3MDG Sexual and Reproductive Health Indicator Guidelines

Version-1, June 2018

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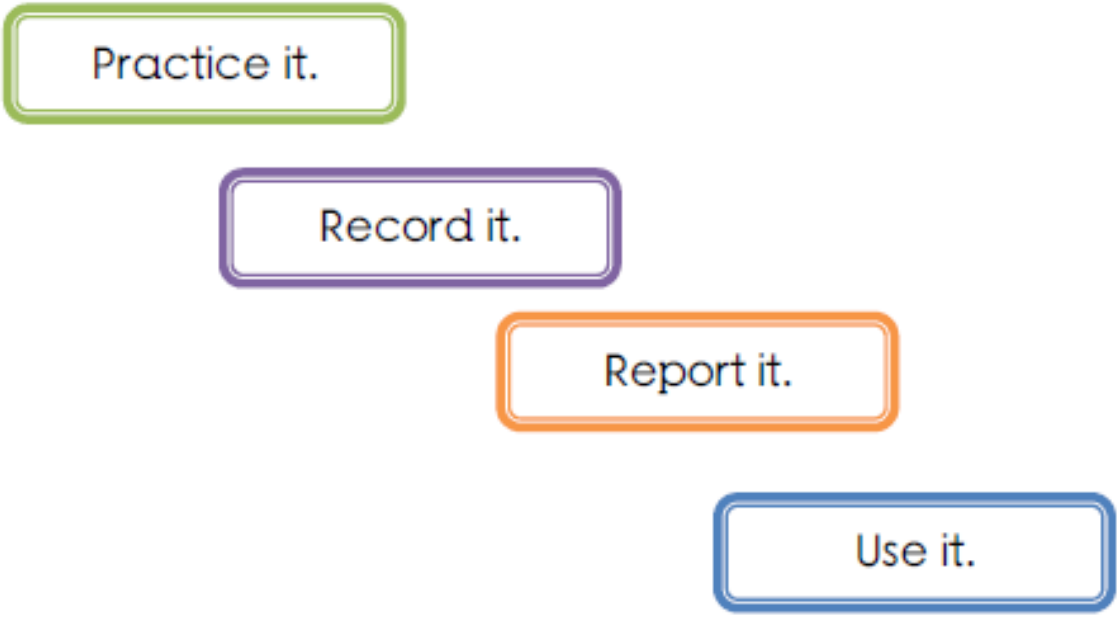

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Acronyms List

3MDG	Three Millennium Development Goal Fund
AEI & CS	Accountability, Equity, Inclusion and Conflict Sensitivity
AIDS	Acquired Immune Deficiency Syndrome or Acquired Immunodeficiency Syndrome
AYFHS	Adolescent and Youth Friendly Health Services
BHS	Basic Health Staff
CBO	Community-Based Organisations
CIN	Cervical Intraepithelial Neoplasia
CLIC	Client Information Centre
DOPH	Department of Public Health
EHO	Ethnic Health Organizations
FHI	Family Health International
FIGO	Federation of Gynaecology and Obstetrics
FMO	Fund Management Office
FP	Family Planning
FPET	Family Planning Estimation Tool
GBV	Gender-Based Violence
GP	General Practitioners
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPV	Human papilloma Virus
IEC	Information, Education and Communication
IP	Implementing Partners
MDHS	Myanmar Demographic Health Survey
MNCH	Maternal, Newborn and Child Health
MoHS	Ministry of Health and Sports
MRH	Maternal and Reproductive Health
MSI	Marie Stopes International
MVA	Manual Vacuum Aspiration
NGO	Non-Governmental Organization
PAC	Post-abortion Care
PAHO	Pan American Health Organization
PSI	Population Service International
RH	Reproductive Health
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
TB	Tuberculosis
USAID	United States Agency for International Development
VIA	Visual Inspection with Acetic Acid
WHO	World Health Organization

Introduction

The overall objective for Sexual and Reproductive Health and Rights (SRHR) activities of the Three Millennium Development Goal Fund (3MDG) is to improve sexual and reproductive health related services and their rights in Myanmar. The indicators are linked/aligned with Five-Year Strategic Plan for Reproductive Health (2014-2018) Logical Framework Matrix and FP2020 Core Indicator 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 Sexual and Reproductive Health and Rights

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 Sexual and Reproductive Health and Rights indicators for 3MDG, which were derived from the 3MDG Logical Framework, Data Dictionary for Health Service Indicators (2014 June, DoPH, MoH), A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs (MEASURE Evaluation, June 2000) and Monitoring National Cervical Cancer Prevention and Control Programmes (WHO, PAHO, 2013). Partners are strongly encouraged to integrate the SRHR 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.

3MDG MNCH SRHR Indicators[1] List

Outcome Indicator			
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
Outcome P.1	Contraceptive prevalence rate	Programme area survey including baseline and end line survey	9
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Additional indicators: Improving access to sexual and reproductive health information/literacy for Youths and promoting safe and responsible behaviors		**Source**	**Page**
SRHR_Output 1.1	Number of youth peer educator volunteers trained and supported in ASRH	Partner record	16
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SRHR_Output 1.3	Number of young people reached by interpersonal communication approach	Partner record	18
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SRHR_Output 2.1	Number of service providers (BHS) who received family planning counselling training during this reporting period	Partner record	20
Additional indicators: Improving access to sexual and reproductive health and rights (SRHR) information for general population (≥25 years)		**Source**	**Page**
SRHR_Output 3.1	Number of men and women (≥25 years) reached by SRHR awareness sessions during this reporting period	Partner record	21
SRHR_Output 3.2	Number of women received family planning service with SRHR information	Partner record	22

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

Additional indicators: Improving access to post-abortion care services at public sector hospitals		**Source**	**Page**
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SRH_Output 5.1	Number of men and women reached by cervical cancer prevention awareness sessions during this reporting period	Partner record	29
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Output 5 Indicators			
Output 5: Enhanced health services accountability and responsiveness through capacity development of target communities, civil society organizations and the public sector.		**Source**	**Page**
Output 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	35
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3MDG SRHR Indicators

Outcome Indicator
P.1. 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 *[Form 3B (4.2)]*
Denominator	Number of married couples with the wife's age between 15 and 49 years in the same period *[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.

Limitation:

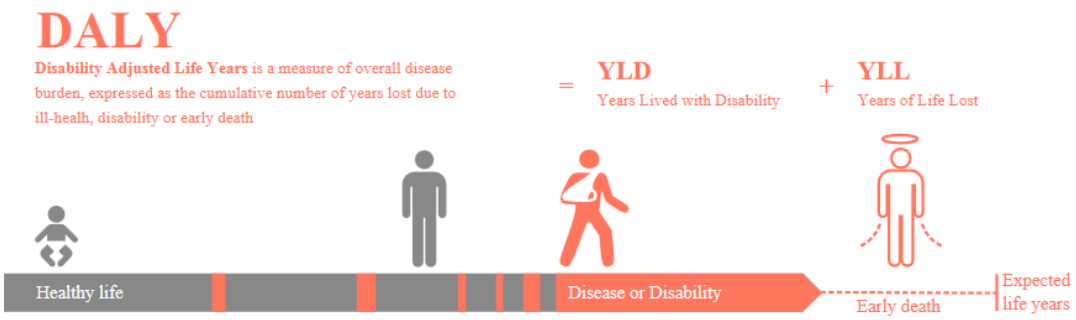
- Ideally, the indicator should reflect married and unmarried couples using modern methods. HMIS Data Dictionary (2014 June) presented as data collection will be disaggregated by modern and other methods among married couples, according to "Population and Yearly Record". This disaggregated data collection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

Outcome Indicator
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).



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 organization'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		

Outcome Indicator
P.3. Numbers of additional users of modern methods of contraception

Definition	**The number of additional women of reproductive age currently using a modern contraceptive method during this reporting period**
Numerator	Total number of additional users (reached by IP) during this reporting period
Data sources	Partner Record
Reporting frequency	Six monthly and/or annually

What it measures:

- This indicator will present 3MDG Fund's contribution and reach (through IPs) to national commitment FP2020.**

Note:

- **"Users"** Here, in general, this term referred to 'women of reproductive age who are using (or whose partner is using) a contraceptive method at a particular point in time, almost always reported for women married or in sexual union. (source: MEASURE Evaluation)
  Different classifications done on the contraceptive users based on the organizational programmatic contexts.
  Eg: Client profile of Marie Stopes International (MSI): (a) adopters: clients who were not using a modern FP method before receiving services. (b) Continuers: clients who were already using a modern FP method, which they received from the service delivery organization. (c) Provider changers: clients who were already using modern FP, but previously received their method from a different provider. (Source: MSI Impact 2)

- **"Modern contraceptive methods"** The term modern contraceptive is rarely defined. Instead, organizations and individuals who use the term simply name contraceptives and approaches that fit into their perception of that label. Here, we will referred to 'A product or medical procedure that interferes with reproduction from acts of sexual intercourse'. With a clear definition of modern contraception methods, the various products and approaches can be categorized. The methods that do not fit under the definition of modern can alternatively be labelled as 'Non-Modern Methods'.

Classifying different contraceptive methods.

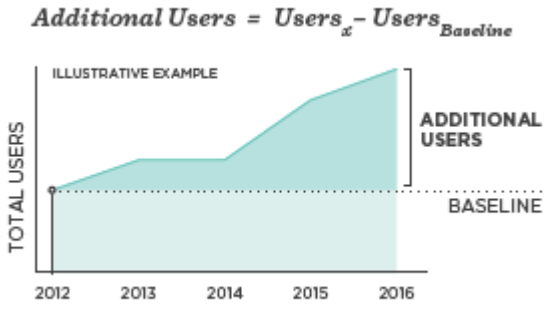
Modern Methods	Non-Modern Methods[a]
Sterilization (male and female)	Fertility awareness approaches[b]
Intrauterine devices and systems	Withdrawal
Subdermal implants	Lactational amenorrhea
Oral contraceptives	Abstinence
Condoms (male and female)	
Injectables	
Emergency contraceptive pills	
Patches	
Diaphragms and cervical caps	
Spermicidal agents (gels, foams, creams, suppositories, etc.)	
Vaginal rings	
Sponge	

[a] The label Non-Modern was selected for ease of use and because labels incorporating terms such as traditional, natural, physiology, and others had many drawbacks.

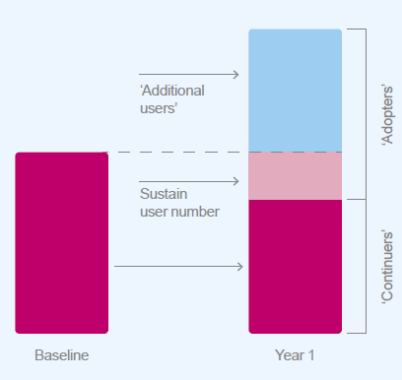
[b] This category includes the following: Standard Days Method, Calendar Rhythm Method, Two-Day Method, Billings Ovulation Method, Symptothermal Method, and the use of devices that help predict the fertile period.

(Source: A definition of modern contraceptive methods, David Hubacher, James Trussell http://www.track20.org/download/pdf/Article%20-%20Hubacher%20and%20Trussell%20Contraception%202015.pdf)

- **"Additional users"** Interpretation may differ among differ level.
  For national level, eg. FP2020, the number of 'additional users' is the difference in the total number of contraceptive users in a population between two points in time: a baseline and a point in time after that baseline. In the case of FP2020, the baseline is the number of modern contraceptive users at the start of the initiative in 2012. See below chart. (Source: Track20)



  For individual organizations, it is also necessary to look at the full picture of contraceptive use, ensuring that organizations are both sustaining existing levels of use, and, reaching additional women. Efforts must be made to sustain own baseline contributions while also expanding services to women not already using FP. See below chart. (Source: Impact 2)



For this 3MDG Fund Indicator 'additional users', Modelling approaches (FPET and Impact-2 as necessary) will be done by using Implementing Partner Organizations' service statistics and commodity distributed. As scope of funding is to organization level with different partners, side data may need to report together with 'additional users' such as (for individual IP) total users and adopters for the reported period.

Limitation:

- **Dynamic patterns among users:** In reality, family planning use is dynamic since women's need for contraception changes over time. During the course of their lives, women start, continue and stop using contraceptives for different reasons. (Impact-2, Track20)
- **'New users' vs 'Additional users':** Many people mistakenly use the term 'new users' interchangeably with 'additional users.' The term 'new users' has multiple definitions, including women new to a provider, new to a method, or new to contraceptive use in general. Regardless of its meaning, 'new user' is an individual-level metric that refers to a specific person, and thus cannot be used interchangeably with the population-level metric of 'additional users.'
- **** Contribution to FP2020:** IPs also have to report national level FP2020 based on overall reach which may be inclusive of 3MDG Funded portion. To avoid overlapping, 3MDG Fund data should not be added to country FP2020 reporting process.
- **Not all IP reach will contributed to national CPR changes:** Some women who are "new" to a provider may not be new to using contraception. While it is important to ensure these women have access to high quality services and a full choice of methods, providing these clients with services will not result in national level increases in contraceptive use. (Impact 2)

Output Indicator
P.1.1. Total number of Couple Years of Protection (CYPs) delivered through public sector services and private sector channels

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[2]**
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
- **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 Depo Provera, this amount is equivalent to 2,500 CYP. Theoretically, this figure represents 2,500 women protected for 12 months each;

[2]CYP calculation is on family planning commodities funded by 3MDG Fund

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'.

SRHR Output Indicator
1.1. Number of youth peer educator volunteers trained and supported in SRHR

Definition	**The total number of youth peer educator volunteers who (i) received training on Sexual and Reproductive Health and Rights (SRHR) information or on-job training on peer education by senior peer educators, and (ii) who are supported by SRHR project**
Data sources	Partner Record
Reporting frequency	Six monthly and annually (number only)

What it measures:

- To discuss openly about SRHR among young people is very essential to avoid risk sexual behaviours among them. To fulfil this demand, peer education is one of the most appropriate methods and this can dissolve the barriers and challenges to describe SRHR problems among young people. Therefore, SRHR project recruits and trains peer educators about basic life skills and/or SRHR, skill development and then they received proper on-job training by senior peer educators. So, this indicator can reflect the number of trained peer educator who can spread comprehensive SRHR information to other young people with regular basis.

Supported:

- Volunteer is supported any kind of incentive, remuneration or in-kind (Visibility and IEC materials)

Limitation:

- Recruitment can be challenging to get expected number of peer educators who have sufficient competency and are willing to work.
- This indicator measures total number of youth peer educator volunteers trained and supported in SRHR, but cannot measure the quality of the training. The training report should be able to capture the quality of the training.

SRHR Output Indicator
1.2. Number of young people completed life skills-based SRHR basic training

Definition	**The total number of young people who received or completed basic life skills-based training on SRHR organized by implementing partners with the support of 3MDG.**
Data sources	Partner Record
Reporting frequency	Six monthly and annually (number only)

What it measures:

- Although it is important to promote knowledge on SRHR among young people, it is not sufficient enough for the young people to avoid the SRHR risks without having protective skills. Therefore adopting life skills is important for young people. SRHR basic training aims to promote knowledge as well as life skills. After this training, young people can adopt healthy behaviours based on acquired knowledge, build capacity to be able to choose appropriate life values which are essential for a successful adult life, choose a good environment and to stay happily and harmoniously in the family and in the environment, enable youth to think rationally in decision making for life. So, this indicator can measure the young people who received appropriate SRHR knowledge and basic life skills.

Young People:

- Young people are defined by the United Nations as people with 10-24 years of age

Limitation:

- This indicator measures total number of young people completed life skills-based training, but cannot measure the quality of the training. The training report should be able to capture the quality of the training.

SRHR Output Indicator
1.3. Number of young people reached by (SRHR education through) interpersonal communication approach

Definition	**The total number of young people who receive SRHR education through interpersonal communication approaches such as awareness raising session, peer education, help line for counselling, events and Edu theatrical activities**
Data sources	Partner Record
Reporting frequency	Six monthly and annually (number only)

What it measures:

- To reach the comprehensive SRHR education to young people is crucial to avoid the risk sexual behaviours and negative impacts on health. There are many channels (both interpersonal and mass media) for the young people to have access to SRHR information. The appropriate channels that can be accessible by young people are awareness raising sessions, peer education; help line for counselling, radio program, and events, edutainment at schools and universities and then trainings on SRHR and basic life skills.
- However, it is very difficult to get exact number reached by the mass media channels. This indicator covers interpersonal communication channels but not mass media programme such as airing program.

Young People:

- Young people are defined by the United Nations as people with 10-24 years of age

Limitation:

- Some of young people prefer information and discussion through social media than phone line nowadays. However, help line counselling service has an advantage on receiving message or information with confidentiality, anonymity and sense of security. Therefore, it is expected that young people who wants to get such advantage will contact and receive information via phones.
- The indicator intends to measure the number of young people, but there is a risk of reported number being frequency rather than head count. The impact of this limitation is expected to be minimal.

SRHR Output Indicator
1.4. Number of service providers who received adolescents and youths friendly services related trainings during this reporting period

Definition	The total number of trained service providers who can give the adolescent and youth friendly services in project implementing townships
Data sources	Partner Record
Reporting frequency	Six monthly and annually (number only)

What it measures:

- Not only getting comprehensive SRHR knowledge but also being accessible to friendly services by young people is also crucial. Therefore, Adolescent & Youth Friendly Health Services (AYFHS) training will be conducted for general practitioners and IP service providers to give friendly services for young people in project implementing areas. The training will be focus on provision of friendly services neither on the technical nor clinical competency. It is expected to promote access to youth friendly services by the local general practitioners (GPs) and IP service providers after receiving the training in the project areas.

Limitation:

- Although it is very difficult to assess user-friendliness of the service provided by the trained GPs / IP service providers, the possible measures will identify with the participatory approach of the GPs / IP service providers from the quality control and sustainability point of view.
- This indicator measures total number of service providers who received adolescents and youths friendly services related trainings, but cannot measure the quality of the training. The training report should be able to capture the quality of the training.

SRHR Output Indicator
2.1. Number of service providers (BHS) who received family planning counselling training during this reporting period

Definition	**Total number of Basic Health Staff (BHS) who received family planning counselling training in project townships during this reporting period.**
Data sources	Partner Record
Reporting frequency	Six monthly and annually (number only)

What it measures:

- It measures the volume of trained service providers (BHS) who could provide quality family planning counselling service.

Note:

- Family planning counselling plays an important role in providing quality family planning service for clients who needs family planning services.
- Myanmar Demographic Health Survey (MDHS) 2015-16 Report shows receiving family planning services with informed choice by clients is an area which needs to be improved. Majority of the populations live in rural area and their family planning services are mainly covered by basic health staff.
- With the support and collaboration of MoHS and 3MDG FMO implementing partner will support training of trainers from Township Health Departments for family planning counselling which will be trained by Maternal and Reproductive Health Division of MoHS. Cascade training will be conducted for BHS at Townships by respective Township Trainers with the support of respective State/Regional Health Department.

Limitation:

- The support of public sector authorities and willingness of public sector service providers will be needed for conducting family planning counselling training. Vacancy and transfer of BHS could affect the training and coverage.
- This indicator measures total number of trainees, but cannot measure the quality of the training. The training report should be able to capture the quality of the training.

SRHR Output Indicator
3.1. Number of men and women (≥25 years) reached by SRHR awareness sessions during this reporting period

Definition	**Total number of men and women (≥25 years) who received SRHR information through awareness raising sessions including one to one and small group session.**
Data sources	Partner Record
Reporting frequency	Six monthly and annually (number only)

What it measures:

- It measures the number of people (≥25 years) in the community who are aware of SRH information and their rights. Indirectly, it reflects the magnitude of community awareness on SRHR for enabling environment.

Limitation:

- Male involvement is challenging because most of them are working age group and pay more attention on earning.
- The indicator intends to measure the number of men and women, but there is a risk of reported number being frequency rather than head count. The impact of this limitation is expected to be minimal.

SRHR Output Indicator
3.2. Number of women received family planning service with SRHR information

Definition	**Total number of women who received family planning services with SRHR information during their visits (static clinics and outreach service delivery points)**
Data sources	Partner Record
Reporting frequency	Six monthly and annually (number only)

What it measures:

- It measures number of women who received SRHR information during their visits for family planning services.

SRHR Information include – MNCH, Gender and GBV, Adolescents' SRHR, Family Planning, Inclusivity, RH Morbidities, and Rights.

Note:

- Static clinics using computerized management information system, Client Information Centre (CLIC), are able to report headcount of women receiving family planning services with SRHR information. For static clinics and outreach service delivery points using paper-based management information system, headcount of women receiving family planning services with SRHR information can be reported by counting client registration number during the reporting period.

Limitation:

- Sometimes, it is challenging to provide SRHR information in addition to family planning counselling within limited available time when there is heavy client loads.

SRHR Output Indicator
4.1. Number of post-abortion care services provided to women through public sector service providers

Definition	**The total number of post-abortion care (PAC) services with appropriate technology provided to women at public sector health facilities through doctors from public sector who received post-abortion care training.**
Data sources	Partner Record (Hospital records)
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 PAC services in a specific area.

Note:

- Complications of unsafe abortion are a major contributor to maternal mortality and morbidity in developing countries and have been recognized by the international community as a key public health issue. Approximately 22 million unsafe abortions take place annually (WHO, 2012), many of which require medical care for complications. These include retained products of conception that lead to infection and haemorrhage, injury to internal organs, and psychological trauma. Many women also face long-term health problems, such as chronic pain, pelvic inflammatory disease, and infertility.
- In Myanmar, maternal death from complications of unsafe abortions is the third leading cause. Improving the quality of PAC services available to women in public-health facilities has paramount importance, because abortion-related complications continue to be a major cause of hospital admissions. An integral component of improving quality of care is ensuring that providers use appropriate technology for uterine evacuation when a woman presents with postabortion complications. The World Health Organization (WHO) and the International Federation of Gynecology and Obstetrics (FIGO) strongly recommend manual vacuum aspiration (MVA) and/or medical methods, using misoprostol, as appropriate technology for safe and effective PAC and should be the first-line of management instead of traditional dilatation and curettage.
- Quality Post abortion care service consists of 5 essential elements: 1) *Treatment* of miscarriage/abortion-related complications that may be potentially life-threatening 2) *Compassionate counseling* to identify and respond to women's emotional and physical health needs and other concerns 3) *Postabortion family planning counseling and service provision* to help women prevent an unwanted pregnancy or practice birth spacing 4) *Related reproductive health services* that are preferably provided onsite or via referrals to accessible facilities and 5) *Community-service provider partnerships* to help women prevent unwanted pregnancies and unsafe abortion, mobilize resources to help women receive appropriate and timely care for abortion-related complications, and ensure health services reflect and meet community expectations and needs.

- Post-abortion care training: Partner organisations are working in collaboration with Maternal and Reproductive Health (MRH) Division, Department of Public Health (DOPH) to make quality PAC services available in public sector health facilities by providing women centred postabortion care trainings to providers to improve their skills and other supports such as manual vacuum aspirators, instruments and equipment that are required for performing quality postabortion care.
- Number of PAC services is recorded in logbooks at public sector sites supported by the implementing partner organisation of the 3MDG Fund. The data will be recorded by methods and age disaggregation.
- Currently, National Postabortion Care Guidelines allow application of appropriate technology for first trimester cases (12 weeks and less than 12 weeks) only.
- In additional to the women who receive post-abortion care services through public sector service providers at public sector health facilities, the women who receive post-abortion care services through EHO service providers, supported by the implementing partner organisation of the 3MDG Fund, at EHO health facilities are also counted under this indicator.
- The number women who receives post-abortion care services through EHO service providers, supported by the implementing partner organisation of the 3MDG Fund, at EHO health facilities is to be mentioned separately in the comment session of 6-monthly reports submitted to the FMO.

SRHR Output Indicator
4.2. Number of health facilities providing post-abortion care services

Definition	**Cumulative number of health facilities (Station, Township and District hospitals) where PAC services with appropriate technology are available in the current reporting period**
Data sources	Partner Records (Hospital records)
Reporting frequency	Six monthly and annually (number only)

What it measures:

- The indicator represents cumulative number of public sector health facilities, with service providers who received PAC training supported by the implementing partner of the 3MDG fund, availability of PAC services in the current reporting period.
- Number of hospitals providing PAC services assume to be the sties with providers who receive either 5 day formal women centered post abortion care trainings or on-the-job trainings.
- The percentage of health facilities with PAC service in the covered area should be able to report by IP in the six monthly and annually report.

Note:

- Quality Post abortion care service consists of 5 essential elements: 1) Treatment of miscarriage/abortion-related complications that may be potentially life-threatening 2) Compassionate counseling to identify and respond to women's emotional and physical health needs and other concerns 3) Post abortion family planning counseling and service provision to help women prevent an unwanted pregnancy or practice birth spacing 4) Related reproductive health services that are preferably provided onsite or via referrals to accessible facilities and 5) Community-service provider partnerships to help women prevent unwanted pregnancies and unsafe abortion, mobilize resources to help women receive appropriate and timely care for abortion-related complications, and ensure health services reflect and meet community expectations and needs.
- Availability of PAC service: It is the situation prospective of health facility where PAC service are available both in terms of tangible factors (e.g., the physical plant, personnel, equipment, and supplies) and the intangibles factors (e.g., treatment received from the staff, educational messages received).
- Collaborating with MoHS, partner organisations support health facilities meeting clinical standard of PAC services and data quality.
- In additional to the public sector health facilities, the EHO health facilities, with service providers who received PAC training supported by the implementing partner of the 3MDG fund, are also counted under this indicator.
- The number the EHO health facilities, with service providers who received PAC training supported by the implementing partner of the 3MDG fund, is to be mentioned separately in the comment session of 6-monthly reports submitted to the FMO.

Limitation:

- As the women centered post abortion care trainings are skilled based trainings which require clinical practice with patients, the number of participants need to be limited to maximum 15. Therefore, not all providers from the hospitals could attend the trainings. Sharing knowledge and transfer of skills by the trained providers back to the other providers at the health facilities.
- Transfer of trained providers can lead to the disruption of providing quality postabortion care services at the respective hospitals. Station hospitals are more facing this challenge as there are only one provider.

SRHR Output Indicator
4.3. Number of doctors from public sector health facilities who received post-abortion care training

Definition	**Number of doctors from public sector health facilities who received PAC training**
Data sources	Partner Record
Reporting frequency	Six monthly and annually (number only)

What it measures:

- This indicator measures the number of doctors in public sector health facilities trained on provision of post-abortion care services supported by the implementing partner of the 3MDG Fund.

Note:

- MoHS arranges trainings for quality PAC services with the support of 3MDG's partner organisations
- Doctors included in this indicator have attended and successfully completed a training on provision of PAC to women and related patient care supported by the partner organisation.
- In additional to the doctors from public sector health facilities who received post-abortion care training, the doctors from EHO health facilities, who received post-abortion care training supported by the implementing partner of the 3MDG fund, are also counted under this indicator.
- The number the doctors from EHO health facilities, who received post-abortion care training supported by the implementing partner of the 3MDG fund, is to be mentioned separately in the comment session of 6-monthly reports submitted to the FMO.

Limitation:

- This indicator measures total number of trainees, but cannot measure the quality of the training. The training report should be able to capture the quality of the training.

SRHR Output Indicator
4.4. Number of hospital nurses from public sector health facilities who received Infection Prevention and Instrument Processing training

Definition	**Number of hospital nurses from public sector health facilities who received Infection Prevention and Instrument Processing Training**
Data sources	Partner Record
Reporting frequency	Six monthly and annually (number only)

What it measures:

- This indicator measures the number of hospital nurses in public sector health facilities trained on provision of Infection prevention and Instrument Processing supported by the implementing partner of the 3MDG Fund.

Note:

- Clinically trained hospital nurses have attended and successfully completed a training on Infection prevention and Instrument Processing related to PAC service supported by the partner organization.

Limitation:

- This indicator measures total number of trainees, but cannot measure the quality of the training. The training report should be able to capture the quality of the training.

SRHR Output Indicator
5.1. Number of men and women reached by cervical cancer prevention awareness sessions during this reporting period

Definition	**The number of men and women who have attended cervical cancer prevention awareness session during the reporting period**
Data sources	Partner Record
Reporting frequency	Six monthly and annually (number only)

What it measures:

- This indicator measures the population coverage of cervical cancer awareness during the reporting period.

Awareness raising session:

- A kind of group discussion facilitated by IP staff (e.g., sexual and reproductive health promoter) which can be either clinic-based or community-based using verbal and visual-aids (e.g., pamphlets, flip charts) communication methods

Limitation:

- The indicator intends to measure the number of men and women, but there is a risk of reported number being frequency rather than head count. The impact of this limitation is expected to be minimal.

SRHR Output Indicator
5.2. Number of women who received cervical cancer screening service (VIA - visual inspection with acetic acid)

Definition	**Number of women aged 30-49 years who have been screened for cervical cancer with Visual Inspection with Acetic Acid (VIA) by IP service providers or IP supported providers within the reporting period.**
Data sources	Partner Record
Reporting frequency	Six monthly and annually (number only)

What it measures:

- In 2012, 528,000 new cases of cervical cancer were diagnosed, and 266,000 women died of the disease, nearly 90% of them in low- to middle-income countries. To address this problem, Visual Inspection with Acetic Acid (VIA), an inexpensive yet effective screening procedure, which has been endorsed by the WHO, has been developed for a wide range of settings (WHO, 2014). The goal of a screen-and-treat programme for cervical cancer is to reduce cervical cancer and related mortality with relatively few adverse events (WHO, 2013).

Visual inspection with acetic acid (VIA)

- It is a method for detecting early cell changes that are visible when using a speculum to inspect the cervix with the naked eye after applying dilute (3–5%) acetic acid to it.2 It requires training and supervision of primary care providers, as well as ongoing quality control and quality assurance. (WHO 2014, Chapter 5. Screening and treatment of cervical pre-cancer, page 144)

Note:

- This indicator measures the number of women aged 30-49 years old who have been screened for the first time with VIA during the reporting period by IP service providers or IP supported providers.
- Double counting is controlled by only counting the number of screening which was done screening for the first time by IP service providers or IP supported providers, not in the referral site and not for second time screening.
- Cervical cancer screening should be performed at least once for every woman in the target age group where most benefit can be achieved: 30–49 years. Cervical cancer screening, at least once, is recommended for every woman in the target age group, but this may be extended to women younger than age 30 if there is evidence of a high risk for CIN2+.HPV testing, cytology and visual inspection with acetic acid (VIA) are all recommended screening test. (WHO 2014, Chapter 5. Screening and treatment of cervical pre-cancer, page 5)
- For cervical cancer prevention to be effective, women with positive screening test results must receive effective treatment. It is recommended to take either a ″screen-and-treat″ approach or a ″screen, diagnose and treat″ approach.
- To be able to determine the incidence of early cell changes at cervix (precancerous lesion), implementing partners need to report number of VIA positive cases together with total number of women aged 30-49 years who have been screened for cervical cancer.

Advantages:

- It will ensure the program that how many women of 30-49 years received screening for cervical cancer.
- It can be calculated from data routinely collected through programs or projects, and thus minimizes the data collection burden.

Limitation:

- Screening only will not be able to reduce the burden of cervical cancer unless screening is linked to the treatment.

SRHR Output Indicator
5.3. Number of women referred for further management

Definition	Number of women who have been tested positive in VIA and referred for further management
Data sources	Partner Record
Reporting frequency	Six monthly and annually (number only)

What it measures:

- It measures the number of women who tested with positive VIA testing result at IP service providers or IP supported service providers and referred for cryotherapy or further management.

Advantages:

- It will ensure the programme that how many of women with cervical cancer precancerous lesions and suspicious invasive cancers received referral for further treatment.
- It can be calculated from data routinely collected through programs or projects, and thus minimizes the data collection burden.

Limitation:

- The VIA test positivity has inter-observer variation.
- The indicator measures the referral attempt, but not measure actual reach for further management.

SRHR Output Indicator
5.4. Number of women who received cryotherapy service

Definition	Number of VIA positive women who have received treatment with cryotherapy
Data sources	Partner Record
Reporting frequency	Six monthly and annually (number only)

What it measures:

- It measures the number of VIA positive women who have received cryotherapy treatment in the reporting period.

Note:

- The cryotherapy treatment will be provided by IP service providers or IP supported service providers or contracted Obstetrics and Gynecology specialists. Compliance with treatment can be improved if a "screen and treat" approach is used where VIA is followed by cryotherapy for precancerous treatment during the same visit.
- Cryotherapy eliminates precancerous areas on the cervix by freezing (an ablative method). It involves applying a highly cooled metal disc (cryoprobe) to the cervix and freezing the abnormal areas (along with normal areas) covered by it. The supercooling of the cryoprobe is accomplished using a tank with compressed carbon dioxide (CO2) or nitrous oxide (N2O) gas. Cryotherapy can be performed at all levels of the health system, by health-care providers (doctors, nurses and midwives) who are skilled in pelvic examination and trained in cryotherapy. It takes about 15 minutes and is generally well tolerated and associated with only mild discomfort. It can, therefore, be performed without anaesthesia. Following cryotherapy, the frozen area regenerates to normal epithelium. Screen-positive women (such as with VIA screening) or women with histologically confirmed CIN2+ are eligible for cryotherapy if the entire lesion and squamocolumnar junction are visible, and the lesion does not cover more than three quarters of the ectocervix. If the lesion extends beyond the cryoprobe being used, or into the endocervical canal, the patient is not eligible for cryotherapy. The patient is not eligible for cryotherapy if the lesion is suspicious for invasive cancer.
  (WHO 2014, Chapter 5. Screening and treatment of cervical pre-cancer, page 155,156)

Advantages:

- It can ensure the program that how many % of VIA positive lesions received treatment.
- It can be calculated from data routinely collected through programs or projects, and thus minimizes the data collection burden.

AEI Core Indicators

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	Partner 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.

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	Partner reports and feedback and response mechanism records
Reporting frequency	Six Monthly and Annually

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.[3]

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.[4] 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.

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

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

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[5] are categorized as Suggestion, (+) Positive Feedback, Concern, (-) Negative Feedback, Question and Others.

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

Output Indicator
5.6. Number of events/meetings conducted during the reporting period that include participation and engagement between health care providers and target communities.

Numerator	Number of events/meetings conducted during the reporting period that include participation and engagement between health care providers and target communities.
Denominator	-
Data Sources	Partner record
Reporting Frequency	Six monthly and Annually

What it measures: The number of events/meetings which were conducting during the reporting period that includes participation and engagement between healthcare providers and target communities. This is based on the notion that participation and engagement between providers and communities will enhance understanding about local needs and experiences in accessing health services, increase community understanding about healthcare provider constraints, build relationships and trust, and overcome information asymmetry in working together for better health outcomes.

Implementing partners are defined as organisations receiving direct funding from 3MDG to execute activities in areas of maternal, new-born and child health, HIV, TB and malaria, and health system strengthening (in this case referring to Collective Voices partners).

Event refers to the any planned public or social occasion (e.g. family show, conference etc.) that includes participation and engagement between healthcare providers and target communities, organized by IPs.

Meeting refers to a situation when two or more people meet, including at least one healthcare provider and one target community member, organized by an IP.

Participation is a process through which members of a community or organization are involved in and have an opportunity to influence on decisions related to health activities that will affect them.

Engagement is a process through which there is a mutual exchange of information, dialogue, ideas and/or resources between healthcare providers and target community members.[6]

Healthcare providers in this case refer to "any public sector individual, institution, or agency that provides health services to healthcare consumers." [7]

A community is a group of people who share an interest or identity, a neighborhood or a common set of circumstances.[8]

[6] Morgan A.M and Lifshay J. *Community Engagement in Public Health,* Public Health Division, Contra Costa Health Services. 2006, http://cchealth.org/public-health/pdf/community_engagement_in_ph.pdf. Accessed 27 Oct 2016.

[7] Mosby's Medical Dictionary, 9th edition. © 2009, Elsevier

[8] Community Participation in Local Health and Sustainable Development , *WHO 2002*

Annex 1: What are the CYP conversion factors?

Method	CYP Per Unit
Copper-T 380-A IUD	4.6 CYP per IUD inserted (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* Global (India, Nepal, Bangladesh)	 10 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 2: Accountability, Equity and Social Inclusion Glossary of Terms

Responsibility	• Practice good governance and accountability • Keep commitments to the people who use health services • Listen (and respond to) the voices of people • Empower and inform users of the health system
Fairness (Equity)	• Being fair and just to all people who use the health system. • Recognising that people are different and need different support to ensure their rights are recognised.
Gender Equity	• Being fair to women and men. • 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. • Understanding the different barriers to health that people face and working to address them. • All people can access quality health care regardless of their socio-economic position, including age, disability, gender or other circumstances. • 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. • Understanding diverse experiences and preferences, and enabling people from many different circumstances (e.g. cultural, linguistic and geographic) to participate in health care planning. • Mutual respect, tolerance and making all people feel valued. • Ensuring that all voices are considered in decision-making processes
Empowerment	• People – both men women and men – taking control over their lives. • People setting their own agendas, gaining skills, building self-confidence, solving problems, and developing self-reliance. • Supporting efforts by communities to carry out collective actions. • Building confident and informed users of the health system. • 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”).

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