malaria testing and treatment services. These areas will be better served by a community-based approach than previously under the National Programme, as this approach is more effective at reaching mobile and remote populations.

RESULTS

During the first half of 2016, almost 195,000 malaria tests, including asymptomatic malaria

cases, were taken, representing 47 percent of the overall 3MDG target for 2016. The malaria peak season only begins in June, therefore this can be considered a satisfactory achievement for the first half of the year.

Around 3,500 confirmed malaria cases received standard treatment, bringing the total number of patients treated for malaria since the Fund began to almost 125,000.

3MDG and its partners contribute to malaria resistance containment through early and effective diagnosis and treatment, particularly focusing on hard-to-reach areas and mobile and migrant populations. To support treatment adherence, community health volunteers provide DOT (Direct Observed Treatment) to those cases that need extra care.

In 2015, 3MDG partnered with USAID/ President’s Malaria Initiative (PMI) to provide joint funding and technical support for Myanmar’s National Malaria Indicator Survey. Work has continued through the first half of 2016, and after laboratory work was finished, the preliminary data was shared with the National Malaria Control Programme and key development partners in August 2016.

Final survey results will be disseminated in December 2016, and will contribute towards the new National Strategic Plan and the coming phase of Global Fund support, by providing



A health worker at a clinic in Ka Toe Hta village, Kayin State. The primary focus is malaria, but the clinic also provides other health services.

evidence for efforts to contain artemisinin resistant malaria and move towards malaria elimination across the country.

CHALLENGES AND LESSONS LEARNED

Retention of trained health care providers

With the majority of cases in remote areas or conflict-affected areas, recruitment, distribution and retention of staff is challenging. Maintaining the community volunteer network and the trained health staff of ethnic health organizations is critical, as they are the front-line treatment providers for malaria diagnosis and treatment within the first 24 hours.

To address this, the Ministry of Health and Sports is in the process of shifting the roles and responsibilities of basic health staff to go beyond clinical treatment to include disease prevention activities. This means that patients can access prevention, diagnosis and treatment in one place, especially important for those in or coming from remote locations.

Effective utilization of trained health workforce and integration of service provision

With prevalence significantly declining, trained malaria volunteers may have poor motivation for their routine tasks, as their incentives are linked with performance and achievements. Re-training these volunteers to deliver broader services, such as tuberculosis referral or maternal, newborn and child health services, would address issues of poor motivation as well as filling other gaps in health services.

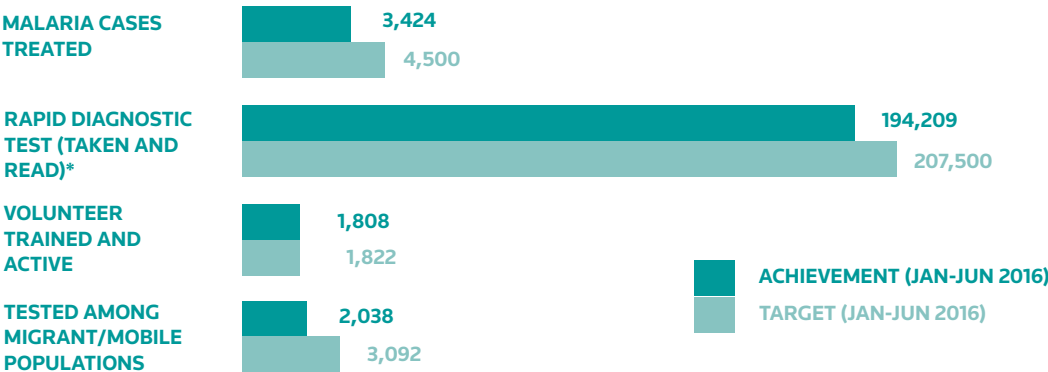
This matter is being discussed at the Technical and Strategic Group for the implementation of Integrated Community Case Management (ICCM), which has been included by the National Malaria Control Programme in the 2017 work plan.

Difficult access to the mobile migrant population, ethnic minorities and language barriers

Though there has been considerable progress, language barriers continue to make it difficult to reach out to ethnic minorities in the high-malaria endemic areas. Further, with some villages under the control of local armed forces, project staff cannot reach out to these areas regularly without permission.

To improve access, partners need to train local staff and build trust with local communities. Further, engagement with ethnic health

FIGURE 10: MALARIA TESTING AND TREATMENT RESULTS AS OF JUNE 2016



*Graph shown to scale 1:10,000



During the rainy season in Myanmar, road conditions make access to healthcare challenging, so trained volunteers conduct malaria outreach activities for target populations.

REACHING WORKSITES

As worksites - including road construction sites, mines and rubber plantations - are high prevalence areas for malaria, 3MDG partners distribute long-lasting insecticide nets (provided by the Global Fund), and provide malaria diagnosis and treatment. In the first half of 2016, over 2,000 cases were tested at the worksites.

To reach mobile populations near the coverage areas, 1,808 trained malaria volunteers are providing malaria case management and Community Partners International conducted 86 outreach mobile activities in the first half of the year.

“We want our sons and daughters to live their lives”

My name is Saw Ae Kaw, and I live in a village called Padauk Myaing, which is located on a hill in Hpapun Township, Kayin State. A few years ago I stood on a landmine, and as a result my right leg had to be amputated.

I became unemployed because of the accident. Then in July 2013, Myanmar Health Assistant Association (MHAA) started a malaria project in our village, giving community-based trainings to local volunteers who wanted to become village health workers.

I knew that malaria was the main health issue in our village, so I joined the training with other people with disabilities to help my community. I learned about malaria prevention, testing, treating and sharing knowledge. After completing the training program, I tested patients free-of-charge and gave treatment to positive cases. Seeing the malaria positivity rate decline brought me great joy.

MHAA also provided mosquito bed nets to distribute in our village. I happily brought the mosquito nets back for my villagers, but when I arrived, people from the local ethnic armed group prohibited me from distributing the nets. I tried to



explain to them that what I was doing was for the benefit of the villagers, but they didn't listen and I was very disappointed.

I requested the whole village to gather together, so that I could tell them the situation, and the villagers agreed to distribute the mosquito nets. We want our generation, our sons and daughters, to live their lives. We don't want them to suffer from these diseases, and that's why we decided we wanted to use the nets, and face any difficulties that will come together.

Now when I walk along the village road after sunset, I can see the blue mosquito nets set up in every house and I see the parents put their children to sleep under the mosquito nets. My disability never held me back - I've been able to contribute to saving many lives from malaria and I am very proud to be a malaria volunteer.

Voices

organizations is critical to improving access to early diagnosis and effective treatment. For example, Community Partners International has worked with ethnic health organizations to establish relationships and trust, meaning they are able to monitor performance as necessary.

3MDG also closely monitors the progress of these organizations and provides constructive feedback to improve implementation. As a result of this work, and the building of trust and transparent communication channels, 3MDG was invited to participate in the annual performance review and co-ordination meetings.

Increasing number of asymptomatic malaria cases

Preliminary outcomes of the Malaria Indicator Survey revealed declining malaria incidence in Myanmar, with only ten cases found malaria positive using the standard Rapid Diagnostic Test (RDT) out of 13,779 tested. However, a total of 526 samples that were ultimately found malaria positive, identified by ultra-sensitive PCR, were not detected by RDT. This shows that some asymptomatic cases with low parasite levels in the blood cannot be detected by routine testing in the field.

Though these individuals were symptom-free, as malaria carriers they present the risk of continued transmission to others. Preventing this type of transmission, and containing drug-resistant malaria is complex, and requires further investment in strengthening the surveillance system and case investigation approaches at the community level. Widespread use of PCR testing would be costly, and require more advanced diagnostic equipment and surveillance. However, in 2017 it is hoped that there will be an operational trial of ultra-sensitive RDTs capable of detecting lower parasite levels than current RDTs.

Improving co-ordination

As the funding of the containment efforts for drug resistant malaria are largely from the Global Fund new funding model and regional grant, it is critical that 3MDG regularly attends co-ordination meetings and engages with the National Malaria Programme and Global Fund – Principal Recipient teams for better programming and to avoid service overlaps. USAID/PMI also plays an important role in the national response. As such, active co-ordination with key funding agencies and partners is critical for the success of programme planning and implementation.





A completed health centre in Magway that was handed over to the Ministry of Health and Sports in the beginning of 2016. The centres have spaces for deliveries, consultations and administration, and solar power and water tanks.

HEALTH SYSTEM STRENGTHENING

COVERAGE AREAS

A responsive, resilient and people-centered health system is critical for sustainable progress and improved health outcomes. 3MDG's health system strengthening component is supporting the Ministry of Health and Sports across its strategic investments in governance and stewardship, human resources, supply chain management, evidence-based policy making and community engagement. Priority areas outlined by the Ministry in 2016 include ensuring essential medicines and health commodities are available at all levels of health facilities, improving and integrating health information systems, and strengthening community engagement. In response, 3MDG is expanding its work to support these priorities to create a more resilient and responsive health system.

RESULTS

A US\$ 6.5 million midwifery programme that aims to strengthen technical capacities and the regulatory framework began in 2015. Through technical assistance provided by Jhpiego, 3MDG is supporting the Ministry of Health and Sports in transforming midwifery education by improving teaching methods, updating technical knowledge, and installing skills labs to allow for skills-based learning. Alongside updating knowledge and teaching methods in midwifery

school faculties by the end of 2016, skills labs were upgraded in 16 schools by June 2016 (ten schools in 2015 and six schools during the first half of 2016). Upgrading of the remaining six midwifery schools and one lady health visitor school will be completed by the end of 2016.

To strengthen supply chain management, another key area of investment, 3MDG is supporting two different programmes. The first focuses on improving the supply chain in Bago, Delta and Magway, and has included working together with the Partnership for Supply Chain Management to design and advocate for a harmonized logistic management information system. It will provide regional health departments with up-to-date consumption and stock out data. The second programme is to expand availability of cold chain equipment nationwide in partnership with UNICEF, and has included procurement and upkeep of new refrigerators and freezers. This has allowed for the introduction of pneumococcal vaccine nationwide in 2016.

3MDG continues to support the Ministry in strengthening public financial management. An assessment was conducted in 2016 that identified key areas for improvement. These include lack of financial management systems, limited human resources and technical capacities in financial management, and weak linkages between planning, budgeting, and

monitoring. Recommendations have been put forward for the Ministry to consider.

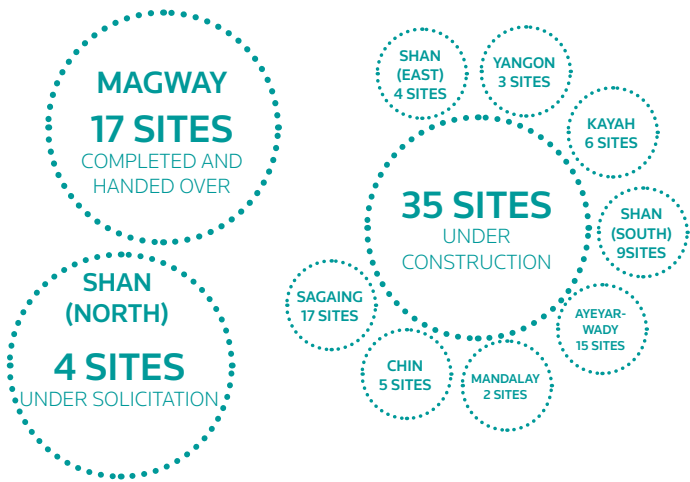
In addition, the World Bank continues to conduct trainings on financial management. From November 2015 to June 2016, 128 national and state/regional and township staff received intensive trainings on financial management. To further reinforce skills from the trainings, hands-on coaching and mentoring has been provided to state/region offices and 65 township offices.

INFRASTRUCTURE

Communities in rural and hard-to-reach areas continue to face geographic barriers in accessing services. 3MDG has committed resources to construct up to 82 rural and sub rural health centres by 2017 in a US\$ 12 million infrastructure programme. The centres have spaces and equipment for the different stages of childbirth, emergency and waiting rooms, and drug storage facilities. On site accommodation for staff, solar lighting, and water storage tanks mean that care, light and water are available when needed.

In early 2016, 17 health centres in Magway Region built in 2015 were handed over to the Ministry of Health and Sports, covering a population of nearly 88,000. By the end of the year, 26 more centres will be completed and handed over and 15 more centres will be completed.

FIGURE 11: STATUS OF THE HEALTH FACILITIES AS OF JUNE 2016



COLLECTIVE VOICES

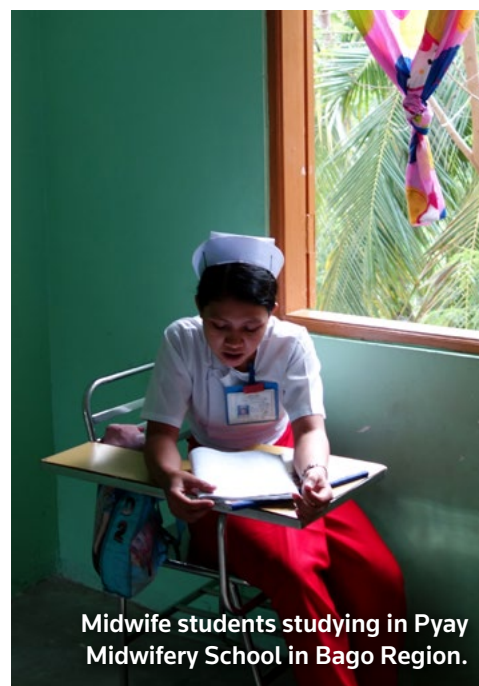
3MDG’s innovative US\$ 1.5 million initiative, *Collective Voices: Understanding Community Health Experiences* partners with 25 local civil society organizations (CSOs).

Local organizations are often better placed to bring about some of the fundamental changes needed in the relationships between healthcare providers and the communities they serve. They have mapped the situation and causes of limited access to healthcare using their own language and conceptual framework. This is critical for poor and marginalized groups who are often intentionally or unintentionally excluded from access to quality healthcare.

In 2016, 3MDG produced a report shedding light on how social factors can impact access to good health, as told by community members themselves. It is based on over 500 meetings held across six states and regions by the Collective Voices organizations, and was launched at the Ministry of Health and Sports in Nay Pyi Taw, which took place just after the end of the reporting period.

The event brought together government and civil society representatives to discuss how community voices can be used to inform health policy-making and programming at every level. They discussed how important it is to take the social factors which impact health into account, to achieve better health outcomes for all people in Myanmar, recognizing that health interventions should be informed by an understanding of how people think and feel, and why they fail to take action to access healthcare.





Midwife students studying in Pyay Midwifery School in Bago Region.

Through to the end of 2017, Collective Voices partners are testing a range of approaches to addressing these barriers to health, including adolescent sexual and reproductive health sessions in schools, organizing conferences that bring together formal and informal healthcare providers, and through ‘family shows’ in villages. These are fun quizzes and games that aim to improve knowledge about health and rights.

CHALLENGES AND LESSONS LEARNED

Low domestic investment in health

Despite recent increases, the Ministry of Health and Sports budget remains low. This impedes the Ministry’s capacity to address emerging health issues as well as ensuring the population has access to basic health services.

To support the Ministry in mobilizing resources, the Fund, through its partners, takes a multi-pronged approach. This includes advocating a stronger investment case for health, commissioning analytical analyses to explore new financing mechanisms such as a tobacco tax, and improving efficiencies in health spending through strengthening public financial management. In all three areas, progress has been slow – due, in part to the complexity of the issues, and in part, to recent changes in the government requiring identification of new policy champions.

Human Resources for Health

Recruitment, distribution and retention of staff remains a major issue particularly in areas that are remote and/or affected by conflict. 3MDG, in collaboration with the WHO and Jhpiego, is working with the Ministry to develop strategies to address rural retention and local recruitment.

Supply chain challenges

A fragmented supply chain system results in inefficiencies and duplications. The Ministry of Health and Sports is in the process of streamlining the supply chain, and strengthening their technical capacities in forecasting, procurement, and distribution. Delays in obtaining necessary approvals for a harmonized logistic information system have resulted in postponement of trainings and limited time to pilot the system.

Support to the Ministry of Health and Sports

Together with support to Ministry of Health and Sports at the central level, it is crucial that 3MDG and other partners support systems strengthening at the state/region, district and township levels. This will ensure that policies are implemented as designed, and adjustments are made as needed. In particular, trainings conducted at the central level need to be coupled with hands-on support at the state/region, township, and community levels, and challenges identified in program implementation at the lower levels should inform policy changes at the central level.



PROCUREMENT AND DISTRIBUTION

In the first half of 2016, the 3MDG procurement unit placed a total of 93 purchase orders for medical commodities for implementing partners, with a combined value of US\$ 1,757,757. A total of US\$ 1,050,217 worth of health commodities have been distributed from the two 3MDG warehouses.

Due to the introduction of a new Enterprise Resource Planning system UNOPS-wide, some procurement actions faced delays of up to three months because of system-related issues. Further delays of up to two months were faced in obtaining tax exemptions due to the introduction of new regulations by the Foreign Economic Relations Department (FERD).

MONITORING & EVALUATION

In the first half of 2016, there were 43 programme monitoring visits and 36 routine data quality assessments for 12 organizations in eight states and regions.

3MDG continues to help strengthen the national health information system through utilization of District Health Information System 2 (DHIS2) in 26 townships, inputs to the Health Information System assessment and development of the National Strategic Plan, and the recent roll-out of the Volunteer Reporting System.

In light of major contextual changes since the Fund's inception, 3MDG conducted a review of its M&E strategy in early 2016. The review has concluded that the vision of the original strategy was overambitious, and aims to rectify this with more realistic strategic guidance to monitoring 3MDG programmes.

An Independent Evaluation Group undertook a data quality audit of 2015 data, covering four implementing partners working on MNCH, HIV and tuberculosis grants. The audit found that follow-up to 2015 recommendations was satisfactory and has led to improvements in the already strong M&E system of 3MDG. The system assessment and data verification have shown that the system is functional, and the audited data is of good quality.

The outputs of the M&E strategy review and Independent Evaluation Group data quality audit are available on the 3MDG website.



Auxiliary midwives attend a training to learn how to use templates and tools for the Volunteer Reporting System. Photo: Relief International



Community health workers at the village level learn how to enter data for the Volunteer Reporting System. Photo: Relief International



Assessment of the District Health Information System 2, supported by 3MDG.



FUND STATUS

As one of the largest contributors of external assistance for health in the country, the Fund 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 US\$ 279.3 million in the period 2012–2017. By bringing key donors together in a single fund, 3MDG increases efficiency, achieves scale, pools risks and provides coordinated support to government priorities. It is managed by the United Nations Office for Project Services (UNOPS).

Programme delivery in the first half of 2016 was US\$ 24.1 million disbursed. The total to date delivery across the 3MDG Fund amounts to US\$ 188.3 million, out of which US\$ 168 million is

being used for programme activities, and US\$ 20.3 million for programme management, governance, monitoring, evaluation, and fund management overhead costs.

Since the Fund began, 89 grants have been awarded to 55 partners. In the first half of 2016, the 3MDG has added two grants and one new partner, for a combined amount of US\$ 999,999 in the new 2016 grants. *Figure 12* shows the value of all grants per component.

Figure 13 shows funds already disbursed plus funds planned for disbursement per component as legally committed in grants. Within the components, funding is allocated against twelve key programmatic areas (*see page 6*), providing a further breakdown of 3MDG investments.

TABLE 8: DONOR CONTRIBUTION RATIO TO 3MDG (INCLUDING EARMARKED TOP-UPS)

	OVERALL COMMITMENTS (MILLION USD)	OVERALL COMMITMENTS (PERCENTAGE)	DISBURSEMENTS RECEIVED (MILLION USD, JUNE 2012-DECEMBER 2015)	DISBURSEMENTS RECEIVED (PERCENTAGE, JUNE 2012-DECEMBER 2015)
THE UNITED KINGDOM (THROUGH THE DEPARTMENT FOR INTERNATIONAL DEVELOPMENT - DFID)	147.2	52.7%	114.1	50.7%
AUSTRALIA (THROUGH THE DEPARTMENT OF FOREIGN AFFAIRS AND TRADE - DFAT)	48.2	17.3%	48.2	21.5%
THE EUROPEAN UNION (EU)	31.5	11.3%	25.9	11.5%
SWEDEN	25.5	9.1%	14.8	6.6%
DENMARK	9.2	3.3%	9.2	4.1%
SWITZERLAND (THROUGH THE SWISS AGENCY FOR DEVELOPMENT AND COOPERATION - SDC)	4.2	1.5%	4.2	1.9%
THE UNITED STATES (THROUGH THE AGENCY FOR INTERNATIONAL DEVELOPMENT - USAID)	6.7	2.4%	5.0	2.2%
ROLL OVER FROM 3DF	5.2	1.8%	3.3	1.5%
ROLL OVER FROM JIMNCH	1.6	0.6%	TBD	-
TOTAL	279.3	100%	224.7	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.

FIGURE 12: GRANT VALUE IN UNITED STATES DOLLAR PER COMPONENT

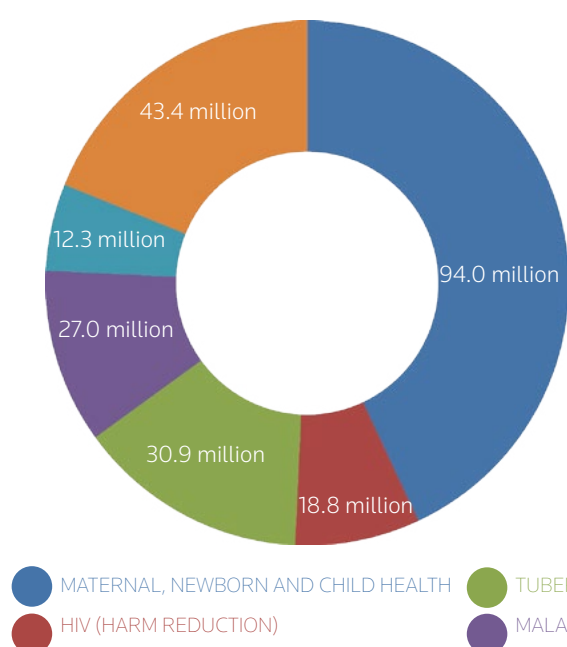
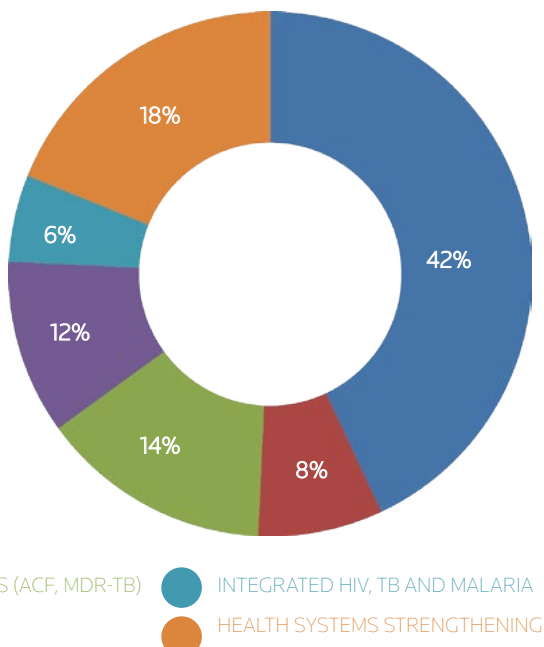


FIGURE 13: FUNDING BREAKDOWN BY COMPONENT





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