# 3MDG Maternal, Newborn and Child Health Indicator Guidelines

## Version 2, January 2016

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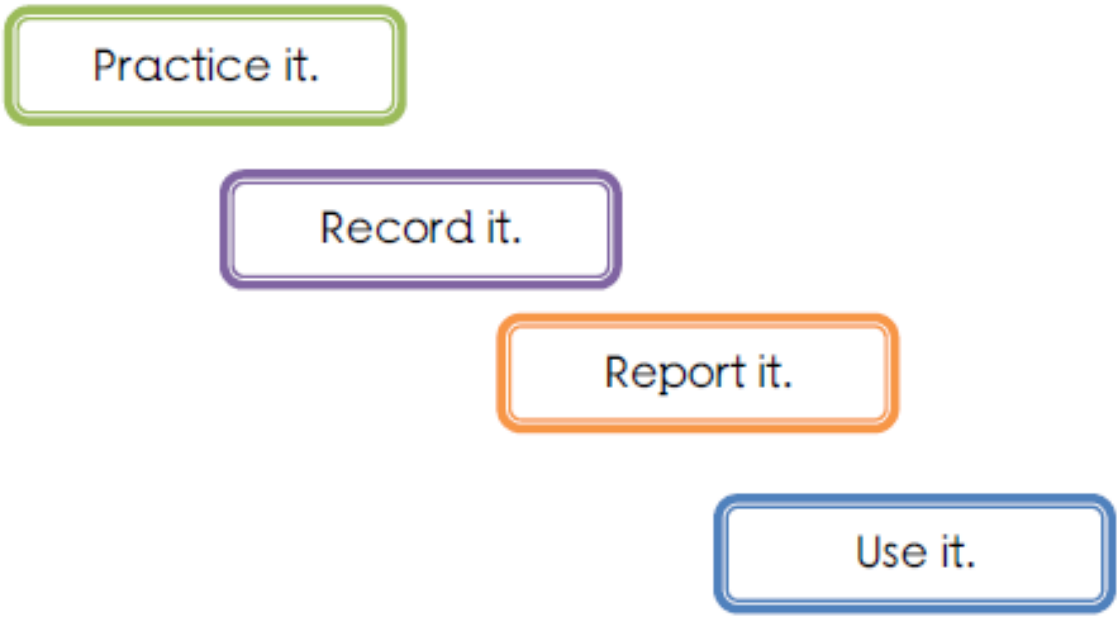



**Ref: Data Dictionary for Health Services Indicators (June, 2014)**

**HMIS, Department of Public Health, Ministry of Health**

## Contents

## Acronyms List

| | |
|---|---|
| 3MDG | Three Millennium Development Goal Fund |
| AMDD | Averting Maternal Death and Disability |
| AMW | Auxiliary Midwife |
| BEmOC | Basic Emergency Management of Obstetric Care |
| BHS | Basic Health Staff |
| CCM | Community Case Management |
| CEDAW | Convention on the Elimination of All Forms of Discrimination against Women |
| CHW | Community Health Worker |
| DHP | Department of Health Planning |
| DHS | Demographic Health Survey |
| DOH | Department of Health |
| DOPH | Department of Public Health |
| DPT | Diphtheria, Pertussis, Tetanus |
| EmOC | Emergency Obstetric Care |
| ECC | Emergency Child Care |
| FMO | Fund Management Office |
| HMIS | Health Management Information System |
| LMIS | Logistic Management Information System |
| M&E | Monitoring and Evaluation |
| MICS | Multiple indicator cluster survey |
| MNCH | Maternal, Newborn and Child Health |
| MoH | Ministry of Health |
| MMR | Maternal Mortality Ratio |
| NMR | Neonatal Mortality Rate |
| NCHS | National Centre for Health Statistics |
| NMCP | National Malaria Control Programme |
| NNC | National Nutrition Centre |
| ORT | Oral Rehydration Therapy |
| RHC | Rural Health Centre |
| Sub-RHC | Sub Rural Health Centre |
| TB | Tuberculosis |
| TT | Tetanus Toxoid Vaccine |
| U5MR | Under five Mortality Rate |
| UNICEF | United Nations Children's Fund |
| UNFPA | United Nations Population Fund |
| VRS | Volunteer Record System |
| WHO | World Health Organization |

## Introduction

The overall goal for component one maternal, newborn and child health (MNCH) of the Three Millennium Development Goal Fund (3MDG) is to improve maternal, newborn and child health in Myanmar. Within the 3MDG operational structure, the Fund Management Office (FMO) is responsible for monitoring and evaluating:

1) The overall progress of the Partner's implementation and the overall situation in Myanmar of maternal, newborn and child health

2) The results, including through gender analysis and social equity analysis, of the 3MDG against its objectives and the priorities established by the Fund Board (FB). As such, it is necessary to have a clear understanding amongst all 3MDG Partners what is being measured

3) The use of resources given to the Partners by the 3MDG.

## Purpose of the Guideline

The primary purpose of this document is to provide 3MDG stakeholders with some essential information on the MNCH core-indicators for 3MDG, which were derived from the 3MDG Logical Framework, *Data Dictionary for Health Service Indicators* (2014 June, DoPH, MoH*), A Guide for Monitoring and Evaluating Child Health Programmes* (MEASURE Evaluation, September 2005) and *Monitoring Emergency Obstetric Care* (WHO/UNICEF/UNFPA/AMDD). Partners are strongly encouraged to integrate the MNCH indicators into their ongoing monitoring and evaluation (M&E) activities.

These indicators are designed to help Partners assess the current state of their activities, their progress towards achieving their targets, and contribution towards the national response. This guideline is designed to improve the quality and consistency of data collected at the township level, which will enhance the accuracy of conclusions drawn when the data are aggregated.

## Commonly Asked Questions

**Q1: Is this guideline a substitute to the National Data Dictionary for Health Services Indicators – (published on June, 2014 of Department of Public Health (DoPH), Department of Health (DOH)?**

***NO**. This guideline is not a substitute to the National Data Dictionary (please also see at the 'purpose of the guideline' session). This document is to be used by 3MDG supported partners to improve upon their routine maternal and child health (MNCH) reporting to the Fund Manager's Office.*

**Q2: Is this guideline the Basic Health Staff Manual?**

***NO**. The Basic Health Staff will use the National Data Dictionary ONLY, which includes the complete set of all National Health Service indicators.*

**Q3: Are the indicators in the guideline aligned with Data Dictionary for Health Services Indicators?**

***YES**. Most of the health service indicators in this guideline are the same as the National Data Dictionary and the achievements will be reported via the Township Health Management Information System (HMIS). Therefore to the greatest extent possible, the indicator definitions are fully aligned with the National Data Dictionary.*

**Q4: Is this guideline dynamic over time?**

***YES.** The indicator definitions will be amended according to changes in the National Data Dictionary, global references and survey findings/programme needs.*

**Q5: Are the indicators different from the 3MDG Log Frame Indicators?**

***NO.** This guideline contains a complete set of all core-indicators which are routinely collected by 3MDG Fund Management Office. The core-indicator set is representing 3MDG Log Frame indicators as well as those indicators included in Township Log Frame template for Implementing Partners to report. Some Indicators from the National Data Dictionary used in the State and Township Health Profiles are included so that 3MDG aligns with MoH reporting.*

**Q6: Not all of the information is available for reporting to 3MDG. How missing or incomplete information should be reported?**

*3MDG will work with partners and technical agencies to support improvements in the HMIS, data quality assurance, integration of private and public sector reporting and strengthening the M&E capacity of partners. 3MDG, as a learning organisation, recognises the importance of sharing information, lessons learnt and systems strengthening. Partners are encouraged to document challenges and limitations with data in order to further improve and strengthen the health system.*

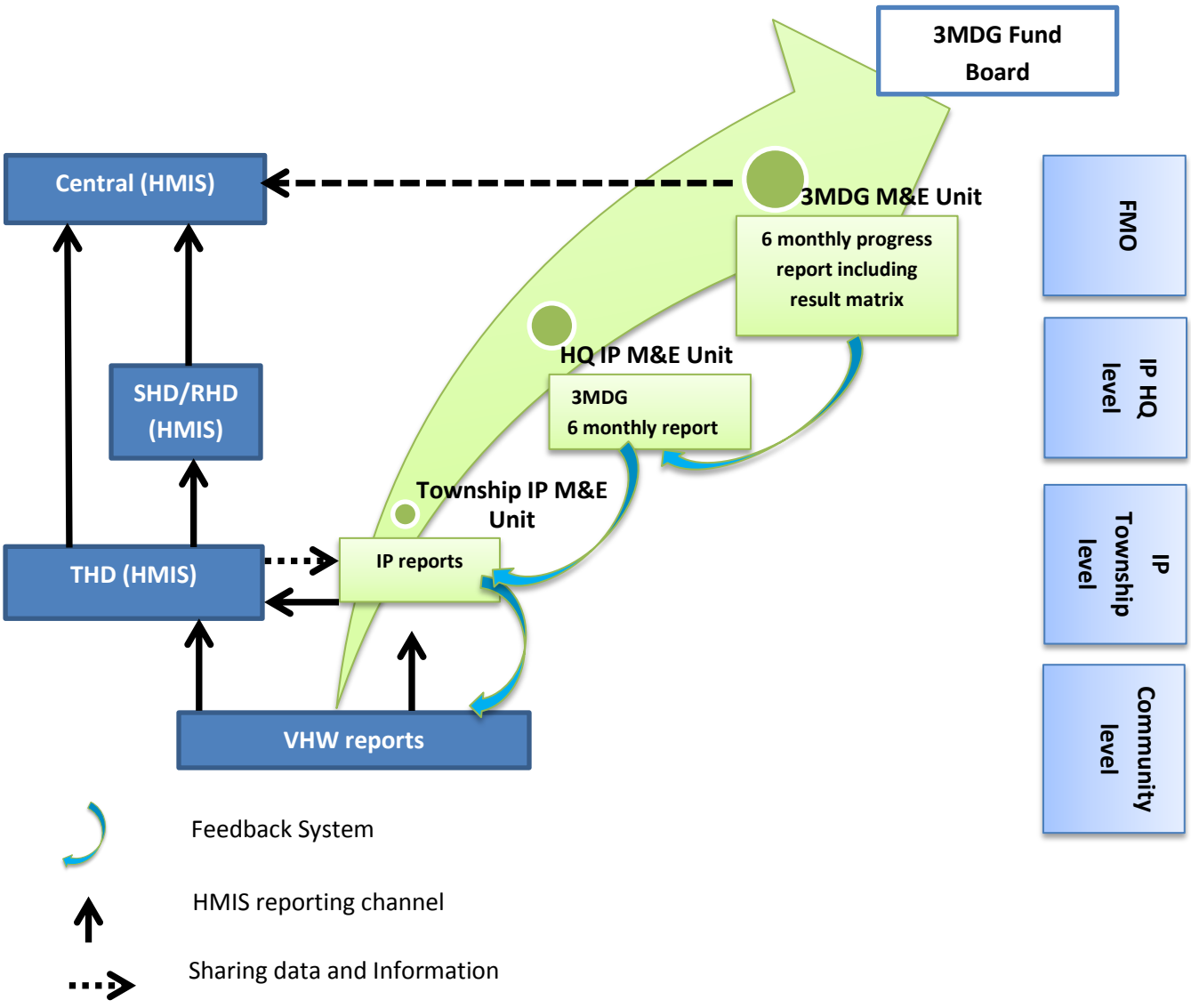
**Q8: How will the private sector measure their results?**

*In Annex 1, there is a list of additional indicators specifically for the private sector monitoring and evaluation purpose. The 3MDG private sector Implementing Partners will have to use a combination of some relevant 3MDG Core Indicators listed and these private sector indicators.*

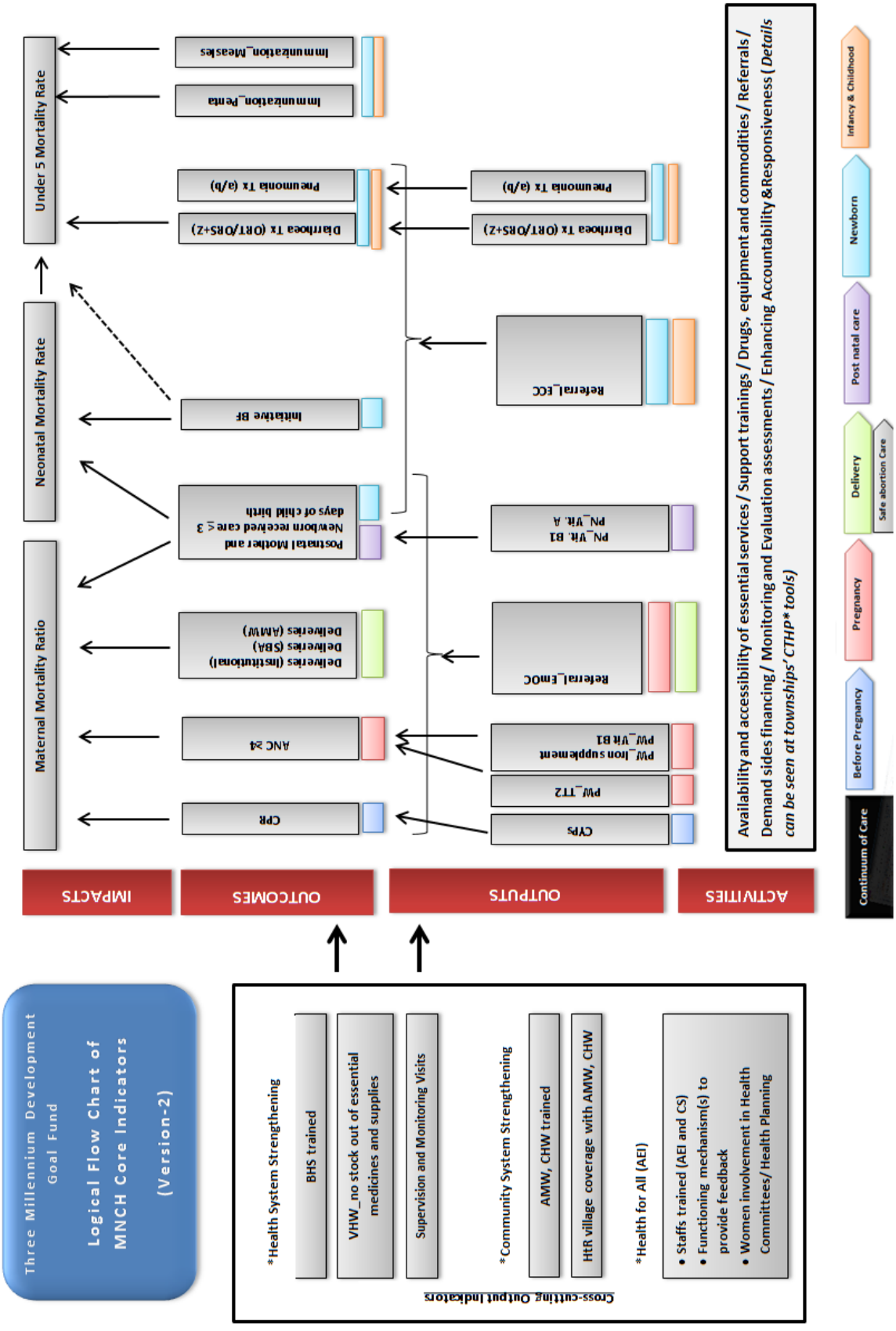
**Q9: Please explain about reporting frequency mentioned under each indicator page?**

*'Six monthly' is for the first half year reporting to 3MDG FMO which is due on August 15$^{th}$ of each year covering the period January to June. And, 'annually' report which is due on February 15$^{th}$ of the following year covering the period January to December of the reported year. For those IPs whose contracts started during the year and does not cover the whole year, they need to report from the beginning of the contract. Please note that results for outcomes indicators should be reported providing a complete data set (%, numerator and denominator).*

## Reporting flow[1] for 3MDG - Component 1_MNCH




[1] This data reporting flow will not be reflected for 3MDG Private Sector Implementing Partners.


Three Millennium Development Goal Fund
Logical Flow Chart of MNCH Core Indicators
(Version-2)
Cross-cutting Output Indicators
*Health System Strengthening
BHS trained
VHW_no stock out of essential medicines and supplies
Supervision and Monitoring Visits
*Community System Strengthening
AMW, CHW trained
HtR village coverage with AMW, CHW
*Health for All (AEI)
• Staffs trained (AEI and CS)
• Functioning mechanism(s) to provide feedback
• Women involvement in Health Committees/ Health Planning
ACTIVITIES
OUTPUTS
OUTCOMES
IMPACTS
Availability and accessibility of essential services / Support trainings / Drugs, equipment and commodities / Referrals / Demand sides financing / Monitoring and Evaluation assessments / Enhancing Accountability &Responsiveness (Details can be seen at townships' CTHP* tools)
CYPs
PW_TT2
PW_Iron supplement
PW_Vit B1
Referral_EmOC
PN_Vit. B1
PN_Vit. A
Referral_ECC
Diarrhoea Tx (ORT/ORS+Z)
Pneumonia Tx (a/b)
CPR
ANC ≥4
Deliveries (institutional)
Deliveries (SBA)
Deliveries (AMW)
Postnatal Mother and Newborn received care ≤ 3 days of child birth
Initiative BF
Diarrhoea Tx (ORT/ORS+Z)
Pneumonia Tx (a/b)
Immunization_Perta
Immunization_Measles
Maternal Mortality Ratio
Neonatal Mortality Rate
Under 5 Mortality Rate
Continuum of Care
Before Pregnancy
Pregnancy
Delivery
Safe abortion Care
Post natal care
Newborn
Infancy & Childhood

# 3MDG MNCH Core Indicators[2] List

| Impact indicators | | | |
|---|---|---|---|
| **Goal: Improved maternal, newborn and child health in areas and populations supported by the 3MDG Fund** | | **Source** | **Page** |
| 1 | Maternal Mortality Ratio per 100,000 live births | Population based survey | 16 |
| 2 | Under-five child mortality per 1,000 live births (disaggregated by sex) | Population based survey | 17 |
| 3 | Neonatal mortality rate per 1,000 live births (disaggregated by sex) | Population based survey | 18 |

| Outcome indicators | | | |
|---|---|---|---|
| **Purpose: Increased access to and availability of essential maternal and child health services for the poorest and most vulnerable in areas supported by the 3MDG Fund** | | **Source** | **Page** |
| 1.1 | Number and percentage of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife) | HMIS | 19 |
| 1.2 | Number and percentage of births attended by trained AMW | HMIS | 21 |
| 1.3 | Number and percentage of institutional deliveries | HMIS | 22 |
| 2 | Number and percentage of women attended at least four times during pregnancy by skilled health personnel for reasons related to the pregnancy | HMIS | 23 |
| 3 | Number and percentage of mothers and newborns who received postnatal care visit within three days of childbirth | HMIS | 25 |
| 4 | Number and percentage of newborns that initiate immediate breastfeeding within one hour after birth (disaggregated by sex) | HMIS | 27 |
| 5 | Contraceptive prevalence rate (HMIS) | HMIS | 28 |
| 6 | Percentage of under five children who had diarrhoea receiving ORT (disaggregated by sex and age) | Population based surveys (DHS, MICS) | 29 |
| 7 | Percentage of under five children with suspected pneumonia who received appropriate antibiotics (disaggregated by sex and age) | Population based surveys (DHS, MICS) | 30 |
| 8.1 | Number and percentage of children under one immunized with DPT3/Penta3 (disaggregated by sex) | HMIS | 31 |
| 8.2 | Number and percentage of children under one immunized with Measles (disaggregated by sex) | HMIS | 32 |

[2] This table contained a complete list of all core-indicators which are routinely collected by 3MDG Fund Management Office. This list is representing 3MDG Log Frame indicators as well as those indicators included in Township Log Frame template for Implementing Partners.

| | | | |
|---|---|---|---|
| 2.1.4 | Number and percentage of hard to reach villages with AMW | Report (THD/Partner) | 53 |
| 2.1.5 | Number and percentage of hard to reach villages with CHW | Report (THD/Partner) | 54 |
| 2.2 | Number and percentage of auxiliary midwives and community health workers receiving quarterly supervision and monitoring | Standardized VHW Supervision Checklist | 55 |
| 2.3 | Number and percentage of functioning AMWs and CHWs who report no stock-outs of essential medicines and supplies | Volunteer record | 57 |

## AEI Core Indicators (Component 1 _MNCH)

| **Outcome indicators** | | | |
|---|---|---|---|
| **Purpose: Increased access to and availability of essential maternal and child health services for the poorest and most vulnerable in areas supported by the 3MDG Fund** | | **Source** | **Page** |
| 14 | Proportion of community members reporting receiving services of 'good' quality or better. | | 60 |
| **Output 5 indicators** | | | |
| **Output 5: Enhanced health services accountability and responsiveness through capacity development of target communities, civil society organisations and the public sector** | | **Source** | **Page** |
| 5.1 | Number of staff from Ministry of Health (MoH), Implementing Partners (IPs), local Non-Governmental Organisations (NGOs) and Community-Based Organisations (CBOs) (at central, regional and township level), trained in Accountability, Equity, Inclusion and Conflict Sensitivity (AEI & CS) | IP training records | 61 |
| 5.2.1 | Numbers and percentage of community members aware of mechanism(s) to provide feedback in 3MDG-supported areas (disaggregated by sex and age) | AEI & CS Assessment Tool | 62 |
| 5.2.2 | Numbers and percentage of community members that use mechanism(s) to provide feedback in 3MDG-supported areas (disaggregated by sex and age) | AEI & CS Assessment Tool | 64 |
| 5.2.3 | Number and percentage of feedback that were addressed by the IP in the reporting period based on the IP's procedure (disaggregated by type of feedback) | IP reports and Feedback and Response Mechanism Records | 66 |
| 5.3 | Number and Percentage of implementing partners with improvement in their Accountability, Equity and Inclusion (AEI) and Conflict Sensitivity (CS) systems and practices | AEI & CS Assessment Tool | 68 |

| | | | |
|---|---|---|---|
| 5.4 | Proportion of women representatives attending the annual Comprehensive Township Health Plan (CTHP) review workshop | IP workshop records & reports | 69 |
| 5.5.1 | Proportion of women representatives on Township Health Committee | Township Health Department (THD) and IP Reports | 70 |
| 5.5.2 | Proportion of women representatives on Village Tract Health Committees/ Village Health Committees | Supervision Checklist (for VTHC and VHC) and Independent Evaluation | 71 |

## 3MDG MNCH Core Indicators (Private Sector)

| **Outcome indicators** | | | |
|---|---|---|---|
| **Purpose: Increased access to and availability of essential maternal and child health services for the poorest and most vulnerable in areas supported by the 3MDG Fund** | | **Source** | **Page** |
| P.1 | Contraceptive prevalence rate | Programme area survey including baseline and end line survey | 73 |
| P.2 | DALYs averted | Partner record | 73 |
| **Output 1 indicators** | | | |
| **Output 1: Delivery of essential services with a focus on maternal and child health, strengthened in target townships** | | **Source** | **Page** |
| P.1.1 | Total number of Couple Years of Protection (CYPs) delivered | Distribution record | 74 |
| P.1.2 | Number of clinics providing family planning and/or under five children health care services (excluding mobile services) | Partner record | 74 |
| P.1.3 | Number of outlets providing family planning products | Partner record | 75 |
| **Output 2 indicators** | | | |
| **Output 2: Strengthened systems for delivery of essential MNCH services in Component 1 townships** | | **Source** | **Page** |
| P.2.1 | Number of trained health personnel (doctor, nurse) providing family planning services | Partner record | 75 |
| P.2.2 | Number of trained field staff providing family planning services | Partner record | 76 |
| **Output 5 indicators** | | | |
| **Output 5: Enhanced health services accountability and responsiveness through capacity development of target communities, civil society organisations and the public sector** | | **Source** | **Page** |

| | | | |
|---|---|---|---|
| P.5.1 | Number of townships in which quality assurance assessments were completed during this reporting period | Partner record | 76 |
| P.5.2 | Number of clinics (excluding mobile services) in which quality assurance assessments were completed during this reporting period | Partner record | 77 |

**Note: "P" refers to private sector**

# 3MDG MNCH Core Indicators

| Impact Indicator |
|---|
| 1. **Maternal Mortality Ratio per 100,000 live births** |

| | |
|---|---|
| **Definition** | **Number of maternal deaths per 100,000 live births** |
| **Unit of measurement** | Deaths per 100,000 live births |
| **Numerator** | All maternal deaths occurring in a given period * 100,000 |
| **Denominator** | Total number of live births in the same period |
| **Data sources** | Population based surveys (Census, DHS), Lives Saved Tool (LiST) Modelling and/or UN modelling for annual data |
| **Reporting frequency** | Based on survey plan |

**What it measures:** Complications during pregnancy and childbirth are a leading cause of death and disability among women of reproductive age in developing countries. The maternal mortality ratio represents the risk associated with each pregnancy, i.e. the obstetric risk. It is also a Millennium Development Goal Indicator for monitoring Goal 5, improving maternal health. The indicator monitors deaths related to pregnancy and childbirth. It reflects the capacity of the health systems to provide effective health care in preventing and addressing the complications occurring during pregnancy and childbirth (WHO Indicator and Measurement Registry 2011).

**Note:**

- ***"*Maternal death"** is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy. Death can stem from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. Maternal deaths fall into two groups, direct and indirect, as follows:

- **"Direct obstetric deaths"** result from obstetric complications of the pregnant state (pregnancy, labour, and puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.

- **"Indirect obstetric deaths"** result from previous existing disease or disease that developed during pregnancy and which was not due to direct obstetric causes, but was aggravated by physiologic effects of pregnancy. (MEASURE Evaluation)

- **Limitation:** Impact indicator reporting is based on national figures (not township level data). Data reference will be from the national level population based surveys (Census, DHS etc,.) or LiST modelling and/or Maternal Mortality Estimation Inter-Agency Group (MMEIG) trends.

| Impact Indicator |
|---|
| **2. Under-five child mortality per 1,000 live births (disaggregated by sex)** |

| | |
|---|---|
| **Definition** | **Number of deaths to children aged 0-4 years in a given period per 1,000 live births in the same period** |
| **Unit of measurement** | Deaths per 1,000 live births |
| **Numerator** | Number of deaths of children aged 0-4 years in a given period * 1,000 |
| **Denominator** | Total number of live births in the same period |
| **Data sources** | Population based surveys (Census, DHS) LiST Modelling and/or UN modelling for annual data |
| **Reporting frequency** | Based on survey plan |

**What it measures:** This indicator measures the risk of dying in infancy and early childhood. It also reflects the social, economic, and environmental conditions in which children (and others in society) live, including their health care. The indicator may be used, therefore, as a measure of children's wellbeing and the level of effort being made to maintain child health.

**Note:**

- A **"live birth"** is described by the United Nations (2001) as "the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered liveborn". HMIS Data Dictionary defines **"live births"** as babies that were born after 22 weeks of pregnancy and shows breathing, heartbeat, movement, and pulse in the placenta immediately after birth (Data Dictionary, 2014 June).

- **Limitation:** Impact indicator reporting is based on national figures (not township level data). Data reference will be from the national level population based survey (Census, DHS etc.) , LiST modelling and/or UN Inter-agency Group for Child Mortality Estimation trends.

| Impact Indicator |
|---|
| **3. Neonatal mortality rate per 1,000 live births (disaggregated by sex)** |

| | |
|---|---|
| **Definition** | **Number of neonatal deaths per 1,000 live births in a given period** |
| **Unit of measurement** | Deaths per 1,000 live births |
| **Numerator** | Number of deaths within the first 28 completed days of life (0-27 days) in a given period * 1,000 |
| **Denominator** | Total number of live births in the same period |
| **Data sources** | Population based survey (DHS), LiST Modelling and/or UN modelling for annual data |
| **Reporting frequency** | Based on survey plan |

**What it measures:** Mortality during the neonatal period accounts for a large proportion of child deaths, and is considered to be a useful indicator of maternal and newborn neonatal health and care. Generally, the proportion of neonatal deaths among child deaths under the age of five is expected to increase as countries continue to witness a decline in child mortality. (Indicator Compendium; Internationale Zusammenarbeit (GIZ) GmbH, 2012)

**Note:**

- **"Neonatal death"** is defined as a death within the first 28 completed days of life (0-27 days). Neonatal deaths (deaths among live births during the first 28 completed days of life) may be subdivided into early neonatal deaths, occurring during the first 7 days of life, and late neonatal deaths, occurring after the 7th day but before the 28th completed day of life. (MEASURE Evaluation)

- **"live birth"** is described by the United Nations (2001) as "the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered liveborn". HMIS Data Dictionary defines **"live births"** as babies that were born after 22 weeks of pregnancy and shows breathing, heartbeat, movement, and pulse in the placenta immediately after birth (Data Dictionary, 2014 June).

- **The day of birth** is counted as day 0, so that "within the first 7 completed days" or "within 1 week" includes babies 0-6 days old (MEASURE evaluation).
- **Limitation:** Impact indicator reporting is based on national figures (not township level data). Data reference will be from the national level population based survey (DHS), LiST modelling and/or UN Inter-agency Group for Child Mortality Estimation trends.

## Outcome indicators

| Outcome Indicator |
|---|
| **1.1 Number and percentage of births attended by skilled health personnel (doctor, nurse, lady health visitor or midwife)** |

| | |
|---|---|
| **Definition** | **The total number and percentage of mothers who gave birth either at *home or at hospitals/clinics/delivery rooms (public and private)* with skilled health personnel trained in providing lifesaving obstetric care, including giving the necessary supervision, care and advice to women during pregnancy, childbirth and the post-partum period; to conduct deliveries on their own; and to care for newborns. Still births, but not abortions are included.**<br>**"Skilled health personnel" are defined as health professionals trained in midwifery skills including doctor, nurse, lady health visitor and midwives.** |
| **Numerator** | The total number of home deliveries and deliveries at public hospitals/clinics/delivery rooms and private hospitals/clinics/delivery rooms by skilled attendants during this reporting period<br><br>*[Form 1B (10.6) Number of live births delivered by skilled health personnel + Form 1B (10.7) Number of stillbirths delivered by skilled health personnel]* |
| **Denominator** | Total number of births in the same period<br>*[Form 3B (2.1) Number of live births + Form 3B (2.2) Number of stillbirths]* |
| **Data sources** | HMIS |
| **Reporting frequency** | Six monthly and annually (both number and percentage together with denominator figure) |

**What it measures:** This indicator measures the extent of women's use of delivery care services. All women should have access to skilled care during pregnancy and childbirth to ensure prevention, detection and management of complications. Assistance by properly trained health personnel with adequate equipment is a key to lowering maternal deaths. As it is difficult to accurately measure maternal mortality, and model-based estimates of the maternal mortality ratio cannot be used for monitoring short-term trends, the proportion of births attended by skilled health personnel is used as a proxy indicator for this purpose. This is an MDG indicator. (World Health Statistics, 2013, WHO)

**Note:**

- Number of live births or stillbirths delivered by skilled health personnel includes the total number of deliveries by BHS at hospitals, deliveries rooms (including public and private), at clinics and at homes.

- Although information/data related to deliveries by private hospitals/ clinics/ delivery rooms is included in the HMIS, actual data collection varies among townships. For some townships, only annual data is possible with some challenges in data accuracy. *Therefore, the Township Health Departments are encouraged to collect private sector related deliveries data every six months. Partner organisations, including the private sector, should assist by reporting this information to the Township Health Departments.*

- HMIS primary denominator source is Annual Form 3.B 2.1 and 2.2. But, for the first six month reporting, Livebirths and Stillbirths can also be taken from Monthly Form 1.B 10.1 and 10.2 (Ref: HMIS Data Dictionary Chapter-3 ,Page-120)

| Outcome Indicator |
| --- |
| **1.2 Number and percentage of births attended by trained AMW** |

| | |
| --- | --- |
| **Definition** | **The total number and percentage of mothers who gave birth at home with the assistance of an Auxiliary Midwife (AMW) trained in providing necessary care and advice to women during pregnancy, childbirth and the post-partum period.** |
| **Numerator** | The number of deliveries made by the AMWs themselves without help from midwives or LHV, during this reporting period<br>*[Form 1B (2.11)]* |
| **Denominator** | Total number of births in the same period<br>*[Form 3B (2.1) Number of live births + form 3B (2.2) Number of stillbirths]* |
| **Data sources** | HMIS |
| **Reporting frequency** | Six monthly and annually (both number and percentage together with denominator figure) |

**What it measures:** In rural Myanmar, there is still an unmet demand for increased access to health facilities across the population. In order to fill the gap, community based AMW have been selected and trained to serve to the community. This indicator measures the coverage of births attended by an AMW.

**Note:**

- Partner organisations are working in collaboration with AMWs through community health activities. The Partners can ensure AMWs report their activities to concerned midwives or respective health centres. Partners can facilitate this process in order to enhance data completeness of AMW activities in the HMIS.

- HMIS primary denominator source is Annual Form 3.B 2.1 and 2.2. But, for the first six month reporting, Livebirths and Stillbirths can also be taken from Monthly Form 1.B 10.1 and 10.2 (Ref: HMIS Data Dictionary Chapter-3 ,Page-120)

| Outcome Indicator |
| --- |
| **1.3 Number and percentage of institutional deliveries** |

| | |
| --- | --- |
| **Definition** | **The number and percentage of deliveries by a skilled health personnel at hospitals/ clinics/ delivery rooms, including still births but not abortions** |
| **Numerator** | Total number of deliveries by skilled health personnel at hospitals and delivery rooms during this reporting period (public as well as private)<br>*[Form 1B (2.6)* the number of women who gave birth at hospitals/clinics/delivery rooms with the health staff providing care. (It includes still births but not abortions.)*+ Form 1B (10.4)* the number live birth delivered at private hospitals, clinics and delivery rooms.*+ Form 1B (10.5)* the number stillbirths delivered at private hospitals, clinics and delivery rooms] |
| **Denominator** | Total number of births in the same period<br>*[Form 3B (2.1) Number of live births + Form 3B (2.2) Number of stillbirths]* |
| **Data sources** | HMIS |
| **Reporting frequency** | Six monthly and annually (both number and percentage together with denominator figure) |

**What it measures:** The main purpose of this indicator is to provide information about coverage of institutional deliveries. Institutional deliveries, especially at the time of obstetrical emergency, and skilled attendant at birth are associated with reduced maternal mortality (Koblinsky et al., 1999). Institutional deliveries have also been found to have strong beneficial effects on infant survival probabilities (Panis, 1994). (MEASURE evaluation)

**Note:**

- Although information/data related to deliveries by private hospitals/clinics/delivery rooms is included in the HMIS, actual data collection varies among townships. For some townships, only annual data is possible with some challenges in data accuracy. *Therefore, the Township Health Departments are encouraged to collect private sector related deliveries data every six months. Partner organisations, including the private sector, should assist by reporting this information to the Township Health Departments.*
- HMIS primary denominator source is Annual Form 3.B 2.1 and 2.2. But, for the first six month reporting, Livebirths and Stillbirths can also be taken from Monthly Form 1.B 10.1 and 10.2 (Ref: HMIS Data Dictionary Chapter-3 ,Page-120)

| Outcome Indicator |
|---|
| **2. Number and percentage of women attended at least four times during pregnancy by skilled health personnel for reasons related to the pregnancy** |

| | |
|---|---|
| **Definition** | **The total number and percentage of mothers (delivered by BHS and others) who received antenatal care 4 times or more from skilled health personnel: at around 12 weeks (up to 14 weeks), 26 weeks (15-28 weeks), 32 weeks (29-34 weeks) and 36 weeks (35 weeks to child birth)**<br>**"Skilled health personnel" are defined as health professionals trained in midwifery skills including doctor, nurse, lady health visitor and midwives.** |
| **Numerator** | Total number of mothers who received at least 4 times of antenatal care from health staff during this reporting period<br>*[Form 1B (2.7)]* |
| **Denominator** | Total number of births in the same period<br>*[Form 3B (2.1) Number of live births + Form 3B (2.2) Number of stillbirths]* |
| **Data sources** | HMIS |
| **Reporting frequency** | Six monthly and annually (both number and percentage together with denominator figure) |

**What it measures:** Antenatal care coverage is an indicator of access and use of health care during pregnancy. The antenatal period presents opportunities for reaching pregnant women with interventions that may be vital to their health and wellbeing and that of their infants. Receiving antenatal care at least four times, as recommended by WHO, increases the likelihood of receiving effective maternal health interventions during antenatal visits. This is an MDG indicator. (World Health Statistics, 2013, WHO). This indicator measures the access of pregnant women to the health facilities or health staff and the ability of the health system to reach women as per the recommended visitation schedule.

**Note:**

- Please see antenatal check at Annex 2, and according to HMIS data dictionary guideline, it mentions to count women who received care four times or more as per the schedule though data quality issue need to be taken account.
  1) 12 weeks (up to 14 weeks)
  2) 26 weeks (15-28 weeks),
  3) 32 weeks (29-34 weeks)
  4) 36 weeks (35 weeks to child birth).

| Pregnant Mother | Frequency | | | | Remark |
|---|---|---|---|---|---|
| | 1st ANC | 2nd ANC | 3rd ANC | 4th ANC | |
| **A** | √ | √ | √ | √ | **Count** |
| **B** | √ | | √ | √ | **Do not count** |

- HMIS primary denominator source is Annual Form 3.B 2.1 and 2.2. But, for the first six month reporting, Livebirths and Stillbirths can also be taken from Monthly Form 1.B 10.1 and 10.2 (Ref: HMIS Data Dictionary Chapter-3 ,Page-120)

| Outcome Indicator |
|---|
| **3. Number and percentage of mothers and newborns who received postnatal care visit within three days of childbirth** |

| | |
|---|---|
| **Definition** | **Total number and percentage of newborns who received newborn care within 3 days after birth (which will be referred as a proxy for postnatal mother care)** |
| **Numerator** | Total number of newborns receiving newborn care within 3 days after birth during this reporting period<br>*[Form 1B (4.11)]* |
| **Denominator** | Total number of live births in the same period<br>*[Form 3B (2.1)]* |
| **Data sources** | HMIS |
| **Reporting frequency** | Six monthly and annually (both number and percentage together with denominator figure) |

**What it measures:** The majority of maternal and newborn deaths occur within a few hours after birth, mostly within the first 48 hours. Deaths in the newborn period (first 28 days) are a growing proportion of all child deaths. Postnatal care contacts, especially within the first few days following birth, are a critical opportunity for improving maternal and newborn health and survival and for provision of information about birth spacing. Extra visits may be provided for mothers or babies at particular risk, for example, those with HIV or for small or preterm babies. Effective referral and quality of emergency care for women and newborns at the referral site are essential for maximising impact. (Countdown to 2015- WHO). In Myanmar, newborn deaths account to 24% of U5 children deaths, and 73% of infant deaths. Causes of death are preterm (31%), sepsis (25%), and birth asphyxia (24%) respectively. The majority of newborn deaths occur within a week after birth. Therefore, during this period, basic health staffs provide newborn care. (Community based newborn care. UNICEF, MoH, AusAID, 2011)

**Note:**

Newborn care includes:

- encouraging early initiation of breastfeeding within one hour after birth and exclusive breastfeeding up to 6 months of age, supporting to keep the newborn infant warmth;
- providing support for keeping the umbilical stump clean and dry to prevent infections;
- skin and eyes care and hygiene, checking danger signs for newborn infant
- counselling family members for recognition of newborn danger signs and the importance to seek health care in a timely manner;

- providing support for birth registration and vaccination according to Expanded Programme on Immunisation schedules; and
- Identification of newborn infants that require special care.
  check the general danger signs (Unable to suck/less suckling, fits, fast breathing, chest in drawing, high fever (> 37.5 degree centigrade), hypothermia (<35.4 degree centigrade), Less movement of the limbs, yellow discoloration of palms and soles, pus discharge from umbilicus, pus discharge from eyes, skin infection)

- HMIS primary denominator source is Annual Form 3.B 2.1. But, for the first six month reporting, Livebirths can also be taken from Monthly Form 1.B 10.1 (Ref: HMIS Data Dictionary Chapter-3 ,Page-120)

- **Limitation:** Though this indicator presented as postnatal care for 'mothers and newborns', the numerator capture to newborn care as it is taken into account as proxy for postnatal mother care. Please see Annex 3 for postnatal care for mothers. For postnatal mother care achievement, HMIS data can be requested to include in the report.

| Outcome Indicator |
|---|
| **4. Number and percentage of newborns that initiate immediate breastfeeding within one hour after birth (disaggregated by sex)** |

| | |
|---|---|
| **Definition** | **Number and percentage of newborns who were put to the breast within one hour of birth** |
| **Numerator** | Total number of newborns put to the breast within one hour of birth by their mothers, during this reporting period *[Form 1B (4.10)]* |
| **Denominator** | Total number of live births in the same period *[Form 3B (2.1)]* |
| **Data sources** | HMIS |
| **Reporting frequency** | Six monthly and annually (both number and percentage together with denominator figure) |

**What it measures:** This indicator measures whether mothers initiate early breastfeeding with its respective benefits to both mothers (reduce postpartum haemorrhage) and infants (skin-to-skin contact and exposure to maternal antibodies in colostrum). Mothers are most likely successfully to initiate lactation, to encounter fewer problems in breastfeeding, and to maintain optimal breastfeeding shortly after birth. Breastfeeding should begin no later than one hour after delivery of the infant. (MEASURE Evaluation)

**Note:**

- HMIS primary denominator source is Annual Form 3.B 2.1. But, for the first six month reporting, Livebirths and Stillbirths can also be taken from Monthly Form 1.B 10.1 (Ref: HMIS Data Dictionary Chapter-3 ,Page-120)

- **Limitation:** Data collection of this indicator has been based on the clinic register and field record of BHS. The facility base indicator does not have as much recall bias, but facility-based rates cannot be used to determine population level trend in many settings because the data only reflect breastfeeding initiation by women who gave birth in facilities. (MEASURE Evaluation)

| Outcome Indicator |
| --- |
| **5. Contraceptive prevalence rate (HMIS)** |

| | |
| --- | --- |
| **Definition** | **The number of married couples with the age of the wife between 15 and 49 that are currently practicing birth spacing (any method)** |
| **Numerator** | Number of married couples practicing birth spacing (any method) at present during this reporting period<br>*[Form 3B (4.2)]* |
| **Denominator** | Number of married couples with the wife's age between 15 and 49 years in the same period<br>*[Form 3B (4.1)]* |
| **Data sources** | HMIS |
| **Reporting frequency** | Annually |

**What it measures:** Contraceptive prevalence rate is an indicator of health, population, development and women's empowerment. It also serves as a proxy measure of access to reproductive health services that are essential for meeting many of the Millennium Development Goals, especially those related to child mortality, maternal health, HIV and AIDS, and gender equality.

**Note:**

- **Limitation:** Ideally, the indicator should reflect married and unmarried couples using modern methods. HMIS Data Dictionary (2014 June) presented as data collection will be disaggregated by modern and other methods among married couples, according to "Population and Yearly Record". This disaggregated data collection will still be a challenge at 3MDG townships, most of which are remote.

| Outcome Indicator |
| --- |
| **6. Percentage of under five children who had diarrhoea receiving ORT (disaggregated by sex and age)** |

| | |
| --- | --- |
| **Definition** | **Percentage of children aged 0-59 months with diarrhea in the last two weeks who were treated with oral rehydration salts and/or recommended home fluids** |
| **Numerator** | Number of children aged 0-59 months with diarrhea in the last two weeks who were treated with oral rehydration salts and/or recommended home fluids |
| **Denominator** | Number of children aged 0-59 months surveyed who had diarrhea in the last two weeks |
| **Data sources** | Population-based surveys (DHS, MICS) |
| **Reporting frequency** | Based on survey plan |

**What it measures:** Diarrhoea is a principal cause of morbidity and mortality among children under five in developing countries. Diarrhoea related deaths are most commonly caused by dehydration caused by acute watery diarrhoea and acute dehydration. (MEASURE evaluation)

**Note:**

- The World Health Organization (WHO) recommends a wide variety of common household recipes and drinks, which can be used to prevent and treat dehydration: unsalted rice water, salted rice water, unsalted vegetable broth, salted vegetable broth, weak tea, green coconut water, yogurt drink, etc. Plain water can also be given. WHO emphasises starting early in order to hopefully prevent dehydration.
- Oral Rehydration Salts (ORS) refer to a balanced mixture of glucose and electrolytes for use in treating and preventing dehydration, potassium depletion and base deficit due to diarrhoea. When ORS is dissolved in water, the mixture is called ORS solution. (MEASURE Evaluation).
- Oral rehydration therapy (ORT) is the administration of fluid by mouth to prevent or correct the dehydration that is a consequence of diarrhoea. http://www.ncbi.nlm.nih.gov/pubmed/12345472 Or ORT refers to oral administration of a solution of electrolytes and carbohydrates in the treatment of dehydration. http://medical-dictionary.thefreedictionary.com
- As report will be based on surveys (e.g DHS, MICS), the parameters used in survey questionnaires will be adopted in this indicator definition.
- **Limitation:** Data referring to any national level surveys may not be fully reflected to specific 3MDG townships.

| Outcome Indicator |
| --- |
| **7. Percentage of under five children with suspected pneumonia who received appropriate antibiotics (disaggregated by sex and age)** |

| | |
| --- | --- |
| **Definition** | **Percentage of children age 0-59 months with suspected pneumonia receiving antibiotics** |
| **Numerator** | Number of children age 0-59 months with suspected pneumonia in the two weeks prior to the survey receiving antibiotics |
| **Denominator** | Total number of children age 0-59 months with suspected pneumonia in the two weeks prior to the survey |
| **Data sources** | Population-based surveys (DHS, MICS) |
| **Reporting frequency** | Based on survey plan |

**What it measures:** This indicator measures the ability of health workers to correctly differentiate between conditions needing antibiotics and those that do not. Unnecessary treatment with antibiotics is not only ineffective, but it presents an unnecessary risk to the child through possible side effects and allergic reactions. Furthermore, the widespread unnecessary use of antibiotics encourages the development of bacteria that are drug resistant. (MEASURE Evaluation)

Note:

- Pneumonia accounts for an estimated 18% of all deaths of children under five years old worldwide (Pneumonia Fact sheet, WHO). Pneumonia prevention and treatment is therefore essential to the achievement of MDG4. A key intervention for controlling pneumonia in children is prompt treatment with a full course of appropriate antibiotics. Effective case management at the community and health facility levels is needed to ensure that sick children receive appropriate treatment. (MEASURE evaluation)
- This indicator is subject to variation, as the denominator – children with suspected pneumonia in the two weeks preceding the survey – will vary by season and caretaker reporting. In terms of the numerator, this indicator does not measure timing or dosage of treatment, or the type of antibiotic used.
- As report will be based on surveys (e.g DHS, MICS), the parameters used in survey questionnaires will be adopted in this indicator definition.
- **Limitation:** Data referring to any national level surveys may not be fully reflected to specific 3MDG townships.

| Outcome Indicator |
| --- |
| **8.1. Number and percentage of children under one immunized with DPT3/Penta3 (disaggregated by sex)** |

| | |
| --- | --- |
| **Definition** | **The number and percentage of children 0-11 months of age who were immunized with DPT3/Pentavalent vaccine for the third time by the age of 12 months** |
| **Numerator** | Number of children 0-11 months immunized with DPT3/Penta vaccine for the third time during this reporting period<br>*[Form 1B (5.4) (3rd)]* |
| **Denominator** | Total number of under1 children in the same period<br>*[Form 3B (1) (under1)]* |
| **Data sources** | HMIS |
| **Reporting frequency** | Six monthly (number only) and annually (both number and percentage together with denominator figure) |

**What it measures:** This indicator measures the ability of the health system to deliver a series of vaccinations. It indicates the continuity of use of immunisation services by caregivers and can serve as a proxy for client satisfaction with services. Hence, it can be used to assess effectiveness of routine service delivery.

**Note:**

- Midyear coverage% will be presented based on estimated U1 population in this township.

- **Limitation:** Sex disaggregation is not available from HMIS.

| Outcome Indicator |
| --- |
| **8.2. Number and percentage of children under one immunized with Measles (disaggregated by sex)** |

| | |
| --- | --- |
| **Definition** | **The number and percentage of children 0-11 months of age who were immunized with measles vaccine for the first time before the age of 12 months** |
| **Numerator** | Number of children 0-11 months immunized with measles vaccine during this reporting period<br>*[Form 1B (5.5) (9 months)]* |
| **Denominator** | Total number of under1 children in the same period<br>*[Form 3B (1) (under1)]* |
| **Data sources** | HMIS |
| **Reporting frequency** | Six monthly (number only) and annually (both number and percentage together with denominator figure) |

**What it measures:** This indicator measures protection against measles, a disease of major public health importance. Measles remains one of the leading causes of child mortality in developing countries and causes approximately 10% of all deaths among children under five years (WHO, 1994). In combination with disease surveillance data, this indicator measures progress towards measles control and elimination.

Note:

- The priorities for countries pursuing accelerated measles control include improving routine vaccination coverage levels to at least 80% in all districts of every country, and achieving at least 90% coverage nationwide. Priorities for countries and regions with a measles elimination goal include improving routine vaccination coverage levels to at least 90% in all districts of every country, resulting in nationwide coverage greater than or equal to 95%. (CDC, 1999)

- Midyear coverage% will be presented based on estimated U1 population in this township.

- **Limitation:** Sex disaggregation is not available from HMIS.

- In addition to reporting the result on this indicator which covers routine immunisations, please specify the number of immunisations through special campaigns, if any have taken place during the reporting period.

## Output Indicators

| Output Indicator |
|---|
| **1.1. Total number of Couple Years of Protection (CYPs) delivered through public sector services and private sector channels in i) Component 1 townships ii) non-Component 1 townships[3]** |

| | |
|---|---|
| **Definition** | **CYP is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, to yield an estimate of the duration of contraceptive protection provided per unit of that method. The CYP for each method is then summed for all methods to obtain a total CYP figure[4]** |
| **Data sources** | Partner service statistics and logistics management information systems |
| **Reporting frequency** | Six monthly and annually (number only) |

**What it measures:** CYP calculation provides an immediate indication of the volume of programme activity. CYP can also allow programmes to compare the contraceptive coverage provided by different family planning methods.

**Note**:

- **CYP conversion factors** are based on how a method is used, failure rates, wastage, and how many units of the method are typically needed to provide one year of contraceptive protection for a couple. The calculation takes into account that some methods, like condoms and oral contraceptives, for example, may be used incorrectly and then discarded, or that IUDs and implants may be removed before their life span is realised (USAID, 2011). Please see the Annex 4: *The CYP conversion factors* (Updated December 2011, USAID)

- **Advantages:**
  - It can be calculated from data routinely collected through programmes or projects, and thus minimises the data collection burden
  - Data can be obtained from all the different service delivery points (clinics, community-based distributors, social/commercial marketing)
  - The CYP calculation is relatively simple to do;
  - CYP allows programmes to compare the contraceptive coverage provided by different family planning methods

[3] Non-component 1 township is referring to those townships not included in 3MDG township list that MoH approved. These extra townships are covered by one private sector IP (PSI) for contraceptive commodity distribution.
[4] CYP calculation is on family planning commodities funded by 3MDG Fund

- **Disadvantages:**
  - It is not easy to understand by those outside the family planning field;
  - One cannot ascertain the number of individuals represented by CYP. For example, if a programme administers 10,000 injections of DepoProvera, this amount is equivalent to 2,500 CYP. Theoretically, this figure represents 2,500 women protected for 12 months each; however, in fact it may refer to 5000 women covered for 6 months each or 10,000 women covered for 3 months each;
  - The validity of the assumptions underlying the choice of conversion factors are complex and debatable;
  - CYP primarily reflects distribution and not actual use or impact;
  - The number of years that are included in the estimates is influenced by the average duration of use.

- **Limitation:** Though CYP conversion factors used are standardized, reported commodity figures have some challenge based on the data availability and organization practice. For example, PSI, key contributor of CYP indicators, approach as social marketing in which CYP calculation on distributed end user cannot be possible. Data collection will be depending on data feasibility and organizational global practice whether commodities 'delivered to site' or 'distributed to end-users'.

| Output Indicator |
| --- |
| **1.2.1. Number and percentage of appropriate EmOC referrals supported-Total** |

| | |
| --- | --- |
| **Definition** | **The total number and percentage of women who require emergency obstetric care at Station, Township or District Hospitals, during pregnancy, delivery and postnatal period that are supported for referrals during this reporting period. Support includes financial assistance for transportation costs and/or meal costs and/or medicine costs and/or investigation costs and/or operation costs. Costs are covered for patients only or both patients and a caregiver.** |
| **Numerator** | Number of women referred and supported for emergency obstetric care during pregnancy, delivery and postnatal period during this reporting period. |
| **Denominator** | Total number of expected pregnancies[5] in the same period. |
| **Data sources** | Referral record (THD/Partner) |
| **Reporting frequency** | Six monthly and annually (number only) |

**What it measures:** A financial constraint is one of the factors that make delay in deciding to seek care. This indicator measures to what extent the programme could contribute to meeting the needs for EmOC in a specified area.

**Note**:

- 3MDG Referral guideline was developed and has been reviewed by the Department of Public Health.

- **"Emergency Referral"** is the term used to define a patient who has a severe life threatening illness, or is suspected to have a life threatening illness that needs both diagnosis and treatment by a skilled health professional.

- **Only count women who referred for emergency obstetric care by identifying pregnancy related causes. Do not count the women who are referred for other types of treatment and care.** Please see 3MDG referral guideline for definition and criteria of emergency obstetric referrals.

[5] In global practice, the denominator is total number of expected deliveries

| Output Indicator |
| --- |
| **1.2.2. Number of appropriate EmOC referrals supported – hard to reach areas** |

| | |
| --- | --- |
| **Definition** | **The total number of women residing in hard to reach villages, who require emergency obstetric care at Station, Township or District Hospitals, during pregnancy, delivery and postnatal period that are supported for referrals during this reporting period. Support includes financial assistance for transportation costs and/or meal costs and/or medicine costs and/or investigation costs and/or operation costs. Costs are covered for patients only or both patients and a caregiver.** |
| **Data sources** | Referral record (THD/Partner) |
| **Reporting frequency** | Six monthly and annually (number only) |

**What it measures:** A financial constraint is one of the factors that make delay in deciding to seek care. This indicator measures to what extent the programme could contribute to meeting the needs for EmOC in a specified area.

**Note**:

- Hard to reach definition has been defined in different perspectives for different purposes. 3MDG defines hard to reach as **geographically** hard to reach based on the length of time to travel to a functioning health facility, on mode of travel to the nearest functioning health facility, road conditions, local transportation costs and other factors such as limited access due to security concerns or weather. Please see Annex 5 for the 3MDG hard to reach definition.

- Adopting HtR definition may sometime varies among 3MDG townships,based on different local context in applying 3MDG's definition and/or prior guidelines set by the respective Township Health Department.

- **Only count women in hard to reach areas that referred for emergency obstetric care by identifying pregnancy related causes. Do not count the women who are referred for other types of treatment and care.** Please see 3MDG referral guideline for definition and criteria of emergency obstetric referrals.

- This indicator achievement figure will be the subset of indicator 1.2.1.

| Output Indicator |
| --- |
| **1.2.3. Number of Emergency Child Care (ECC) referrals supported – Total** |

| | |
| --- | --- |
| **Definition** | **The total number of children under five that require emergency child care at Station, Township or District Hospitals that are supported for referrals during this reporting period. Support includes financial assistance for return transportation costs and/or meal costs and/or medicine costs and/or investigation costs and/or operation costs. Costs are covered for patients only or both patients and a caregiver.** |
| **Data sources** | Referral record (THD/Partner) |
| **Reporting frequency** | Six monthly and annually (number only) |

**What it measures:** This indicator measures to what extent the programme could contribute to meeting the needs for ECC in a specified area.

**Note:**

- 3MDG Referral guideline was developed and has been reviewed by the Department of Public Health.

- **"Emergency Referral"** is the term used to define a patient who has a severe life threatening illness, or is suspected to have a life threatening illness that needs both diagnosis and treatment by a skilled health professional.

- Only count children under five that require emergency child care. Please see 3MDG referral guideline for definition and criteria of emergency obstetric referrals.

| Output Indicator |
| --- |
| **1.2.4. Number of ECC referrals supported - hard to reach areas** |

| | |
| --- | --- |
| **Definition** | **The total number of children under five residing in hard to reach villages that require emergency child care at Station, Township or District Hospitals that are supported for referrals during this reporting period**<br>**Support includes financial assistance for transportation costs and/or meal costs and/or medicine costs and/or investigation costs and/or operation costs. Costs are covered for patients only or both patients and a caregiver.** |
| **Data sources** | Referral record (THD/Partner) |
| **Reporting frequency** | Six monthly and annually (number only) |

**What it measures:** This indicator measures to what extent the programme could contribute to meeting the needs for ECC in a specified area.

**Note**:

- Hard to reach definition has been defined in different perspectives for different purposes. 3MDG defines hard to reach as **geographically** hard to reach based on the length of time to travel to a functioning health facility, on mode of travel to the nearest functioning health facility, road conditions, local transportation costs and other factors such as limited access due to security concerns or weather. Please see Annex 5 for hard to reach definition.

- Adopting Hard to reach definition in townships varies based on local context back-boning on 3MDG's definition and/or guidelines set by the respective Township Health Department.

- Only count children under five in hard to reach areas that require emergency child care. Please see 3MDG referral guideline for definition and criteria of emergency obstetric referrals.

- This indicator achievement figures will be the subset of indicator 1.2.3.

| Output Indicator |
| --- |
| **1.3.1. Number of under five children diarrhoea cases treated with ORT at Health Facilities** |

| | |
| --- | --- |
| **Definition** | **The total number of under five children (aged 0-59 months) with diarrhoea who were given *extra fluids available at home* such as soups, rice water, fruit juice, plain water *and oral rehydration solution***<br><br>*HMIS [Form 1B (4.4)]***.** |
| **Data sources** | HMIS |
| **Reporting frequency** | Six monthly and annually |

**What it measures**: Diarrhoea is a principal cause of morbidity and mortality among children under five in developing countries. Diarrhoea related deaths are most commonly caused by dehydration caused by acute watery diarrhoea and acute dehydration. (MEASURE evaluation) The World Health Organization (WHO) recommends a wide variety of common household recipes and drinks, which can be used to prevent and treat dehydration: unsalted rice water, salted rice water, unsalted vegetable broth, salted vegetable broth, weak tea, green coconut water, yogurt drink, etc. Plain water can also be given. WHO emphasises starting early in order to hopefully prevent dehydration.

**Note:**

- Oral Rehydration Salts (ORS) refer to a balanced mixture of glucose and electrolytes for use in treating and preventing dehydration, potassium depletion and base deficit due to diarrhoea. When ORS is dissolved in water, the mixture is called ORS solution. (MEASURE Evaluation)

- Oral rehydration therapy (ORT) is the administration of fluid by mouth to prevent or correct the dehydration that is a consequence of diarrhoea. http://www.ncbi.nlm.nih.gov/pubmed/12345472 Or ORT refers to oral administration of a solution of electrolytes and carbohydrates in the treatment of dehydration. http://medical-dictionary.thefreedictionary.com

- Operational definition is adopted from HMIS Data Dictionary (June, 2014). As diarrhoea (being an acute disease) is recorded for all new episodes, total number reflects to the cases instead of person count for this indicator.

- IP will be asked to report Denominator[6] figure along with this indicator achievement figure. Both numerator and denominator of this indicator can be obtained from HMIS.

- Treated at Health Facilities**:** inclusive of all cases received treatment from health staff (at clinics/health facilities and during field visits) Ref: HMIS Data Dictionary 2014 June-Pg47

[6] **Denominator**: Total number of under five children with diarrhoea in the same period -*Form 1B (4.2)*

| Output Indicator |
| --- |
| **1.3.2 Number of under five children diarrhoea cases treated with ORS + Zinc at community by volunteers** |

| | |
| --- | --- |
| **Definition** | **Number of under five children diarrhoea cases treated with ORS and Zinc supplements through trained volunteers during this reporting period** |
| **Data sources** | Volunteer record (from VRS) |
| **Reporting frequency** | Six monthly and annually |

**What it measures:** Diarrhoea is a principal cause of morbidity and mortality among children under five in developing countries. Diarrhoea related deaths are most commonly caused by dehydration caused by acute watery diarrhoea and acute dehydration. (MEASURE evaluation) This indicator will highlight the community based intervention coverage through volunteer approach.

**Note:**

**Diarrhoea** is three or more loose or watery stools during 24-hour period (MEASURE Evaluation). This indicator data source is volunteer record, where the volunteers need to identify diarrhoea in accordance with current CHW manual and Community Case Management (CCM) guideline.

- Oral Rehydration Salts (ORS) refer to a balanced mixture of glucose and electrolytes for use in treating and preventing dehydration, potassium depletion and base deficit due to diarrhoea. When ORS is dissolved in water, the mixture is called ORS solution. (MEASURE Evaluation).

- Oral rehydration therapy (ORT) is the administration of fluid by mouth to prevent or correct the dehydration that is a consequence of diarrhoea. http://www.ncbi.nlm.nih.gov/pubmed/12345472 Or ORT refers to oral administration of a solution of electrolytes and carbohydrates in the treatment of dehydration. http://medical-dictionary.thefreedictionary.com

- Volunteers referred in this indicator, to be inclusive of all those trained and functioning Community Health Workers (CHW)[7]. 3MDG Fund supports volunteer kits to volunteers on routine basis.

[7] For some 3MDG townships, AMW are also covering CHW responsibilities at some villages. These AMW are also involved in defining 'volunteer' for this indicator.

- Trained: Volunteers those who have been trained for treating diarrhoea cases using ORS and Zinc Sulphate by different types of trainings (eg: Community Case Management training - CCM[8] or CHW Basic Training).
- As diarrhoea (being an acute disease) is recorded for all new episodes, total number reflects cases (instead of person count) treated by trained volunteers

- IP will be asked for additional information for total number of under five children diarrhoea cases visiting to CHW along with this indicator achievement. Both figures can be obtained from the Volunteer monthly report.

[8] Community case management training should be rolled out in 3MDG townships in quarter 4, 2015. Number of Trained CCM volunteers may vary according to budget planning and selection criteria.

| Output Indicator |
| --- |
| **1.4.1 Number of under five children suspected pneumonia cases treated with antibiotics at Health Facilities** |

| | |
| --- | --- |
| **Definition** | **The total number of children aged 0-59 months with pneumonia receiving antibiotics treatment among under five children who suffered from pneumonia.**<br><br>*HMIS [Form 1B (4.8)]* |
| **Data sources** | HMIS |
| **Reporting frequency** | Six monthly and annually |

**What it measures:** This indicator measures the ability of health workers to correctly differentiate between conditions needing antibiotics and those that do not. Unnecessary treatment with antibiotics is not only ineffective, but it presents an unnecessary risk to the child through possible side effects and allergic reactions. Furthermore, the widespread unnecessary use of antibiotics encourages the development of bacteria that are drug resistant. (MEASURE Evaluation)

**Note:** Pneumonia accounts for an estimated 18% of all deaths of children under five years old worldwide (Pneumonia Fact sheet, WHO). Pneumonia prevention and treatment is therefore essential to the achievement of MDG4. Pneumonia is closely associated with under-nutrition and poor home environments that leave children more exposed to disease-causing pathogens, which means that pneumonia deaths are highly concentrated in the world's poorest settings. A key intervention for controlling pneumonia in children is prompt treatment with a full course of appropriate antibiotics. Effective case management at the community and health facility levels is needed to ensure that sick children receive appropriate treatment. (MEASURE evaluation)

- Operational definition is adopted from HMIS Data Dictionary (June, 2014). As pneumonia (being an acute disease) is recorded for all new episodes, total number reflects to the cases instead of person count for this indicator.
- IP will be asked to report Denominator[9] figure along with this indicator achievement figure. Both numerator and denominator of this indicator can be obtained from HMIS.
- Treated at Health Facilities: inclusive of all cases who received antibiotic treatment from health staff (at clinics/health facilities and during field visits) Ref: HMIS Data Dictionary 2014 June-Pg47.

[9] **Denominator:** Total number of under five children receiving treatment for pneumonia in the same period (total number of under five children receiving treatment by health personnel for cough and fast or difficult breathing + total number of under five children receiving treatment by health personnel for severe pneumonia) *[Form 1B (4.6) + Form 1B (4.7)]*

| Output Indicator |
| --- |
| **1.4.2 Number of under five children suspected pneumonia cases treated with antibiotics at community by volunteers** |

| | |
| --- | --- |
| **Definition** | **Number of under five children suspected pneumonia cases treated with antibiotics through trained volunteers, during this reporting period** |
| **Data sources** | Volunteer record (from VRS) |
| **Reporting frequency** | Six monthly and annually |

**What it measures:** Pneumonia accounts for an estimated 18% of all deaths of children under five years old worldwide (Pneumonia Fact sheet, WHO). Pneumonia prevention and treatment is therefore essential to the achievement of MDG4. Pneumonia is closely associated with under-nutrition and poor home environments that leave children more exposed to disease-causing pathogens, which means that pneumonia deaths are highly concentrated in the world's poorest settings. A key intervention for controlling pneumonia in children is prompt treatment with a full course of appropriate antibiotics. Effective case management at the community and health facility levels is needed to ensure that sick children receive appropriate treatment. (MEASURE evaluation) This indicator measures pneumonia case management by community health workers.

**Note:**

- Volunteers: are those trained and functioning Community Health Workers (CHW)[10]. 3MDG Fund supports volunteer-kits to volunteers on routine basis.
- Trained: Volunteers those who have been trained for treating pneumonia cases using antibiotics by getting proper trainings (eg: Community Case Management training - CCM[11]). Volunteers who have not been trained in the use of anti-biotics should not administer them.
- As pneumonia (being an acute disease) is recorded for all new episodes, total number reflects cases(instead of person count) treated by trained volunteers
- This indicator data source is volunteer record, where the volunteers need to define pneumonia in accordance with current DoPH guidelines (e.g. CCM guideline and CHW manual)
- Treated with antibiotics: need to be consistent with DoPH guidelines (e.g. CCM)
- IP will be asked for additional information for total number of under five children pneumonia cases visiting to CHW along with this indicator achievement. Both figures can be obtained from the Volunteer monthly report.

[10] In some 3MDG townships, AMW are also covering CHW responsibilities at some villages. These AMW are also involved in defining 'volunteer' for this indicator.

[11] Community case management training should be rolled out in 3MDG townships in quarter 4, 2015. Number of Trained CCM volunteers may vary according to budget planning and selection criteria.

| Output Indicator |
| --- |
| **1.5.1. Number and percentage of postnatal mothers who received Vitamin A supplements** |

| | |
| --- | --- |
| **Definition** | **The number and percentage of postnatal mothers who received 200,000 units of Vitamin A supplements within 42 days after childbirth (during 6-weeks postnatal period)** |
| **Numerator** | Total number of postnatal mothers who received Vitamin A supplements during this reporting period<br>*[Form 1B (3.10)]* |
| **Denominator** | Estimated number of pregnant women in the same period |
| **Data sources** | HMIS |
| **Reporting frequency** | Six monthly and annually (both number and percentage together with denominator figure) |

**What it measures:** This indicator is a measure of extent of protection of the newborn against Vitamin A deficiency (VAD). During lactation, maternal Vitamin A requirements rise to replace the Vitamin A lost daily in breast milk and to maintain the needs of the rapidly growing infants during at least the first month of life. Vitamin A supplementation during lactation raises (and maintains) the concentration of Vitamin A in the breast milk of women with Vitamin A Deficiency. (www.cpc.unc.edu/measure)

**Note:** One dose of Vitamin A (200,000 IU) is distributed for all lactating mothers within one and a half months after delivery. (National Nutrition Unit)

**Output Indicator**

**1.5.2. Number and percentage of postnatal mothers who received iron supplements 4 times or more during pregnancy**

| | |
|---|---|
| **Definition** | **The total number and percentage of post-natal mothers who received iron supplement tablets 4 times or more (at least 91 iron supplement tablets) during pregnancy among the pregnant women who gave birth in the assigned area during this reporting period** |
| **Numerator** | Total number of postnatal mothers who received iron supplements 4 times or more during pregnancy during this reporting period *[Form 1B (3.6)]* |
| **Denominator** | Estimated number of pregnant women in the same period |
| **Data sources** | HMIS |
| **Reporting frequency** | Six monthly and annually (both number and percentage together with denominator figure) |

**What it measures:** It is estimated that 41.8% of pregnant women worldwide are anaemic (WHO guideline, 2012). At least half of this anaemia burden is assumed to be due to iron deficiency. Pregnant women require additional iron and folic acid to meet their own nutritional needs as well as those of the developing foetus. Deficiencies in iron and folic acid during pregnancy can potentially negatively impact the health of the mother, her pregnancy, as well as foetal development. WHO recommends daily oral iron and folic acid supplementation as part of the antenatal care to reduce the risk of low birth weight, maternal anaemia and iron deficiency.

**Note:** According to the surveys conducted by National Nutrition Centre, the prevalence of anaemia was 45% among non-pregnant women (2001), 26% in adolescent school girls (2002), 71% in pregnant women (2003) and 75% in under five year children (2005). (Source: Health in Myanmar 2012). Please see Annex 6*: Administering Iron Supplement Tablets* recommended by MoH. (Source: Data Dictionary for Health Services Indicators)

| Postnatal Mother that received iron supplements during pregnancy | Frequency | | | | Remark |
|---|---|---|---|---|---|
| | 1st time | 2nd time | 3rd time | 4th time | |
| A | √ | √ | √ | √ | Count |
| B | √ | | √ | √ | Do not Count |

- **Limitation:** According to national data dictionary definition, data counting and reporting are considerable for quality unless proper data registration is taken into account.

| Output Indicator |
| --- |
| **1.5.3 Number and percentage of pregnant mothers who received B1 tablets** |

| | |
| --- | --- |
| **Definition** | **The total number and percentage of the pregnant women after 36th weeks of pregnancy that received Vitamin B1 supplement tablets (in the last months of pregnancy) during this reporting period. (Four weeks doses of Vitamin B1 tablets 10 milligrams B1 28 tablets (or) 50 milligrams Vitamin B1 7 tablets should be provided** |
| **Numerator** | Total number of pregnant mothers who received B1 supplements during this reporting period<br>*[Form 1B (3.7)]* |
| **Denominator** | Estimated number of pregnant women in the same period |
| **Data sources** | HMIS |
| **Reporting frequency** | Six monthly and annually (both number and percentage together with denominator figure) |

**What it measures:** This indicator is a measure of the extent of protection of the newborn against infantile Beriberi. Beriberi is caused by the deficiency of thiamine (Vitamin B1). Maternal dietary interventions or supplementation can increase the secretion of many of these nutrients in breast milk, and improve infant nutritional status.

**Note:** According to *Cause Specific under Five Mortality Survey* (2003), Infantile Beriberi is the fifth leading cause of death among children between 1-12 months (7.12%) in Myanmar. For children under six months, deaths due to Beriberi were nearly 9%. The findings from the National Nutrition Centre (2009) revealed that the prevalence of Vitamin B1 deficiency was 6.8% among pregnant women and 4.4% among lactating women.

| Output Indicator |
| --- |
| **1.5.4. Number and percentage of postnatal mothers who received B1 tablets** |

| | |
| --- | --- |
| **Definition** | **The number and percentage of postnatal mothers who received Vitamin B1 supplements within 42 days after childbirth (during 6 weeks of the postnatal period) during this reporting period. (Six weeks doses of Vitamin B1 tablets, 10 milligrams B1 42 tablets or 50 milligrams B1 10.5 tablets, should be provided)** |
| **Numerator** | Total number of postnatal mothers who received B1 supplements during this reporting period<br>*[Form 1B (3.8)]* |
| **Denominator** | Estimated number of pregnant women in the same period |
| **Data sources** | HMIS |
| **Reporting frequency** | Six monthly and annually (both number and percentage together with denominator figure) |

**What it measures:** From a global perspective, lactating women are more likely to suffer from micronutrient deficiencies than from a shortage of dietary energy or protein. Mothers with Beriberi produce breast milk low in the vitamin, which can result in infantile Beriberi within 3-4 weeks of birth (Manual of practical problems in obstetrics. Jaypee Brothers Medical Publishers, 2012). Maternal supplementation with the Vitamin increases milk concentration rapidly and reduces the risk of infantile Beriberi.

| Output Indicator |
| --- |
| **1.6. Number and percentage of pregnant women vaccinated against tetanus toxoid (TT2)** |

| | |
| --- | --- |
| **Definition** | **The number and percentage of pregnant women that have received immunisation against tetanus (TT) for the first and second times. The first immunisation injection should be given as soon as the pregnant woman has been registered and the second injection should be given at least 4 weeks later. In cases where care has been sought later in the pregnancy, the second injection should take place more than 2 weeks before the baby is due.** |
| **Numerator** | Number of pregnant women who received the 2nd dose of tetanus toxoid during this reporting period<br>*[Form 1B (5.6) (2nd)]* |
| **Denominator** | Estimated number of pregnant women in the same period |
| **Data sources** | HMIS |
| **Reporting frequency** | Six monthly and annually (both number and percentage together with denominator figure) |

**What it measures:** Neonatal tetanus is major public health problem in the developing world (MEASURE evaluation). The protection of the newborn against neonatal tetanus is determined by the immunisation status of the mother. In order to protect neonates, previously unimmunized women should receive two doses of TT vaccine during their first pregnancy and one dose of TT during each subsequent pregnancy up to a maximum of five doses. This measure is additional to the use of clean practices during delivery and the care of infant's umbilical cord. Protective antibody levels are attained in 80%-90% of individuals after the second dose and in 95%-98% of women after the third dose (Minimum Activities for Mothers and Newborns, USAID, 2007).

| Output Indicator |
| --- |
| **2.1.1. Number of doctors, nurses and midwives who participated in at least one MNCH training including delivery and emergency obstetric care** |

| | |
| --- | --- |
| **Definition** | **The number of doctors, nurses and midwives including lady health visitors who have received at least one training on MNCH subject** |
| **Numerator** | Number of BHS in the township trained during this reporting period (BHS by highest number in each type _Doctor, Nurse, MW, THN, LHV) should be reported only once, no matter how many trainings s/he received during the reporting period). |
| **Denominator** | NA |
| **Data sources** | Training record (THD/Partner) |
| **Reporting frequency** | Six monthly and annually |

**What it measures:** This indicator measures coverage of training. **MNCH related trainings** can be referred from the current updated CTHP tools (HRH_technical session)[12]

Note:

- Types of training attendants are Doctor, Nurse, Township Health Nurse (THN), Lady Health Visitor (LHV) and midwife. IP could include HA in the eligible training attendants if they are promoted from LHV (i.e. they are trained as Skilled Birth Attendant).

- BHS (Basic Health Staff) for this indicator mentioned to those who are eligible for MNCH related interventions such as delivery, emergency obstetric care etc.

- At least one training: This indicator is intended to capture headcount not participants. Count only once even they get more than one training during a reporting period. A standard recording excel designed by FMO and provided to IPs automatically calculates the number of BHS who received <u>at least one MNCH training</u> from several trainings conducted during a year.

[12] For more information, please contact to 3MDG Component 1 MNCH team.

The example below illustrates the measurement:

| | Training 1 | Training 2 | Training 3 | Count as: | Count only once even they get more than one training (head count only). |
|---|---|---|---|---|---|
| Doctors | **10** | 5 | 3 | 10 | |
| Nurses | 10 | **15** | 5 | 15 | |
| LHV | 0 | 3 | **5** | 5 | |
| MW | 20 | 30 | **50** | 50 | |
| THN | **2** | 0 | 1 | 2 | |

Known limitation: This way of measuring means that there may be some new BHS joining later in the year and doing a training who are not included in the result. However, the impact of this is not expected to be significant.
If IPs have a system to track unique individuals attending trainings without significant burden, reporting the number of unique individuals is encouraged.

| Output Indicator |
| --- |
| **2.1.2. Number of new Auxiliary Midwives (AMW) trained** |

| | |
| --- | --- |
| **Definition** | **The total number of new AMWs who received basic training in providing necessary care and advice to women during pregnancy, childbirth and the post-partum period by Basic Health Staffs according to Ministry of Health training manuals** |
| **Data sources** | Training record (THD/Partner) |
| **Reporting frequency** | Six monthly and annually (number only) |

**What it measures: Only count AMWs that have completed 6 months of training during reporting period.** The first 3 months of training is devoted to theory and takes place at the Township Health Department. The second 3 months of training is practical and is based at the respective Rural Health Centre under the supervision of Health Assistants and Midwives.

| Output Indicator |
| --- |
| **2.1.3. Number of new Community Health Workers (CHW) trained** |

| | |
| --- | --- |
| **Definition** | **The total number of new CHWs that received basic 28 days CHW training course by Township Health Training team according to Ministry of Health Training Manual** |
| **Data sources** | Training record (THD/Partner) |
| **Reporting frequency** | Six monthly and annually (number only) |

**What it measures: Only count CHWs who have attended lectures and practical sessions for 21 days and completed field work for 7 days during reporting period.** CHWs are selected according to criteria established by the Ministry of Health and are trained in order to provide the community with easily accessible primary health care services.

| Output Indicator |
| --- |
| **2.1.4. Number and percentage of hard to reach villages with AMW** |

| | |
| --- | --- |
| **Definition** | **The total number** and percentage **of hard to reach villages with functioning AMWs** |
| **Numerator** | Total number of hard to reach villages with functioning AMWs during this reporting period |
| **Denominator** | Total number of hard to reach villages in that area in the same period |
| **Data sources** | Report (THD/Partner) |
| **Reporting frequency** | Six monthly and annually (both number and percentage together with denominator figure) |

**Note:**

- Functioning is assessed against the agreed criteria set by the District/Township Health Department and partners.

- Hard to reach definition has been defined in different perspectives for different purposes. 3MDG defines hard to reach as geographically hard to reach based on the length of time to travel to a functioning health facility, on mode of travel to the nearest functioning health facility, road conditions, local transportation costs and other factors such as limited access due to security concerns or weather. Please see Annex 5 for hard to reach definition.

| Output Indicator |
| --- |
| **2.1.5. Number and percentage of hard to reach villages with CHW** |

| | |
| --- | --- |
| **Definition** | **The total number and percentage of hard to reach villages with functioning CHWs** |
| **Numerator** | Total number of hard to reach villages with functioning CHWs during this reporting period |
| **Denominator** | Total number of hard to reach villages in that area in the same period |
| **Data sources** | Report (THD/Partner) |
| **Reporting frequency** | Six monthly and annually (both number and percentage together with denominator figure) |

**Note:**

- Functioning is assessed against the agreed criteria set by the District/Township Health Department and partner.

- Hard to reach definition has been defined in different perspectives for different purposes. 3MDG defines hard to reach as geographically hard to reach based on the length of time to travel to a functioning health facility, on mode of travel to the nearest functioning health facility, road conditions, local transportation costs and other factors such as limited access due to security concerns or weather. Please see Annex 5 for hard to reach definition.

| Output Indicator |
| --- |
| **2.2. Number and percentage of auxiliary midwives and community health workers receiving quarterly supervision and monitoring** |

| | |
| --- | --- |
| **Definition** | **The total number of existing auxiliary midwives and community health workers who received quarterly supervision and monitoring by BHS or IP themselves or joint supervision team (BHS and IP together) using the supervision checklist** |
| **Numerator** | Number of AMW and CHW in total who received supervision and monitoring by BHS, or IP, or joint supervision team (BHS and IP together) using the supervision checklist **during each quarter,** for the reporting period |
| **Denominator** | Total number of functioning auxiliary midwives and community health workers **during each quarter** |
| **Data sources** | IP reports (Data collection based on Standardized VHW Supervision Checklist ) |
| **Reporting frequency** | Six monthly and annually (both number and percentage together with denominator figure) |

**Note:**

- Supervision checklist: To conduct supervision/monitoring upon a particular sector/area in systematic approach, using a checklist is recommended. A standardised volunteer supervision checklist was developed in 2014 at Regional Health Department (Ayarwaddy) led by RHD together with all THDs[13] and IPs[14]. This standardized checklist can be adjusted if necessary in accordance with local context in townships.
- Using supervision checklist:
- For this indicator, only those supervision done by using checklist need to be reported. But, it is not a must to cover all sections in the checklist during supervision.
- Using checklist partially or completely may be dependent upon time available and site of supervision.
- BHS: For a particular volunteer supervision, the midwife who responsible for this particular volunteer will be the direct supervisor. But, in this indicator, basic health staffs (BHS) are inclusive of all health staffs i.e. Midwife and above.

[13] Township Health Department representatives from six 3MDG funded townships (Bogale, Dedaye, Labutta, Mawlamyinegyun, Pyapon, Ngapudaw).

[14] Implementing Partners for six townships (IOM, SC, MdM, RI).

- Functioning: Functioning volunteers are counted at end of each year by concerned midwives for annual HMIS reporting. Functionality of volunteer will be assessed against the set criteria by the District/Township Health Department and partner.

- Quarterly supervision: Ideal measurement should be tied with status of each volunteer receiving at least one supervision per quarter during a year. But, there are a number of challenges in practical situation as 3MDG funded townships are remote townships with geographical difficulties. Here, for this indicator, quarterly supervision will be captured from supervisors' activity coverage perspective as 'how many volunteer can be supervised in each quarter' instead of supervision effectiveness perspective as 'how many time a particular volunteer can be reached'. Newly trained volunteers during July-December period are needed to include in counting for annual reporting.

- **Limitation:** All functioning volunteers receiving quarterly supervision will be a challenge for some townships due to the workload of BHS, as well as issues of geographic access during certain times of the year.

The example below illustrates the measurement:

| **Volunteers** | **Supervision received during:** | | | | |
|---|---|---|---|---|---|
| | **Quarter 1 (Jan-Mar)** | **Quarter 2 (Apr-June)** | **Quarter 3 (Jul-Sep)** | **Quarter 4 (Oct-Dec)** | **Annual (Jan- Dec)** |
| A | Yes | No | Yes | Yes | |
| B | Yes | No | No | Yes | |
| C | No | Yes | No | Yes | |
| D | Yes | Yes | No | No | |
| Volunteers reached during each quarter | 3 | 2 | 1 | 3 | |
| Existing/Functioning VHW | 4 | 4 | 4 | 4 | |
| % of volunteers reached during each quarter | 75% (3 out of 4) | 50% (2 out of 4) | 25% (1 out of 4) | 75% (3 out of 4) | |
| Report | Jan-Jun = average of Q1 and Q2 = 63% | | | | Annual = average of Q1 to Q4 = 56% |

| Output Indicator |
|---|
| **2.3. Number and percentage of functioning AMWs and CHWs who report no stock-outs of essential medicines and supplies** |

| | |
|---|---|
| **Definition** | **The total number and percentage of functioning AMWs and CHWs reported no stock out of selected (essential) items of medicines and supplies, during this reporting period.**<br>**For AMW:**<br>**1. Oral Contraceptives**<br>**2. Condom**<br>**3. Ferrous Sulphate**<br>**For CHW:**<br>**1. ORS**<br>**2. Zinc Sulphate**<br>**3. Paracetamol** |
| **Numerator** | **Monthly:** Total number of functioning AMWs and CHWs reporting no stock out of ANY of the above selected medicines and supplies at any time during the reported month |
| **Denominator** | **Monthly:** Total number of functioning AMWs and CHWs. |
| **Calculation** | **Six monthly & Annually:** average of monthly percentage of functioning AMWs and CHWs who report no stock-outs of essential medicines and supplies (based on monthly volunteer reports) |
| **Data sources** | Volunteer record (from VRS) |
| **Reporting frequency** | Six monthly and annually (both number and percentage together with denominator figure) |

**What it measures:** This indicator measures product availability/absence over a period of time and serves as a proxy indicator of community level service readiness.

**Note:**

- Functioning volunteers are counted at the end of each year by concerned midwives for annual HMIS reporting. Functionality of volunteer will be assessed against the set criteria by the District/Township Health Department and partner. Functioning AMWs and CHWs term all AMWs and CHWs who received supplies from any sources. From programmatic point of view, all AMWs and CHWs trained (including recently trained) should receive supplies.

- Reporting period: For mid-year reporting, the period will be January to June of each year. For July-Dec reporting, reporting period will cover the whole year (Jan-Dec)

- No stock out: the assessment concerns the six essential items of medicine and supplies listed above (those that are included in 3MDG supported item list). 'Stock out' is defined as any one item of the above list become absent in hand of volunteer for any period of time, regardless of the supply source. Example: Paracetamol is one of the 3MDG supplied items. If a volunteer received paracetamol from 2 sources such as 3MDG IP and MW, then this volunteer only need to report as 'stock out' when there is completely no paracetamol stock (either from 3MDG IP or MW) in his/her supplies.

- What if no monthly report from the volunteer**?: If the volunteer did not submit a report in any given month, the 'stock-out' status for the missed month can be verified at the next submission before the cut-off dates for six monthly and annual reporting.**

- Missing reports do not mean that the volunteer is excluded from the denominator – they are part of the denominator every month, as long as they are considered 'functioning'. Supervision is the critical role to assess for the functioning status of volunteer. Functionality assessments of volunteers are differently set at township level based on local context.

  The example below illustrates the measurement:

Y = stock out reported, N = no stock out report, X = no report received

| | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **June** |
|---|---|---|---|---|---|---|
| Volunteer A | N | N | Y | Y | N | N |
| Volunteer B | N | N | N | N | N | N |
| Volunteer C | X | N | N | X | N | N |
| **No stock out #** | **2** | **3** | **2** | **1** | **3** | **3** |
| **Functioning #** | **3** | **3** | **3** | **3** | **3** | **3** |
| Monthly Percentage: | 67% | 100% | 67% | 33% | 100% | 100% |
| Six monthly | For Jan to June = (67 + 100+ 67+33+100+100)/6 = **78%** | | | | | |

Annual reporting: average of monthly percentage throughout a year (based on monthly volunteer reports)

# AEI Core Indicators (Component 1_MNCH)

**Outcome Indicator**

**14. Proportion of community members reporting receiving services of 'good' quality or better**

This indicator is under discussion and wait for Fund Board' further guidance

| Output Indicator |
|---|
| **5.1. Number of staff from Ministry of Health (MoH), Implementing Partners (IPs), local Non-Governmental Organisations (NGOs) and Community-Based Organisations (CBOs) (at central, regional and township level), trained in Accountability, Equity, Inclusion and Conflict Sensitivity (AEI & CS)** |

| | |
|---|---|
| **Definition** | **The number of staff from MOH, IPs, local NGOs and CBOs at central, regional and township level receiving AEI&-CS related trainings conducted by IP and 3MDG resource persons disaggregated by sex and age.** |
| **Numerator** | Number of staff from MoH, IPs, local NGOs and CBOs (at central, regional and township level) in AEI & CS in a calendar year (disaggregated by sex and age). |
| **Denominator** | N/A |
| **Data sources** | IP training records |
| **Reporting frequency** | Six monthly and annually |

**What it measures**: The number of staff from MOH, IPs, local NGOs and CBOs at central, regional and township level receiving AEI & CS related training conducted.

Trained is defined as attendance at an AEI&CS-related training or workshop. Trainings are disaggregated into the following categories (i) Basic training, (ii) refresher training and (iii) Training of Trainers and to avoid double counting, all data will be captured using standardized tools. For AEI training, specific attendance sheets capturing above information have to be used.

Only that staffs that attends the entire training, refresher training or training of trainers will be counted as trained. Training/workshop reports should include documentation of overall satisfaction of training/workshop given, including lessons learnt for improving upon training/workshop methods.

Training is defined as an organized activity aimed at imparting information and/or instruction to improve the recipient's performance or to help him or her attain a required level of knowledge or skill.

Workshop is defined as a class or seminar in which the participants work individually and/or in groups to solve actual work-related tasks to gain hands-on experience.

Age is defined 15-24 (youth), 25-59 (adult), 60 and over as senior/pensioner. These categories are defined using the most recent information from the 2014 census and existing pension laws. These definitions are subject to change.

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| Output Indicator |
| --- |
| **5.2.1 Numbers and percentage of community members aware of mechanism(s) to provide feedback in 3MDG-supported areas (disaggregated by sex and age)** |

| | |
| --- | --- |
| **Definition** | **Percentage of community members in focus group discussions who are aware of formal mechanism(s) to provide feedback in 3MDG-supported areas at the time of measurement. (disaggregated by sex and age).** |
| **Numerator** | Number of community members from the focus group discussion who report being aware of formal mechanism(s) to provide feedback in 3MDG-supported areas at time of measurement (disaggregated by sex and age) |
| **Denominator** | Total number of community members from the focus group discussion in 3MDG-supported areas (disaggregated by sex and age) |
| **Data sources** | AEI & CS Assessment Tool |
| **Reporting frequency** | Annually |

**What it measures:** The extent to which community members are aware of the feedback mechanism(s) of implementing partners funded by 3MDG.

Community members are defined as people living within the 3MDG supported project areas. They are main users of the feedback mechanisms.

Mechanisms to provide feedback are defined as the formal method(s) that implementing partners utilise to collect feedback from the communities in which they work to better understand their programs and projects from community members' perspectives. These mechanisms give the implementing partners information to adjust their programs and projects to best meet individual and community needs.[15] Examples include suggestions boxes, focus group discussions, community meetings, directly in-person at the organisation, through health staff, workshops, providing ready to post envelopes etc.

Feedback refers to opinions, concerns, suggestions and advice of anyone affected by the IP to improve any aspect in the interaction between themselves and the IP. This

[15] Definition adapted from World Vision, Complaints and Response Mechanisms Resource Guide, First Edition, 2009.

interaction can relate to decision-making processes, operations, standards of technical performance, communications or any other aspect in the IP's work. Feedback also refers to the specific grievance of anyone who has been negatively affected by the IP or who believes that the IP has failed to meet a stated commitment. This commitment can relate to a project plan, beneficiary criteria, an activity schedule, a standard of technical performance, an organizational value, a legal requirement, staff performance or behavior, or any other point.[16]

AEI & CS Assessments are defined as the process of assessing an organisation's AEI & CS-related policies, systems and practices using the AEI & CS Assessment Tool. The process entails interviews with the implementing partner's management team, staff, communities, partners and other key external stakeholders, and is led by an external organisation or the implementing partner itself.

Focus Group Discussions (FGDs) are required as part of the 3MDG AEI & CS Assessment process. FGDs must be conducted by 3MDG implementing partners in a minimum of 2 different townships, which have different operational contexts (urban/rural, access to health care services, conflict affected or not, etc.), including a minimum of 1 FGD with men and 1 FGD with women in each township. Selection of FGD participants must include intended project beneficiaries (including at least one person under 15 years old, at least one person over 60 years old, and one person from other traditionally disadvantaged groups (PWD, chronically sick, ethnic/ religious minority, extremely poor).

Sampled: As part of the AEI & CS assessment process, community members will be chosen to participate in focus group discussions concerning their experiences and perceptions about an implementing partner's AEI & CS practices.

Limitation: Data collection will be done at Focus Group Discussion Session and this may not reflect all community levels.

[16] Definition adapted from HAP, The Guide to the HAP Standard, Published by Oxfam GB, 2008.

| Output Indicator |
| --- |
| **5.2.2. Numbers and percentage of community members that use mechanism(s) to provide feedback in 3MDG-supported areas (disaggregated by sex and age)** |

| | |
| --- | --- |
| **Definition** | **Percentage of community members in focus group discussions that use formal mechanism(s) to provide feedback in 3MDG-supported areas at the time of measurement (disaggregated by sex and age)** |
| **Numerator** | Number of community members from the focus group discussion and who use formal mechanism(s) to provide feedback in 3MDG-supported areas at time of measurement (disaggregated by sex and age) |
| **Denominator** | Total number of community members from the focus group discussion in 3MDG-supported areas (disaggregated by sex and age) |
| **Data sources** | AEI & CS Assessment Tool |
| **Reporting frequency** | Annually |

**What it measures:** the extent to which community members that uses the feedback mechanism(s) of implementing partners funded by 3MDG. This indicator will only be collected from 2016 as systems and process will be developed in 2015 to address data collection.

Community members are defined as people living within the 3MDG supported project areas. They are main users of the feedback mechanisms.

Mechanisms to provide feedback are defined as the formal method(s) that implementing partners utilise to collect feedback from the communities in which they work to better understand their programs and projects from community members' perspectives. These mechanisms give the implementing partners information to adjust their programs and projects to best meet individual and community needs.[17] Examples include suggestions boxes, focus group discussions, community meetings, directly in-person at the organisation, through health staff, workshops, providing ready to post envelopes etc.

Feedback refers to opinions, concerns, suggestions and advice of anyone affected by the IP to improve any aspect in the interaction between themselves and the IP. This interaction can relate to decision-making processes, operations, standards of technical performance, communications or any other aspect in the IP's work. Feedback also refers to the specific grievance of anyone who has been negatively affected by the IP or who believes that the IP has failed to meet a stated commitment. This commitment can relate

[17] Definition adapted from World Vision, Complaints and Response Mechanisms Resource Guide, First Edition, 2009.

to a project plan, beneficiary criteria, an activity schedule, a standard of technical performance, an organizational value, a legal requirement, staff performance or behavior, or any other point.[18]

AEI & CS Assessments are defined as the process of assessing an organisation's AEI & CS-related policies, systems and practices using the AEI & CS Assessment Tool. The process entails interviews with the implementing partner's management team, staff, communities, partners and other key external stakeholders, and is led an external organisation or the implementing partner itself.

Focus Group Discussions (FGDs) are required as part of the 3MDG AEI & CS Assessment process. FGDs must be conducted by 3MDG implementing partners in a minimum of 2 different townships, which have different operational contexts (urban/rural, access to health care services, conflict affected or not, etc.), including a minimum of 1 FGD with men and 1 FGD with women in each township. Selection of FGD participants must include intended project beneficiaries (including at least one person under 15 years old, at least one person over 60 years old, and one person from other traditionally disadvantaged groups (PWD, chronically sick, ethnic/ religious minority, extremely poor).

Sampled: As part of the AEI & CS assessment process, community members will be chosen to participate in focus group discussions concerning their experiences and perceptions about an implementing partner's AEI & CS practice.

Limitation: Data collection will be done at Focus Group Discussion Session and this may not reflect all community levels.

[18] Definition adapted from HAP, The Guide to the HAP Standard, Published by Oxfam GB, 2008.

| Output Indicator |
| --- |
| **5.2.3 Number and percentage of feedback that were addressed by the IP in the reporting period based on the IP's procedure (disaggregated by type of feedback)** |

| | |
| --- | --- |
| **Definition** | **Number and percentage of feedback addressed in the reporting period based on the IP's procedure, disaggregated by type of feedback (as defined in the procedure).** |
| **Numerator** | Number of feedback received by implementing partners that were addressed in the reporting period based on the IP's procedure. |
| **Denominator** | Total number of feedback received by implementing partners through formal mechanisms to provide feedback in the reporting period. |
| **Data sources** | IP reports and Feedback and Response Mechanism Records |
| **Reporting frequency** | Six Monthly |

**What it measures:** the extent to which feedback received by the IP through formal mechanisms is addressed by the IP based on a procedure that follows good practice.

Feedback refers to opinions, concerns, suggestions and advice of anyone affected by the IP to improve any aspect in the interaction between themselves and the IP. This interaction can relate to decision-making processes, operations, standards of technical performance, communications or any other aspect in the IP's work. Feedback also refers to the specific grievance of anyone who has been negatively affected by the IP or who believes that the IP has failed to meet a stated commitment. This commitment can relate to a project plan, beneficiary criteria, an activity schedule, a standard of technical performance, an organizational value, a legal requirement, staff performance or behavior, or any other point.[19]

Mechanisms to provide feedback are defined as the formal method(s) that implementing partners utilise to collect feedback from the communities in which they work to better understand their programs and projects from community members' perspectives. These mechanisms give the implementing partners information to adjust their programs and projects to best meet individual and community needs.[20] Examples include suggestions boxes, focus group discussions, community meetings, directly in-

[19] Definition adapted from HAP, The Guide to the HAP Standard, Published by Oxfam GB, 2008.

[20] Definition adapted from World Vision, Complaints and Response Mechanisms Resource Guide, First Edition, 2009.

person at the organisation, through health staff, workshops, providing ready to post envelopes etc.

Addressed means that the IP has fully followed the procedure (see below) and decided that no further action can or will be taken in relation to the feedback.

Procedure refers to a specified series of actions *defined by the IP* based on the context and taking into account good practice, through which the IP processes feedback and ensures that feedback is reviewed and acted upon. The procedure clarifies the purpose and limitations of feedback, how feedback can be raised, types of feedback and steps to be taken in order to decide if the feedback requires any action and/or a response to the feedback provider, the response timeframe for communicating with the feedback provider, etc.

Types of feedback[21] are categorized as Suggestion, (+) Positive Feedback, Concern, (-) Negative Feedback, Question and Others.

[21] Categories are adapted from 3DF Community Feedback Mechanism Report Template

| Output Indicator |
| --- |
| **5.3 Number and Percentage of implementing partners with improvement in their Accountability, Equity and Inclusion (AEI) and Conflict Sensitivity (CS) systems and practices** |

| | |
| --- | --- |
| **Definition** | **Percentage of implementing partners with improvement in their AEI & CS systems and practices in a calendar year, as measured through an AEI & CS assessment.** |
| **Numerator** | Number of implementing partners with improvement in their AEI & CS systems and practices in a calendar year, measured through an AEI & CS assessment |
| **Denominator** | Number of new or existing implementing partners contracted by 3MDG who had implemented AEI&CS assessment in the previous year |
| **Data sources** | AEI & CS Assessment Tool |
| **Reporting frequency** | Annually |

**What it measures:** The proportion of implementing partners that have taken practical steps and improved their organizational AEI & CS systems and practices.

Implementing partners are defined as organizations that have received grants from 3MDG to design, implement or deliver MNCH, HIV, TB or Malaria-related project, programs or services under Components 1 or 2 of the 3MDG program.

Improvement is defined as any increase in total score (percentage) on the AEI & CS Assessment Tool.

AEI & CS systems are comprised of the following elements:

1. Dedicated and capacitated **staff** with clear roles and responsibilities
2. **Funding** for development and implementation of AEI & CS systems and practices
3. Organizational **policies** and strategic plans for addressing AEI & CS needs/issues
4. Specific operating **procedures** or guidelines around AEI & CS issues or practices e.g. client complaints, stakeholder participation in service delivery
5. **Tools** that support AEI & CS policy and procedure operationalization
6. **Information systems** that support addressing AEI & CS needs, feedback, learning and performance improvement

Practice is defined as the actual application of AEI & CS concepts, theories and systems.

AEI & CS Assessments are defined as the process of assessing an organisation's AEI & CS-related policies, systems and practices using the AEI & CS Assessment Tool. The process entails interviews with the implementing partner's management team, staff, communities, partners and other key external stakeholders, and is led by an external organisation or the implementing partner itself.

| Output Indicator |
| --- |
| **5.4 Proportion of women representatives attending the annual Comprehensive Township Health Plan (CTHP) review workshop** |

| | |
| --- | --- |
| **Definition** | **Proportion of representatives attending the annual CTHP review workshop that are women.** |
| **Numerator** | Number of women representatives who attend the annual CTHP review workshop |
| **Denominator** | Total number of representatives attending the annual CTHP review workshop |
| **Data sources** | IP workshop records & reports |
| **Reporting frequency** | Annually |

**What it measures:** The representation of women in the CTHP review workshop, which is a local health decision-making and planning process in which communities, through their representatives, have an opportunity to influence health services planning to ensure services meet their needs.

The annual Comprehensive Township Health Plan (CTHP) review workshop is defined as the key annual workshop held at township level to assess CTHP progress and revision. It is led by the Township Medical Officer (TMO) and supported by 3MDG implementing partners.

Representatives are defined as persons chosen (through appointment, election or self-selection) to act and speak on behalf of a wider group in the annual CTHP review workshop.

Attending is defined as having been recorded as present on the annual CTHP review workshop attendance sheet for the duration of the workshop.

| Output Indicator |
| --- |
| **5.5.1 Proportion of women representatives on Township Health Committee** |

| | |
| --- | --- |
| **Definition** | **The total number of women representatives who sit on township health committee among the total representatives** |
| **Numerator** | Number of women representatives who sit on township health committee |
| **Denominator** | Total number of representatives who sit on township health committee |
| **Data sources** | Township Health Department (THD) and IP Reports |
| **Reporting frequency** | Six Monthly |

**What it measures:** This indicator assesses the representation of women in health decision-making bodies at the Township level.

Representatives are defined as persons chosen (through appointment, election or self-selection) to act and speak on behalf of a wider group in the respective health committee.

At each level of the Myanmar health system there is a Health Committee chaired by the Local Authority with membership of health officials and, at the lower levels, volunteers.

Township Health Committee definition is under review.

| Output Indicator |
| --- |
| **5.5.2 Proportion of women representatives on Village Tract Health Committees/Village Health Committees** |

| | |
| --- | --- |
| **Definition** | **The total number of women representatives who sit on village tract health committees/village health committees of the total representatives** |
| **Numerator** | Number of women representatives who sit on village tract and/or village health committees |
| **Denominator** | Total number of representatives who sit on village tract and/or village health committees |
| **Data sources** | Supervision Checklist (for VTHC and VHC) and Independent Evaluation |
| **Reporting frequency** | Six Monthly |

**What it measures:** This indicator assesses the representation of women in health decision-making bodies at village level. The participation of communities in health planning and implementation is enabled through village tract and village health committees, which play an increasingly important role in community health initiatives, assessments and fund management for emergency referrals. At each level of the Myanmar health system there is a Health Committee chaired by the Local Authority with membership of health officials and, at the lower levels, volunteers.
Representatives are defined as persons chosen (through appointment, election or self-selection) to act and speak on behalf of a wider group in the respective health committee.

Village Tract Health Committee and Village Health Committee definitions are under review. Some INGOs working at the village level have defined VHC for practical application. For example, on 3MDG implementing partner defines Village Health Committee (VHC) as an auxiliary body elected by the village members who plan, implements, supervises and evaluates village health activities (Improving Rural Access to Primary Health Care Project, 1999). VHCs are headed by the Chairperson or responsible person and include heads of related government departments and representatives from the social organisations as members. Heads of the health departments are designated as secretaries of the committees (Merlin 2013). The 3MDG Fund will work with partners to define Village Tract Health Committees and Village Health Committees. The participation of communities in health planning and implementation is enabled through village tract and village health committees which play an increasingly important role in community health initiatives, assessments and fund management for emergency referrals.

Supervision Checklist is a tool developed with 3MDG partners to routinely support and feedback on the routine activities of the village health committees. The 3MDG Independent Evaluation Group (IEG) will conduct independent evaluations (mid-term, final and impact) on the overall 3MDG programme and its gender programming.

# Annex 1: 3MDG MNCH Core Indicators (Private Sector)

(These Annex 1 indicators are intended only to be reported by 3MDG IPs contracted under Private Sector.)

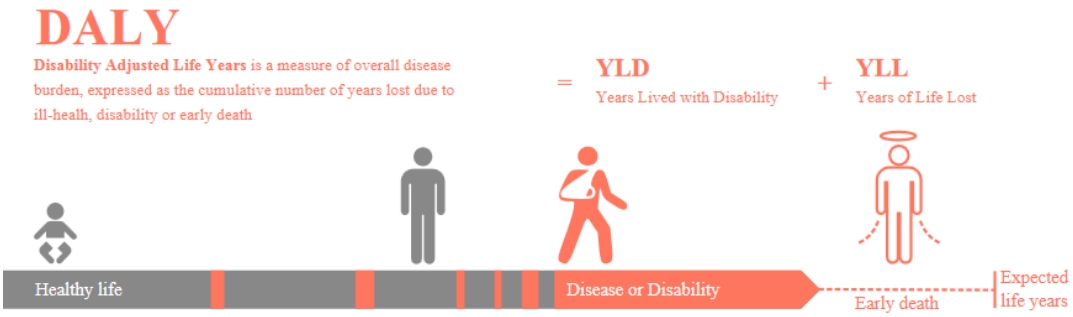
| Outcome Indicator |
| --- |
| **P.1 Contraceptive prevalence rate** |

Please refer to outcome indicator 5.2

| Outcome Indicator |
| --- |
| **P.2 DALYs averted** |

| | |
| --- | --- |
| **Definition** | The total number of DALYs averted, calculated based on the intervention (products/services) provided during this reporting period |
| **Data sources** | Partner record |
| **Reporting frequency** | Six monthly and annually |

**What it measures:** Disability-adjusted life year (DALY) is a time-based measure that combines years of life lost due to premature mortality (YLLs) and years of life lost due to time lived in states of less than full health, or years of healthy life lost due to disability (YLDs). http://www.who.int/healthinfo/global_burden_disease/gbd/en/index.html




Source:
http://en.wikipedia.org/wiki/File:DALY_disability_affected_life_year_infographic.svg

One DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability. http://www.who.int/healthinfo/global_burden_disease/metrics_daly/en/

**Note:** Calculation will be based on individual organisation's standard modelling tool. For reporting purpose, it is needed to provide breakdown DALYs calculation by each relevant intervention (products/services)

| Intervention products/services | Distribution (Annual) | Total DALYs averted by intervention |
|---|---|---|
| A | | |
| B | | |
| C | | |

**Output Indicator**

**P.1.1 Total number of Couple Years of Protection (CYPs) delivered**

Please refer to output indicator 1.1

**Output Indicator**

**P.1.2 Number of clinics providing family planning and/or under five children health care services (excluding mobile services)**

| | |
|---|---|
| **Definition** | **The number of clinics providing family planning services and/or under five children health care services during this reporting period** |
| **Data sources** | Partner record |
| **Reporting frequency** | Six monthly and annually |

**What it measures:** This indicator measures access to family planning (FP) products and services and child health services. The private sector can help increase clients' access to services and products by a number of means from having convenient hours and locations, maintaining supplies when public sector providers experience stock outs, using generic products to reduce prices, to utilising alternative approaches, such as mobile units to reach underserved areas. (MEASURE evaluation PRH)

Family planning services refer to clinical services (oral contraceptive pills, injections, IUD insertion, Implantation, and condom distribution), and/or counselling and/or also awareness session and/or behaviour communication change sessions and/or referrals for methods requiring higher levels of care such as sterilisation that are provided in the clinic.

**Note:** A clinic is a health care facility that is primarily devoted to care of out- patients. For this indicator, a clinic can be directly managed by the organisation or privately operated clinic (GP) supported by the organisation, which can be static (almost always operate at fixed place and regular clinic hour/day).

| Output Indicator |
| --- |
| **P.1.3 Number of outlets providing family planning products** |

| | |
| --- | --- |
| **Definition** | **The number of outlets providing family planning products during this reporting period** |
| **Data sources** | Partner record |
| **Reporting frequency** | Six monthly and annually |

**What it measures:** This indicator measures the availability of family planning products by beneficiaries in needs.

Outlets refer to commercial pharmacy and non-pharmacy outlets, and clinics just receiving family planning products excluding the clinics (mentioned in P.1.2's note). Family planning products include oral contraceptive pills, injections and condoms.

| Output Indicator |
| --- |
| **P.2.1 Number of trained health personnel (doctor/nurse) providing family planning services** |

| | |
| --- | --- |
| **Definition** | **Number of doctors and nurses in a 3MDG supported partner clinic (including GPs supported by the partner) that have received training in providing family planning services** |
| **Data sources** | Partner record |
| **Reporting frequency** | Six monthly and annually |

**What it measures:** This indicator measures the coverage of training. It does not measure the quality of training. Development of human capacity through training is one of the indicators for strengthening systems for delivery of family planning services. Family planning services refer to clinical services (oral contraceptive pills, injections, IUD insertion, Implantation, and condom distribution), and/or counselling and/or also awareness session and/or behaviour communication change sessions and/or referrals for methods requiring higher levels of care such as sterilisation.

| Output Indicator |
| --- |
| **P.2.2 Number of trained field staff providing family planning services** |

| | |
| --- | --- |
| **Definition** | **Number of partner staff responsible for field/outreach activities that have received training in providing family planning services** |
| **Data sources** | Partner record |
| **Reporting frequency** | Six monthly and annually |

**What it measures:** Please refer to output indicator P.2.1

| Output Indicator |
| --- |
| **P.5.1 Number of townships in which quality assurance assessments were completed during this reporting period** |

| | |
| --- | --- |
| **Definition** | **Number of township in which quality assurance assessments such as mystery clients, client exit interviews and/or quality assurance monitoring that assess whether minimum clinical standards are followed** |
| **Data sources** | Partner record |
| **Reporting frequency** | Six monthly and annually |

**What it measures:** This indicator measures the quality of specific services provision (family planning service) and whether all required elements/steps are present to provide routine care, for example, diarrhoea treatment for child health services, routine procedure of IUD insertion for family planning services. The assessment tools such as questionnaires/checklists used for quality assurance assessment defined in this indicator, must reflect generally accepted standards for family planning services and child health services in accordance with standard technical guidelines such as 'UNFPA guidelines on reproductive health' and 'IMMCI' with local adaptation as necessary whenever relevant.

| Output Indicator |
| --- |
| **P.5.2 Number of clinics (excluding mobile services) in which quality assurance assessments were completed during this reporting period** |

| | |
| --- | --- |
| **Definition** | **Number of clinics in which quality assurance assessments such as mystery clients, client exit interviews and/or quality assurance monitoring that assess whether minimum clinical standards are followed** |
| **Data sources** | Partner record |
| **Reporting frequency** | Six monthly and annually |

**What it measures:** Please refer to output indicator P.5.1.

**Note:** Clinic is a health care facility that is primarily devoted to care of out-patients. For this indicator, clinic can be the one directly managed by the organisation or privately operated clinic (GP) supported by the partner, which can be static (almost always operate at fixed place and regular clinic hour/day).

# Annex 2: Antenatal check

(1) Obstetric history
(2) Previous obstetric history
(3) Present obstetric care
- Blood pressure (BP) is measured
- Fundal height is measured
- Presenting part is determined
- Weight of the mother is taken
- Height of the mother is taken
- Foetal heart is auscultated
- Mother is examined for pallor
- Mother checked for oedema
- Urine Protein checked
- Urine sugar checked
- HIV screening done
- Tested for syphilis
- Deworming medications given
- Iron supplementation given

(Source: Myanmar MCH handbook)

# Annex 3: Postnatal check for mothers

Postnatal care
- Body Temperature
- Blood Pressure
- Pallor
- Breast examination
- Abdominal examination
- Vaginal discharge or prolonged or excessive bleeding
- Wound healing of any tears or episiotomy
- B1 tablets are provided
- Vit A is provided
- Iron/Folate supplementation is provided
- Family planning counselling (within 45 days)
- Others signs

(Source: Myanmar MCH handbook)

# Annex 4: What are the CYP conversion factors?

| Method | CYP Per Unit |
|---|---|
| Copper-T 380-A IUD | 4.6 CYP per IUD inserted<br>(3.3 for 5 year IUD e.g. LNG-IUS) |
| 3 year implant (e.g. Implanon) | 2.5 CYP per implant |
| 4 year implant (e.g. Sino-Implant) | 3.2 CYP per implant |
| 5 year implant (e.g. Jadelle) | 3.8 CYP per implant |
| Emergency Contraception | 20 doses per CYP |
| Fertility Awareness Methods | 1.5 CYP per trained adopter |
| Standard Days Method | 1.5 CYP per trained adopter |
| LAM | 4 active users per CYP (or .25 CYP per user) |
| Sterilisation*<br>Global<br>(India, Nepal, Bangladesh) | <br>10<br>13 |
| Oral Contraceptives | 15 cycles per CYP |
| Condoms (Male and Female) | 120 units per CYP |
| Vaginal Foaming Tablets | 120 units per CYP |
| Depo Provera (DMPA) Injectable | 4 doses per CYP |
| Noristerat (NET-En) Injectable | 6 doses per CYP |
| Cyclofem Monthly Injectable | 13 doses per CYP |
| Monthly Vaginal Ring/Patch | 15 units per CYP |

***The CYP conversion factor for sterilisation varies because it depends on when the sterilisation is performed in the reproductive life of the individual.**

Source: USAID, 2011

# Annex 5: 3MDG hard to reach definition

**BACKGROUND**

Identification of hard-to-reach (HtR) villages in 3MDG funded townships is important for policy formulation, programme planning and delivery of services because it enables the FMO, donors, partners and the Government to have a clear view of populations that face serious inequities based on physical location, communication difficulties, security challenges, poverty and socioeconomic status.

**RATIONALE**

***Problems with 'Hard to reach' terminology (ISR Working Paper, January 2007, Nicola Brackertz)***

There is a lack of clarity about what exactly is meant by 'hard to reach'. The term is employed inconsistently; sometimes it is used to refer to minority groups, such as ethnic people, gays and lesbians, or homeless people; it can be used to refer to 'hidden populations', i.e. groups of people who do not wish to be found or contacted, such as illegal drug users or gang members; while at other times it may refer to broader segments of the population, such as old or young people or people with disabilities (Jones & Newburn 2001: vi).

In the service context, hard to reach often refers to the 'underserved', namely minority groups, those slipping through the net, and the service resistant (Doherty et al. 2004). An alternative term used in the sampling context is 'hidden populations' (Atkinson & Flint 2001; Duncan et al. 2003), as in they are hidden from the point of view of sampling. Hidden populations may also actively seek to conceal their group identity, as for example in the case of illicit drug users, gays and lesbians, sexually active teens, etc. (Duncan et al. 2003).

***The Nature of HtR Classifications within JIMNCH (Source: Documenting Lesson Learnt from JIMNCH)***

At the start of JIMNCH, HtR communities were said to be jointly identified by the township health authority and the implementing partners using geographical criteria. Final selections were decided by township health authorities, considering the views of township health staff and standard criteria within the Expanded Programme on Immunisation (EPI), based on vaccination coverage. Several informants stated that there was no prior consensus on HtR definitions or the selection criteria. This was mirrored by a reported lack of a generally agreed strategy for reaching HtR populations among donors, partners and the Government. One set of criteria used in these initial allocations, based on EPI definitions, incorporated distance to service delivery points and included:

- Within 5 km: Midwife visits are reduced and mothers are expected to visit the clinic (not including journeys by river) is not HtR
- Within 5 to 10 km: A clear definition was not reached as to if this was HtR or not HtR.
- Above 10 km: Planned as mobile visits is HtR

Other HtR criteria varied with different implementers and included:

- Over 3 to 5 miles distance from the health centre (RHC or a Sub Centre)
- More than 2 hours distance to reach to the nearest health centre
- Outreach teams cannot get out and return to the health station within a day trip
- Where there is no appointed MW in the village or village tract for more than a year

*"There was not really a clear definition, there was a hard to reach mapping workshop only this rainy season just now. For everyone, hard to reach is "hard to get there" and is really far away, for people in the community is hard to get to the health facility. There were arguments and questions about does H2R mean people living in urban slums, due to their social awareness and skills lacking, they were hidden among the population. But for me I don't think they are hard to reach if the programme is working and if you have the right strategy they can be reached. This is still a debate."* **Key informant partner interviewee, Yangon**

In response to these inconsistencies, HtR workshops at regional and central levels were conducted with partners and township health authorities in mid-2012. In these discussions, central level stakeholders supported a GAVI definition of "Hard to Reach" that included geographically inaccessible areas, the urban poor, populations living in conflict areas, and other socially or economically marginalised populations. However many township level implementers argued that for Ayeyarwady geographical criteria were more important and that an overly broad definition would not help with clear HtR identification or a focused strategy. The result was that IP identification of HtR remained largely geographical with few changes of defined HtR areas. These opinions are representative of a broad acknowledgement that in reality being HtR represents more than just geographical location and also includes criteria such as local availability of transportation, socio-economic status, and ethnicity.

However, the findings of the review suggested that the geographical definition has predominated, that a totally clear definition of HtR is yet to be established, and that there is still work to do to identify whether geographical or socio economic criteria should have priority.

*"There is no target set for hard to reach village. There are various definitions on hard to reach, geographically hard to reach, economically hard to reach, culturally hard to reach, socially hard to reach. There is not only geographically hard to reach. There are other categories of hard to reach. The definition is there but just defining hard to reach took nearly one and a half year (laughing). Just reaching the hard to reach, is it what we want? So reaching to a heard to reach area once means, we reach the hard to reach. So there must be a target: once a month, twice or thrice. What is the target, there is no target to reach, only when you reach four times you say this is complete like that is not defined. So I don't think target is not defined to reach exactly."* **Key informant interviewee, Yangon**

**3MDG FMO Definition on Hard to Reach Villages**

In 3MDG funded townships, the entire population will benefit from the Fund including urban poor, sociocultural or economically marginalised people. The main intention of defining hard to reach areas is to make sure for those, who fail to access to nearest health facility because of geographical barriers, which also limits the health staff access them in order to provide health services, receive at least basic essential health care services for mothers and children like immunisation and quality antenatal care as well as access to emergency referral services.

Based on a literature review and for simplicity and feasibility, **3MDG will define hard-to-reach as geographically hard-to-reach,** as the measurement can be standardised (travelling hours, mode of travel etc. and it is relatively simple to calculate. The Fund acknowledges that there are different contexts, factors and different scenarios that impact upon the ability to reach certain populations, however the most practical approach will be followed by the Fund.

When calculating hard-to-reach, geographic and transportation barriers should be considered, for example, travelling the same distance in the Magway central plain region and a Chin hilly area requires different levels of effort, time and cost. Transport charge is locally adapted cost by village identified to the nearest health post. It is particularly reflected on distance and mode of transport. It can be categorised into high, medium, low and no cost. In addition, seasonal variations and road conditions are important factors when defining hard-to-reach.

In terms of security, the scope limits to armed conflict and ethnic conflict. Public services provision including health services comes up with difficulties or not so possible in concerned area. It is generally regarded as unreached or uncovered if there is security concern. However, there are other influencing factors that the area becomes possible to reach. One of the factors may be local health staff gets a deal with local security forces to provide service. As it is rather complex in security issue, the Fund will have the list of uncovered or unreached villages defined by Township Health Department.

**3MDG hard-to-reach is defined primarily by geographical barriers and is scored as follows:**

| Description | Criteria | Total |
|---|---|---|
| **A.** Traveling time to nearest functioning health facility (by any means) (functioning is defined as a health facility with a midwife and necessary basic supplies) | 1. More than 4 hours | 3 |
| | 2. 2 to 4 hours | 2 |
| | 3. 1 to 2 Hours | 1 |
| | 4. Less than 1 hour | 0 |
| | **Score** | |
| **B.** Mode of travel to nearest functioning health facility (functioning is defined as a health facility with a midwife and necessary basic supplies) | 1. Walking | 3 |
| | 2. Vehicle (non-motorised, laboured) | 2 |
| | 3. Vehicle (animal powered) | 1 |
| | 4. Motorised vehicle | 0 |
| | **Score** | |
| **C.** Transport charge | 1. High | 3 |
| | 2. Medium | 2 |
| | 3. Low | 1 |
| | 4. No cost | 0 |
| | **Score** | |
| **D.** Road access affected by seasonal variation | 1. Affected year round | 3 |
| | 2. Affected 8 months | 2 |
| | 3. Affected 4 months | 1 |
| | 4. Not affected | 0 |
| | **Score** | |

Score ranges from 0 to 12, can be divided into three groups – Non hard to reach (0 - 3), hard to reach (4 – 7) and very hard to reach (8 and above). The villages score hard to reach and very hard to reach are grouped as Hard to Reach Villages.

# Annex 6: Administering Iron Supplement Tablets

1. A pregnant woman should take 180 iron supplement tablets during pregnancy, receiving 30 tablets for 6 times.

2. Before the seventh month of pregnancy, one iron supplement tablet (ferrous sulphate) should be taken at bedtime.
   (Once the pregnancy is ascertained, 30 iron supplement tablets (one tablet per day every day for a month) should be provided every month until seventh month of pregnancy.)

3. After the seventh month of pregnancy, one iron tablet should be taken at a time, two times a day (one in the morning and one at bedtime). (30 tablets should be provided each time, in a dose of two tablets per day for two weeks.)

Source: Data Dictionary for Health Services Indicators (MoH, Myanmar)

# Annex 7: Accountability, Equity and Social Inclusion Glossary of Terms

| | |
|---|---|
| Responsibility | • Practice good governance and accountability<br>• Keep commitments to the people who use health services<br>• Listen (and respond to) the voices of people<br>• Empower and inform users of the health system |
| Fairness (Equity) | • Being fair and just to all people who use the health system.<br>• Recognising that people are different and need different support to ensure their rights are recognised. |
| Gender Equity | • Being fair to women and men.<br>• Taking specific actions to address historical and social discrimination and disadvantages in Myanmar that prevent women and men from otherwise operating as equals |
| Health Equity | • All people have the opportunity to have the highest level of health.<br>• Understanding the different barriers to health that people face and working to address them.<br>• All people can access quality health care regardless of their socio-economic position, including age, disability, gender or other circumstances.<br>• Ensuring that health policies and services respond to the specific needs of different groups of people. |
| Inclusion | • Involves all people in decisions that affect their health.<br>• Understanding diverse experiences and preferences, and enabling people from many different circumstances (e.g. cultural, linguistic and geographic) to participate in health care planning.<br>• Mutual respect, tolerance and making all people feel valued.<br>• Ensuring that all voices are considered in decision-making processes |
| Empowerment | • People – both men women and men – taking control over their lives.<br>• People setting their own agendas, gaining skills, building self-confidence, solving problems, and developing self-reliance.<br>• Supporting efforts by communities to carry out collective actions.<br>• Building confident and informed users of the health system.<br>• Creating ownership |
| Conflict Sensitivity | • Capacity of an organisation to understand the context in which it operates, how its activities influence that context and vice-versa, and to act upon that understanding to maximise positive impacts and avoid negative ones (“do no harm”). |

## Annex 8[22]: At Glance Sheet for 3MDG Component 1: MNCH Core Indicators and AEI indicators

| Indicator | Numerator | Denominator | Source | Reporting frequency | Note |
|---|---|---|---|---|---|
| **Maternal Mortality Ratio per 100,000 live births** | All maternal deaths occurring in a given period * 100,000 | Total number of live births in the same period | Population based surveys (Census, DHS), Lives Saved Tool (LiST) Modelling and/or UN modelling for annual data | Based on survey plan | Impact indicator 1 |
| **Under-five child mortality per 1,000 live births (disaggregated by sex)** | Number of deaths of children aged 0-4 years in a given period * 1,000 | Total number of live births in the same period | Population based surveys (Census, DHS) LiST Modelling and/or UN modelling for annual data | Based on survey plan | Impact indicator 2 |
| **Neonatal mortality rate per 1,000 live births (disaggregated by sex)** | Number of deaths within the first 28 completed days of life (0-27 days) in a given period * 1,000 | Total number of live births in the same period | Population based survey (DHS), LiST Modelling and/or UN modelling for annual data | Based on survey plan | Impact indicator 3 |
| **Number and percentage of births attended by skilled health personnel (doctor,** | The total number of home deliveries and deliveries at public hospitals/clinics/delivery rooms and private hospitals/clinics/delivery | Total number of births in the same period | HMIS | Six monthly and annually (both number and | Outcome indicator 1.1 |

[22] Generally, primary Data source for all HMIS indicators is the HMIS recording forms recorded by the responsible BHS. For those indicators implemented by implementing partner (IP) (e.g referral), the data source will be the IP's records. Individual township impact result cannot be reported without having population based survey. Data source for impact indicators will be the national survey and/or UN estimation. Implementing partners are responsible to report these all indicators in accordance with the contracted Log Frame, to 3MDG FMO six monthly basis for first half of the year covering the period of January to June and second half of the year covering the period of January to December of reported year. Detail explanation can be seen in guideline.

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| **nurse, lady health visitor or midwife)** | rooms by skilled attendants during this reporting period | | | percentage together with denominator figure) | |
| **Number and percentage of births attended by trained AMW** | The number of deliveries made by the AMWs themselves without help from midwives or LHV, during this reporting period | Total number of births in the same period | HMIS | Six monthly and annually (both number and percentage together with denominator figure) | Outcome indicator 1.2 |
| **Number and percentage of institutional deliveries** | Total number of deliveries by skilled health personnel at hospitals and delivery rooms during this reporting period (public as well as private) | Total number of births in the same period | HMIS | Six monthly and annually (both number and percentage together with denominator figure) | Outcome indicator 1.3 |
| **Number and percentage of women attended at least four times during pregnancy by skilled health personnel for reasons related to the pregnancy** | Total number of mothers who received at least 4 times of antenatal care from health staff during this reporting period | Total number of births in the same period | HMIS | Six monthly and annually (both number and percentage together with denominator figure) | Outcome indicator 2 |
| **Number and percentage of mothers and newborns who received postnatal care visit within** | Total number of newborns receiving newborn care within 3 days after birth during this reporting period | Total number of live births in the same period | HMIS | Six monthly and annually (both number and percentage | Outcome indicator 3 |

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| **three days of childbirth** | | | | together with denominator figure) | |
| **Number and percentage of newborns that initiate immediate breastfeeding within one hour after birth (disaggregated by sex)** | Total number of newborns put to the breast within one hour of birth by their mothers, during this reporting period | Total number of live births in the same period | HMIS | Six monthly and annually (both number and percentage together with denominator figure) | Outcome indicator 4 |
| **Contraceptive prevalence rate** (HMIS) | Number of married couples practicing birth spacing (any method) at present during this reporting period | Number of married couples with the wife's age between 15 and 49 years in the same period | HMIS | Annually | Outcome indicator 5 |
| **Percentage of under five children who had diarrhoea receiving ORT (disaggregated by sex and age)** | Number of children aged 0-59 months with diarrhea in the last two weeks who were treated with oral rehydration salts and/or recommended home fluids | Number of children aged 0-59 months surveyed who had diarrhea in the last two weeks | Population-based surveys (DHS, MICS) | Based on survey plan | Outcome indicator 6 |
| **Percentage of under five children with suspected pneumonia who received appropriate antibiotics (disaggregated by sex and age)** | Number of children age 0-59 months with suspected pneumonia in the two weeks prior to the survey receiving antibiotics | Total number of children age 0-59 months with suspected pneumonia in the two weeks prior to the survey | Population-based surveys (DHS, MICS) | Based on survey plan | Outcome indicator 7 |
| **Number and percentage of** | Number of children 0-11 months immunized with | Total number of under1 children in | HMIS | Six monthly (number | Outcome indicator |

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| **children under one immunized with DPT3/Penta3 (disaggregated by sex)** | DPT3/Penta vaccine for the third time during this reporting period | the same period | | only) and annually (both number and percentage together with denominator figure) | 8.1 |
| **Number and percentage of children under one immunized with Measles (disaggregated by sex)** | Number of children 0-11 months immunized with measles vaccine during this reporting period | Total number of under1 children in the same period | HMIS | Six monthly (number only) and annually (both number and percentage together with denominator figure) | Outcome indicator 8.2 |
| **Total number of Couple Years of Protection (CYPs) delivered through public sector services and private sector channels in i) Component 1 townships ii) non-Component 1 townships** | CYP is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, to yield an estimate of the duration of contraceptive protection provided per unit of that method. The CYP for each method is then summed for all methods to obtain a total CYP figure | | Partner service statistics and logistics management information systems | Six monthly and annually (number only) | Output indicator 1.1 |

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| **Number and percentage of appropriate EmOC referrals supported - Total** | Number of women referred and supported for emergency obstetric care during pregnancy, delivery and postnatal period during this reporting period. | Total number of expected pregnancies [23] in the same period | Referral record (THD/Partner) | Six monthly and annually (number only) | Output indicator 1.2.1 |
| **Number of appropriate EmOC referrals supported – hard to reach areas** | The total number of women residing in hard to reach villages, who require emergency obstetric care at Station, Township or District Hospitals, during pregnancy, delivery and postnatal period that are supported for referrals during this reporting period. Support includes financial assistance for transportation costs and/or meal costs and/or medicine costs and/or investigation costs and/or operation costs. Costs are covered for patients only or both patients and a caregiver | | Referral record (THD/Partner) | Six monthly and annually (number only) | Output indicator 1.2.2 |
| **Number of ECC referrals supported – Total** | The total number of children under five that require emergency child care at Station, Township or District Hospitals that are supported for referrals during this reporting period. Support includes financial assistance for return transportation costs and/or meal costs and/or medicine costs and/or investigation costs and/or operation costs. Costs are covered for patients only or both patients and a caregiver. | | Referral record (THD/Partner) | Six monthly and annually (number only) | Output indicator 1.2.3 |
| **Number of ECC referrals supported - hard to reach areas** | The total number of children under five residing in hard to reach villages that require emergency child care at Station, Township or District Hospitals that are supported for referrals during this reporting period | | Referral record (THD/Partner) | Six monthly and annually (number only) | Output indicator 1.2.4 |

[23] In global practice, the denominator is total number of expected deliveries

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| | Support includes financial assistance for transportation costs and/or meal costs and/or medicine costs and/or investigation costs and/or operation costs. Costs are covered for patients only or both patients and a caregiver | | | |
| **Number of under five children diarrhoea cases treated with ORT at Health Facilities** | The total number of under five children (aged 0-59 months) with diarrhoea who were given *extra fluids available at home* such as soups, rice water, fruit juice, plain water *and oral rehydration solution* | HMIS | Six monthly and annually | Output indicator 1.3.1 |
| **Number of under five children diarrhoea cases treated with ORS + Zinc at community by volunteers** | Number of under five children diarrhoea cases treated with ORS and Zinc supplements through trained volunteers during this reporting period | Volunteer record (from VRS) | Six monthly and annually | Output indicator 1.3.2 |
| **Number of under five children suspected pneumonia cases treated with antibiotics at Health Facilities** | The total number of children aged 0-59 months with pneumonia receiving antibiotics treatment among under five children who suffered from pneumonia. | HMIS | Six monthly and annually | Output indicator 1.4.1 |
| **Number of under five children suspected pneumonia cases treated with antibiotics at community by volunteers** | Number of under five children suspected pneumonia cases treated with antibiotics through volunteers, during this reporting period | Volunteer record (from VRS) | Six monthly and annually | Output indicator 1.4.2 |

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| **Number and percentage of postnatal mothers who received Vitamin A supplements** | Total number of postnatal mothers who received Vitamin A supplements during this reporting period | Estimated number of pregnant women in the same period | HMIS | Six monthly and annually (both number and percentage together with denominator figure) | Output indicator 1.5.1 |
| **Number and percentage of postnatal mothers who received iron supplements 4 times or more during pregnancy** | Total number of postnatal mothers who received iron supplements 4 times or more during pregnancy during this reporting period | Estimated number of pregnant women in the same period | HMIS | Six monthly and annually (both number and percentage together with denominator figure) | Output indicator 1.5.2 |
| **Number and percentage of pregnant mothers who received B1 tablets** | Total number of pregnant mothers who received B1 supplements during this reporting period | Estimated number of pregnant women in the same period | HMIS | Six monthly and annually (both number and percentage together with denominator figure) | Output indicator 1.5.3 |
| **Number and percentage of postnatal mothers who received B1 tablets** | Total number of postnatal mothers who received B1 supplements during this reporting period | Estimated number of pregnant women in the same period | HMIS | Six monthly and annually (both number and percentage together with denominator figure) | Output indicator 1.5.4 |
| **Number and percentage of** | Number of pregnant women who received the | Estimated number of pregnant women | HMIS | Six monthly and annually | Output indicator |

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| **pregnant women vaccinated against tetanus toxoid (TT2)** | 2nd dose of tetanus toxoid during this reporting period | in the same period | | (both number and percentage together with denominator figure) | 1.6 |
| **Number of doctors, nurses and midwives who participated in at least one MNCH training including delivery and emergency obstetric care** | Number of BHS in the township trained during this reporting period (BHS by highest number in each type _Doctor, Nurse, MW, THN, LHV) should be reported only once, no matter how many trainings s/he received during the reporting period). | | Training record (THD/Partner) | Six monthly and annually | Output indicator 2.1.1 |
| **Number of new AMW trained** | The total number of new AMWs who received basic training in providing necessary care and advice to women during pregnancy, childbirth and the post-partum period by Basic Health Staffs according to Ministry of Health training manuals | | Training record (THD/Partner) | Six monthly and annually (number only) | Output indicator 2.1.2 |
| **Number of new CHW trained** | The total number of new CHWs that received basic 28 days CHW training course by Township Health Training team according to Ministry of Health Training Manual | | Training record (THD/Partner) | Six monthly and annually (number only) | Output indicator 2.1.3 |
| **Number and percentage of hard to reach villages with AMW** | Total number of hard to reach villages with functioning AMWs during this reporting period | Total number of hard to reach villages in that area in the same period | Report (THD/Partner) | Six monthly and annually (both number and percentage together with denominator figure) | Output indicator 2.1.4 |
| **Number and percentage of hard** | Total number of hard to reach villages with | Total number of hard to reach | Report (THD/Partner) | Six monthly and annually | Output indicator |

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| **to reach villages with CHW** | functioning CHWs during this reporting period | villages in that area in the same period | | (both number and percentage together with denominator figure) | 2.1.5 |
| **Number and percentage of auxiliary midwives and community health workers receiving quarterly supervision and monitoring** | Number of AMW and CHW in total who received supervision and monitoring by BHS, or IP, or joint supervision team (BHS and IP together) using the supervision checklist **during each quarter,** for the reporting period | Total number of functioning auxiliary midwives and community health workers **during each quarter** | IP reports (Data collection based on Standardized VHW Supervision Checklist ) | Six monthly and annually (both number and percentage together with denominator figure) | Output indicator 2.2 |
| **Number and percentage of functioning AMWs and CHWs who report no stock-outs of essential medicines and supplies** | **Monthly:** Total number of functioning AMWs and CHWs reporting no stock out of ANY of the above selected medicines and supplies at any time during the reported month | **Monthly:** Total number of functioning AMWs and CHWs. | Volunteer record (from VRS) | Six monthly and annually (both number and percentage together with denominator figure) | Output indicator 2.3 |
| **Proportion of community members reporting receiving services of 'good' quality or better** | This indicator is under discussion and wait for Fund Board' further guidance | | | | Outcome indicator 14 |
| **Number of staff from Ministry of Health (MoH), Implementing Partners (IPs), local Non-Governmental** | Number of staff from MoH, IPs, local NGOs and CBOs (at central, regional and township level) in AEI & CS in a calendar year | N/A | IP training records | Six monthly and annually | Output indicator 5.1 |

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| **Organisations (NGOs) and Community-Based Organisations (CBOs) (at central, regional and township level), trained in Accountability, Equity, Inclusion and Conflict Sensitivity (AEI & CS)** | (disaggregated by sex and age). | | | | |
| **Numbers and percentage of community members aware of mechanism(s) to provide feedback in 3MDG-supported areas (disaggregated by sex and age)** | Number of community members from the focus group discussion who report being aware of formal mechanism(s) to provide feedback in 3MDG-supported areas at time of measurement (disaggregated by sex and age) | Total number of community members from the focus group discussion in 3MDG-supported areas (disaggregated by sex and age) | AEI & CS Assessment Tool | Annually | Output indicator 5.2.1 |
| **Numbers and percentage of community members that use mechanism(s) to provide feedback in 3MDG-supported areas (disaggregated by sex and age)** | Number of community members from the focus group discussion and who use formal mechanism(s) to provide feedback in 3MDG-supported areas at time of measurement (disaggregated by sex and age) | Total number of community members from the focus group discussion in 3MDG-supported areas (disaggregated by sex and age) | AEI & CS Assessment Tool | Annually | Output indicator 5.2.2 |
| **Number and percentage of feedback that were addressed by the IP in** | Number of feedback received by implementing partners that were addressed in the reporting | Total number of feedback received by implementing partners through | IP reports and Feedback and Response Mechanism | Six Monthly | Output indicator 5.2.3 |

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| **the reporting period based on the IP's procedure (disaggregated by type of feedback)** | period based on the IP's procedure | formal mechanisms to provide feedback in the reporting period | Records | | |
| **Number and Percentage of implementing partners with improvement in their Accountability, Equity and Inclusion (AEI) and Conflict Sensitivity (CS) systems and practices** | Number of implementing partners with improvement in their AEI & CS systems and practices in a calendar year, measured through an AEI & CS assessment | Number of new or existing implementing partners contracted by 3MDG who had implemented AEI&CS assessment in the previous year | AEI & CS Assessment Tool | Annually | Output indicator 5.3 |
| **Proportion of women representatives attending the annual Comprehensive Township Health Plan (CTHP) review workshop** | Number of women representatives who attend the annual CTHP review workshop | Total number of representatives attending the annual CTHP review workshop | IP workshop records & reports | Annually | Output indicator 5.4 |
| **Proportion of women representatives on Township Health Committee** | Number of women representatives who sit on township health committee | Total number of representatives who sit on township health committee | Township Health Department (THD) and IP Reports | Six monthly | Output indicator 5.5.1 |
| **Proportion of women representatives on Village Tract Health Committees/Village Health Committees** | Number of women representatives who sit on village tract and/or village health committees | Total number of representatives who sit on village tract and/or village health committees | Supervision Checklist (for VTHC and VHC) and Independent Evaluation | Six monthly | Output indicator 5.5.2 |

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