Myanmar Prioritized Actions: 2018-2020

Contents

Prioritized Actions 2018-2020

Prioritized Actions for Focal Point and in-country stakeholder	Institution/person responsible	Timeline					
		2018	2019				2020
		Q4	Q1	Q2	Q3	Q4	Q1
STOCK-OUTS							
1.1. Engage in National Supply Chain Task Force Meeting (MRH-DoPH)	MRH,UNFPA (contingent upon invitation	X		X		X	
1.2. Promote sharing of RH-LMIS data among the fragmented systems (MRH-DoPH, IPs)	MRH, UNFPA	X	X	X	X	X	X
1.3. Continue to advocate for increase in domestic budget allocation for contraceptive commodities, storage, distribution and warehousing of FP commodities.	MRH, UNFPA, DFID, MSI	X	X	X	X	X	X
1.4. Continue monitoring of GFF progress in Myanmar	MSI	X	X	X	X	X	X

1.5. Continue to disseminate revised CIP (estimated time of publication is December 2018), and use it as an budget advocacy tool to secure funding for FP (both domestic and international resources).	MRH, UNFPA,	X	X	X	X	X	X
1.6. With the lead from DFID, continue to advocate DFID and other like-minded donors (Sweden, Canada and Gates) for financial support for advocacy budget and commodities (early 2019)	DFID	X	X	X			
COMPREHENSIVE COMMUNITY ENGAGEMENT							
2.1. Advocacy, communication and social mobilization on family planning targeting on community, religious and ethnic leaders, women and youth groups (MoHS, IPs)	MRH, UNFPA, DFID, CSO, Youth	X	X	X	X	X	X
2.2. Increased opportunity to listen to the community voices (MoHS, Donors, UN and CSOs)	MoHS, Donors, UN and CSOs	X	X	X	X	X	X
2.3. Develop the capacity of service providers in provision of FP information (MoHS and IPs), including youth-friendly family planning services	MRH, UNFPA	X	X	X	X	X	X
2.4. Promote women empowerment and gender equality to improve decision making on FP (MoHS, Donor, UN and CSOs)	CSO, Youth	X	X	X	X	X	X
2.5. Invest in meaningful engagement of youth leaders in policy making and program design, implementation, review and accountability. In particular, FP2020 Focal Points will work with Youth	Youth Representative	X		X		X	

Representative to map out strong Youth advocates and networks. Supporting capacity building of youth networks should be considered.							
2.6. Revive engagement of existing TWGs and expand them by inviting other sectors (Ministry of Finance and Planning, Ministry of Social Welfare, youth representatives, etc.).	MRH	X	X	X	X	X	X
2.7. Build the capacity of youth leaders in leadership and advocacy skills. Invite pro-youth government agents to youth-led events. Focal Points to encourage and arrange participation.	CSO,	X		X		X	
POST-PARTUM FAMILY PLANNING							
3.1. Improve quality SRH services and programme and strengthen emergency referral support (MoHS, IPs)	MRH, IPs	X	X	X	X	X	X
3.2. Strengthen LMIS and supply chain system (MoHS, Donors, UN and CSOs)	MRH, Donors, UN, CSO	X	X	X	X	X	X
3.3. Develop capacity of health staff on quality PPFP counseling and services (MoHS, IPs)	MRH	X	X	X	X	X	X

Annex 1
Country Profile: FP2020 Focal Point Team & In-Country Coordination

List of Focal Points	Government	Dr. Hnin Hnin Lwin, Deputy Director, Maternal and reproductive Health Division, Ministry of Health and Sports
	Donor	Dr. Yin Yin Htun Ngwe, Assistant Representative, United Nations Population Fund
		Dr. Mya Thet Su Maw, Senior Health Programme Manager, Department For International Development
	Civil Society	Dr. Sid Naing, Country Director, Marie Stopes International, Myanmar
	Youth	Zar Ti Nwe Nu Aung, Youth Representative
	1. MRH-DOPH 2. PSI 3. MSI 4. MMA 5. MMCWA-IPPF 6. CHAI 7. Ipas 8. DKT 9. UNFPA 10. UNOPS-3MDG 11. DFID 12. Canada 13. JSI 14. JHPIEGO 15. CPI	

CURRENT MECHANISMS FOR IN-COUNTRY COORDINATION of FP work (beyond Focal Points)				
Mechanism	**Convening/ Coordinating body**	**Members**	**Frequency** *(monthly, quarterly, semi-annually, etc.)*	**Notes on efficacy** *(How efficient & effective are these?)*
Myanmar Health Sector Coordinating Committee meeting	Myanmar Health Sector Coordinating Committee	Government, UN, Donor, INGO, NGO, CBO, Private Sector, People live with disability, Academic Constituency	Quarterly	
Coordination Mechanism for FP	FP Core Working Group	MRH, PSI, MSI, MMA, UNFPA, DFID, DKT, JSI, MMCWA, IOM, Pathfinder, CHAI, UNOPS-3MDG, CPI, HPA	Quarterly	
Coordination Mechanism for FP	FP2020 focal points Group	MRH, MSI, DFID, UNFPA	Quarterly	
FP2020 Consensus Workshop	FP 2020 M&E Team	Track20 Team, MRH, PSI, MSI, MMA, UNFPA, DFID, DKT, JSI, MMCWA, IOM, Pathfinder, CHAI, UNOPS-3MDG, CPI, HPA	Bi-annually	

Please list additional opportunities to improve coordination:

- **Programme Review meeting on RH**
- **National Supply Chain Task Force**
- **RMNCAH TSG**

Annex 2: Identification of Challenges & Prioritization of Actions

Myanmar's FP2020 Commitments
COMMITMENT 1: Innovative financing solutions, especially for commodities: 1.1 Myanmar will explore innovative financing models such as Global Financing Facility (GFF) to ensure donor and national resources of $3 – 5 million USD annually, incrementally for family planning commodities and to ensure sufficient and timely availability of quality contraceptives for all the reproductive aged women of Myanmar. 1.2 Myanmar will work with the development partners and UNFPA to procure high-quality contraceptives regularly and consistently and to expand the range of affordable modern contraceptive methods available for women and girls in Myanmar. 1.3 Myanmar pledges to increase the health budget to cover all women and eligible couples by 2020. The Myanmar Ministry of Health and Sports commits to working towards increasing the resources allocated to family planning in state budgets. The government is also committed to ensuring results-based management through new initiatives for effective fund flow mechanisms and internal auditing. 1.4 Procurement practices to enhance value for money to be explored with DPs. It is also important that all family planning programmes are aligned to the implementation of Myanmar's National Health Plan (2017-2021). MOHS commits that the Essential Package of Health Services (EPHS) has contraceptives and Long Acting Reversible Contraceptives (LARCs) are especially positioned as part of EPHS interventions. 1.5 Myanmar aims to strengthen the policy of providing modern contraceptive methods by trained/skilled nurses, midwives and trained volunteers through better collaboration among a wide range of stakeholders. 1.6 The Government of Myanmar also pledges to implement people-centered policies to address regional, social and gender-related barriers, including disparities and inequities between

urban and rural, and rich and poor populations in accessing affordable modern contraceptive methods.

1.7 In addition, Myanmar commits to expanding the forum of family planning under the umbrella of the Health Sector Coordinating Committee. The Technical Strategy Group on Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) has been formed by the MOHS, and under which are the Lead FP working group, the Lead RH working group, and the Lead Child Health working group.

COMMITMENT 2: Strengthening supply chains and expanding the range of contraceptives available to women:

2.1 Ministry of Health and Sports will bring on board, and work closely with, development partners and implementing agencies to strengthen the integrated national supply chain and ensure that no woman is left empty-handed for her family planning needs, and that women will have informed choice of contraceptives even at the last mile.

2.2 The Government of Myanmar will continue to strengthen the logistics management information system (LMIS), to ensure reproductive health commodity security through improved quantification, forecasting, and integrated procurement planning, supply, storage, systematic distribution, and inventory control. To fulfill that commitment, there will be rolling out of an RH commodities logistic system training to midwives and health staff members in additional 4 States/Regions (out of 14 States/Regions), of training on LARC method (implant in particular) and expansion throughout the country (currently half of the country has already been covered), and supporting collaboration among EHO and local CSO, etc.

2.3 Introduction of a new contraceptive method for the women in Myanmar: a programme of providing Subcutaneous DMPA (Sayana Press) was initiated in 2017 especially for the women in hard to reach regions.

COMMITMENT 3: Empowering young people to thrive:

3.1 Myanmar will ensure adolescent and youth friendly health services including access to information on sexual and reproductive health for in-school and out-of-school youth as well as contraceptive services.

3.2 2017 marks initiation of adolescent and youth sexual and reproductive health and rights programme with focus on availability and access to information and contraception services. Youth mobile application "*Love Question, Life Answer*" developed aligned to Comprehensive Sexuality Education principles will be launched to young people in all states and regions to

provide accurate sexual and reproductive health information and reference to services delivery points if young people should need it.

3.3 Adolescent and Youth Friendly Health Services manual developed in Myanmar context is being disseminated and distributed, and basic health staff members are being trained to provide youth friendly ASRH services including contraception.

3.4 Young people will be encouraged to speak about Sexual and Reproductive Health and Rights (SRHR), and empowered to have capacity for policy dialogue so that more young people will have information and knowledge, and skills to communicate about SRHR in Myanmar.

COMMITMENT 4: Reaching the hardest to reach:

4.1 Myanmar will work with its civil society organizations, ethnic health organizations and private sector to make sure that women experiencing humanitarian crises or facing other socio-cultural barriers can access the contraceptive services and supplies that they need to protect their health.

4.2 In addition, Myanmar will implement a monitoring system to strengthen quality of care, and to ensure women have a full range of contraceptive options. Given gender inequality, including gender-based violence (GBV) and other forms of harmful or disenfranchising social and cultural barriers to accessing or making choices in SRHR and family planning, the MOHS – working together with UNFPA, development partners, implementing agencies, and other Ministries – is committed to rolling out standard operating procedures for preventing and responding to GBV, especially sexual violence, in an integrated approach. This will be linked to providing family planning services of choice for the women to decide if they need contraception.

4.3 The Government of Myanmar will review and revise its current Five-Year Strategic Plan for Reproductive Health and Costed Implementation Plan (CIP) for FP2020 through a consultative process, and Myanmar's family planning programme will identify and address social and cultural barriers as well as regional disparities and inequalities in line with the WHO revised guidelines.

4.4 The government also commits to improving availability in health facilities so that the method mix is improved: especially in offering long-acting and reversible contraceptives, and also permanent methods adding to offering method of choice and ensuring quality of care.

4.5 Myanmar seeks to boost partnership with the private sector, civil society organizations, and other partners including ethnic health organizations for expanded service delivery in family planning.

Summary of Myanmar's Costed Implementation Plan (CIP) – *if applicable*

Prioritized areas:

The costed implementation plan for FP2020 is updated based on the information from the following surveys and tools;

- the Myanmar Demographic Health Survey (MDHS 2015-16),
- estimate of mCPR (married women) using Track20's Family Planning Estimation Tool (FPET),
- intervention impact calculation using Avenir Health's FP Goals Model and
- Report on 2016 Health Facility Assessment on availability of contraceptives, RH commodities and services (UNFPA)

The prioritized intervention areas in the revised costed implementation plan for FP2020 are mentioned as follow:

1. Stock out reduction

The 25% stock out reduction in most states and regions and 100% in 5 States and regions; Kayin, Chin, Rakhine and Shan states and Magway region, will contribute an increase in 3.2% of the mCPR at the national level. It is the most required high impact practices to achieve the FP2020 goals in Myanmar.

2. Comprehensive Community Engagement

All states and regions will introduce the comprehensive community engagement programme, reaching women and their community with social behavior change message on family planning, together with provision of community based family planning service package, and task shifting to auxiliary midwives and community health workers that reached 25% of WRA population. In addition, strengthening comprehensive community engagement in 4 states and regions, namely Magway region and Kayin, Rakhine and Shan states, which aims to reach 50% of WRA population in these states and regions, could contribute 1.3% increase in mCPR at the national level in 2020.

3. Introduction of new methods/Revitalize: Implants

Scaling up on service accessibility for long acting reversible methods like implants can also increase mCPR. When 12% to 25% of WRA population can get better access to implant insertion and removal services in all states and regions and 100% of WRA population to be able to access implant services in Sagaing Region and Mon State, this will help increase 1.7% of mCPR at the national level.

4. Post-partum Family Planning

The following interventions would be implemented in all states and regions.

1. 25% coverage of community based SBCC designed to provide pregnant and post-partum women with information and counseling on PPFP in all regions.
2. 100% of facilities offering high-quality PPFP counseling integrated into facility based prenatal care and PPFP counseling and services into facility based delivery and postnatal care
3. 50% of pregnant women (at a minimum) delivering at health facilities.

The intervention on post-partum family planning will increase 0.2% of mCPR at the national level.

5. Mass Media

In 5 states and regions; Tanintharyi and Magway Regions and Kayin, Rakhine and Shan States, the mass media based on SBCC on family planning will scale up and design to reach women with information on family planning. It will contribute to increase 0.1% of mCPR at the union level.

By implementing these prioritized interventions for family planning in Myanmar, the mCPR will increase 6.5% in 2020 and Myanmar can reach the FP2020 goals of 60% CPR in 2020 as committed

Step 1. From the above commitment(s) and/or CIP priority area(s) which is your country having the greatest difficulty in making progress on? (*the table below can be extended, if you'd like to cover more than three*)

Please reference your 2018 commitment self-report questionnaire, if needed.

1. Reduction of stock out
2. Comprehensive Community Engagement
3. Post-partum Family Planning

Step 2. What progress toward each commitment/CIP priority *(listed in Step 1)* has been made? What efforts have been made?

Please reference your 2018 commitment self-report questionnaire (attached) as well as any available data in country (e.g. DHS report, materials of the recent Data Consensus Meeting, etc.) as evidence. Additional data summary will be shared by the Secretariat and Track20 in the next few weeks.

1. Reduction of stock out

Reproductive Health Commodity Logistics System for RH-LMIS was piloted in 2014 and has been implemented since 2015. By the end of 2017, RH-LMIS was rolled out in 115 townships in 9 States and Regions and more than 8,000 health staffs were trained to understand the inventory control system and LMIS. In 2018, the LMIS continues roll out in 61 townships of new 3 states and regions. The electronic automated LMIS system was set up in 79 townships in 6 states and regions. The health officials were trained to utilize data generated from the electronic LMIS system. As a result, they could perform stock reallocation, avoiding over stock or stock out and improving commodity security. The NGOs and implementing partners conduct regular monitoring on stock balance for FP commodities so that they could easily manage their stock out situation.

2. Comprehensive Community Engagement

Introduction of new methods on sub-cutaneous DMPA was done in 2016, together with task shifting to auxiliary midwives and community based volunteers, as well as distribution to ethnic health organizations. Young, poor and marginalized women and girls have increased access to family planning services through community based family planning package. The community consultation meetings with local women groups, ethnic groups and religious groups were conducted, thereby promoting family planning services in the community. The family planning methods training including SC_DMPA were completed in 9 states and regions in 2017 and continues to roll out in remaining states and regions in 2018. The strategy of total market approach was factored into SC_DMPA roll out, which aims to increase additional users on family planning and reduce unmet need for family planning in Myanmar.

3. Post-partum Family Planning

According to Myanmar Demographic Health Survey (2015-16), post-partum women are approximately 6% of total Women in Reproductive Age population (WRA). Among them, 53% of women have access to post-partum family planning while 68% of women who delivered at the health facilities received the post-partum family planning.

Step 3. What are the key challenges or blockages faced when trying to accelerate progress towards the above selected commitments? Where does there seem to be resistance? What are the root causes of those *challenges and blockages*?

3.1. KEY CHALLENGES AND BLOCKAGES (e.g. operational, technical, political)
1. **Reduction of stock out**
Reduction in percentage stock out has been observed since 2014 by strengthening LMIS and providing staff training to be able to practice PULL system. However, some significant challenges in supply chain system still remain unaddressed, such as sustainable financing for family planning, warehousing and storage, national common platform for electronic LMIS system, in addition to conflict and disaster. These challenges have great impact on achieving fundamental improvement in procurement, supply, distribution and commodity security in Myanmar. Moreover, human resource shortage in supply chain management of Myanmar public health sector is also an important area to address.
2. Comprehensive Community Engagement
When the new method, SC_DMPA, was introduced in the community, it was targeted for remote and border areas in which women are not accessible to family planning services. This creates misunderstanding among ethnic groups that family planning is trying to control population of ethnic minority. Therefore, community consultation meetings were done and explained that family planning is an individual choice and women can choose methods as well as limit or space on number of children as they prefer. Bearing all these community perceptions on family planning, more community consultation meetings need to be conducted and community engagement strategy should be as comprehensive as possible to overcome social-cultural barrier, influence from elders and peer pressure. Gender inequality in decision making on family planning, poor male involvement should be considered, and women leadership should be encouraged to increase access on family planning information and services.
3. Post-partum Family Planning

There are state and regional disparity on post-partum family planning and 8 States and Regions have lower coverage than national average; Rakhine (32%), Kayin (36%), Kachin (36%), Shan (41%), Tanintharyi (44%), Magway (50%), Mon (52%) and lowest in Chin (14%). It was also found that women who delivered at health facilities have more accessibility to post-partum family planning than the women who delivered at home.

The percentage of institutional delivery (37%) was low and post-partum family planning counseling and services are required in all health facilities.

Post-natal care within the first two days of birth was 71.2% while the delivery by skilled birth attendant is only 60.2%.

3.2. ROOT CAUSES PER CHALLENGE LISTED ABOVE

(i.e. What are the root causes of the challenges faced in accelerating progress towards the listed commitments? Please reference the guidance note below.

Step 3.2. Guidance note: *This step can be done through asking 5 "why questions"*

5 WHY questions: an iterative interrogative technique used to explore the cause-and-effect relationships underlying a particular challenge. The primary goal of the technique is to determine the root cause of a challenge or problem by repeating the question "Why?" Each answer forms the basis of the next question. Here is an example:

- *Community based health workers (CBWs) are not yet in place at the district level (the challenge)*
  a. *Why? - CBWs have not received a basic training yet (First why)*
  b. *Why? - District health offices have not yet received the updated training manual from the central level (Second why)*
  c. *Why? - Budget cuts for the training department at the Ministry delayed training manual development at the central level (Third why)*
  d. *Why? - Health minister was not successful in budget negotiation with the Ministry of Finance for this fiscal year (Fourth why)*
  e. *Why? – According to feedback, supporting documents for budget negotiation were not sufficient (e.g. policy briefs, visualized data summary) to allow the Health Minister to show the impact and urgency of the program (Fifth why, a root cause)*

1. Reduction of stock out

Challenges	⇦	Root causes

1. Warehouse & Storage 2. National common platform for LMIS 3. Sustainable financing for family planning 4. Human Resource for supply chain management in public sector		1. inadequate Infrastructure and supply chain coordination among MOHS and partners 2.fragmented LMIS system: Yangon CMSD – iStock, Mandalay CMSSD and Bago, Magway and Ayeyarwaddy, HIV, TB and Malaria warehouses (mSupply), RH Programme (Logistimo), Hospitals (Zulu), Southern Shan and other CMSSD and non-LMIS townships – paper based record. 3.a. limited budget allocation of MoHS (for both DoPH and DMS) for family planning programme, commodities, storage and distribution 3.b. high Inflation and escalating exchange rate 4. lack of dedicated person for supply chain management in state and regional and township level
2. Comprehensive Community Engagement		
Challenges	⇦	Root causes
● Acceptance on family planning methods ● Discontinuation of FP methods and lack of awareness ● Poor Decision Making on family planning		● Community Resistance and misunderstanding on FP ● Poor community involvement and participation in programme planning, design, implementation and monitoring of FP programme ● Insufficient FP counselling to provide information on method mix, side effects and management of side effects ● Poor quality of service providers on FP counseling and information ● Inadequate women leadership and male involvement on decision making on FP ● Limited outreach to youth and adolescents
3. Post-partum Family Planning		

Challenges	⇦	Root causes
● Institutional delivery is only 37% according to MDHS (2015-16) ● Percentage of health facilities that can offer 5 methods of contraception in secondary and tertiary level reduced years by years ●Insufficient Post-partum family planning and counseling services		· Inadequate investment in referral support to increase institutional delivery · Weak supply chain management · Limited human resource and training on PPFP counseling and services

Step 4. What actions are required to tackle the root causes (in 3.2 above) for the identified challenges? Where does the greatest opportunity stand to influence the system, overcome resistance and accelerate changes?

4.1. What is needed in order to tackle the root causes for the identified challenges/blockages (listed in 3.2 above)? Based on your assumptions about what could work well and what will not, think about all possible actions/interventions.	
1. Reduction of stock out	
Root causes	**Actions/interventions to be taken**
1. Inadequate Infrastructure and supply chain coordination among MOHS and partners	1. Engage in National Supply Chain Task Force Meeting
2. Fragmented LMIS system: Yangon CMSD – iStock, Mandalay CMSSD and Bago, Magway and Ayeyarwaddy, HIV, TB and Malaria warehouses (mSupply), RH Programme (Logistimo), Hospitals (Zulu), Southern Shan and other CMSSD and non-LMIS townships – paper based record.	2. Promote sharing of RH-LMIS data among the fragmented systems
3.a. Limited budget allocation of MoHS (for both DoPH and DMS) for family planning programme, commodities, storage and distribution	3.a. Advocate for increase domestic budget allocation for storage, distribution and warehousing of FP commodities as well as for programme implementation 3.b. Depend on Government Economic Policy

3.b. high Inflation and escalating exchange rate 4. Lack of dedicated person for supply chain management in state and regional and township level	4. Explore possible model for supporting supply chain person in state and regional HRH
2. Comprehensive Community Engagement	
Root causes	**Actions/interventions to be taken**
● Community Resistance and misunderstanding on FP ● Poor community involvement and participation in programme planning, design, implementation and monitoring of FP programme ● Insufficient FP counselling to provide information on method mix, side effects and management of side effects ● Poor quality of service providers on FP counseling and information ● Inadequate women leadership and male involvement on decision making on FP ● Limited outreach to youth and adolescents	· Advocacy, communication and social mobilization on family planning targeting on community, religious and ethnic leaders and women groups ·Increased opportunity to listen to the community voices ·Develop the capacity of service providers in provision of FP information ·Promote women empowerment and gender equality to improve decision making on FP ·Advocacy and better inter-ministerial coordination among MoSWRR, MoHS and MoE
3. Post-partum Family Planning	
Root causes	**Actions/interventions to be taken**

· Inadequate investment in referral support to increase institutional delivery · Weak supply chain management ·Limited human resource and training on PPFP counseling and services	· Improve quality SRH services and programme and strengthen emergency referral support · Strengthen LMIS and supply chain system · Develop capacity of health staffs on quality PPFP counseling and services

4.3. How can all focal points and other stakeholders best leverage their influence to support these interventions to accelerate progress? (Refer back to the stakeholder list above)

1. Reduction of stock-out

1.1. Engage in National Supply Chain Task Force Meeting (MRH-DoPH)

1.2. Promote sharing of RH-LMIS data among the fragmented systems (MRH-DoPH, IPs)

1.3. Continue to advocate for increase in domestic budget allocation for contraceptive commodities, storage, distribution and warehousing of FP commodities.

1.4. Continue monitoring of GFF progress in Myanmar

1.5. Continue to disseminate revised CIP (estimated time of publication is December 2018), and use it as a budget advocacy tool to secure funding for FP (both domestic and international resources).

1.6. With the lead from DFID, continue to advocate DFID and other like-minded donors (Sweden, Canada and Gates) for financial support for advocacy budget and commodities (early 2019)

2. Comprehensive community engagement

2.1. Advocacy, communication and social mobilization on family planning targeting on community, religious and ethnic leaders, women and youth groups (MoHS, IPs)

2.2. Increased opportunity to listen to the community voices (MoHS, Donors, UN and CSOs)

2.3. Develop the capacity of service providers in provision of FP information (MoHS and IPs), including youth-friendly family planning services

2.4. Promote women empowerment and gender equality to improve decision making on FP (MoHS, Donor, UN and CSOs)

2.5. Invest in meaningful engagement of youth leaders in policy making and program design, implementation, review and accountability. In particular, FP2020 Focal Points will work with Youth Representative to map out strong Youth advocates and networks. Supporting capacity building of youth networks should be considered.

2.6. Revive engagement of existing TWGs and expand them by inviting other sectors (Ministry of Finance and Planning, Ministry of Social Welfare, youth representatives, etc.).

2.7. Build the capacity of youth leaders in leadership and advocacy skills. Invite pro-youth government agents to youth-led events. Focal Points to encourage and arrange participation.

3. Post-partum family planning

3.1. Improve quality SRH services and programme and strengthen emergency referral support (MoHS, IPs)

3.2. Strengthen LMIS and supply chain system (MoHS, Donors, UN and CSOs)

3.3. Develop capacity of health staffs on quality PPFP counseling and services (MoHS, Ips)