Description of Action
Multi Donor 3MDG Fund
2012-2016

Members of 3MDG Multi Donor Fund are the
Governments of Australia, Denmark, the Netherlands, Norway, Sweden, United Kingdom and the European Union

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Acronyms

3 MDG Fund	Three Millennium Development Goal Fund
3DF	Three Diseases Fund
ACT	Artemisinin Combination Therapy
AIDS	Acquired Immune Deficiency Syndrome
AMW	Auxiliary Midwife
ARI	Acute Respiratory Infection
ART	Antiretroviral Therapy
AusAID	Australian Agency for International Development
B/CEmONC	Basic/Comprehensive Emergency Obstetric and Newborn Care
BCC	Behaviour Change Communication
CBO	Community Based Organisation
CCM	Country Coordinating Mechanism (Global Fund)
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CHW	Community Health Worker
CMAM	Community Management of Acute Malnutrition
CRC	Convention on the Rights of the Child
DAC	Development Assistance Committee
DALY	Disability Adjusted Life Year
DFID	Department for International Development (UK)
DHS	Demographic Health Survey
DOH	Department of Health
DPT3	Diphtheria, Pertussis, Tetanus (3rd immunisation)
EC	European Commission
EHSP	Essential Health Service Package
EPI	Expanded Programme on Immunisation
EU	European Union
FB	Fund Board
FM	Fund Manager
FSW	Female Sex Worker
GAVI	Global Alliance for Vaccines and Immunisation
GDP	Gross Domestic Product
GFATM	Global Fund to fight HIV/AIDS, TB and Malaria (Global Fund)
GNI	Gross National Income
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSS	Health Systems Strengthening
ICER	Incremental Cost Effectiveness Ratios
ICPD	International Conference on Population and Development
IDU	Injecting Drug User
INGO	International Non-Government Organisation
IOM	International Organization for Migration
IP	Implementing Partner
ITN	Insecticide Treated (bed) Net
JICA	Japan International Cooperation Agency
JIMNCH	Joint Initiative on Maternal and Neonatal Child Health
LBW	Low Birth Weight
LIFT	Livelihoods and Food Security Trust Fund
LiST	Lives Saved Tool
LLIN	Long Lasting Insecticide Treated Net

M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MICS	Multi Indicator Cluster Survey
MNCH	Maternal, Newborn and Child Health
MMA	Myanmar Medical Association
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSI	Marie Stopes International
MSM	Men who have Sex with Men
MTE	Mid-Term Evaluation
MW	Midwife
NGO	Non-Government Organisation
OECD	Organisation for Economic Cooperation and Development
ORS	Oral Rehydration Salts
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission (HIV)
PONREPP	Post-Nargis Recovery and Emergency Preparedness Plan
PSI	Population Services International
RDT	Rapid Diagnostic Test
RH	Reproductive Health
RHC	Rural Health Centre
SCG	Senior Consultation Group
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
TCG	Tripartite Core Group
TMO	Township Medical Officer
TOR	Terms of Reference
TSG	Technical and Strategy Group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNOPS	United Nations Operations and Procurement Services
USAID	United States Agency for International Development
US$	United States Dollars
VCT	Voluntary Counselling and Testing
WFP	World Food Programme
WHO	World Health Organisation

1. Summary

The Three Diseases Fund (3DF) was established by a consortium of seven donors (Australia, Denmark, the Netherlands, Norway, Sweden, UK and the EU) after the withdrawal of the Global Fund to fight HIV/AIDS, TB and Malaria (Global Fund) from Myanmar/Burma in August 2005. The 3DF donor consortium has committed US$138 million over 5 years (2007-2012) for a humanitarian response to address HIV/AIDS, TB and malaria.

These seven donors are strongly committed to work together to support the next phase of multi-donor funding for health in Myanmar/Burma. This next phase of funding, referred to as the Three Millennium Development Goal Fund (3MDG Fund), will continue to provide joint donor support to address the basic health needs of the most vulnerable people in Myanmar/Burma, and expand the scope of support beyond the three diseases to encompass maternal and child health and longer-term sustainability. This reflects the priority given by donors to the MDGs, in particular those related to maternal health, child health and to HIV, TB and malaria, as well as increasing recognition that sustaining improved health outcomes requires strong health systems.

The 3MDG Fund will be supported through a pooled donor fund. Donor commitment is likely to be in the range of US$250 million to $300 million over 5 years. The Fund will be implemented in line with aid effectiveness principles, ensuring harmonisation with the initiatives of other donors such as the Global Fund and GAVI (Global Alliance for Vaccines and Immunisation) and taking steps to further strengthen adherence to the principles of country ownership, alignment and mutual accountability. In this respect, the 3MDG Fund will build on 3DF progress in supporting wider sector coordination, transparency and accountability.

Maternal and child mortality is acknowledged to be high, and most deaths are from preventable causes. Among specific diseases, the leading causes of death and illness in Myanmar/Burma are TB, malaria and HIV/AIDS. There are significant inequalities in health status and in access to affordable, quality health care, especially in rural and hard-to-reach areas and among the most vulnerable populations. Health system challenges undermine the capacity of the public sector to deliver basic health care. Although there has been limited sector-wide or systems analysis, available information highlights challenges relating to health financing, planning and management, human resources for health, infrastructure and essential drugs and supplies, health information, and stewardship of the sector. There are currently few initiatives to strengthen the health system in Myanmar/Burma.

The overarching goal of the 3MDG Fund is to contribute to national progress towards the health MDGs through a rights-based approach. This will reflect the principles of non-discrimination, equality, participation, transparency and accountability and will give high priority to strengthening voice and accountability including through building the capacity of civil society and community structures.

The goal is: Improved maternal, newborn and child health and a reduction in communicable disease burden in areas supported by the 3MDG Fund. The purpose is: Increased access and availability of (i) essential maternal and child health services for the poorest and most vulnerable in townships supported by the 3MDG Fund and (ii) HIV, TB, and malaria interventions for populations and areas not readily covered by the Global Fund. The programme will deliver six outputs/results:

1) Delivery of essential services, with a focus on maternal, newborn and child health, in townships supported by the 3MDG Fund.

2) Strengthened capacity for delivery of essential MNCH services in townships supported by the 3MDG Fund.
3) Prioritised HIV, TB and malaria interventions provided to targeted populations or areas not readily covered by the Global Fund.
4) Prioritised components of the health system strengthened for long term sustainability.
5) Enhanced health services accountability and responsiveness through capacity development of target communities, civil society organisations and the public sector.
6) Fund Management demonstrates value for money and cost-effectiveness, generates evidence to inform policy, funding and programming decisions, and strengthens aid effectiveness.

The 3MDG Fund proposes to achieve these outputs/results through three components:

- Component 1: Increased availability and accessibility of essential services focusing on maternal, newborn and child health.
- Component 2: Flexible and strategic support for HIV, TB and malaria interventions for populations and geographical areas that are not supported by the Global Fund.
- Component 3: Complementary health systems strengthening to support long-term sustainability.

Component 1 will adopt a continuum of care through a range of service providers at township level that is aligned with national strategies for reproductive and child health. This component will prioritise high impact, low cost interventions and integrated delivery of services as close to the beneficiaries as possible, for example at primary and community level. This will ensure provision of a package of essential health services that will address the main causes of maternal, newborn and child death and illness for poor and vulnerable populations in Myanmar/Burma. The 3MDG Fund will support training of Basic Health Staff, in particular of midwives for skilled attendance at birth, community health workers and auxiliary midwives, drugs, equipment and commodities, referral for and provision of emergency obstetric and neonatal care, and minor refurbishment of health facilities. It will also support demand-side financing to reduce financial and other barriers to use of health services. Activities at township level will be implemented under the auspices of the coordinated township health plan.

Component 2 will support priority gaps in the national responses for HIV, TB and malaria that are not readily funded by the Global Fund. Priority will be given to vulnerable and marginalised populations, to hard-to reach areas and to emerging health threats. Complementing and adding value to Global Fund and other donor programmes will be a key guiding principle. This component will also provide technical support for future Global Fund applications.

Component 3 will support complementary health systems strengthening at central and decentralised levels of the health system, to help develop a more effective and a more responsive health system. This component reflects increased donor commitment to capacity development and to strengthening national systems. It aims to support the longer-term sustainability of investment in the maternal, newborn and child health services and communicable disease control components of the 3MDG Fund and to complement existing health systems strengthening initiatives. Systems strengthening will also include measures to strengthen voice and accountability and to build related capacity.

The programme budget is indicatively allocated as follows: Component 1, 74%; Component 2, 15%; and Component 3, 11%. The main beneficiaries will be mothers, newborns and children under five in the 40 townships covered under Component 1. The 3MDG Fund is expected to avert 25,150 deaths in children under five and 3,153 maternal deaths and to significantly reduce the disease burden in mothers and children. For most interventions, in areas where Component 1

operates a cumulative increase in coverage of 25% over 5 years is anticipated. So, for example, in townships where the 3MDG Fund is delivering an essential package of maternal, newborn and child health services, skilled attendance at birth coverage will increase from 56% to 81%, appropriate treatment of childhood diarrhoea with ORS and zinc from 24% to 49% and from 5% to 30% respectively, and appropriate case management of childhood pneumonia with oral antibiotics from 18% to 43%.

Component 1 is expected to result in an estimated additional 46,706 births attended by a skilled health professional, an additional 30,202 pregnant women receiving full antenatal care, an additional 95,060 children being immunised with DPT3, and an additional 34, 693 infants aged 0-5 months being exclusively breastfed. Other members of the community will also benefit from improvements in health service availability and quality resulting from Components 1 and 3.

The main beneficiaries under Component 2 will be people with HIV, TB and malaria in the selected areas or populations. Efforts to address emerging threats will also have significant wider social and health benefits.

The proposed governance arrangements for the 3MDG Fund will build on the experience of the 3DF. The core governance structure will be the Fund Board, which will include representatives from all donors to the Fund and three independent experts and will provide oversight of the Fund. The 3MDG Fund will be guided by existing structures for policy dialogue and coordination of national responses to MDGs 4, 5 and 6 and will promote transparent and accountable coordination mechanisms at national, regional and local levels.

The 3MDG Fund will need to be accountable for delivering results, showing that funding and inputs lead to effective and accountable services, increased utilisation of services and, ultimately, better health outcomes. Funding will also need to demonstrate that programmes and interventions are cost effective and make optimal use of resources available.

The Fund Manager will be responsible for effective, transparent and efficient management on behalf of the Fund Board. Programme implementation is expected to commence in the second quarter of 2012. The programme will be implemented directly and indirectly through implementing partners including public sector health services, UN agencies, international and local NGOs, CBOs, and the private sector. The 3MDG Fund is also sufficiently flexible to allow for a transition to direct support for public health services and increased use of government systems should circumstances permit. This is an ambitious programme that has the potential to deliver significant health benefits, but it also involves risks. The Fund Board and Fund Manager will ensure that monitoring and mitigation of risks is given high priority.

2. Justification

2.1. Country context

Myanmar/Burma is a union of 7 states and 7 regions with an estimated population of 57.5 million[1]. Approximately 32% of the population live in urban areas[2]. The country is geographically and culturally diverse, with 135 groups speaking over 100 languages and dialects. Ethnic groups comprise an estimated 35-40% of the population.

[1] UN Thematic Analysis March 2011 (Statistical Yearbook 2009, CSO)
[2] UN country profile Myanmar

Myanmar/Burma is ranked 149 out of 168 countries in the Human Development Index. Agriculture remains central to the economy, accounting for over 50% of GDP, although substantial revenue is generated by export of natural resources. Although both absolute and relative poverty declined between 2005 and 2010, 25% of the population live below the poverty line, with 5% living in extreme poverty. Poverty incidence is around twice as high in rural areas as in urban areas at 29% and 15% respectively. Poverty is also unevenly distributed across the country's states and regions, with 73% of the population in Chin, 44% in Rakhine and over 30% in Shan, Tanintharyi and Ayeyarwady States and Regions living below the poverty line. One third of the poorest people live in the densely populated Mandalay and Ayeyarwady regions[3].

Levels of public expenditure are low and social sectors are critically under-funded. Myanmar/Burma also receives very low levels of development assistance. There has been no World Bank lending since 1987 and no IMF programme since 1981-1982. Overall development assistance is the second lowest per capita amongst low-income countries.

Following more than 40 years' of military rule, the November 2010 election brought in a new government and constitution which makes provisions for a degree of local decision-making in the 14 state and regional parliaments. Decentralisation should enable local leaders to take greater responsibility for provision of services, including health services. The space for dialogue created by both the 3DF and post-Nargis collaboration has increased the confidence of the international community. This in turn has resulted in increased humanitarian support, as well as attempts to move into more substantive development programming, although access remains an issue, especially in remote and conflict-affected areas.

Myanmar/Burma has experienced internal conflict for more than 60 years. Although this is now confined to a few areas of the country, basic services have yet to recover from the damage caused by earlier conflict. Civil society organisations are few and have limited capacity to represent the interests of poor or excluded groups to service providers and limited political space to advocate for appropriate policies and programmes.

Myanmar/Burma has made several international commitments to increased gender equality and equity, including participation in the Fourth World Conference on Women in 1995, accession to CEDAW in 1997 and, more recently, signing of international protocols regarding trans-national organised crime, trafficking in persons and the smuggling of migrants. Despite the formal national organisations and civil society organisations working for the implementation of CEDAW, limited progress has been made, due in part to lack of resources. However, there is commitment from the Ministry for Women's Affairs to CEDAW and increasing government interest in adopting a National Strategic Plan of Action on Women.

Women and men have equal rights under the law, including in employment, and gender-based discrimination is not highly visible. However, women's ability to enjoy these rights is influenced by cultural beliefs and by the effectiveness of legal systems and many are not aware of their rights. Equal enrolment of girls and boys in primary and secondary education has almost been reached. Female representation in politics and positions of authority is, however, not equal. No women were appointed as ministers in the new government in February 2011. Comparison of the situation in Myanmar/Burma with international benchmarks such as the Gender-related Development Index is not possible due to inadequate data. Capacity building is needed for gender analysis and mainstreaming in planning and programming[4].

[3] UNDP, 2011. Integrated Household Living Conditions Assessment
[4] UNFPA, 2010. Report on situation analysis of population and development, reproductive health and gender in Myanmar

2.2. Health sector analysis

2.2.1 Sector overview

Policy context. The Fourth Five-Year Plan sets out Myanmar/Burma's development objectives, which include strengthening the health and education sectors. The Myanmar Health Vision 2030 is an ambitious 30-year plan that aims to address health challenges.

The National Health Policy developed in 1993 aims to achieve 'health for all' through a primary health care approach, producing sufficient as well as efficient human resources for health, expanding health services not only to rural but also to border areas, and augmenting the role of the private sector and non-government organisations (NGOs) in delivery of health care. The National Health Plan 2007-2011 is also based on the primary health care approach and places particular emphasis on equitable access to health care. On health systems, it aims to: improve health; improve responsiveness; and improve fairness of financial contributions.

The National Health Plan 2011-2016, which is currently being finalised, will continue to give priority to maternal, newborn and child health (MNCH), communicable diseases and health systems strengthening, as well as to sector coordination. Rural health is also an emerging policy priority.

The policy framework in the sector is relatively well developed. A framework for health systems strengthening (HSS) has been developed by the Ministry of Health (MOH) in partnership with GAVI HSS, which identifies the need to address service delivery, coordination and human resources gaps. National strategic policies and plans for areas such as reproductive health, child health, HIV, TB and malaria are comprehensive and technically sound. The Government of Myanmar has expressed commitment to achievement of the health-related Millennium Development Goals (MDGs)[5]. Recently announced commitments to the Global Strategy for Women and Children's Health include to ensure: 80% antenatal care coverage; 80% of births attended by a skilled attendant; 70% access to emergency obstetric care; and 80% coverage for prevention of mother-to-child transmission of HIV and integration within MCH care, as well as commitments to universal childhood immunisation coverage, increased coverage of newborn care, increased contraception prevalence and reduced unmet need for contraception, to improve the midwife to population ratio from 1:5,000 to 1:4,000, and develop a new human resources for health plan for 2012-2015.

Governance and institutional context. The National Health Committee is the high-level inter-ministerial and policymaking body. Health Committees at each administrative level support collaboration and coordination.

The Country Coordinating Mechanism (CCM) has been re-convened to provide oversight of Global Fund grants. The CCM, as a representative multi-stakeholder forum, seeks to meet international aid principles of transparency and accountability. The Minister of Health, who chairs the CCM, has indicated that this structure should play a wider sector coordination role. The CCM Technical and Strategy Groups (TSGs) for HIV, TB and malaria are responsible for coordinating national strategies, preparing operational plans and budgets and are ensuring coordination between implementing partners. The TSGs are chaired by the MOH and include elected representatives from a wide range of stakeholders. A TSG for MNCH has recently been established and existing steering committees for reproductive and child health will be integrated into this structure. The TSG for MNCH is expected to follow the example of the disease-specific TSGs in terms of stakeholder participation, transparency and accountability.

[5] MDG 4 focuses on child health, MDG 5 on maternal health, and MDG 6 on HIV, TB and malaria

There is a National Health Sector Steering Committee for Health Systems Strengthening, which currently focuses on GAVI HSS activities. This includes MOH, UN agency and international NGO representatives. Bilateral donor participation is limited.

The MOH is organised at three levels: central, state or region, and township level. Decentralisation is currently under consideration, but the implications for roles and responsibilities at state, region and township levels are not yet clear. The MOH has seven departments, the largest of which is the Department of Health, which employs 93% of over 58,000 personnel and accounts for approximately 75% of MOH expenditure. The Department is responsible for the preventive, curative and rehabilitative services and for supervising health departments in the 7 regions, 7 states, 66 districts and 325 townships, as well as hospitals and clinics.

Township health administrations serve a population of approximately 100,000-300,000 and are headed by a Township Medical Officer. Urban areas are served by Township Hospitals, Urban Health Centres, School Health Teams and Mother and Child Health Centres. In rural areas, Township Health Departments oversee 1-3 Station Hospitals and 4-5 Rural Health Centres. Each Rural Health Centre has 4-7 sub-centres and outreach centres. Sub-centres are intended to be staffed by a midwife and a public health supervisor (PHS 2), while outreach centres are served by volunteer community health workers and auxiliary midwives.

The private sector is an important provider of health care in Myanmar/Burma; MOH and WHO report that the private sector provides 75-80% of ambulatory care. It consists of private hospitals and general practitioners, government health staff who practice out of hours, pharmacists and drug sellers. Formal private sector providers are mostly concentrated in Yangon, Mandalay and township centres. Available evidence suggests that a significant proportion of childhood illness is treated by a private practitioner and that the private sector provides a significant proportion of family planning services. Limited information is available about utilisation of the private sector by the poor, although one study found that subsidised private TB care is reaching the poorest populations of TB patients in urban areas. The 3DF has supported public-private partnerships in delivery of products and services, including through social marketing and social franchising of private practitioners.

There are reported to be 63 registered international NGOs, 82 local NGOs and 455 community-based organisations (CBOs) operating in Myanmar/Burma. A number of these work closely with or are implementing partners for donor-funded programmes. Some NGOs, and many CBOs, provide health services to hard-to-reach areas and populations. In order to operate in Myanmar/Burma, NGOs must be registered with the Ministry of Home Affairs. Health sector NGOs must also agree to a Memorandum of Understanding with the Ministry of Health to establish scope of work and geographical areas of operation.

Economic and social context. Areas of the country are poorly served by health services. Delivery of essential services is hindered by difficult terrain, geographical remoteness, conflict and cultural diversity. Even where services are available, access for the poorest is limited by financial and other barriers. High out-of-pocket expenditure, both within and outside the public health sector, means that households bear the brunt of financing for health. Serious illness or a medical emergency can lead to ‘catastrophic’ expenditure, resulting in or exacerbating household poverty.

Available information indicates significant inequalities in health status and in access to affordable, quality health care, especially in rural and hard-to-reach areas and among the most vulnerable populations. The Expanded Programme on Immunisation (EPI), for example, has identified low immunisation coverage in geographically inaccessible areas and among the urban poor, the

socially and economically marginalised and those living in areas affected by conflict[6]. There are also considerable differences in measles immunisation coverage between the poor and the non-poor at 76% and 86% respectively, and between rural and urban dwellers, at 80% and 92% respectively. Similar gaps between the poor and non-poor and urban and rural dwellers exist with respect to access to health care, nutritional status, antenatal care coverage and skilled attendance at birth[7].

Achieving greater equity in access to services will require greater efforts to improve public sector service coverage both in hard to reach areas and in unreached areas and populations within townships that are considered to be 'covered'. The challenges of expanding coverage are also compounded by limitations on where non-state implementing partners are permitted to work. It will also require efforts to enhance rights and accountability in the health sector.

Around 60% of the population are mothers and children. Maternal and child health indicators show that women and girls of reproductive age, and young children, are the most adversely affected by the lack of affordable, quality health services in Myanmar/Burma. Women and girls often face particular health issues and particular forms of discrimination. Women are more vulnerable to ill health, yet have fewer resources and opportunities to protect their health or to seek care. For example, women's lack of access to reproductive health services in general and to emergency obstetric care in particular is often the result of unequal access to financial resources within the household. However, there is a lack of gender-related health research on issues such as health-seeking behaviour and access to and quality of health care. Women also face the triple burden of productive, domestic and community tasks, and are expected to care for the sick. Risky sexual behaviour of men, especially those in the military and migrant workers, put women at increased risk of HIV infection. There is little robust data on the prevalence of gender-based violence, but anecdotal evidence indicates this may be a significant problem in Myanmar/Burma.

2.2.2 Problem analysis

Health status. High rates of mortality mean that maternal and child health is a priority. At least 2,400 pregnant women and 70,000 children die every year from largely preventable causes[8]. The maternal mortality rate is estimated to be 240/100,000 live births[9] and the under-five mortality rate at 71/1,000 live births[10].

The leading direct causes of maternal death are post-partum haemorrhage, hypertensive disease of pregnancy and abortion-related sepsis. Antenatal care coverage is poor. Skilled birth attendance is lower than the 2015 target of 80%, and the proportion of institutional deliveries is estimated to be 36%[11]. Emergency obstetric care is neither adequate nor available nor affordable for all women who need it. The leading causes of newborn deaths are asphyxia, sepsis, and prematurity. In children under five, the leading causes of death after the neonatal period are pneumonia, diarrhoea and malaria[12]. Only a third of children are estimated to receive antibiotic treatment for suspected pneumonia[13]. Under-nutrition is also an important contributory factor in maternal and child mortality[14]. The exclusive breastfeeding rate is low, at just under 24%. The proportion of children

[6] GAVI, 2008. Health systems barriers to improving immunisation and MCH coverage in Myanmar
[7] UNDP, 2011. Integrated Household Living Conditions Assessment
[8] UNICEF, 2010. Levels and trends in child mortality. Estimates developed by the UN inter-agency group for mortality estimates
[9] H4, 2008
[10] UNICEF, 2010. Levels and trends in child mortality. Estimates developed by the UN inter-agency group for mortality estimates
[11] MICS, 2009-2010
[12] MOH and UNICEF, 2003. Nationwide overall and cause-specific under-five mortality survey
[13] MICS, 2009-2010
[14] Globally, under-nutrition contributes to 30% of child deaths. Black, R et al, 2008. Maternal and child under nutrition: Global and regional exposures and health consequences. Lancet, 371(9608): pp 243-260

with moderate or severe stunting is 48% and the proportion moderately or severely underweight is 28%[15].

The Reproductive Health Strategic Plan 2009-2013 highlights the need to improve antenatal, delivery, postpartum and newborn care, as well as to provide quality services for birth spacing and prevention of abortion complications. The Strategic Plan for Child Health Development 2010-2014 highlights the need to improve essential newborn care and community case management of diarrhoea and pneumonia, to provide a continuum of care that includes immunisation, prevention and treatment of malaria, good hygiene practices, water and sanitation, and nutrition, and to promote improved home care of childhood illness and early and appropriate care seeking.

Among specific diseases, the leading causes of death and illness in Myanmar/Burma are TB, malaria and HIV/AIDS. The 2009-2010 TB prevalence survey found that TB prevalence was three times higher than previously thought[16]. Latest figures estimate TB prevalence at 525/100,000. A recent review of the national TB programme identified the need to strengthen case finding. Multi-drug resistant TB (MDR-TB) is also a concern, with 4,800 cases reported in 2009, but addressing this is a challenge in a country where laboratory technicians and health workers who can diagnose and manage such cases are in short supply.

Malaria is a major cause of death and illness in adults and children. Estimates of the number of cases of malaria range from 4.2 million to 8.6 million a year, and 76% of the population lives in malaria-endemic areas[17]. The emergence of artemisinin-resistant malaria on the country's eastern borders is a serious concern, which has significant global implications. A response strategy, the Myanmar Artemisinin Resistance Containment Framework, which is line with the WHO Global Plan for Artemisinin Resistance Containment, was launched in March 2011[18].

There is a concentrated HIV epidemic with prevalence of 0.60% in the adult population. Prevalence is higher among most-at-risk groups: 2009 HIV sentinel surveillance data showed prevalence at 11.2% among female sex workers, 22.3% among men who have sex with men, and 34.6% among people who inject drugs. Only 20% of those in need receive antiretroviral treatment.

Health system challenges. Health system challenges undermine the capacity of the public sector to deliver basic health care. Although there has been limited sector-wide or systems analysis, available information highlights challenges relating to health financing, planning and management, human resources for health, infrastructure and essential drugs and supplies, health information, and stewardship of the sector.

Inadequate funding for the health sector is the main underlying challenge. Public expenditure on health is very low, at less than US$1 per capita per year. Overall per capita health expenditure, including donor support, public and out-of-pocket expenditure, is less than US$8 per year. International estimates for the cost of financing an essential package of health services range from US$12 to US$34 per capita per year[19]. Out-of-pocket expenditure represents more than 80% of total health expenditure and relates to care seeking from both the public and private sectors. To address the high cost of health care to households and reduce financial barriers to accessing health care, the MOH has identified alternative financing mechanisms as a priority.

[15] MICS, 2009-2010
[16] MOH, 2010. Report on national TB prevalence survey 2009-2010
[17] M&E Reference Group. Roll Back Malaria. 2009
[18] MOH and WHO. Strategic Framework for Artemisinin Resistance Containment in Myanmar 2011-2015.
[19] The 1993 World Development Report essential package was costed at $12 per capita for low-income countries (now about $16), while the 2001 Commission on Macroeconomics and Health package was estimated at around $34 per capita. According to the 2010 World Health Report, which focused on health financing, low income countries will need to spend around US$60 per capita by 2015, considerably more than the US$32 they currently spend, in order to achieve the Health MDGs

The sector faces challenges in planning, management and organisation. A multiplicity of programmes and projects, with separate planning, management and monitoring arrangements, contributes to inefficiencies and fragmentation in service delivery. Capacity for planning, management and coordination at township level requires strengthening. Coordinated township health plans are being developed under the leadership of the MOH, with support from GAVI HSS, and there have been some efforts to provide leadership and management training.

The shortage of Basic Health Staff, in particular of midwives, combined with a high turnover of staff in rural areas, is a constraint to provision of MNCH care. Pre-service training does not provide midwives and nurses with full skills and knowledge to address all competencies for basic and emergency obstetric care, although steps are being taken to address this. In-service training is mainly provided by projects and programmes, and poorly coordinated. There is a need to increase numbers of skilled and experienced trainers. Improving the delivery and quality of services requires efforts to strengthen supervision of health workers and improve remuneration and morale. Wider issues, such as the planning, production and deployment of human resources for health and fundamental review of roles and responsibilities of Basic Health Staff, also need to be addressed. The MOH has committed to developing a medium-term strategic plan for human resources.

Construction of hospitals has taken priority over expansion of rural health facilities. The heath infrastructure is poor at Rural Health Centre and sub-centre level, and many facilities require upgrading and refurbishment. Transport is inadequate to ensure effective service delivery, supervision and monitoring, and referral for mothers and children who need emergency care. According to the UN agencies, shortages of essential drugs and supplies are one of the main barriers to provision of basic services. Analysis of national procurement and supply chain systems has been limited, but there are reported to be problems with storage and distribution of supplies, especially to facilities at township level and below. Most donor-funded programmes have established parallel procurement and distribution systems.

National health data is available, but disaggregated township data is not. Data is incomplete and of inconsistent quality, with wide variations in estimates for key health indicators. There has been no national survey of maternal and under-five mortality since 2002. The Health Management Information System (HMIS) has some weaknesses and there are gaps in data from the community level and from hard-to-reach areas. Data is reported up through the system, but there is little feedback. Analysis and use of data at township level is limited. The MOH has conducted training for some Township Medical Officers to improve capacity in this area. There are also significant gaps in knowledge. For example, research is needed on issues such as health-seeking behaviour and household expenditure on health, as well as to strengthen the evidence base for wider reform.

Stewardship of the health sector also needs strengthening. Users have little influence on decisions about or delivery of health care. Much of the growing private sector is unregulated. Greater efforts are required to improve accountability and the responsiveness of health services, as well as to build MOH capacity to provide effective oversight of non-state providers.

2.2.3 The response of donors and other actors

Bilateral and multilateral donors. Australia, Denmark, EC, Netherlands, Norway, Sweden and the UK have been the main bilateral donors to the health sector through the 3DF. The 3DF donor consortium has committed US$138 million to a 5-year programme (2007-2012) supporting a humanitarian response to HIV, TB and malaria, which is implemented through UN agencies working with public sector services and international and national NGOs. As of the end of 2010, the 3DF had awarded grants to 34 implementing partners, supporting 28 HIV projects, 10 malaria projects, 9 TB projects, and 4 integrated projects.

Australia, Norway and the UK are funding the Joint Initiative on Maternal, Neonatal and Child Health (JIMNCH, formerly the Health PONREPP). These donors have committed US$12.8 million to the JIMNCH, which represents per capita per year expenditure of US$4.54. This 3-year initiative targets 5 townships in areas affected by Cyclone Nargis, providing a package of maternal and child health services, including nutrition and immunisation, as well as responding to psychosocial needs and supporting emergency preparedness activities. Activities are based on joint assessments and coordinated township plans. The JIMNCH is implemented through international organisations, supporting service delivery in partnership with township health services.

There are few other significant bilateral donors. Japan has provided some support for TB and malaria programmes and plans to continue support for communicable disease control. Japan is also financing the construction and refurbishment of rural health facilities in the dry zone and of warehousing for drug stocks at state and region level, and provision of equipment for Rural Health Centres and sub-centres. Another project is developing the capacity of MOH trainers of Basic Health Staff, focusing on training methodology. Support is planned for a new maternal and child health project, which will include training for midwives.

In addition to supporting relief and recovery in Cyclone Nargis affected areas, the United States provides support for humanitarian programmes in the dry zone, which focus on maternal and child health as well as the establishment of village health and development funds and women's empowerment groups. Regional HIV, TB and malaria programmes also support activities in Myanmar/Burma.

Global health programmes. In 2009, Myanmar/Burma submitted a successful Round 9 proposal to the Global Fund for US$320 million over 5 years to support national programme responses to HIV, TB and malaria in more than 284 townships. Global Fund support commenced in January 2011. Activities are implemented through UN agencies and international and national NGOs working in partnership with the MOH. Apart from some support for minor refurbishment, Global Fund Round 9 does not include funding for health systems strengthening.

GAVI HSS is funding the main current initiative to strengthen the health system in Myanmar/Burma, which aims to cover 180 townships in hard-to-reach areas. The GAVI HSS budget is around US$34m for 4 years[20]. This does not cover service delivery of essential maternal, newborn and child health interventions and, with a budget of less than US$0.5 per capita per year, additional funding will be required to meet the programme's objectives.

The GAVI HSS programme aims to address key service delivery, organisational, management and human resource barriers, by strengthening coordination, planning and management and increasing the number of midwives and other health staff, in order to improve delivery of essential MCH, immunisation, nutrition and environmental health interventions. Funds are channelled to MOH through WHO, which is responsible for overall management and administration of the programme, technical assistance and recruitment of technical staff and international consultants. The programme is financing WHO and central MOH staff to support GAVI-HSS health system strengthening activities.

Township assessment and planning guidelines have been developed and WHO is supporting the MOH to conduct assessments and develop coordinated township health plans through short-term deployment of technical officers recruited from the government system. To date, 20 assessments and 1 township plan have been completed. The intention is to complete a further 40 assessments and plans in 2012, 40 in 2013 and 60 in 2014. The township assessment and planning process has

[20] 83% of the GAVI-HSS budget will be allocated to the township level (59% for recurrent costs or around US$ 0.35 per capita, based on an average of 150,000 people per township; essential drugs and supplies will represent around US$ 0.12 per capita).

some limitations: the time allocated does not allow for comprehensive assessment and planning, and the process does not include the private sector contribution or address accountability issues.

The GAVI HSS programme plans to support the MOH to develop a human resources for health strategy, identify options for improving deployment and retention of health workers in hard-to-reach areas, including a trial of a financial allowance scheme, and develop a proposal to MOH for making fully functional all posts in 90 townships. Other activities will include continuing education and implementation of a management effectiveness programme, as well as some support for M&E. The programme also plans to support construction of 1-2 sub-centres and renovation of 1-2 Rural Health Centres in each of the 180 townships. UNICEF is responsible for procurement of drugs and supplies and related technical assistance. GAVI HSS does not include support for HMIS, population-based surveys or qualitative research.

UN agencies. There are 13 UN agencies operating in Myanmar/Burma. WHO, UNICEF, UNFPA and UNAIDS support the MOH on policy development and implementation. WHO leads on malaria and TB, UNAIDS coordinates UN support on HIV, UNICEF supports maternal and child health activities and UNFPA addresses maternal and reproductive health including family planning. WHO and UNICEF are working with the MOH to address gaps in national policy and guidelines on community-based newborn care and community case management of pneumonia and diarrhoea in children.

UNICEF oversees the Women and Child Health Development programme, which includes capacity development and commodity procurement for 149 townships, and provides around 90% of vaccines for childhood immunisation. UNFPA procures and distributes reproductive health commodities to public sector facilities in 142 townships, provides training to health workers and supports community initiatives for pregnant women and people affected by HIV. WHO is supporting implementation of the National TB Programme in 325 townships[21]. Other UN agencies support projects that address maternal and child nutrition, and HIV, TB and malaria in vulnerable and hard-to-reach communities. UN agencies channel funds through the government and through international and local NGOs for service delivery.

Australia is proposing to fund a joint UN MNCH programme until the 3MDG Fund is established, to be implemented by WHO, UNICEF and UNFPA. It will include preventive interventions and case management of childhood illness, provision of reproductive health commodities, drugs, equipment and supplies for institutional and home-based delivery and preventive and curative care for children, as well as policy dialogue, capacity development and training.

2.3. Rationale for the 3 MDG Fund

2.3.1 Accelerating progress towards the health MDGs

Need for increased investment and to complement other donor programmes. The health status of women and children in Myanmar/Burma is poor. Progress towards the health-related MDGs is categorised as 'insufficient'[22] and these goals are unlikely to be achieved without a significant increase in funding for the health sector and in access to essential health services for the poorest and most vulnerable populations. The 3DF facilitated the establishment of policies, strategies and implementation procedures for addressing HIV, TB and malaria and paved the way for funding from the Global Fund. However, similar levels of funding are not currently available for MNCH. Unless the Government of Myanmar increased the budget allocation to the health sector, financing for MNCH will remain inadequate without intervention from the 3MDG Fund donors.

[21] UN. 2010. At work together: United Nations in Myanmar. Office of the UN Resident/ Humanitarian Coordinator
[22] Countdown to 2015 . Decade report 2000-2010: Taking stock of maternal, newborn and child survival. Lancet 375; pp2032-2044

There is a global consensus that strengthening health systems is critical to the achievement of the health-related MDGs and in particular to improving maternal and child health. However, current initiatives to strengthen the health system in Myanmar/Burma are limited. Most efforts are focusing on the township level, and sector-wide analysis and support has been minimal. In view of this, and donor commitment to capacity development, the 3MDG Fund will include a health systems strengthening component to address the challenges that undermine provision of basic health care and to support the longer-term sustainability of its investment in MCNH and communicable disease interventions. The 3MDG Fund will complement the MNCH programmes of other bilateral donors, UN agencies and GAVI HSS, funding for HIV, TB and malaria provided through Global Fund Round 9, and the support for health systems strengthening being provided through GAVI HSS and UN agencies.

Evidence on impact and cost-effectiveness. The package of interventions to be supported by the 3MDG Fund (see Annex 2) is consistent with the evidence base on high-impact, cost-effective MNCH interventions and with current global guidance[23]. The evidence base shows that this package can deliver results.

The technical interventions[24] and global evidence point to achieving a good balance between the demand- and supply-side policies and programming necessary to address maternal and child death and illness. This should ensure increased uptake of timely high-quality services by women and children, with trained staff able to provide delivery, emergency obstetric and newborn care and treatment of common childhood illnesses. In addition to trained staff, facilities, medicines, commodities and equipment are required. If all women had access to contraceptives and could deliver in properly equipped clinics with trained midwives, it is estimated that maternal and child deaths could be halved[25]. Providing services in the community through community health workers can impact on neonatal mortality[26] and, coupled with community-based case management of diarrhoea, pneumonia and malaria, reduce under-five mortality. Evidence from community-based trials and complementary modelling activities have overwhelmingly demonstrated that, to maximise impact, interventions should be delivered as a coordinated package or a 'continuum of care' and coverage of the interventions must be at scale.

In addition, modelling of the causes of mortality identified the interventions that would have the most impact in Myanmar/Burma. For children, community-based provision of health services will result in the greatest number of lives saved. Home-based identification and management of sepsis would contribute to a reduction of almost one-third in under-five mortality. Breastfeeding promotion and community case management of pneumonia, malaria and diarrhoea are also critical. For mothers, emergency obstetric care and treatment of postpartum bleeding are the two interventions that would save the greatest number of lives. These interventions are central to the 3MDG Fund.

Economic analysis shows that the proposed approach to Component 1 is cost-effective[27]. Provision of a package of essential health services through the public sector, together with complementary private sector delivery of targeted interventions with the potential to increase health impact for the poor, is expected to avert 28,258 deaths over 5 years, of which 3,153 would be maternal deaths (11%) and 25,150 would be under-five deaths (89%), and to avert 766,915

[23] Essential interventions, commodities and guidelines for reproductive, maternal, newborn and child health. A global review of key interventions 2011; and the Consensus on Maternal and Newborn Health 2009.
[24] Bellagio study group, 2003. Knowledge into action for child survival. Lancet 262; pp 323-327
[25] Countdown to 2015 . Decade report 2000-2010: Taking stock of maternal, newborn and child survival. Lancet 375; pp 2032-2044
[26] Cochrane Review: Community-based intervention packages for reducing maternal and neonatal morbidity and mortality and improving neonatal outcomes
[27] The costs and effects of Components 2 and 3 have not been analysed, but these will contribute to control of HIV, TB and malaria and strengthening the health system for longer-term sustainability of services and improved health outcomes

DALYs[28]. It will generate direct health benefits to the people of Myanmar/Burma that are estimated to provide a 28% return on investment. The cost per death averted is $7,216 and the cost per DALY averted is $266[29]. Against the standard for cost-effectiveness used by the Commission for Macroeconomics and Health, which is based on comparison of cost per DALY with GDP/capita, the selected option is cost-effective in that the cost per DALY is less than the GDP for Myanmar/Burma of $702[30].

These benefits are based on assumptions about increased coverage of high impact interventions over 5 years with 3MDG Fund support[31]. For most interventions, a cumulative increase in coverage over 5 years is anticipated. So, for example, in areas where the Fund is operational, skilled attendance at birth coverage will increase from 56% to 81%, appropriate treatment of childhood diarrhoea with ORS and zinc from 24% to 49% and from 5% to 30% respectively, and appropriate case management of childhood pneumonia with oral antibiotics from 18% to 43%. The cumulative increase in family planning coverage in Component 1 townships is expected to be 50% over 5 years, from 37% to 87%, and the same applies to coverage with effective treatment of malaria with anti-malarial drugs, which is expected to increase from 5% to 55%. Higher increases in coverage for family planning and malaria interventions reflect the expected contribution of the private as well as the public sector in delivering these interventions.

2.3.2 Building on lessons learned

The 3MDG Fund will build on the experience of the 3DF and the JIMNCH, and of other donor-funded programmes. The design of the 3MDG Fund is institutionally feasible, as it builds on structures, systems and procedures that have been shown to be functional and durable. Key lessons learned, based on experience of the 3DF, JIMNCH[32] and other donor programmes, including the Global Fund and GAVI-HSS, are:

- Aid can be delivered effectively, results can be achieved and vulnerable populations can be reached through increased and focused investment despite a challenging political and operating environment[33]. More timely, cost-effective and accountable funds flow mechanisms to township level are needed.

- Effective and functional governance arrangements can be established for joint donor support[34].

- The MOH is open to coordination with partners and entering into policy dialogue[35]. Support to strengthen MOH leadership and ownership is critical. MOH engagement in planning and development of the JIMNCH can provide the basis for a similar approach to the 3MDG Fund.

- Effective and functional national coordination structures, led by the MOH, that involve consultation with a wider group of stakeholders and are consistent with the principles of accountability and transparency can be established, as the CCM and TSGs have demonstrated.

[28] Based on modelled data using the Lives Saved Tool (LiST). Data was obtained in Myanmar/Burma and from secondary analyses
[29] This compares favourably with the estimated cost per DALY of a package of maternal and newborn health interventions of US$223 in 2000, based on the WHO-CHOICE model
[30] IMF, 2010
[31] Based on modelled data using the Lives Saved Tool (LiST). Data was obtained in Myanmar/Burma and from secondary analyses
[32] Merlin, Save the Children, IOM. Experience and lessons learnt from service delivery in hard to reach areas and for vulnerable groups
[33] Verulam Associates Ltd, 2009. Three Diseases Fund Myanmar. Mid-Term Evaluation June-July 2009, Final Report
[34] Verulam Associates Ltd, 2009. Three Diseases Fund Myanmar. Mid-Term Evaluation June-July 2009, Final Report
[35] Verulam Associates Ltd, 2009. Three Diseases Fund Myanmar. Mid-Term Evaluation June-July 2009, Final Report

- Some current funding and programming approaches contribute to fragmentation of the essential health package and service delivery and to gaps in services, uneven geographical coverage and weak coordination at township level[36]. More effective coordination between all implementing partners at township level is critical to avoid parallel systems and vertical interventions. Joint assessment and planning of health needs and interventions is feasible at township level, as are complementary working relationships between the public sector and the non-public sector including international and national NGOs, CBOs and the private sector.

- The focus on international NGOs had led to the establishment of parallel systems and a concentration of NGOs in some areas, with potential duplication of activity. Some international NGOs have also been unwilling to be seen working too closely with township health authorities.

- For sustainability, there is a need for capacity building of public sector institutions, systems and staff to ensure the building blocks are in place to support delivery of essential health services.

- Approaches are needed that strengthen the pivotal role of township health authorities in taking full responsibility for planning, management and coordination of services of all providers.

- Implementing partners need predictable, multi-year funding to facilitate planning and sustainable support for interventions[37].

- Approaches are needed that can both increase the stewardship and management capacity of public health authorities at all levels, and to build the capacity of civil society organisations and users of health services to hold service providers to account.

- Programme monitoring needs to be better linked to existing data collection and reporting systems and needs to be used more effectively for operational planning and reflective learning.

- Support for national surveys can improve the availability and quality of health data, which can, in turn, support more targeted health interventions.

- Involvement of the private sector in improving access to essential health care for the poor is feasible[38].

- Community participation in the planning, implementation and monitoring of programmes and services is possible. The JIMNCH experience highlights the need for mechanisms to ensure inclusiveness of all relevant actors at township level to be clear and explicit.

- Emerging evidence from the JIMNCH suggests that support for demand- and/or supply-side costs can significantly increase utilisation and referral rates.

2.3.3 Strengthening aid effectiveness

Implementation of the aid effectiveness principles set out in the Paris Declaration[39] is critical to maximise the impact of aid and to achieve the necessary changes for long-term, sustainable

[36]Verulam Associates Ltd, 2009. Three Diseases Fund Myanmar. Mid-Term Evaluation June-July 2009, Final Report
[37]Verulam Associates Ltd, 2009. Three Diseases Fund Myanmar. Mid-Term Evaluation June-July 2009, Final Report
[38]Montagu D et al, 2011. Can subsidised private TB care serve the poor? Evidence from Myanmar. Global Health Group and PSI.
[39] (i) *Ownership:* Partner countries exercise effective leadership over their development policies and strategies and co-ordinate development actions; (ii) *Alignment:* Donors base their overall support on partner countries' national development strategies and procedures; (iii) *Harmonisation:* Donors' actions are more harmonised, transparent and collectively effective; (iv) *Managing for Development Results*: Results-oriented policies and programmes are needed, and actual outcomes are regularly monitored, in order to identify corrective measures where relevant; (v) *Mutual accountability*: Donors and partners are accountable for development results

development. In the health sector, this can improve sector planning, budgeting and governance capacities and strengthen national systems. Experience suggests that, when shifting from humanitarian to development mode, coordinated policy and management processes can strengthen health systems and service delivery.

Donor collaboration through the 3DF has supported implementation of the aid effectiveness principles to the extent currently possible in Myanmar/Burma. Donor assistance has also reflected the OECD DAC principles of engagement in fragile states, which aim to build effective and responsive institutions capable of promoting sustained development[40]. The 3DF has been supported through a pooled donor fund, involving seven of the nine main donors to the health sector in Myanmar/Burma, and managed through a Donor Consortium and Fund Board.

Experience has shown that the 3DF arrangements have enhanced *health sector* coordination, policy dialogue and information sharing and increased country leadership and ownership, in particular through support for the CCM TSGs, strengthened national sector strategies and plans, and promoted wider stakeholder engagement.

3DF pooled funding and governance arrangements have also enhanced *donor* coordination, ensured harmonised support for the three diseases aligned as far as possible with national strategies and priorities, and facilitated the development of common arrangements including joint donor planning, implementation, monitoring and reporting frameworks. There has also been progress towards joint analytical work, missions and programme reviews. Harmonised donor support has avoided a multiplicity of individual programmes and projects, reducing duplication and inefficiency and maximising the impact of limited aid resources. A health sub-group of donors, under the partnership group on aid effectiveness (PGAE), also meets regularly and provides a forum for promoting coordination. Less progress has been possible in donor alignment of aid with national planning cycles, use of country systems, use of common arrangements such as sector-wide and programme-based approaches, and with respect to the principle of mutual accountability.

3MDG Fund assistance will continue to be consistent with donor requirements and policy positions with respect to Myanmar/Burma. It will build on the experience and institutional arrangements for the 3DF and maximise opportunities to catalyse stronger adherence to aid effectiveness principles. Specifically, it will:

- Strengthen country ownership through ongoing support for TSG leadership on policy dialogue and coordination and for more inclusive consultation processes and the involvement of non-state actors. Support for the development and implementation of coordinated township plans will also increase ownership at township level, as well as strengthening the coordination of aid and of public sector, civil society and private sector activities at township level.

- Strengthen harmonisation through use of joint funding arrangements and common planning, financial management, M&E and reporting procedures. The Fund will undertake joint analytical work and programme reviews. It will complement other donor funded programmes including health systems strengthening activities supported through GAVI HSS and three diseases activities supported through the Global Fund, and encourage greater coherence and coordination of UN and donor programmes, including through the CCM and TSGs.

[40] These principles are: take context as the starting point, do no harm, focus on state-responsiveness, prioritise prevention, recognise the links between political, security and development objectives, promote non-discrimination as a basis for inclusive and stable societies, align with local priorities in different ways in different contexts, agree on practical coordination mechanisms between international actors, act fast but stay engaged long enough to give success a chance, and avoid pockets of exclusion

- Strengthen alignment through ensuring interventions funded are consistent with national reproductive and child health strategies and national HIV, TB and malaria strategies and priorities. Support at township level will build on existing coordinated township plans, developed through the GAVI HSS supported assessment and planning process. This will ensure that Fund support and the activities of all partners are aligned with township plans. M&E will be aligned as closely as possible to the HMIS and use national indicators.

- Strengthen managing for results and mutual accountability through commitment to multi-year funding and aid transparency, strengthening national and township level accountability mechanisms and building capacity for more responsive, accountable health services.

3MDG donors have expressed an interest in seeing support framed in a way that is as close to 'normal development' as possible and the health systems strengthening component is designed to provide the foundations for further improvements in aid effectiveness in future. This approach is intended to pave the way, should circumstances permit, for increased sector-based support, donor-government sector dialogue, alignment with and use of national systems, and joint assessment of sector progress.

3. Detailed programme description

3.1. Objectives

The logical framework in Annex 1 sets out the expected impact, outcome and outputs of 3MDG Fund support. These are summarised below.

Goal At impact level, the 3MDG Fund is expected to result in: Improved maternal, newborn and child health and a reduction in communicable disease burden in areas supported by the 3MDG Fund.

Purpose. The expected outcome of 3MDG Fund support is: Increased access and availability of (i) essential maternal and child health services for the poorest and most vulnerable in areas supported by the 3MDG Fund and (ii) HIV, TB, and malaria interventions for populations and areas not readily covered by the Global Fund.

Results 3MDG Fund support is expected to deliver six outputs:

1) Delivery of essential services, with a focus on maternal, newborn and child health, in townships supported by the 3MDG Fund.
2) Strengthened capacity for delivery of essential MNCH services in townships supported by the 3MDG Fund.
3) Prioritised HIV, TB and malaria interventions provided to targeted populations or areas not readily covered by the Global Fund.
4) Prioritised components of the health system strengthened for long term sustainability.
5) Enhanced health services accountability and responsiveness through capacity development of target communities, civil society organisations and the public sector.
6) Fund Management demonstrates value for money and cost-effectiveness, generates evidence to inform policy, funding and programming decisions, and strengthens aid effectiveness.

The overarching goal of the 3MDG Fund is to contribute towards national progress towards the health MDGs through a rights-based approach. Progress towards the health MDGs depends on

the actions of other stakeholders including the Government of Myanmar, the Global Fund, the UN and international and national NGOs. Given this, and the targeted nature of the proposed support under the 3MDG Fund, it will not be feasible to directly attribute national progress at this level to the 3MDG Fund. However, tracking the most relevant national indicators[41] will provide a benchmark to allow comparison of performance at township level with national performance.

3.2. Overall principles and approach

There is strong donor commitment to continue to provide joint donor support to address the basic health needs of the most poor and vulnerable people in Myanmar/Burma, and expand the scope of support beyond HIV, TB and malaria to encompass maternal and child health and health systems strengthening for longer-term sustainability. Donor commitment is based on support for good governance, civil society capacity building, health, education, poverty alleviation, basic needs and livelihoods for the poorest and most vulnerable populations, and environmental protection.

The design of the 3MDG Fund is intended to promote transformational change and a rights-based approach (see Box 1 and Section 3.5). This includes support for representative accountability mechanisms that enable communities and beneficiaries to engage in the design, implementation and monitoring of health services and hold decision-makers to account (see Section 3.3), and an emphasis on non-discrimination and excluded and marginalised groups, equality of access to health services, and transparency of information.

Box 1: A human rights based approach to health

The World Health Organisation defines the right to health as "the right to the enjoyment of the highest attainable standard of physical and mental health". The right to health is codified in both the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC), the two UN international treaties ratified by Myanmar. In a human rights-based approach to development, human rights **standards** determine the desirable outcomes. The 3MDG Fund aims to contribute to the achievement of MDGs 4, 5 and 6. These goals reflect human rights standards in relation to the continuum of maternal, newborn and child health and nutrition. Human rights **principles** represent criteria for an acceptable process. In a rights-based approach, equal attention should be given to both the achievement of desirable outcomes and the quality of the process leading to these outcomes. The following most commonly used human rights principles will underpin the 3MDG Fund: non-discrimination; equality; participation; accountability; and transparency.

The 3MDG Fund will:

- Prioritise support for the public sector, focusing on building the capacity of township health authorities to deliver essential services through partnerships with other implementing partners under the auspices of coordinated township health plans.

- Target support for essential health services to poor and under-served townships and populations within those townships, and provide support to enable these populations to overcome barriers, for example, affordability and social exclusion, to accessing these services.

[41] Under-five mortality rate; neonatal mortality ratio; maternal mortality ratio; percentage of all deaths that are due to malaria (confirmed malaria diagnosis)

- Prioritise high-impact, cost-effective interventions to improve maternal, newborn and child health delivered through a continuum of care at community and primary health care levels and increase access to life-saving emergency obstetric and neonatal care.

- Support complementary private sector delivery of targeted interventions where this has the potential to increase affordability and health impact for the poorest women and children (see Annex 3 for a range of possible options for collaboration with the private sector for better health outcomes).

- Provide strategic and flexible support for HIV, TB and malaria interventions for vulnerable populations and hard-to-reach areas and to address emerging health threats, where these are not readily supported by the Global Fund.

- Prioritise capacity building that strengthens service delivery and civil society, including local NGOs and CBOs.

- Support longer-term sustainability through support for health systems strengthening that complements other initiatives.

- Strengthen mechanisms to promote accountability and the responsiveness of health services.

- Place a strong emphasis on achieving results and value for money, ensuring that funding leads to delivery of effective and accountable services, increased use of services and, ultimately better health outcomes.

- Ensure that all aspects of programming are informed by a rights-based approach.

- Ensure that all aspects of programming are informed by gender analysis and use every opportunity to promote gender equality and address gender discrimination and gender norms that undermine the rights of women.

- Put in place measures to minimise the risk of corruption, and incorporate safeguards regarding child protection and environment in line with donor requirements.

- Continue to support the aid effectiveness agenda, including through encouraging effective coordination, harmonisation and alignment of action to address MDGs 4, 5 and 6 and building in the flexibility to transition to new arrangements for contracting and funds flow should circumstances permit.

- Enhance support for building government capacity and explore options for increased use of government systems.

See Section 3.5 for more on human rights, gender, corruption, environment and child protection.

3.3. Programme components

The 3MDG Fund will support three components:

- Component 1: Increased availability and accessibility of essential services focusing on maternal, newborn and child health.
- Component 2: Flexible and strategic support for HIV, TB and malaria interventions for populations and geographical areas that are not supported by the Global Fund.

- Component 3: Health systems strengthening to support long-term sustainability.

3.3.1 Component 1

Component 1 will adopt a continuum of care approach (see Box 2) that is aligned with national strategies for reproductive and child health. This will ensure provision of a package of essential health services for maternal, newborn and child health at township level and below. As discussed in Section 2.3.1, the package consists of proven cost-effective interventions that will address the main causes of maternal, newborn and child death and illness in Myanmar/Burma. Midwives, auxiliary midwives and community health workers will play a central role. The 3MDG Fund will support the following staff to population ratios to achieve increased coverage: auxiliary midwife 1:2,000 and community health worker 1:2,000. More detailed information about the package of essential health services and how it will be delivered is in Annex 2.

This component will address supply-side barriers through provision of drugs, equipment and commodities, referral for and provision of emergency obstetric and neonatal care, and minor refurbishment of health facilities. Training in MNCH for government-employed Basic Health Staff, in particular of midwives for skilled attendance at birth, community health workers and auxiliary midwives will be a critical element of support (this is included in the budget under health systems strengthening). Training will be based on needs assessment and linked to supervision. Health staff who have not been working in the health service for some time, or who have waited significant periods of time before being appointed to their post, and community health workers who may not have received any training for several years are likely to require intensive refresher training.

Box 2: Continuum of care

Maternal health services	Child health services
• Improved access to family planning • Skilled birth attendance • Emergency obstetric and neonatal care • Prevention and management of postpartum haemorrhage • Antenatal and postpartum care • Nutrition • Safe blood supply	• Essential newborn care • Case management of diarrhoea, acute respiratory infection, malaria • Breastfeeding and complementary feeding • Immunisation • Nutrition • Malaria prevention, control and treatment • Water, latrines, hand washing

Pre-pregnancy → Pregnancy → Birth → Neonatal → Childhood

Reimbursement of travel costs will ensure that midwives, community health workers and auxiliary midwives can fulfil their roles and responsibilities and report data. Support will also be provided to enable the township health team to supervise Basic Health Staff and to enable midwives to supervise auxiliary midwives and community health workers. Particular emphasis will be given to strengthening the interface between the community level and the public health system at the RHC level through support to link midwives with auxiliary midwives and community health workers. All 3MDG Fund support will be guided by MOH policies and guidelines for service delivery, essential drug and equipment lists and health management. All implementing partners will coordinate 3MDG Fund-supported activities with those of other programmes under the auspices of a coordinated township plan.

In addition to supply-side barriers, there are also demand-side barriers to accessing health care. Component 1 will therefore also include financing schemes to reduce financial and other barriers to use of health services. A range of initiatives is currently being used or tested. Some focus on reimbursement or subsidy of patient costs, for example, of transport or treatment, while others focus on removal of fees by covering facility costs. These include piloting a maternal and child health voucher scheme, piloting of community health insurance, and township hospital or equity funds to cover payment for care for the poorest. The approach taken by the 3MDG Fund will be determined by the outcome of an upcoming review, which will map current initiatives, identify options, and agree a way forward with the MOH.

Component 1 will target 40 townships. Coverage of townships will be scaled up over the duration of the programme, from 10 in Year 1, to 20 in Year 2, and 40 in Years 3, 4 and 5, reaching an estimated total of between 4 million and 12 million people, assuming the population of a township ranges between 100,000 and 300,000. Maximal efficiency depends on fully funding a core package of services across an entire township as opposed to funding a partial package over many townships. Equity will be addressed by targeting the most under-served townships and populations within these townships.

The estimated cost of the township package ranges from US$272,300 in Year 1 to US$946,800 by Year 5. The increased cost over time reflects increased coverage of 5% per annum and commensurate increases in the budget for drugs, commodities and so on. The mean estimated annual cost per township per annum is US$605,000. This represents a per capita expenditure of between US$6.05 and US$2.01, assuming the population of a township ranges between 100,000 and 300,000. If the costs of support for delivery of the package are factored in, the per capita expenditure is between US$11.47 and US$3.82, which is still low compared with international estimates for the cost of financing an essential package of health services, which range from US$12 to US$34 per capita per year.

3.3.2 Component 2

This component will support priority gaps in the national responses for HIV, TB and malaria that are not readily funded by the Global Fund. Priority will be given to vulnerable and marginalised populations, including female sex workers, men who have sex with men, people who inject drugs and prisoners, to hard-to reach areas and to emerging health threats. The component will provide technical support for future Global Fund applications. Potential support under Component 2 will be guided by the following principles:

- Maintenance of high-priority HIV, malaria and TB interventions currently supported through the 3DF and not readily supported by Global Fund Round 9 or subsequent rounds such as work in areas or with populations that the Global Fund cannot access.

- Top-up support to Component 1 townships where HIV, malaria and TB interventions are required based on the disease epidemiology but are not readily funded by the Global Fund Round 9 or subsequent rounds.

- Interim support for high priority interventions currently supported through the 3DF, and not supported by Global Fund Round 9, and for interventions not supported by 3DF or Round 9, until the next round. Based on a gap analysis, this might include support for continued life-saving ART where an organisation can demonstrate value for money, for first-line TB drugs, for containment of MDR-TB and artemisinin resistance, and for safe blood.

- HIV, TB and malaria interventions funded under the 3MDG Fund will be consistent with national strategies and priority groups.

- Flexible funding to enable the 3MDG fund to respond to emerging health threats and emergencies that disproportionately affect the poor and marginalised.

- Complementarity with, and adding value to, Global Fund and other donor programmes.

3.3.3 Component 3

Component 3 will support complementary health systems strengthening at national, state/region and township levels, to help develop a more effective and a more responsive health system. This component aims to support the longer-term sustainability of investment in the maternal, newborn and child health services and communicable disease control components of the 3MDG Fund and to complement existing health systems strengthening initiatives.

Component 3 will encompass support for institutional development and sub-systems strengthening, improving strategic information, and strengthening stewardship, voice and accountability, in addition to significant support for MNCH training. In line with fragile states principles, the 3MDG Fund will promote voice and accountability both through the structures that are directly linked to the Fund and through support to increase the transparency and accountability of national and local structures (see Section 3.5).

Fund support for civil society will emphasise capacity development for increased transparency and accountability. It is expected that civil society will play a key role in independent monitoring and feedback. The 3MDG Fund will build on 3DF progress in developing a Beneficiary Accountability Framework (see Box 3), ensuring this is linked to existing structures and township plans.

Box 3: Objectives of the Beneficiary Accountability Framework[42]

1. Improve the way an agency engages with local communities in decisions that affect them by striving to enhance participation and to seek informed consent.
2. Share information with beneficiaries to promote and improve transparency and information provision.
3. Provide beneficiaries with channels through which concerns can be raised. This is part of the ethical commitment to listen, monitor and respond to beneficiary concerns.
4. Ensure that all staff are provided with a thorough understanding of Accountability and Quality Management Principles and Standards.

The 3MDG Fund will support health systems strengthening through policy dialogue and advocacy, long-term and short-term technical support, capacity development and training, sector and systems analysis and reviews, research studies and other activities to improve information for decision making. It is expected that the Fund's approach to health systems strengthening will be graduated, focussing in the early stages of the Fund on analysis and assessment, including identification of priorities and agreement on areas where there are best prospects for change. Based on initial consultations, the possible scope of 3MDG Fund support for health systems strengthening is outlined below. Support at state and region level will be determined once the decentralisation agenda has been further developed.

[42] See 3DF Beneficiary Accountability Framework. August 2010

Institutional and sub-systems development

- At national level this might include strengthening policy and strategy development for maternal, newborn and child health, sector financing, planning and budgeting; sector coordination; human resources for health; procurement, logistics and supply chain management; and demand-side financing.

- At regional/state level this might include strengthening capacity for planning, budgeting, and support to township health authorities.

- At township level this might include supporting township health authorities to conduct more comprehensive assessments and develop more detailed coordinated township health plans; and leadership and management training for township health teams.

Strategic information

- At national level this might include strengthening the HMIS; supporting communicable disease surveillance; improving the availability of data on maternal and child mortality; strengthening the capacity of the TSG M&E working groups; and supporting health systems and qualitative research.

- At regional/state level this might include strengthening the HMIS focusing on analysis, feedback and use of data.

- At township level this might include training for township health teams to improve analysis and use of data; and strengthening the maternal and neonatal death audit system.

Stewardship and accountability

- At national level this might include developing policy options and approaches to strengthen accountability; training to develop capacity on accountability and responsiveness issues; and improving capacity for oversight and regulation of the private sector.

- At regional/state level this might include training to develop capacity on accountability and responsiveness issues.

- At township level this might include reviewing the capacity of existing structures for accountability; training for township health teams and committees; capacity building for civil society organisations for independent monitoring of service delivery; strengthening community mechanisms for voice and accountability and ensuring that these are integrated within coordinated township plans.

3.4. Expected beneficiaries and key stakeholders

3.4.1 Beneficiaries

The main beneficiaries will be mothers and women and girls of reproductive age, newborns and children under five in townships covered under Component 1. Other members of the community are also expected to benefit from improvements in health service availability and quality. The assumption is that poor people will use public sector services if they are more accessible and of better quality, hence reducing out-of-pocket expenditure. The burden of health care costs for the poor, in particular women and children, will also be addressed by 3MDG Fund support for demand-side financing schemes. These reductions, and changes in access to health services, will need to be monitored through routine data collection, operational studies and population-based surveys.

The main beneficiaries under Component 2 will be people living with HIV and people with TB and malaria in the selected townships and who are most vulnerable or at risk. This includes people in hard-to-reach areas, and marginalised groups such as female sex workers, men who have sex with men, people who inject drugs, and prisoners. Efforts to address emerging threats under Component 2 will also have significant wider social and health benefits. Apart from the direct beneficiaries of the programme, the wider population should – in the longer term – benefit from Component 3 support to strengthen the health system.

3.4.2 Key stakeholders

MOH. The MOH will be central to planning and implementation of Component 3, and to coordination and implementation of Components 1 and 2 at central and decentralised levels through the TSGs and township health authorities respectively. MOH staff at national, possibly region/state, township and community levels will be key stakeholders. The MOH will benefit from capacity building and systems strengthening activities at all levels.

Township health authorities and health staff. Township health authorities will be key stakeholders, as they have primary responsibility for delivery and sustainability of services. Township health authorities will lead on township assessments and the development of coordinated township plans, with support from MOH and UN agencies. Township health teams, Basic Health Staff and community health workers will be the focus of training and support from other implementing partners to build capacity for planning, coordination, management, implementation and monitoring of health services. Delivery of the essential package of maternal, newborn and child health interventions will increase the workload of health workers. Training of additional community health workers should reduce the burden and reimbursement of travel costs is expected to provide an incentive for health workers, including community volunteers, to provide these interventions and report on their activities.

NGOs. International and national NGOs have considerable operational experience and will be important implementing partners in supporting public sector service delivery. The number of eligible NGO partners may be limited both by geographical reach, absorptive capacity and willingness to engage more closely with township health authorities. Local NGOs and CBOs often have greater access to hard-to-reach and underserved communities. Consequently, strategic partnerships with these organisations for service delivery are likely to be a feature of the 3MDG Fund. Local NGOs and other civil society organisations will also play an important role in efforts to strengthen accountability and in independent monitoring. Where NGOs work in remote areas with limited organisational capacity and support, this can increase fiduciary risk; this in turn means that there need to be robust systems in place for project monitoring and accountability. National and local NGOs will also benefit from capacity development, as appropriate, for service delivery, accountability and independent monitoring.

UN agencies. UN agencies have considerable operational experience in Myanmar/Burma and capacity to work at scale and across townships and to support procurement of essential drugs, equipment and commodities. The UN also has an important normative role and agencies such as WHO, UNICEF and UNFPA are well-placed to engage in policy dialogue with the MOH as well as to provide technical support for health systems strengthening and for implementation of essential MNCH services and communicable disease control activities. Given the role of these agencies in support to Global Fund and GAVI HSS implementation, there are some concerns about absorptive capacity and it will be important for the 3MDG Fund to seek strategic partnerships that capitalise on the UN's comparative advantage.

Private sector. The private sector has widespread networks in Myanmar/Burma, and the 3MDG Fund will explore opportunities to build on the experience of the 3DF in managed engagement of the private sector using not-for-profit intermediaries in order to improve the health of the poorest women and children as well as to enhance HIV, TB and malaria control efforts. The 3MDG Fund will also improve the capacity of private providers to deliver quality MNCH care and explore options for improving regulation, accreditation and quality assurance processes.

Communities. Communities will be key stakeholders, through their involvement in township assessment and planning processes, Village Health Committees, community based demand-side financing initiatives and beneficiary accountability mechanisms.

3.5. Cross-cutting issues

3.5.1 Human rights

The 3MDG Fund will ensure that the most commonly used human rights principles are applied under the next phase of support. The right to health implies that all individuals are entitled to basic health services without discrimination. Non-discrimination implies that the State adopts a national public health strategy and plan of action, on the basis of epidemiological evidence, that address the health concerns of the whole population, with particular attention to all vulnerable or marginalised groups. Health data can hide significant disparities in realisation of health rights. The principle of equality also implies that the State ensures the right of access to health facilities, goods and services on a non-discriminatory basis. Equal access to health facilities, good and services depends on availability, accessibility, acceptability and quality.

Individuals also have the right to active, free and meaningful participation in decisions that directly affect them such as the design, implementation and monitoring of health services and interventions. Participation increases ownership and helps ensure that policies and programmes are relevant and responsive to the needs of the people they are intended to benefit. Transparency means that people are able and encouraged to know about policies and programmes that affect them, including how decisions and made and who makes decisions, what is being spent and what is being achieved. The right to information is a necessary condition for people to be able to participate and to hold to account those who are responsible for decisions and for providing services, at national and local level. Transparency is also critical in the fight against corruption.

In addition, people must be able to hold decision makers to account for meeting their obligations and commitments. This requires mechanisms for review and monitoring of government performance and for reporting on government failure to meet obligations. Local decision-making bodies, for example, at township level, must also meet the commitments made by national government regarding human rights. Accountability depends on transparent information and civil society organisations with the capacity and political space to monitor individuals and institutions, measurable indicators to assess progress, and functional complaints mechanisms supported by parliamentarians and access to legal aid.

To ensure a rights-based approach, the 3MDG Fund will take the following steps:

- The programme design aims to ensure that essential services are available, accessible, acceptable and of a high quality.
- Activities at community level will inform people about their health rights, as well as supporting accountability and responsiveness measures under Component 3, including strengthening the functions and representativeness of heath committees.

- Excluded, marginalised and discriminated groups will be identified and given special attention, and data collected to monitor outcome or impact indicators will be disaggregated accordingly. Indicators related to the availability, accessibility, acceptability and quality of health care will also be included in baseline surveys and routine monitoring. This will require collecting more detailed information on exclusion and barriers to access in general, and practical identification and mapping of groups and issues at township level.
- Delivery of essential interventions through public and private health providers will expand women's reproductive health choices.
- Demand-side financing will assist people who cannot afford to pay for health care.
- The programme will support a partnership approach that recognises and strengthens the role of all partners, including CBOs, self-help groups and communities in addressing the health MDGs and in accountability processes.
- The potential to establish local complaints mechanisms to which people can report cases of discrimination in health service delivery will also be explored under Component 3.
- Implementing partners will set out clearly how they will involve beneficiaries in planning and in design, implementation and monitoring of health services and interventions, as well as supporting inclusive participation in township and community coordination mechanisms. In a number of townships the Township Medical Officer already convenes a multi-stakeholder body to coordinate partners working in the health sector, and this offers a potential model for other townships.
- Village Health Committees are important focal points for coordination of community activities. The 3MDG Fund will support efforts to ensure that these structures are representational, transparent and accountable.
- The Fund Manager will take steps to make public all official documents, including tender decisions, budgets, programme and project plans, monitoring and evaluation reports.
- The Fund will establish clear accountabilities on the part of service providers, which will be defined and monitored at township and community levels, as well as mechanisms for accountability and independent monitoring.
- Reporting on Fund's activities will provide clear and easily understandable information about governance structures, staff roles and responsibilities, implementation progress and results.

3.5.2 Gender

Gender issues are discussed elsewhere in this document (see in particular Sections 2.1 and 2.2). To promote gender equality, the 3MDG Fund will take the following steps:

- Target delivery of an essential package of health services that will primarily benefit women and girls of reproductive age and children.
- Implement demand-side financing that will increase access to services for poor people, in particular poor women and their children, and monitor the impact on service uptake by women.
- Support research that improves understanding of how gender affects health, health seeking behaviour, health care expenditure and other gender-related issues, including knowledge and attitudes of men and women concerning utilisation of health services.
- Ensure that accountability mechanisms support equal engagement of women and men and promote women's representation and voice, and monitor the participation of women.
- Ensure that Fund Manager and implementing partner staff have a good understanding of gender issues and that the Fund Manager has access to gender expertise.
- Include gender-relevant indicators in the logical framework and collect disaggregated data as appropriate.

3.5.3 Anti-corruption

In 2008, Transparency International ranked Myanmar/Burma 178 out of the 179 assessed countries[43]. The World Bank's Worldwide Governance Indicators also highlighted concerns about control of corruption. The 3MDG Fund will take steps to ensure that the risk of corruption is minimised by channelling resources through a UN or International Organisation (the Fund Manager) which has international fiduciary controls in place; conducting fiduciary risk assessment of implementing partners and monitoring fiduciary risk as part of ongoing risk management. Specific measures to reduce financial and fraud risk are:

Pre-emptive work – financial capacity assessments of implementing partners:

Selection of implementing partners is in accordance with the Fund Managers procedures but will involve calls for proposals or expressions of interest or open procurement. This includes appraisal of evidence on the organisation's experience and track record in managing funds according to international accounting standards. The Fund Manager will also conduct financial management capacity assessments to rate partners as high, medium, serious or high risk. Funding will be suspended for any implementing partners receiving a high risk rating until critical recommendations made by the Fund Manager have been implemented. The financial capacity of implementing partners will then be reassessed.

Looking for danger signals - regular monitoring of partners

Fund Management staff will conduct project monitoring visits. The project visits will include visits to field offices and discussions with project and support staff. One of the objectives of these visits will be to review whether adequate management and oversight processes are in place. Visits will also include data quality assurance. Findings from field monitoring will be documented through a standard approach and shared with the management team.

Financial audits of implementing partners

All non-UN implementing partners will audited annually by an independent international audit firm. The audit firm will be contracted by the Fund Manager. Areas of audit focus include: a) Effective, efficient and economical use of resources; b) Reliability of reporting; c) Safeguarding of assets; and d) Compliance with applicable legislation. Summaries of audit findings across all partners will be presented to the Fund Board; together with a tracking mechanism on progress on closing all audit issues. Progress against audit findings will be monitored at each Fund Board meeting.

UN partners will not be audited separately. UN organizations are governed by UN 'one audit principle' agreed at the Executive Boards.

Commodity tracking

The Three Diseases Fund conducted commodity tracking reviews to ensure that all commodities procured with 3DF grants were utilised according to the agreements and all implementing partners have functional and transparent commodity tracking systems in place. The reviews, which were conducted amongst 23 partners, were outsourced to an independent company with international experience in evaluating pharmaceutical distribution systems. A similar system of commodity tracking will be established for the 3MDG Fund.

Audits of the Fund Manager

[43] (http://www.transparency.org/policy_research/surveys_indices/cpi)

The Fund Manager will be audited regularly according to the audit procedures agreed at the governing body of the organisation.

Culture of reporting suspicions of fraud and procedures for action:

The 3MDG Fund will have procedures for reporting suspicions of fraud within the operational guidelines and grant agreements with partners.

3.5.4 Environment

Overall the environmental risks associated with the 3MDG Fund are minimal. The main area where there is a potential risk relates to increased environmental contamination associated with the production of hazardous medical waste as a result of expansion of health services into rural areas. To mitigate this, improved waste management is an integral part of proposed support to townships.

The effects of climate change pose a potential risk to health. With a large coastal population, Myanmar/Burma is vulnerable to the potential effects of climate change and natural disasters as recently demonstrated by the devastating effects of *Cyclone Nargis*. Changes in rainfall patterns will further influence the distribution of water- and vector-related infections such as diarrhoea and malaria. Shortening of the monsoon season, already being experienced, and flash floods also threaten agricultural productivity, increasing the risk of food insecurity and under-nutrition.

Reported sanitation coverage in Myanmar/Burma is reasonable, urban coverage having risen from 77% in 1995 to 86% in 2008 and rural coverage from 39% to 79% during the same period. If figures are accurate, this could help reduce the risk of cholera posed by severe weather events. Rural access to safe drinking water is reported to have risen from 47% in 1900 to 69% in 2008, but urban coverage has declined from 87% to 75%. This is a concern, given the high population density of urban areas and the vulnerability of poor urban communities to cholera epidemics. It is also unclear why, despite reported high water and sanitation coverage, rates of diarrhoea and associated deaths in children under five remain so high. Poor hygiene conditions and practices may be responsible, so efforts to improve infant and child health will include hygiene promotion. Support for provision of clean delivery kits will reduce the risk of maternal and neonatal sepsis.

3.5.5 Child protection

The Government of Myanmar is increasingly aware of the importance of child protection. The Ministries of Social Welfare and Home Affairs, the Police Force and Correctional Department, the Supreme Court and the Attorney General's Department are taking action on such issues as trafficking, juvenile justice and children without parental care. Even so, limited resources are allocated to services related to child protection. Children in Myanmar/Burma, a country that has ratified the Convention on the Rights of the Child, are both right-holders and claim-holders, with valid claims on duty-bearers. These duty-bearers include families, local communities, teachers, civil society and ultimately the State authorities at all levels. As part of a human rights-based approach, the 3MDG Fund will aim to develop the capacities of duty-bearers to meet their duties.

3.6. Timing

The duration of the 3MDG Fund will be 60 months. It is expected to commence in the second quarter of 2012. The final 3 months will be dedicated to Fund closure activities.

3.7. Budget

Table 1 summarises the indicative budget for 2012-2016. The indicative range of donor commitment to the 3MDG Fund over 5 years is between US$250 million and US$300 million. The budget assumes donor commitment at the high end of the indicative range and a 3% annual inflation rate.

The indicative allocation of the programme budget to Components 1, 2 and 3 is 74%, 15% and 11%. The figures for Components 1, 2 and 3 include an allocation of 6% for M&E and of 7% for indirect costs. The budget reflects the increase in townships covered under Component 1 from 10 in Year 1, to 20 in Year 2, to 40 in Years 3, 4 and 5. The budget also includes the costs of fund management, governance and independent evaluation, with 7% added for indirect costs related to these. Costs for independent evaluation have been spread over the 5 years, although it is likely that the main costs will be incurred in Years 3 and 5, for the mid-term and final evaluations.

Table 1: Summary indicative budget (US$)

	2012	2013	2014	2015	2016	Total
Component 1	8,625,644	20,692,794	50,388,715	58,186,697	66,019,262	203,913,112
Component 2	8,362,000	8,030,910	8,271,837	8,519,992	8,775,592	41,960,332
Component 3	2,959,470	4,453,330	7,559,066	7,734,130	7,951,599	30,657,598
Governance	155,720	160,400	140,910	144,990	149,270	751,290
Fund Manager	2,800,000	2,884,000	2,970,520	3,059,640	3,151,430	14,865,590
Independent evaluation	475,000	489,500	503,930	519,050	534,620	2,521,850
Indirect costs (7%)	240,150	247,355	253,075	260,658	268,472	1,269,710
Total	**23,617,995**	**36,958,039**	**70,088,053**	**78,425,157**	**86,850,245**	**295,939,489**

4. Management and implementation arrangements

4.1. Governance and management

Governance arrangements for the 3MDG Fund build on the experience and lessons learned from the 3DF, while also taking into account the expanded scope of the 3MDG Fund. Consideration has also been given to international best practice concerning the following principles: promote participation and accountability; “do no harm”; foster capacity building; ensure transparency and financial probity; promote a rights-based approach; and support the aid effectiveness agenda. The core structure to oversee the Fund is the Fund Board.

4.1.1 Fund Board

The principal role of the Fund Board will relate to oversight of the 3MDG Fund. Membership of the 3MDG Fund Board will include donor representatives and three independent experts recruited by the 3MDG Fund donors. The Fund Board will:

- Contract and oversee the Fund Manager.
- Support 3MDG Fund replenishments.
- Make funding decisions for the 3MDG Fund.
- Review and approve operating policies developed by the Fund Manager.
- Receive analysis of national strategies and operational plans to inform decision making.
- Dialogue with the Ministry of Health, national coordination structures including the Country Coordinating Mechanism and Technical Strategy Groups, and with other key stakeholders.

- Receive and approve annual work plan and budget, annual reports and audit reports and tracking of action points from the Fund Manager.
- Identify any additional output and result areas required.
- Ensure appropriate 'voice and accountability' within governance of the 3MDG Fund.
- Commission[44] and receive independent external evaluation reports from the Evaluation Group.
- Monitor, and where appropriate, mitigate risks.
- Official communications for the Fund.

The independent experts will complement donor experience and skills, providing technical support on maternal, newborn and child health, HIV, TB and malaria, and the political and operational context in Myanmar/Burma[45]. The independent experts will also provide inputs on issues including oversight of the Fund Manager; development of TOR for reviews, evaluations, special studies and surveys; review of narrative and financial reports submitted by the Fund Manager; development of 3DMG Fund policies and guidelines; policy dialogue; assessment of national strategies, programmes and operational plans as a basis for allocation of 3DMG Fund resources, and monitoring risk. Provision will be made for fees, retainers and costs.

4.1.2 Senior Consultation Group

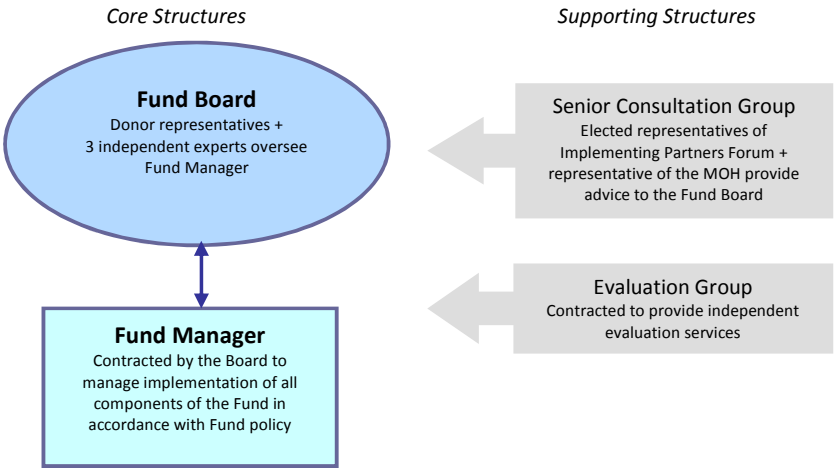
The Senior Consultation Group will provide high level inputs to the Fund Board. The Senior Consultation Group will be a formal advisory group and 'sounding board' for the Fund Board. Members will include senior representatives from the MOH and other representatives elected by the Implementing Partners Forum. The Senior Consultation Group will formally meet with the Fund Board before each regular Board meeting to review programme implementation and provide advice and recommendations to the Board. The Group will also: consult with the Implementing Partners Forum (see Section 4.1.4), MOH and other stakeholders prior to Fund Board meetings and report back to the Implementing Partners Forum following Board meetings; monitor the performance of the 3MDG Fund with respect to gender, human rights and accountability; and monitor risks and advise the Fund Board on risk mitigation. The services of the Senior Consultation Group do not need to be procured, but provision will need to be made for reimbursement of costs.

4.1.3 Evaluation Group

The Evaluation Group will be selected by, and report to, the Fund Board. The main role of the Evaluation Group is to provide independent evaluation services (see Section 4.4.4). Specifically, the Evaluation Group will establish an evaluation framework at the outset of the fund, ensure that programme M&E design, including baseline surveys, will generate required data, conduct a mid-term and a final evaluation, and conduct an impact evaluation, and other special studies as required.

Figure 1: Oversight and management of the 3MDG Fund

[44] The Fund Board will be responsible for evaluation of proposals and selection of the independent Evaluation Group
[45] National experts would be especially valued in this role



4.1.4 Coordination, policy dialogue and feedback

Components 1 and 2 of the 3MDG Fund will be implemented in line with national policies and strategies for maternal, newborn and child health and the three diseases. A steering group of key stakeholders including MOH, UN and Fund Board members will oversee the detailed planning and implementation of Component 3 of the 3MDG Fund. Component 3 will also be implemented in line with national policies and strategies for health system strengthening.

Policy dialogue and guidance, and coordination of activities supported by the 3MDG Fund, will take place under the auspices of the TSGs, and the 3MDG Fund will provide support for the effective functioning of the TSGs. The 3MDG Fund donors will also explore the scope to engage in sector-wide policy dialogue with the MOH. It is also anticipated that the MOH might play an increased role in 3MDG Fund decision making should there be further positive developments in the political context.

To further promote and support consultation, an Implementing Partners Forum will be established, which will be open to all implementing partners of the 3MDG Fund and other key stakeholders. This forum will provide a mechanism for exchange of experience and review of progress, focusing on the 3MDG Fund, and will provide feedback to the Senior Consultation Group and the Fund Board. It is not intended to replace the CCM or TSGs or other coordination bodies, which oversee national strategies for health.

In addition, feedback from beneficiaries and through accountability mechanisms will be collated by the Fund Manager and provided to the Senior Consultation Group and the Fund Board, to ensure that the voices of beneficiaries, communities and implementing partners at township level are heard by those responsible for 3MDG Fund management and oversight.

4.1.5 Fund Manager

The 3MDG Fund Manager will be responsible for effective, transparent and efficient management of the 3MDG Fund on behalf of the Fund Board, and will have delegated authority for the management of the 3MDG Fund in accordance with the policy and priorities established by the Fund Board. While the Fund Manager is expected to liaise with the MOH and national coordination structures, including the CCM and TSGs, the Fund Manager will refer any issues concerning 3MDG Fund policy, strategy and funding to the Fund Board.

The Fund Manager will be expected to ensure that there is sufficient technical expertise within its own staffing and to have access to additional technical expertise and support as required in their contractual arrangements. Core areas of expertise and responsibility will include maternal, newborn and child health, health systems, capacity development and training, engagement with partners including MOH, NGOs and the private sector, human rights, equity and gender.

In summary the Fund Manager will be responsible for:

- Implementation of the 3MDG Fund in line with the Description of Action, donor priorities, agreed policies and procedures, and best practice principles for international aid.
- Establishing effective working relationships with all stakeholders.
- Establishing transparent financial systems, managing and disbursing funds in an efficient manner and demonstrating excellent value for money.
- Drafting, under the auspices of the Fund Board, 3MDG Fund operating policies and guidelines.
- Managing service commissioning through direct and competitive grant-making procedures.
- Providing high quality technical advice, drawing upon expert resources as necessary to augment Fund Manager staff capacity, to implementing partners and the Fund Board.
- Ensuring that the agreed outputs of the 3MDG Fund are delivered, monitored and reported on in a timely and cost-effective manner.
- Providing central procurement services for implementing partners or contracting, where appropriate, independent agents to undertake procurement of commodities, and ensuring that drugs, equipment and commodities procured meet internationally recognised quality criteria.
- Ensuring that implementation is consistent with rights-based approaches and advances gender equality, including the representation of women in decision-making roles at all levels.
- Timely preparation of annual work plans and budgets, and summary of audit findings.
- Developing an overall M&E plan, including baseline studies, financial and technical monitoring of implementing partner performance, and mechanisms for lesson learning.
- Programme and financial reporting to the Fund Board, submission of financial forecasts and commissioning of external audits.
- Establishing an Implementing Partners Forum.
- Monitoring risks and implementing a risk management strategy.
- Providing sub-contracting, administrative and secretariat support to the Fund Board.
- Developing and implementing a 3MDG Fund Communications Strategy.

4.2. Implementation

4.2.1 Implementing partners

Implementing partners for the 3MDG Fund will include public sector health services, UN agencies, international organisations, international and local NGOs, CBOs, private sector providers and research institutions. The following outlines potential implementing partners for each component.

Component 1 Implementing partners will include township health authorities, international and local NGOs, UN agencies and the private sector. Township health authorities will be responsible for coordination of service delivery partners. Township health authorities receiving 3MDG Fund support will work with other 3MDG Fund partners to assess township health needs and priorities, focusing on poor and underserved populations, develop a coordinated township health plan, make relevant information and data available, coordinate the actions of health sector partners within the township to maximise allocation efficiencies, facilitate staff participation in training and work with other implementing partners within health facilities to ensure optimal support, supervision and oversight of health staff.

UN agencies and international and local NGOs will work in partnership with township health authorities to address supply-side and demand-side barriers. The 3MDG will draw on the comparative advantages of UN agencies to provide support across all townships covered by Component 1 including, for example, for township assessment and planning, and training for trainers of health workers in MNCH. Working with relevant UN agencies may present opportunities for efficiency gains based on collaborative working, the use of standardised approaches, and increased access to relevant data and information from within the UN system.

International NGOs are expected to play a key role in providing direct support for implementation of interventions, including facilitating training of Basic Health Staff and community health workers, ensuring the availability of essential drugs supplies and commodities, facilitating supervision and referral, supporting minor refurbishment of health facilities, and strengthening the capacity of local NGOs. Complementary private sector activities are expected to be supported, where these have the potential to improve coverage and health outcomes for poor women and children, through an intermediary organisation or organisations. These activities are expected to focus on childhood case management and family planning.

The 3MDG Fund will encourage consortia and collaborative working in order to ensure that townships receive a comprehensive package of support. All implementing partners will be expected to coordinate activities under the auspices of the township plan, to make full use of accountability mechanisms and to participate in joint reviews of progress, through existing structures, which include township coordination and health committees and village committees. The modalities of coordination and partnership at township level will need to be further developed during programme planning, and it is anticipated that these modalities will be reviewed and adapted to reflect lessons learned from experience of implementation.

Component 2 Implementation is likely to use a similar approach to that taken by the 3DF and implementing partners will continue to include public sector programmes working with UN agencies, international and national NGOs, CBOs, and private sector partners, in partnership with national and decentralised MOH.

For Component 2*,* there will be coordination and collaboration between implementing partners, including with township health authorities as for the 3DF. Township health authorities will ensure that these activities are coordinated with new interventions funded through other joint funding initiatives, such as the Global Fund and GAVI programmes. Where new strategic initiatives are proposed under the 3MDG Fund, the township health authority will be requested to work with other 3MDG Fund implementing partners in a similar way to that described for Component 1.

Component 3 Implementing partners will include MOH, UN agencies, international and local NGOs, international and national research institutions. The MOH, UN agencies and other technical partners will participate in joint planning of health systems strengthening support from the 3MDG Fund and other joint funding initiatives. The MOH will participate in performance management of the technical support provided, as well as relevant joint reviews and evaluations.

The range of eligible partners to support health systems strengthening will be limited to those that have the capacity and track record. UN agencies that have experience of working with national government, and specifically the MOH, are likely to be preferred implementing partners, for example, to support policy development, leadership and management capacity building, and strengthening of national systems. Synergies with existing UN agency programmes will be maximised. Non-government organisations, including international NGOs, are the most likely

implementing partners for accountability activities. The 3MDG Fund will encourage applications from consortia that include partnership with local civil society organisations.

4.2.2 Implementation steps

Implementation will be divided into two phases: the inception phase and the implementation phase. The timeframe for the inception phase will be 5 months (April-August 2012). The inception phase will include establishing the Fund Manager and key supporting structures, developing 3MDG Fund standard operating procedures and guidelines, planning and preparatory work, and consultation. The implementation phase will be from September 2012 to the end of the programme timeframe. Key initial steps to be taken for each component are summarised below.

Component 1

i. Identification of criteria for potential target townships Identification of criteria for townships eligible for 3MDG Fund support will be based on health needs, poverty levels and service coverage and will consider ranking exercises that have already been conducted by GAVI, the Global Fund, UNICEF and the MOH[46], sources such as the Integrated Household Living Conditions Assessment, and analysis of existing township data.

ii. Selection and contracting of partners to support implementation Selection of implementing partners or consortia will be undertaken by the Fund Manager using standard grant appraisal procedures to assess eligibility, capacity and experience. Implementing partners will need to demonstrate that the townships they propose to work in meet the criteria set out in Step (i). The mix of implementing partners will also be determined by strategic issues including: availability; implementation and absorptive capacity; authorisation to work in selected townships; access to selected townships and poor and under-served populations; efficiency gains from economies of scale; scope to provide capacity building to ensure longer term sustainability through local organisations; and opportunities to maximise synergies and efficiencies with other initiatives.

iii. Completion of comprehensive township assessments and coordinated health plans Township assessment and planning is expected to involve the full range of stakeholders at township level, and to follow MOH guidelines. The process will be facilitated by MOH and UN agencies, such as WHO, which is currently providing support for township assessment and planning. Should selected UN agencies be unable to facilitate operational plans in a particular area then the Fund Manager may contract an alternative Implementing Partner, such as an NGO with appropriate technical skills and capacity. More detailed assessment and planning will be supported as required, including ensuring that plans include all stakeholders including the private sector.

Where a coordinated township plan exists, the 3MDG Fund will support and build on this. Where a township has not yet developed a coordinated plan, the 3MDG Fund will provide support for assessment and planning under the leadership of the township health authorities. The coordinated plan will reflect all inputs required to deliver the package of essential health services. It is expected that in some townships, there will be some inputs from UN and other donor-funded programmes. Where this is the case, the 3MDG Fund will address gaps, based on township assessments, to ensure that the full package of services is provided. This approach takes into consideration both equity and efficiency. Maximal

[46] GAVI has selected 180 townships based on immunisation coverage; the Global Fund will cover approximately 280 townships, excluding townships in difficult to reach border areas; MOH has identified 70 townships as hard-to-reach; UNICEF has prioritised 150 townships of which 70 are the same townships defined as hard-to-reach by MOH

efficiency depends on fully funding a core package of services across an entire township as opposed to funding a partial package over many townships. Equity will be addressed by targeting the most under-served townships and populations within these townships.

iv. Baseline data collection The Fund Manager will coordinate the development of a common protocol for surveys to establish baseline data in the selected townships. This will be done in close consultation with the MOH, UN agencies and other implementing partners. Baseline data will be collected within 6 months of agreements being signed.

v. Develop work plans and budgets The implementing partners will be expected to develop a 3-year work plan and a 1-year detailed operational plan and budget, based on support to be provided to selected townships. This will include procurement requirements and baseline data collection.

Component 2

i. Finalise analysis of gaps and priorities The Fund Manager, in consultation with the Fund Board, will outline the process to address strategic gaps identified, as per the principles set out in Section 3.3.2.

ii. Selection and contracting of implementing partners The Fund Manager will review the performance of existing implementing partners. Consideration will be given to a bridging extension of existing contracts where performance is considered satisfactory and partners meet the criteria for support under Component 2, to ensure a smooth transition between the 3DF and the 3MDG Fund and avoid gaps in implementation. Apart from cases where a strong justification for continuation can be made, selection of implementing partners will be undertaken by the Fund Manager using standard calls for proposals to assess eligibility, capacity and experience.

iii. Development of a procurement plan This is a critical early step, to ensure continuity of drugs and supplies. This plan will need to be integrated into the overall procurement plan for the 3MDG fund as township plans under Component 1 are developed.

Component 3

i. Further consultation with the MOH and other key stakeholders and further analysis A steering group of key stakeholders including MOH, UN and Fund Board members will oversee the detailed planning and implementation of Component 3 of the 3MDG Fund. Priorities for specific support will be determined following further consultation and, as needed, further analysis. Further scoping will be also be conducted to identify health systems strengthening requirements at state and region level, as plans for decentralisation are finalised. Revision of indicators in the logframe will be done to reflect the choices made on support for health system strengthening, and will include qualitative indicators.

ii. Selection and contracting of implementing partners Implementing partners and specific implementation modalities for each area of activity will be determined after joint planning with the MOH and key stakeholders.

4.3. Fund operation and management

4.3.1 Donor arrangements

The terms of participation in the Fund Board will be governed by a Joint Collaboration Arrangement between donors contributing to the 3MDG Fund.

4.3.2 Contracting of implementing partners

The 3MDG Fund Manager will be a UN agency or international organisation. All contracts implementing the action will be awarded and implemented in accordance with the procedures and standard documents laid down and published by that international organisation. Financial resources can be allocated to implementing partners through direct or competitive grants.

Direct grants may be allocated to partners that meet certain criteria as established by the Fund Board, which may include demonstrated technical competence, capacity, speed of delivery, monopoly, coherence with ongoing activities, and access to specific target areas or populations.

A competitive grant allocation procedure will be used in any other case. The Fund Manager will evaluate proposals and make recommendations to the Fund Board. All expressions of interest and proposals will be assessed against standard assessment criteria relating to eligibility, capacity, experience and track record. Specific contracting arrangements for 3MDG Fund components will be in accordance with the Fund Manager rules and procedures and are likely to be as follows:

Component 1

- Selected UN agencies may be contracted through a direct grant agreement to provide technical support across townships supported by the 3MDG Fund, including for activities such as township assessment and planning, and training of trainers. In exceptional circumstances where an NGO or another organisation is required to undertake this task, the Fund Manager will need to extend the procurement procedure to a call for proposals.

- The Fund Manager will issue a call for proposals to support direct implementation of services in both the public and private sectors at township level. This may include an initial call for expressions of interest followed by submission of a full proposal or a direct call for proposals. To ensure a manageable number of contracts and achieve economies of scale, preference will be given to organisations or consortia that have the capacity to provide support to at least five townships during the timeframe of the 3MDG Fund.

Component 2

- Selected UN agencies may be contracted through a direct grant to enable them to provide technical support for specific activities related to the three diseases as appropriate.

- Other partners may also be contracted through a direct grant, where this is necessary to avoid gaps in implementation during the transition from the 3DF to the 3MDG Fund. Renewal of direct grant agreements will be subject to satisfactory performance, meeting the criteria set for this component, and demonstrated value of money by the implementing partner[47]. Procurement may also be undertaken using restricted procurement procedures and a direct grant where it is clear that there is one or only very few eligible organisations.

[47] Should performance of the existing Implementing Partner prove unsatisfactory, an alternative provider may be sought through a restricted procurement process.

- For other activities, as far as possible, selection of implementing partners will be through open competition following calls for expressions of interest, and subsequent calls for full proposals[48].

Component 3

- Selected UN agencies may be contracted through a direct grant to provide technical support for health systems strengthening to the MOH at national and sub-national levels. The Fund Manager may also support direct contracting of long-term and short-term technical assistance.

- The Fund Manager may issue a call for expressions of interest and/or invitation to submit a full proposal for organisations to implement activities to support strengthening of accountability mechanism and related capacity development for the MOH at central and decentralised levels, civil society organisations and communities.

- Research activities may also be contracted by the Fund Manager following a call for proposals or through standard procurement procedures for service contracts.

The Fund Manager will enter into contracts with individual implementing partners. The duration of the contracts for Component 1 will be for 2-3 years. Multi-year contracts will provide predictable funding to enable partners to plan implementation over a longer timeframe but will also enable the 3MDG Fund Board to consider a transition to direct contracting with township level health authorities after 2-3 years. Such a transition will depend on the political context and on assessment of public financial management systems and fiduciary risk.

The duration of contracts for Component 2 will depend on the nature of the activity. In some cases it is likely that support will be required for the entire 5 year duration of the 3MDG Fund, in others, interim support may only be required for 1 year. Similarly, with Component 3, some activities, such as long-term technical assistance or research studies, may require a contract for at least 2-3 years, while for other activities, such as specific reviews, analyses or pilot projects, the duration of contracts may be less than 1 year.

Following successful grant awards, the Fund Manager will be responsible for administering grant allocations, auditing and fund monitoring, and undertaking annual performance monitoring. Performance monitoring will involve regular visits to project sites, data quality assessments, review of narrative and financial reports and rates of expenditure, review of progress in implementing planned activities, achievement of agreed targets and milestones, and approval of a costed work plan for the following year. All contracts will be conditional on performance.

Independent evaluation

The independent Evaluation Group will be contracted through the Fund Manager under the auspices of the Fund Board. The contract will be a service-level agreement to provide evaluation services (see Section 4.4.4). The contract will be completed by June 2017.

4.3.3 Procurement and distribution

All contracts implementing the action will be awarded and implemented in accordance with the procedures and standard documents laid down and published by the international organisation selected to be the Fund Manager.

[48] As for Component 1, the Fund Manager will need to issue all calls for expressions of interest and development of full proposals in consultation with the Fund Board.

3MDG Fund resources will be used by the Fund Manager and contracted partners to finance the purchase of essential drugs, commodities and equipment; to support the costs of facilitating training and supervision, referral, minor refurbishment of health facilities, and M&E; operating, maintenance and office costs; baseline and end line surveys and other studies; and local and international technical assistance.

The Fund Manager will be responsible for fixed assets[49], drugs, medical supplies and commodities, whether the procurement is done directly through the Fund Manager or indirectly through implementing partners. Experience from the 3DF suggests that there are advantages in allowing flexibility for both central procurement and procurement by implementing partners. Procurement may also involve strategic partnerships with UN agencies and international NGOs with significant procurement experience. The procedures of the Fund Manager organisation will be applied. The Fund Manager will need to develop Standard Operating Procedures for implementing partners for local procurement. The Fund Manager will ensure that essential drugs and non-pharmaceutical medical supplies procured under the 3MDG Fund meet internationally recognised quality criteria.

It is anticipated that initiatives associated with the Global Fund Round 9 and GAVI HSS grants will lead to a general strengthening of national procurement and supply chain systems. The initiative for continued support for strengthening procurement and supply chain management of HIV-related commodities in Myanmar originally funded by the 3DF also provides an opportunity for more integrated approaches to procurement of drugs and supplies and systems strengthening.

National supply chain systems can be used by UN agencies. Efforts have been made to strengthen drug and supplies management for the three diseases. Supplies of essential drugs and commodities from central to township levels appear to be reasonably reliable, but distribution to facilities at township level is problematic. The 3MDG Fund Manager will need to work closely with implementing partners to ensure there are adequate local distribution systems in place. The emphasis will be on strengthening existing systems as far as possible, rather than establishing parallel systems. All aspects of supply systems used will be monitored by the Fund Manager.

4.3.4 Financial flows

The 3MDG donors will sign bilateral agreements with the Fund Manager, based on the agreed Description of Action. The 3MDG Fund financial flows will be in line with donor requirements. Funds will flow from the 3MDG Fund donors to the Fund Manager, with strategic direction being provided by the Fund Board. Signing of grant agreements will trigger fund flows from the 3MDG Fund Manager to contracted implementing partners, in accordance (methods and timing) with the terms and conditions of the agreement. Payments will be made in US dollars or local currency as applicable. As a co-signatory, the implementing partner will be responsible for implementing agreed activities and for managing and accounting for 3MDG funds.

Direct funding by the Fund Manager of township health authorities will be considered, with a view to enhancing their role as implementing partners and reducing transaction costs. The Fund Manager will analyse models set up by the Global Fund and GAVI-HSS and commission a fiduciary risk assessment which will make recommendations on how to take forward harmonisation of approaches and ensure fiduciary oversight.

In keeping with international good practice, a number of elements have been included in the design of the 3MDG Fund to reduce fiduciary risk. These include: provision for appropriate accounting and reporting, external scrutiny, independent monitoring and external audits; separation of roles and

[49] Non-expendable goods (vehicles, furniture, medical and non-medical equipment, IT equipment etc)

functions between the Fund Board and the Fund Manager, and the Fund Manager and implementing partners; and opportunities for ensuring accountability to beneficiaries.

4.3.5 Accounting and audit

The Fund Manager will establish the accounting and financial system to be followed by the implementing partners. Independent audits of implementing partners' annual financial statements will be submitted to the Fund Manager. Annual independent audits of the Fund Manager accounts will be in accordance with the internal and external procedures provided for in the Financial Regulations, Rules and Directives applicable to that organisation. Audit requirements for UN organisations acting as implementing partners will be as per decisions made at the governing bodies of these organisations. Should the audit report of the Board of Auditor of the organisation contain observations relevant to the contributions of the donors, such information will be made available to the donors. The Fund Manager will be expected to conduct or facilitate independent audit of procurement, drug management and supply systems if requested by the donors.

4.4. Reporting, monitoring and evaluation

4.4.1 Programme and financial reporting

Implementing partners will submit 6-monthly narrative and financial reports to the Fund Manager. These reports will document performance against targets. Corrective steps will be agreed with the Fund Manager, where performance is inadequate. Quantitative data from routine reporting will be complemented by qualitative reporting, for example, on significant change stories as well as on challenges encountered. Reports will also be shared with township medical officers. The second 6-monthly report each year will serve as an annual report, setting out progress and achievements. The Fund Manager and the implementing partners will jointly develop a format for partner reports.

The Fund Manager will submit 6-monthly narrative and financial reports, based on consolidated implementing partner reports, for approval by the Fund Board. The second 6-monthly report in each year will serve as an annual report, providing a more detailed account of progress and achievements. The format for Fund Manager reporting will be approved by the Fund Board. All stakeholders including the MOH will review progress through Fund Manager reports and the annual review process. As far as possible, reviews will be part of wider reviews of the sector or national strategies related to the MDGs, under the leadership of the MOH.

4.4.2 Programme monitoring and evaluation

The 3MDG Fund will not develop an M&E system that operates in parallel to national M&E structures and the HMIS. 3MDG Fund M&E will harmonise efforts with existing MOH structures and efforts at the same time as collecting information on specific programme activities supported through the Fund as required. Township baseline surveys will generate robust population-based data. The 3MDG Fund will also consider support for national surveys that will improve strategic information on specific health issues and support to strengthen the national HIMS, under Component 3. This three-pronged approach aims to ensure that robust data is generated and to strengthen the MOH routine monitoring system. The following provides a brief overview of the key elements of 3MDG Fund M&E:

- Strengthening MOH leadership of M&E and capacity of the MOH to use data generated to inform planning.

- Coordination with MOH-led M&E, TSG M&E working groups, and the M&E activities of other donor-funded programmes.

- Implementation of surveys in townships supported by the 3MDG Fund to collect robust population-based baseline data. Currently, baselines are based on national or state-level statistics. Lack of population-level data is a challenge to assessing the impact of the programme, and establishing population-based township-level baselines for the selected townships will be a priority activity for the Fund Manager, together with other stakeholders, during the first 6 months of implementation. This will be essential to enable progress and results to be measured at output, outcome and impact levels. These surveys will use a common survey protocol, developed in close consultation with MOH, UN agencies and other key stakeholders, across all townships and will be implemented under the auspices of the township health authorities.

- Indicators that are aligned with national strategies and international best practice, and are clearly defined. Indicators to measure effects at output/results, outcome/purpose and impact/goal levels are included in the logical framework in Annex 1. Where appropriate, indicators will be disaggregated by age and sex, in the latter case to track the extent to which the programme is advancing gender equality and equal engagement of men and women.

- A rights-based approach to M&E, founded on the principles of impartiality, independence, credibility, and usefulness. The M&E framework will measure the availability, accessibility, acceptability and quality of health services. It will also measure issues including non-discrimination, equality, participation, inclusion, transparency and accountability, through indicators in the logical framework and, where needed, through qualitative studies.

- Analysing the differential impact of the 3MDG Fund interventions on the poor and other vulnerable groups, including in-depth analysis of the best approach for reaching the hard-to-reach, poorest and most vulnerable.

- Targets based on township assessments and plans. Baselines and targets may need to be adjusted when baseline surveys have been completed.

- Support from implementing partners to strengthen routine monitoring and reporting of health and service delivery data by facility and community health workers to the township health team. Training will be provided to enhance reporting. Monitoring will be part of wider efforts to strengthen supervision and foster improvements in service delivery.

- Data quality assurance and monitoring visits and reviews in partnership with the MOH to verify data, remedy data quality issues, and verify reported progress and achievements.

- Working with the MOH, in particular at township level, on analysis and use of data to assess whether planned activities are on track, assess implementation and coverage of interventions, and modify approaches as needed.

- Building in learning through documenting and disseminating lessons, sharing of experience and review processes.

The Fund Board will provide oversight, with advice provided by the SCG and the TSG M&E working groups. It is anticipated that the Fund Manager will report on M&E to the CCM and TSG meetings to enable these structures to review 3MDG Fund results.

The Fund Manager will report on M&E to the Fund Board. Specifically, the Fund Manager will be responsible, in collaboration with partners, including the MOH, for: developing an overall M&E framework and plan; establishing methods to obtain the data required to measure progress and results; establishing robust baselines; conducting routine programme monitoring and periodic quality assurance checks; providing technical support for M&E to implementing partners; and ensuring that data is analysed and disseminated. The Fund Manager will coordinate and collaborate with the Evaluation Group to ensure that timely and substantive evaluations are undertaken for the 3MDG Fund (see Section 4.4.4).

Implementing partners for Component 1 will support the collection and reporting of data at township level by health workers and health facilities, which feeds into the HMIS through the township medical officer and into partners own M&E and reporting to the Fund Manager. Implementing partners for Components 2 and 3 will monitor and evaluate activities separately or as part of wider M&E as appropriate.

4.4.3 Programme review

Annual progress reviews will be conducted. The Fund Manager will be responsible for coordinating the review process. It is expected that the 3MDG Fund donors, implementing partners, including township health authorities and central MOH, the TSGs and other stakeholders, including beneficiaries and other donor programmes, will participate. If possible reviews will be part of wider reviews of the sector or national strategies related to the MDGS, under the leadership of the MOH.

4.4.4 Independent evaluation

The main role of the Evaluation Group is to provide independent evaluation services. Specifically, the independent Evaluation Group will:

- Establish an evaluation framework at the outset of the fund.
- Ensure that programme M&E design, including baseline surveys, will generate required data.
- Conduct a mid-term and a final evaluation.
- Conduct an impact evaluation, and other special studies as required.
- Consult the MOH with respect to evaluations, with a view to promoting mutual accountability.

The Evaluation Group will report to the Fund Board. The Evaluation Group would be precluded from any implementation role under the 3MDG Fund to avoid any conflict of interest.

4.5. Sustainability

The 3MDG Fund will provide support at central and decentralised levels of the health system and at community level, to help develop a more effective and a more responsive health system. Three broad strategies will be used to build sustainability: strengthening health systems; building the capacity of key stakeholders in the health sector; and ensuring sustained health benefits, including through institutionalising services and activities[50].

The 3MDG Fund will strengthen the health system through:

[50] Shediac-Rizkallah M, Bone L, 1998. Planning for the sustainability of community-based health programs: Conceptual frameworks and future directions for research, practice and policy. Health Education Research 13 (1): 87-108

- Institutional and sub-systems development including strengthening health sector planning, management and coordination, supporting analysis and identifying opportunities to strengthen health financing, human resources for health and specific sub-systems, for example, procurement and logistics.
- Support to enhance strategic information including improving the availability and quality of health data, strengthening the HMIS, building M&E capacity and supporting targeted research, in order to improve information for longer-term planning and implementation.
- Building capacity for oversight and accountability at national, township and community levels.

The 3MDG Fund will build capacity through:

- Support for technical assistance to national MOH.
- Support and training for township health teams in planning, coordination, monitoring and evaluation of health services and to develop leadership and management skills.
- Training of MOH trainers in maternal, newborn and child health.
- Support for international and national NGOs to deliver services at scale.
- Training for private providers to deliver quality maternal, newborn and child health services.

The 3MDG Fund will ensure sustained health benefits including through institutionalising services and activities through:

- Integration with public sector health service delivery, reinforcing and strengthening existing systems rather than creating parallel systems. 3MDG Fund support will, for example, strengthen referral systems, supervision of community health workers, and reporting of community data.
- Coordination of activities with township coordinated health plans to strengthen institutionalisation of these plans as well as to maximise efficiency gains through better coordination of investments from multiple sources.
- Implementation of a continuum of care that includes health education and other activities to promote behaviour change, for example, management of childhood illness and care seeking for maternal, newborn and child health problems that require treatment, disease prevention and promotion of immunisation and good hygiene and nutrition practices.
- Provision of supplies and commodities to support disease prevention and behaviour change, for example, insecticide treated nets.
- Training for Basic Health Staff, particularly midwives.
- Minor refurbishment of health facilities and provision of basic equipment.
- Support for implementation of agreed policy for demand-side financing to reduce financial barriers to accessing health care.

The long-term goal is to achieve institutional and financial sustainability of public sector health services and government stewardship of the wider health sector including service delivery. The phased implementation of Component 1 allows for transition to increased responsibility for township health authorities over time as capacity is strengthened, and to direct contracting and funding of township health authorities, provided that satisfactory measures are in place to manage fiduciary risk. This phased approach will enable a gradual handover and will be central to the development of an exit strategy. However, any exit strategy, and any prospect of reducing donor support for basic health services, will require a significant increase in public sector expenditure on health. Policy dialogue and other proposed activities under Component 3 aims to encourage this. However, given the level of need it is reasonable to expect that the 3MDG Fund will provide the building blocks to strengthen health systems and service delivery, but that longer-term interventions by donors and Government may also be needed to sustain these benefits.

4.6. Risks and risk management

The 3MDG Fund is high risk, but the risk is considered to be justified by the potential impact on the lives of people in Myanmar/Burma. Risks relate to the political environment, the operating context, and to programme management and implementation.

- Political risks include the unpredictable political environment, relationship between the Government of Myanmar and 3MDG Fund donor countries, domestic political priorities in donor countries, Government of Myanmar and MOH support and approval for key elements of the 3MDG Fund, and restrictions on the operation of non-state actors.
- Contextual risks include the policy environment for MNCH interventions, capacity of township health authorities and of the health system, including shortages of midwives, absorptive capacity of UN and NGO implementing partners, predictability of funding from other sources, in particular the Global Fund, and challenges of working in areas where renewed tensions and conflict are a possibility.
- Programme management and implementation risks include the timeframe for start-up and commencement of implementation, capacity and skills of the Fund Manager and implementing partners, and management and coordination at township level.

Programme management and implementation risks can be managed by the Fund Board and the Fund Manager, through early planning, development of clear TOR and effective performance monitoring, and capacity development. Contextual risks can be mitigated to some extent through policy dialogue, support for analytical work, including that related to human resources for health, engagement with the CCM and TSGs and with UN agencies, and capacity development. Political risks can also be mitigated to some extent through effective donor coordination and communication with senior management and diplomatic presence, building on the credibility of the 3DF, maintaining dialogue through the CCM and TSGs, close consultation with the MOH on identification of eligible townships and planning for health systems strengthening activities, and complementary capacity building for government and civil society on accountability and responsiveness issues.

However, to a considerable extent, contextual and political risks are outside the control of the Fund Board and the Fund Manager. Consequently, the Fund Board and the Fund Manager will need to develop a risk management strategy, to identify actions required to manage and mitigate risks and to monitor the effectiveness of these actions as well as any changes in the environment that influence risk. Key aspects of the risk management strategy will include:

- Regular review of risks and risk mitigation measures by the Fund Manager and at each Fund Board meeting.
- Scope to hold *ad hoc* Fund Board meetings should the need arise.
- Regular review of risks and risk mitigation measures by a risk management advisory group, comprising UN, donor, Fund Manager and independent representatives. Feedback from this group will be reviewed by the Fund Board. There may be options to combine risk management advisory groups to monitor risks across all donor-funded programmes for the sector and this group will also monitor and manage risks associated with the 3MDG Fund.
- Inclusion of risk management on the agenda of donor meetings with the MOH.
- Inclusion of risk management and risk advice in the responsibilities of the Fund Manager CEO.
- Inclusion of risk monitoring in the 3MDG Fund M&E plan.
- Development and implementation of a communications strategy agreed by the 3MDG Fund donors and coordinated by the Fund Manager.

4.7. Visibility

A communication and visibility plan will be developed during the inception phase of the programme, responding to the donors' requirements.

Annex 1. Logical Framework

3MDG FUND								
IMPACT	**Impact Indicator 1**		**Baseline (2010)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	

Improved maternal, newborn and child health and a reduction in communicable disease burden (HIV, TB, malaria) in areas and populations supported by the 3MDG Fund[53]	Under-five mortality rate per 1000 in Component 1 townships (disaggregated by sex)	**Planned**	71 (UNICEF)	69	65	61	57
		Achieved					
			Sources:				
			HMIS, MICS, programme progress reports, population-based programme-area surveys				
	Impact Indicator2		**Baseline (2003)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**
	Neonatal mortality rate per 1000 in Component 1 townships	**Planned**	48	45	42	39	36
		Achieved					
			Sources:				
			HMIS, MICS, programme progress reports, population-based programme-area surveys				
	Impact Indicator 3		**Baseline (2010)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**
	Maternal mortality ratio per 100,000 live births in Component 1 townships	**Planned**	240	238	236	234	232
		Achieved					
			Sources:				
			HMIS, MICS, programme progress reports, population-based programme-area surveys				
	Impact Indicator 4		**Baseline (2007)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**
	Percentage of all deaths due to malaria (per confirmed malaria diagnosis) in programme areas	**Planned**	10%	9%	8%	6%	5%
		Achieved					
			Sources:				
			HMIS, national progress reports, household surveys, verbal autopsies, implementing partner reports, population-based programme-area surveys				
	Impact Indicator 5		**Baseline (2007)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**

[53] Until townships are selected, population numbers are unknown and figures for mortality rates and targets cannot be estimated. These will be added once townships are selected and baselines are established

Contraceptive prevalence rate (number and percentage currently married women using a modern method) in Component 1 townships (by age, all women, poorest 40% of women)	**Planned**	38.4% (Department of Planning and UNFPA)	57%[54]	67%	77%	87%
	Achieved					
		Sources:				
		UN surveys, national progress reports, implementing partner reports, population-based programme-area surveys				
Impact Indicator 6		**Baseline (2011)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**
Percentage of infants age 0-6 months exclusively breastfed in Component 1 townships (by sex and poorest)	**Planned**	23.6% (MICS 2009-2010)	33%	38%	43%	48%[55]
	Achieved					
		Sources:				
		MICS, UN surveys, national progress reports, implementing partner reports, population-based programme-area surveys				
Impact Indicator 7		**Baseline (2009)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**
HIV prevalence among people who inject drugs (disaggregated by sex)	**Planned**	34.61% (2009 HIV sentinel surveillance)	25%	22%	19%	16%
	Achieved					
		Sources:				
		UNAIDS reports, sentinel surveillance, implementing partner progress reports				
Impact Indicator 8		**Baseline (2009)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**
TB mortality per 100,000 population/year (disaggregated by sex and age)	**Planned**	59 (National TB Prevalence Survey, 2009-2010)	57	55	53	50
	Achieved					
		Sources:				
		National progress reports, HMIS, implementing partner reports, population-based programme-area surveys				

[54] Reproductive Health Strategy target is 45% by 2013. MICS 2009-2010 figure is 46%
[55] Child Health Strategy Implementation Plan target is 60% by 2015; this may be too ambitious

OUTCOME	Outcome Indicator 1		Baseline (2011)	Milestone 2013	Milestone 2014	Milestone 2015	Target 2016	Assumptions
Increased access to and availability of (i) essential maternal and child health services for the poorest and most vulnerable in areas supported by the 3MDG Fund and (ii) HIV, TB, and malaria interventions for populations and areas not readily covered by the Global Fund	Percentage (and number) of births attended by skilled health personnel (doctor, nurse or midwife) in Component 1 townships (all women, poorest 40% of women)	**Planned**	56%	66%	71%	76%	81%[56]	• Sufficient numbers of midwives in post • Demand side barriers addressed by financing schemes • Cold chain functions effectively • Township health services and implementing partners are able to identify and target poorest and most vulnerable populations • Good working relationship between township health teams and other implementing partners
		Achieved						
			Sources:					
			Population-based programme-area surveys					
	Outcome Indicator 2		**Baseline (2011)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	
	Percentage (and number) of diarrhoea cases treated with ORS and zinc (by sex, age and poorest 20%)	**Planned**	ORS 24% Zinc 5%	ORS 34% Zinc 15%	ORS 39% Zinc 20%	ORS 44% Zinc 25%	ORS 49%[57] Zinc 30%	
		Achieved						
			Sources:					
			HMIS, implementing partner reports, population-based programme-area surveys					
	Outcome Indicator 3		**Baseline (2011)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	
	Percentage (and number) of children under 5 immunised with (i) DPT3 and (ii) measles (disaggregated by sex)	**Planned**	**(i)** 85%[58] **(ii)** 82%[59]	91% 88%	94% 91%	>95% 93%	>95% >95%	
		Achieved						
			Sources:					
			HMIS, implementing partner reports, population-based programme-area surveys					
	Outcome Indicator 4		**Baseline (2007)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	

[56] Broadly consistent with Reproductive Health Strategy target of 80% by 2015. figures based on List and 5% increase per annum. Baseline will need to be established for Component 1 townships
[57] List figures; assumes 5% per year increase in coverage. Child Health Development Strategy implementation plan target for ORS and zinc 40% by 2015
[58] List figures; assumes 3% per year increase in coverage. No coverage target in Child Health Strategy implementation plan
[59] List figures; assumes 3% increase per year in coverage. No coverage target in Child Health Strategy implementation plan

	Number and percentage of Component 1 townships with at least 3 facilities providing BEmONC and at least 1 facility providing CEmONC (per 200,000 population)	**Planned**	10	20	40	40	40	• Access to all sites continues • Baselines are accurate or can be adjusted • Targets are realistic
		Achieved						
			Sources:					
			HMIS, UN agency reports, implementing partner reports, surveys					
	Outcome Indicator 5		**Baseline (2009)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	
	Number and percentage of people who inject drugs receiving HIV prevention and treatment services in programmes areas (disaggregated by sex)	**Planned**	To be established during inception phase based on analysis of 3DF support					
		Achieved						
			Sources:					
			UNAIDS, HIV surveillance, implementing partner reports, surveys					
	Outcome Indicator 6		**Baseline (2011)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	
	Number and percentage of confirmed malaria cases treated in accordance with national guidelines within 24 hours of onset of symptoms in MARC high risk (Tier 1 and Tier 2) townships	**Planned**	15% (MARC Framework, April 2011)	30%	45%	60%	75%[60]	
		Achieved						
			Sources:					
			WHO and national progress reports, implementing partner reports, HMIS, population-based programme-area surveys					
INPUTS ($)	**Total**							
OUTPUT 1	**Output Indicator 1.1**		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	**Assumptions**
Delivery of essential services, with a	Percentage (and number) of pregnant women who report at least 4 ANC visits	**Planned**	64% (RH strategy)	70%	75%	80%	85%[61]	. Sufficient numbers of midwives in
		Achieved						

[60] MARC framework target is 75% by 2015
[61] Reproductive Health Strategy target is 80% by 2015

focus on maternal and child health, strengthened in target townships	in Component 1 townships	**Sources:**					post . Auxiliary midwives are incentivised and adequately supervised to conduct post-natal visits . Policy change to allow full choice of contraceptive methods to be provided . Financial barriers to uptake of ANC addressed . Effective BCC conducted by community health workers
		HMIS, MICS, implementing partner reports, population-based programme-area surveys					
	Output Indicator 1.2		**Baseline (2011)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**
	Percentage (and number) of newborns receiving at least 4 visits post-delivery (24 hours, 3, 7 and 15 days) in Component 1 townships (disaggregated by sex)	**Planned**	0%	20%	40%	60%	80%[62]
		Achieved					
		Sources:					
		HMIS, implementing partner reports, population-based programme-area surveys					
	Output Indicator 1.3		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**
	Total number of CYPs delivered through public sector services and private sector channels in Component 1 townships	**Planned**	2,000[63]	2,200	2,420	2,662	2,928
		Achieved					
		Sources:					
		HMIS, implementing partner progress reports, population-based programme-area surveys.					
	Output Indicator 1.4		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**
	Number of appropriate EmOC referrals supported in Component 1 townships	**Planned**	To be determined by baseline surveys				
		Achieved					
		Sources:					
		HMIS, implementing partner progress reports, population-based programme-area surveys.					
		Programme-area surveys, implementing partner reports, independent evaluation					
	Output Indicator 1.5		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**

[62] Child Health Development Strategy implementation plan target 80% by 2015
[63] Based on estimated coverage increase of 10% per year; baselines to be established within 6 months of start of programme implementation

	Number of HIV-positive pregnant women receiving a complete course of antiretrovirals to prevent mother-to-child transmission	**Planned**	Baseline 2,118 (2009, UNGASS report 2010), milestones and targets to be determined					
		Achieved						
		Sources:						
		Implementing partner reports, national HIV programme reports.						
	Output Indicator 1.6		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	
	Percentage (and number) of mothers/caretakers of children aged 0-59 months who washed their hands with soap at least twice the previous day (by poorest 20%)	**Planned**	25%[64]	30%	35%	40%	45%	
		Achieved						
		Sources:						
		Programme area surveys						
IMPACT WEIGHTING (%)								**RISK RATING**
25%								**Medium**
INPUTS ($)	**Total**							
OUTPUT 2	**Output Indicator 2.1**		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	**Assumptions**
Strengthened systems for delivery of	Percentage (and number) of doctors, nurses and midwives trained in MNCH	**Planned**	To be determined by review of township assessments	>80%	>85%	>90%	>95%	• Sufficient numbers of skilled and

[64] Percentages based on List and assumed increased in coverage of 10% per annum. Baselines to be established.

essential MNCH services in Component 1 townships	including delivery and emergency obstetric care in Component 1 townships	**Achieved**						experienced trainers of trainers • Effective coordination of training by Township Medical Officers and all implementing partners to avoid duplication of individuals trained • Access to all sites continues • Data available from township assessments and baselines can be collected • Effective procurement and distribution of drugs and commodities by Fund Manager, implementing partners and township health authorities
		Sources:						
		MOH and implementing partner reports						
	Output Indicator 2.2		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	
	Number of Component 1 townships with 1 trained auxiliary midwife per 2,000 population and 1 trained community health worker per 2,000 population	**Planned**	10	20	40	40	40	
		Achieved						
		Sources:						
		MOH and implementing partner reports						
	Output Indicator 2.3		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	
	Percentage (and number) of auxiliary midwives and community health workers receiving monthly supervision and monitoring visits	**Planned**	To be determined by review of township assessments and baseline surveys	30%	50%	70%	>80%	
		Achieved						
		Sources:						
		Implementing partner reports						
	Output Indicator 2.4		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	
	Stock outs for 5 selected essential MNCH drugs at RHC and sub-centre levels (defined as not available for > 1 week)	**Planned**	To be determined by review of township assessments and baseline surveys	<20%	15%	<10%	<5%	
		Achieved						
		Sources:						
		HMIS, implementing partner reports, facility and community surveys, independent evaluation						
IMPACT WEIGHTING (%)								**RISK RATING**
25%								**Medium**
INPUTS ($)	**Total**							

OUTPUT 3	**Output Indicator 3.1**		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	**Assumptions**
Prioritised HIV, TB and malaria interventions not readily covered by the Global Fund provided to targeted populations or areas	Number of (i) LLINs and (ii) net treatments distributed to prevent malaria in areas or populations not readily covered by the Global Fund	**Planned**	Baseline and targets to be determined during inception phase					• Co-funding from other donors for HIV, TB and malaria activities • Private sector provider participation • Townships coordinate inputs from Global Fund, 3MDG fund and other programmes • Access to all sites continues • Effective HIV, TB and malaria surveillance • Technical support for national programmes from WHO and UNAIDS . Efficient distribution of blood screening kits
		Achieved						
		Sources:						
		National malaria control programme and WHO reports, implementing partner reports, surveys						
	Output Indicator 3.2		**Baseline (2009)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	
	Number and percentage of new smear-positive TB patients notified to the national TB programme per year per 100,000 population (disaggregated by age and sex)	**Planned**	83% (National TB Programme)	85%	87%	89%	91%	
		Achieved						
		Sources:						
		National TB control programme and WHO reports, implementing partner reports, surveys						
	Output Indicator 3.3		**Baseline (2008)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	
	Number and percentage of adults and children with HIV in target population known to be on treatment 12 months after initiating ART	**Planned**	81% (MSF Holland, delivering 62% ARVs in 2008)	83%	85%	85%	85%	
		Achieved						
		Sources:						
		National HIV programme and UNAIDS reports, implementing partner reports, surveys						
IMPACT WEIGHTING (%)								
15%								
INPUTS ($)	**Total**							**RISK RATING**
								Medium

OUTPUT 4	Output Indicator 4.1		Baseline (2012)	Milestone 2013	Milestone 2014	Milestone 2015	Target 2016	Assumptions
Prioritised components of the health system are strengthened for greater sustainability	Number of evidenced-based policies reviewed and adopted by the MOH	**Planned**	To be established during inception phase	To be determined	To be determined	To be determined	To be determined	• UN agencies engage in effective dialogue with MOH • Appropriate policies and practices supported by the Government of Myanmar • Sufficient resources mobilised to deploy adequate numbers of skilled staff in hard-to-reach and rural areas, and effective retention measures implemented . Agreement reached on policy concerning financing schemes • MOH and implementing partners have capacity for effective
		Achieved						
		Sources:						
		FM reports, TSG meeting reports						
	Output Indicator 4.2		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	
	HRH strategy developed and implemented to increase coverage of midwives in hard-to-reach and rural townships, and to address wider HRH issues	**Planned**	Qualitative indicator	To be determined	To be determined	To be determined	To be determined	
		Achieved						
		Sources:						
		FM and programme reports						
	Output Indicator 4.3		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	
	Number of analytical studies and systems reviews completed (e.g. of sector financing, procurement and distribution systems, HMIS)	**Planned**	To be determined in consultation with MOH and other stakeholders	To be determined	To be determined	To be determined	To be determined	
		Achieved						
		Sources:						
		FM and programme reports						
	Output Indicator 4.4		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	
	Number of townships implementing schemes, in line with national policy, to address financial barriers to accessing MNCH services	**Planned**	10	20	40	40	40	
		Achieved						
		Sources:						
		MOH and implementing partner						

		reports						leadership and management training of township health teams • Central level engagement continues to be possible
	Output Indicator 4.5		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	
	Number of township health teams training in leadership and management	**Planned**	10	20	40	40	40	
		Achieved						
		Sources:						
		MOH, FM and implementing partner reports, independent evaluation						
IMPACT WEIGHTING (%)								
20%								
INPUTS ($)	**Total**							**RISK RATING**
								High
OUTPUT 5	**Output Indicator 5.1**		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	**Assumption**
Enhanced health services accountability and responsiveness through capacity development of target communities, civil society organisations and the public sector	Number of central and township MOH staff trained in accountability and responsiveness	**Planned**	To be established during inception phase	To be determined	To be determined	To be determined	To be determined	• Township Health Coordination Committees continue as an institution • Township Medical Officers allow feedback and accountability mechanisms to function • MOH is interested in accountability and responsiveness
		Achieved						
		Sources:						
		MOH and implementing partner progress reports, independent evaluation						
	Output Indicator 5.2		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	
	Percentage of beneficiaries reporting receiving services of 'good quality' or better	**Planned**	To be established during inception phase	To be determined	To be determined	To be determined	To be determined	
		Achieved						
		Sources:						
		Beneficiary and implementing partner surveys by independent civil society organisations						
	Output Indicator 5.3		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	

	Number of civil society organisations trained in accountability and responsiveness and performing independent monitoring function	**Planned**	To be established during inception phase	To be determined	To be determined	To be determined	To be determined	issues and training . Communities are interested in participating and willing to provide feedback . Civil society organisations are able to conduct independent monitoring . Township committees and communities support increased representation of women
		Achieved						
		Sources:						
		Implementing partner reports, independent evaluation						
	Output Indicator 5.4		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	
	Percentage of community members who say they have access to mechanisms to provide feedback to township health committees and the 3MDG Fund (disaggregated by gender)	**Planned**	0%	30%	45%	60%	75%	
		Achieved						
		Sources:						
		Implementing partner reports, surveys, independent civil society monitoring reports, independent evaluation						
	Output Indicator 5.5		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	
	Proportion of female representatives on (i) township health committees (ii) village health committees	**Planned**	To be determined	To be determined	To be determined	To be determined	50%	
		Achieved						
		Sources:						
		Implementing partner reports, surveys, independent civil society monitoring reports, independent evaluation						
IMPACT WEIGHTING (%)								**RISK RATING**
10%								**High**
INPUTS ($)	**Total**							
OUTPUT 6	**Output Indicator 6.1**		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	**Assumptions**

Fund Management demonstrates value for money and cost-effectiveness, generates evidence to inform policy, funding and programming decisions, and strengthens aid effectiveness	Fund Manager performance: (i) percentage of Fund Manager annual work plan milestones achieved and (ii) number of FM monitoring visits conducted as planned	**Planned**	(i) >90% (ii) To be determined	>90%	>90%	>90%	>90%	• Government enables access for implementation and monitoring • Coverage and impact are monitored • Implementing partners have capacity to effectively monitor their programmes • Fund Manager has effective M&E system in place • Fund priorities reflect international best practice and learning • Transparent and open relationship among FB, FM and IPs • Sufficient funding has been dedicated for recording and reporting
		Achieved						
		Sources:						
		FM reports, independent evaluation, Fund Board minutes						
	Output indicator 6.2		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	
	Documented examples of cost efficiency and value for money	**Planned**	To be established during first six months of implementation					
		Achieved						
		Sources:						
		FM Reports						
		Achieved						
		Sources:						
	Output Indicator 6.3		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**	
	Number of (i) operational research studies and (ii) case studies produced and disseminated	**Planned**	To be established during inception phase	To be determined	To be determined	To be determined	To be determined	
		Achieved						
		Sources:						
		FM reports, research reports, case studies, independent evaluation						

	Output Indicator 6.4		**Baseline (2012)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**
	Number of policy dialogue and technical and strategic forums where 3MDG Fund progress and results are presented and discussed	**Planned**	To be determined during inception phase	To be determined	To be determined	To be determined	To be determined
		Achieved					
		Sources:					
		FM reports, TSG reports, independent evaluation					
	Output Indicator 6.5		**Baseline (2011)**	**Milestone 2013**	**Milestone 2014**	**Milestone 2015**	**Target 2016**
	Perception of progress in strengthening aid effectiveness principles	**Planned**	Analysis for 3MDG design	To be determined	To be determined	To be determined	To be determined
		Achieved					
		Sources:					
		FB reports, FM reports, interviews, independent evaluation					
IMPACT WEIGHTING (%)							**RISK RATING**
5%							**Medium**
INPUTS ($)	**Total**						

Annex 2. Component 1: Essential MNCH Health Services Package

Continuum of care	Intervention	Who delivers the intervention				
		TMH	RHC	SC/MW	AMW	CHW
Pre-pregnancy	**Community based provision of RH services**			x	x	x
	Identification of pregnant women and women trying to conceive; distribution of FP commodities				x	
Pregnancy	**Management septic abortion**	x	x			
	Antenatal Care					
	Micronutrient supplements		x	x		
	Malaria prevention		x	x		
	Tetanus toxoid immunisation		x	x		
	Infection prevention		x			
	Postpartum haemorrhage prevention		x	x		
	De-worming		x	x		
	Under nutrition		x	x		
	Conduct of enhanced ANC; Identification and prevention of malaria in pregnancy; Identification and management of maternal under nutrition; Identification and management of pre-eclampsia			x		
	Preventative MNCH care services (BCC)					
	Identification of pregnant women through "Married Women of Reproductive Age" (MWRA) screening				x	
	Labour onset notification				x	
	Home visit at 12-16 weeks of pregnancy				x	
	Home visit at 32-34 weeks of pregnancy				x	
	Conduct of pregnant women's groups to provide ongoing forum for behaviour change communication				x	
Delivery care	**Comprehensive EMOC: *Township Hospital***					
	EmOC equipment purchase	x				
	Cold chain	x				
	Facility recurrent costs	x				
	Referral for delivery complications	x		x	x	
	Basic EMOC: *RHC and SubRHC levels only*					
	Cold chain		x			
	Minor upgrade: communication systems for referral, assurance of running water, etc		x			
	EmOC equipment purchase		x			
	Communication systems for referral		x			
	Skilled birth attendance					
	Reimbursable service delivery cost (midwives)			x		
Postpartum care	**Family planning**			x	x	x

Newborn	**Essential newborn care package, and referral sick newborn**				
	Newborn Care (NC) Visit 1: 0-48 hours post delivery			x	
	NC Visit 2: Day 3			x	
	NC Visit 3: Day 7			x	
	Reimbursement for treatment of newborn illnesses		x	x	
	Home based treatment of newborn infections		x		
	Identification and prevention of birth asphyxia, Kangaroo Mother care, Exclusive breastfeeding, and Cord care management		x	x	
Infancy and Childhood	**Community case management diarrhoea, malaria, measles, pneumonia and under nutrition**				
	Identification and management of illness		x		x
	Commodity distribution		x		x
	Referral for children <5		x		x
	BCC breastfeeding, nutrition, hand washing			x	x
	Micronutrient supplementation (sprinkles & vitamin A)				x
	Expanded programme immunisation		x		

Annex 3 – Private sector within the 3MDG Fund

Introduction

The private sector is referred to in the 3MDG Fund Description of Action, which states that the programme will be implemented directly and indirectly through Implementing Partners including UN agencies, international and local NGOs, CBOs, private sector organisations and decentralised public sector health services. It also notes that the 3MDG Fund can potentially work with private sector providers and CBOs through another organisation. It suggests that consideration be given to review of the potential role of private sector providers in the health sector, including assessment of opportunities for public private partnerships (PPP), and that opportunities to deliver MNCH interventions through PSI's national social marketing programme, which includes a network of private providers, should also be explored.

The following provides more detail on possible options on the specific role that the private sector might play, in order to improve health outcomes and, more widely, might strengthen the contribution of the private sector in Myanmar.

Rationale

- In many countries the inability of the public sector to provide adequate health services results in the private sector, including private-not-for-profit and private-for-profit providers, providing a significant percentage of these services. Myanmar is no exception. Ministry of Health and WHO reports suggest that the private sector provides 75%-80% of ambulatory care (Scoping Mission Report 2010).

- Available information indicates that the private sector in Myanmar consists of general practitioners and government doctors who practice out of hours; other health staff who set up private clinics and pharmacies; trained (non-allopathic) and untrained individuals who set up their own clinics or travel from village to village selling drugs and providing medical advice. Formal private sector providers are mostly concentrated in Yangon, Mandalay and towns and have limited involvement in public sector health programmes. However, there is limited information available about private sector providers, and their contributions are not well documented or understood. There is also limited evidence on utilisation of this care by the poor or quality of care. Experience elsewhere suggests that an unregulated private sector represents a risk to public health, where for example, poor prescribing practices result in sub-optimal or inappropriate treatment.

- A comprehensive health sector approach to addressing the MDGs involves reviewing the role of the private sector and identifying opportunities to strengthen the regulatory framework and stewardship role of the public sector and to increase impact on health outcomes through public-private partnerships.

- Preliminary analysis suggests that the 3MDG Fund could achieve 10% increases in coverage for key interventions, e.g. family planning, treatment of diarrhoea in children under five, and treatment of tuberculosis and malaria, through social franchising and social marketing approaches. This would enable the 3MDG Fund to achieve more immediate health impact alongside building public sector capacity for service delivery.

- This builds on the successful approach taken by the 3DF, which supports public-private partnerships in delivery of services and products, e.g. PSI has successfully managed

sizeable grants for social marketing initiatives related to HIV, reproductive health and malaria, based on franchising of around 1,500 private sector practitioners. These initiatives provide a precedent for managed engagement of the private sector using not-for-profit intermediaries under the 3MDG Fund.

- Other programmes in Myanmar work with private sector partners. For example, UNFPA works with PSI, MSI and the MMA to provide family planning and other services through franchised clinics and to deliver health education. WHO and the National TB Programme work with MMA and PSI to train private providers, and WHO estimates that 20% of TB cases are identified and managed through private sector partners. Partners such as PSI and MSI have achieved high township coverage and account for a significant proportion of service delivery, e.g. family planning, TB and malaria services.

Objectives

The goal of engaging with the private sector through the 3MDG Fund is to improve health outcomes. Specific objectives are:

1. To increase the coverage of high impact interventions.
2. To improve the evidence base.
3. To enhance the quality of care.
4. To strengthen policy, governance and accountability.

Implementation within the 3MDG Fund

The following summarises how these objectives link to the 3MDG Fund components.

Objective	**Component**
1. Increase coverage of high impact interventions	Component 1 & 2
2. Improve the evidence base	Components 1, 2 & 3
3. Enhance the quality of care	Components 1, 2 & 3
4. Strengthen policy, governance and accountability	Component 3

Scope of activities

The 3MDG Fund could consider support for service delivery, training, reviews and analyses, and policy and strategy development. The possible scope of activities under each component is as follows:

Component 1:

- Review of available evidence and further analysis of where people seek care and why for key MNCH services, across all providers including the private sector providers. This will involve an in-depth assessment of barriers to accessing health care.

- Delivery of MNCH services and products through social franchising, social marketing and outreach, focusing on childhood case management and family planning, particularly where these will increase coverage amongst poor populations.

    - This could include provision of an expanded range of family planning methods, ORS, water treatment, insecticide-treated nets etc.

- Training to enhance quality of care would be provided as required.
- Implementing partners would be expected to coordinate inputs, implementation and reporting with the township plan, township health authorities and other implementing partners for Component 1.

Component 2

- Continued and expanded support for private sector partners implementing activities relating to the three diseases under 3DF not covered by GF 9, e.g. MARC framework, and particularly where these will increase coverage amongst poor populations.

Component 3

- Analysis to define the private sector and improve understanding of the extent of service provision by the private sector, especially in rural areas, and to map existing private providers and public-private partnerships. This will include analysis referred to under Component 1 of where people seek care and why for key health services.

- Support for private sector engagement in national policy and strategy development, in line with Paris Declaration principles, e.g. through the MMA and MMC.

- Review of the regulatory environment for the private sector and support for enhancing the stewardship role of government in partnership with relevant associations.

- Analysis of the quality of information and medicines provided by private pharmacists, e.g. through market surveys, and support to develop a strategy to improve advice and to improve public awareness of issues such as counterfeit drugs. However, given the number of pharmacies and drug shops, careful consideration will be required of the most cost-effective way to work with them.

- Support to develop quality standards, for example, protocols for common procedures and case management, infection control checklists, and minimum requirements for clinic equipment, supplies and maintenance. Any effort to develop quality standards should be coordinated with government to ensure that the private sector standards meet MOH requirements.

<u>Immediate steps</u>

Scoping

This would comprise:

1. Analysis of where people seek care and why for key health services, across all providers including the private sector providers and an in-depth exploration of barriers to access to health care. This analysis would need to focus in particular on barriers for the poor and other vulnerable groups.
2. Review of GAVI HSS township assessments and coordinated plans to assess the extent to which private providers are included and, if necessary, further analysis of coverage of private sector providers, specifically social franchising and social marketing organisations, of and within townships selected for Component 1;
3. Assessment of operational feasibility at township level;

4. Identification of the package of interventions to be delivered by private sector partners; and
5. Analysis of costs and budget development.