CHDN (Karenni State)
Civil Health and Development Network

Plan of Action
2018 - 2021

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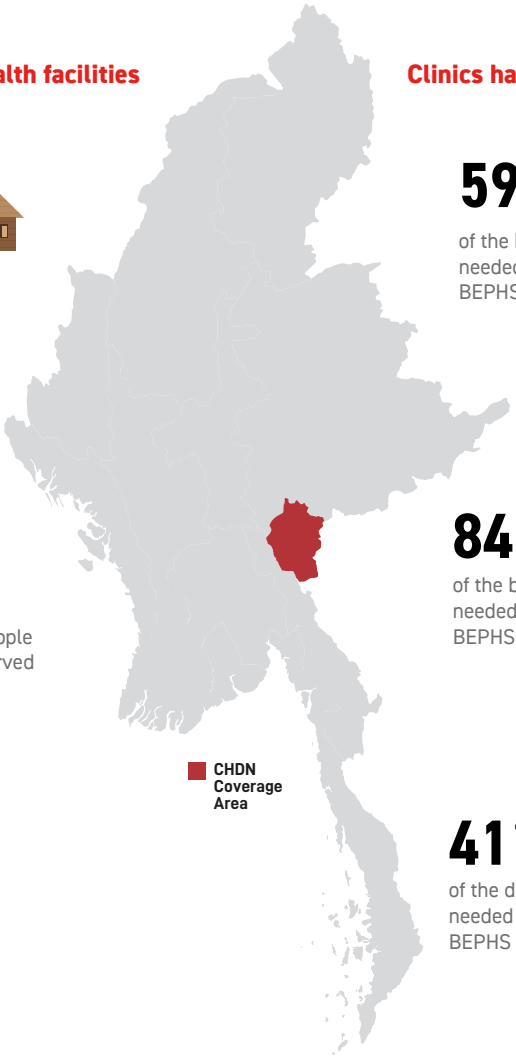
CHDN Assessment Findings - March 2018

Total number of health facilities

24 clinics operated

57,000 people served



Clinics have on average:

59 % of the basic amenities needed to provide BEPHS

84 % of the basic equipment needed to provide BEPHS

41 % of the diagnostic tools needed to provide BEPHS

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
AMW	Auxiliary Midwives
BBG	Burma Border Guidelines
BEPHS	Basic Essential Package of Health Services
CBO	Community-based Organization
CHDN	Civil Health Development Network
CHW	Community Health Worker
CPI	Community Partners International
CSO	Civil Society Organization
EHO	Ethnic Health Organization
EHSSG	Ethnic Health Systems Strengthening Group
EmOC	Emergency Obstetric Care
ENT	Ear, Nose and Throat
EPHS	Essential Package of Health Services
EPI	Expended Program on Immunization
HE	Health Education
HIS	Health Information System
HMIS	Health Management Information System
HQ	Head Quarter
HIV	Human Immunodeficiency Virus
HR	Human Resource
HRH	Human Resource for Health
HSS	Health System Strengthening
IDP	Internally Displaced Person
ICMV	Integrated Community Malaria Volunteer
INGO	International Non-Governmental Organization
IT	Information Technology
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MNCH	Maternal, Newborn, and Child Health
MoHS	Ministry of Health & Sports
NCD	Non-Communicable Diseases
OPD	Out-Patient Department
POA	Plan of Actions
PSI	Population Service International
QIT	Quality Improvement Team
RDT	Rapid Diagnostic Test
SD	Standard Deviation
SWOT	Strengths, Weakness, Opportunities, and Threats
TB	Tuberculosis
TMO	Township Medical Officer
USD	United States Dollar
VTHC	Village Tract Health Center
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

Civil Health Development Network (CHDN) is a local Non-Govern- mental Organization (NGO) based in Karenni State. It was established in August 2012 by the health sector of the six political groups that signed ceasefires in Karenni State. Prior to the formation of CHDN, each political group had already been implementing health activities in hard to reach villages by mobilizing community health workers (CHWs) and auxiliary midwives (AMWs). The six political parties that formed CHDN are:

- KNPP (KnMHC) - Karenni National Progressive Party
- KNPLF – Karenni Nationalities People's Liberation Front
- KNLP - Kayan New Land Party
- KNSO - Karenni National Solidarity Organization
- KNPDP - Karenni National Peace and Development Party
- KNG - Kayan National Guard

Their experienced medics have trained and empowered CHWs and AMWs to carry out advanced medical outreach in remote villages. In addition, they have a pool of "backpackers" to carry medicines to remote area and provide basic health care. Even though each political group has been conducting mobile clinics, there are still many villages that lack access to basic health care in Karenni State. CHDN is currently covering 547 villages in Kayah State through 24 clinics and field staffs.

Mission Statement

CHDN is founded primarily for the purposes of providing basic health care to border areas where the government health care system is not available, or where villagers have no access due to the complexity of border issues, lack of health education, little knowledge about health care, and hardship for survival. Most importantly, CHDN stands firmly on the conviction that civil health policy must address the needs of the people and respect their rights.

Vision

Equal access to quality health care services to each individual to advance society.

Mission

CHDN, in collaboration with the community and partners, is providing quality healthcare and development programs by collecting health information, advocating health rights, building capacity, and engaging in the National Peace and Reconciliationprocess.

Care Values

(1) To sacrifice oneself for the sake of our people: Members of CHDN are fully committed to give priority to the people's healthcare and their development needs above one's own welfare.

(2) Collaboration and cooperation: All members of CHDN endeavor towards successful implementation of the programs by means of collaboration and cooperation community and partners.

with the

(3) Equality: Towards successful implementation of all programs, CHDN is against all kinds of discrimination in regards to locality, race, religion, gender or class.

(4) Quality: During implementation of health activities in the community, CHDN makes sure quality health care services are provided by capable health care providers.

(5) Transparency: CHDN, along with the community and it's partners, values transparency with regards to the implementation of all of it's activities, including financial records and reports.

Purpose of Assessment and Plan of Action

The Myanmar Ministry of Health and Sports (MoHS) began implementing the National Health Plan (NHP) (2017-2021) after a formulation period in an effort to promote participation and inclusiveness from a range of stakeholders including ethnic health organizations (EHOs). The plan specifically acknowledges the key role of EHOs in the implementation process and is focused on improving both the demand and supply for health care services throughout Myanmar.

A core component of the first phase of implementation of the NHP is to extend access to a Basic Essential Package of Health Services (BEPHS) to the whole country by 2020-2021. The BEPHS is the materialization of the NHP's vision that everyone in Myanmar have access to at least a minimum package of quality health services. It is therefore important to understand the contribution that EHOs are currently making and what investments are needed for them to fulfill their role in delivering Universal Health Coverage (UHC).

As a preparation for this, the service availability and readiness assessment of CHDN's health facilities was conducted by CPI to identify areas for improvement, further investment and strengthening.

Following the assessments conducted in summer 2018, CPI teams discussed the findings with CHDN, including service availability, service readiness and system issues. Discussion and reports were organized according to the WHO's six building blocks of a health system. For every

building block, based on the assessment findings, CHDN came up with the actions they would like to take to improve upon that area.

Following internal planning and budgeting, these actions were then ranked according to priority, creating a Plan of Action for the next three years. Additionally, CHDN identified its own risk management plan as well as monitoring and evaluation plan. This is contained as the final sections of this report.

Key Assessment Findings

In early 2018, CPI data collectors surveyed 21 of CHDN's facilities in Karenni state, as well as conducting leadership interviews and holding Focus Group Discussions to evaluate the readiness of CHDN to deliver the Basic Essential Package of Health Services to its communities. A typical CHDN clinic serves over two thousand people and offers a range of services, with particular strengths in Reproductive Maternal Newborn and Child Health(RMNCH), Non- communicable Diseases(NCDs) and malaria services. They have some of the closest links to the communities, and clinics are usually staffed by a two Medics leading a team of two Community Health Workers. Twenty of the twenty one facilities described themselves as health posts, with one village level facility.

The facilities are mostly wood, bamboo and brick construction with solar systems as the primary source of electricity, and a spring or other water source piped directly into the facility. On average, each facility had 4.5 functioning patient beds.

According to standardized infrastructure indices, CHDN facilities had an average score of 59.5% (range: 21.4% to 100%) for basic amenities, 84.1% (16.7% - 100%) for basic equipment, and 41.1% (0% - 75.0%) for diagnostic capacity. In addition, CPI investigated the readiness of the clinics to provide a range of specific service types contained within the BEPHS.

Service readiness was defined as the presence of functional equipment, drugs or diagnostics for each health service on the day of the survey.

All clinics were shown to have the necessary equipment to deliver BEPHS, though further support is still needed if facilities are to demonstrate adequacy in terms of basic amenities and diagnostic capacity. Further detail is contained in the report, breaking these down to disease level, showing what the average clinic for CHDN looks like, and listing the common stock levels for clinics.

Assessment Methodology and Results

The Myanmar Ministry of Health and Sports (MoHS) began implementing the National Health Plan (NHP) (2017-2021) after a formulation period marked by significantly greater participation and inclusiveness from a range of stakeholders including ethnic health organizations (EHOs).

The plan specifically acknowledges the key role of non-MoHS providers in the implementation process and is focused on improving both the demand and supply for health care services throughout Myanmar. The NHP aims to lay the foundations for the achievement of Universal Health Coverage by 2030, ensuring that everyone, regardless of their social or economic circumstances, can access the health services they need without suffering financial hardship.

A core component of the first phase of implementation of the NHP is to extend access to a Basic Essential Package of Health Services (BEPHS) to the whole country by 2020-2021. Therefore, regardless of the health care provider, it is critical to have technical alignment across the board for building and strengthening each type of health care provider's system.

As a preparation for this, the service availability and readiness assessment of CHDN's health facilities was conducted to identify areas for improvement, further investment and strengthening, in order to ensure compliance with BEPHS..

Methodology

Service Availability and Readiness Assessment (SARA) is designed to systematically assess and monitor a comprehensive set of core indicators of health service delivery, which can contribute to understanding the performance of health system strengthening over time. Findings can be grouped into service availability, general service readiness, and service-specific readiness. Service availability describes whether a range of services are provided and utilized at the facility level.

Service readiness describes whether the facility has the capacity to provide health care interventions related to family planning, child health services, basic and comprehensive emergency obstetric care, HIV, tuberculosis, malaria, and non-communicable diseases. General service readiness is captured by basic amenities, basic equipment, standard precautions against infection, diagnostic and other laboratory capacity and medicines. Service-specific readiness is captured by a list of tracer indicators related to equipment, diagnostic and laboratory capacity, medicines and capacities to deliver individual health services. Results

of the SARA can be used for evidence-based decision making to support planning and managing of a health system, and were therefore used to inform development of EHO-specific Plans of Action.

EHOs provided a sampling frame of clinics to CPI. For EHOs with less than 25 facilities, all identified clinics were included in the SARA. For EHOs with more than 25 facilities, a random sample of 20% of identified clinics were included in the SARA due to feasibility constraints.

According to SARA methodology, data were collected by conducting key informant interviews, typically with the most senior health worker who was present at the facility (e.g., clinic- in-charge), as well as by direct observation of the physical presence of health infrastructure, health personnel, equipment, and supplies at the time of the interview.

The WHO standard core questionnaire for health facilities was used to make the data comparable both across countries and within Myanmar. However, the questionnaire was contextually adapted in two important ways. First, the health services assessed were based on the most up- to-date draft of Myanmar's Basic Essential.

Health Services available at the time of data collection. Second, the tracer indicators for general and service-specific readiness were simplified to match the aims and objectives of the assessment - namely, to conduct a rapid assessment to inform development of Plans of Action specific to each EHO.

By simplifying the readiness tracer indicators, the assessment did not include the relatively complicated assessments of the capacity of core health personnel to perform general or service- specific health services, nor observations of quality of care provided by core health personnel. CPI provided a 3-day training to EHO staff to collect data using the SARA tool, and CPI and EHO staff completed all facility assessments between February and April 2018.

Data were analyzed according to WHO guidelines for calculating tracer indicators and composite indicators. Tracer indicators provide detailed information about important, individual factors that make up service availability and readiness indices. Composite indicators (i.e. indices) summarize multiple tracer indicators to give an overall picture of the facilities in the health system.

Tracer indicators were calculated as averages across facilities. First, a tracer item was given a value of "1" if the criteria were met (e.g., a service was available

or a type of medicine was observed) and "0" if the criteria were not met. The average availability of a tracer indicator was calculated by dividing the number of facilities where a tracer item was available by the total number of facilities assessed, and then multiplying by 100 to get a percentage.

To calculate an index score (e.g., "essential medicines") for an individual facility, the number of observed tracer indicators was divided by the total number of tracer indicators included in the index, and multiplied by 100 to get a percentage. To calculate a mean index score for the health system, the index score for all facilities was averaged.

Qualitative data were collected through two focus group discussions with community members in the surveyed clinics' catchment areas to understand geographic barriers, travel time, healthcare seeking behavior, and quality of care received, which could not be captured in the standard SARA assessment.

Assessment Findings

In February and March 2018, data collectors surveyed 21 of CHDN's facilities in Karenni State including Demoso, Hpasawng, Hpruso, Loikaw, Loi Lin Lay, Mese, Pe Kon, and Shadaw townships. The facility assessment was adapted from the WHO Service Availability and Readiness Assessment and the draft basic Essential Package of Health Services (BEPHS) from the Ministry of Health & Sports (MoHS).

In line with the WHO SARA aims and methodology, the objective of this assessment was to generate reliable, systematic data on tracer indicators for key health systems components, including infrastructure, human resources, and service delivery, in order to inform the development of CHDN's Plan of Action (POA).

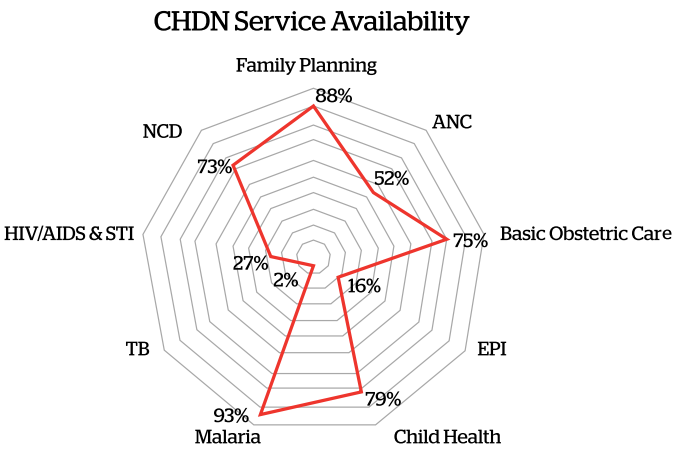
Service Readiness And Availability

According to standardized infrastructure indices, CHDN facilities had an average score of 59.5% (range: 21.4% to 100%) for basic amenities, 84.1% (16.7% to 100%) for basic equipment, and 41.1% (0% to 75%) for diagnostic capacity.

In addition to the summary infrastructure figures for how prepared CHDN clinics were, CPI investigated the readiness of the clinics to provide a range of specific service types contained within the BEPHS.

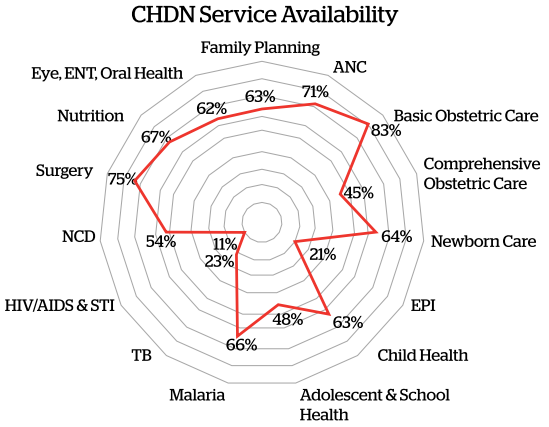
Service readiness was defined as the presence of functional equipment, drugs or diagnostics for each health service on the day of the survey.

Figure 1. Average facility service readiness index scores at CHDN facilities (n=21).



CPI then investigated the availability of facility- based services for the community. This was measured by asking clinics whether they provide a range of different services included in the BEPHS related to the service types listed below. These could include, for example, whether the clinic conducts health education, diagnoses, treats, and/or refers for a condition at the clinic level. Within each broad service type, all services were weighted equally.

Figure 2. Average facility service availability index scores at CHDN facilities (n=21) for all services included in the draft BEPHS.



Infrastructure

21 CHDN facilities were surveyed in the following townships in Karenni State: Demoso (3), Hpassaung (4), Hpruso (5), Loikaw (3), Loi Lin Lay (1), Mese (1), Phae Kone (2), Shardaw (2). Of the 21 CHDN facilities, most (20) described themselves as health posts and 1 described itself as a village level facility. Across all 21 facilities, the average age of the building was 9.3 years (range 0 to 29 years).

In terms of building materials, all facilities were constructed of sturdy materials. Specifically, half (11) are made from bamboo and wood, and the other half are made from brick and wood, with the remaining 2 facilities constructed of wood only. In terms of general building conditions, about one third (8) were classified as "good, no need to repair;" one third (7) were classified as "good, need minor repairs," 2 were classified as "not good, need major repairs," and 4 were classified as "not good, need to build a new one."

There was high consistency in how many hours per day the facilities were available. Most (71%, 15/21) facilities were available 24 hours per day; 3 facilities were available 9-16 hours per day; and 3 facilities were available 5-8 hours per day. Half of the facilities (11) had no private rooms at all; 5 facilities had rooms with only visual privacy; and 5 facilities had rooms with both visual and audio privacy. 19% (4) facilities had a functional labor room; 2 additional facilities had labor rooms but they were not functional or needed repairs. 19% (4) facilities had functional laboratories. 1 facility had a functional operating room; 2 additional facilities had operating rooms that were not functional or needed repairs. 38% (8) facilities had a functioning medical store room; 5 additional facilities had medical store rooms but they were not functional or needed repairs.

No facilities had a vaccine cold room. About half of facilities (12/21) had any patient beds. Across the 21 facilities surveyed, there was a total of 94 beds (not including dedicated maternity beds) available, all of which were functional. Individual facilities had between 0 and 30 functioning beds each, with an average of 4.5 functioning beds per facility. Two thirds (67%, 14/21) of facilities had dedicated maternity beds [note: this implies that some facilities had dedicated maternity beds but not general outpatient beds].

Across the 21 facilities, there was a total of 15 dedicated maternity beds, of which only two thirds (67%, 10/15) were functional.

Infrastructure

21 CHDN facilities were surveyed in the following townships in Karenni State: Demoso (3), Hpassaung (4), Hpruso (5),

Loikaw (3), Loi Lin Lay (1), Mese (1), Phae Kone (2), Shardaw (2). Of the 21 CHDN facilities, most (20) described themselves as health posts and 1 described itself as a village.

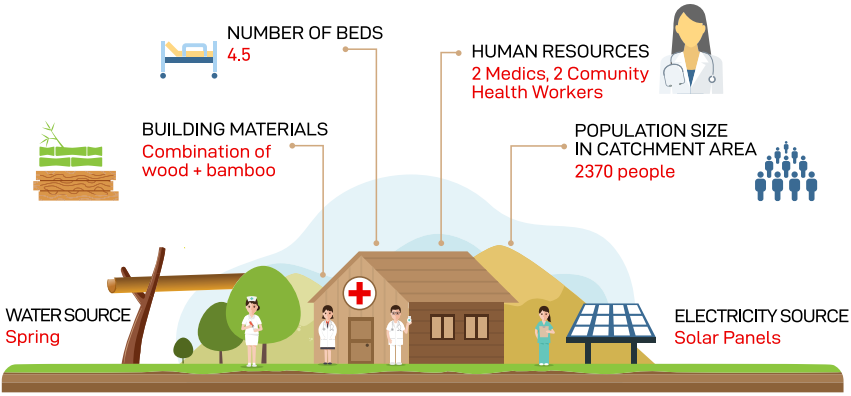
The number of dedicated maternity beds per facility ranged from 0 to 2, with an average of 0.7 dedicated maternity beds per facility. Only 13 of the 21 facilities (62%) had latrines that were functional. Each facility had between 1 and 6 latrines, with an average of 1.7 latrines per facility.

The latrine type at all facilities is a pit latrine. None of the 21 facilities reported that they had been affected by armed conflict within the past 6 months. Most (76%, 16/21) facilities have electricity. Most of the facilities that have electricity (14/16) said that they had enough electricity for all of their needs; only 2 facilities said that they had only enough electricity for lights and communication. For 15 facilities that responded, 5 reported that they had power for 5- 8 hours per day, 3 facilities reported that they had power for 9-16 hours per day, and 7 facilities reported that they had power for 24 hours per day, based on the past week. About half of facilities that had electricity relied on the national or community grid as their main source of electricity (7) and the other half relied on solar power (9).

Only 4 of the facilities had a backup source of power, which was a generator for 1 facility and solar power for 3 facilities. For the 1 facility that had a generator, the generator was functional but no fuel was available on the day of the survey. For the 12 facilities that relied on solar power as the main or backup power source, only 5 facilities had a solar system that was functional on the day of the survey.

Half (52%, 11/21) of facilities reported having access to the internet for communication purposes. Only 9.5% (2/21) facilities had access to a functioning computer; 1 additional facility had a computer but said that it was only sometimes functional. Half (52%, 11/21) facilities had access to a functioning phone line; 8 additional facilities had access to a phone line, but said that it was only sometimes functional

Typical Facility



Service Provision

Out of 21 total facilities, 17 reported any population data. Out of 17 reporting facilities, the total population covered was 40,337, ranging from 230 to 11000 people per facility, with an average population size of 2373 people per facility. Only 8 facilities provided information on target patient load for the facility, which ranged from 9 to 3691 patients per facility, with an average of 998 target patients per facility. For individual types of service delivery based on data from the previous year, 19 facilities reported data for ANC1. The number of ANC1 services provided in the previous year ranged from 0 to 113 per facility, for an average of 27 ANC1 services per facility and a total of 488 ANC1 services across all 19 reporting facilities for 2017.

18 facilities reported data for delivery services. The number of deliveries ranged from 0 to 70 per facility, with an average of 16.8 deliveries per facility, and a total of 286 deliveries across all 18 reporting facilities for 2017. Only 1 facility reported providing any DTP3 services, and the number of services provided in the previous year was 1. 14 facilities reported data on number of OPD services provided. The number of OPD services provided per facility ranged from 2 to 3500, with an average of 882 services per facility, and a total of 11,460 OPD services across all 14 facilities in 2017.

Referrals

For the 13 facilities that had access to a truck/car for referral, to reach the primary place of referral from the facilities takes an average of 159 minutes by car (range: 15 minutes to 12 hours). The travel time to the second place of referral was almost an hour longer (211 min, on average) compared to the travel time to the primary place of referral by truck/car. Across the 5 facilities that had access to motorbikes for emergency

transport, to reach the primary place of referral takes an average of 270 minutes (range 1 hour to 12 hours). The travel time to the second place of referral was again approximately one hour longer (278 minutes) compared to the travel time to the primary place of referral by motorbike.

For the 2 facilities that had access to a tractor for emergency transport, it took an average of 120 minutes (range: 90 to 180 minutes) to reach the primary place of referral and an average of 180 minutes (range: 30 to 300 minutes) to reach the second place of referral. 81% (18/21) facilities have an SOP/ guidelines for referral. 81% (18/21) of facilities have an approval mechanism for referral outside clinic hours. Two thirds (67%, 14/21) facilities report that they always had access to at least 1 functioning vehicle for emergency transportation, and 2 facilities reported that they sometimes had access to a functioning vehicle, and 5 facilities reported that they did not have any access. Most facilities had had access to emergency vehicles used a truck/car (13), followed by motorbikes (5), and tractors (2). First choices for referral were Loikaw Hospital (8 facilities); Hpruso Hospital (4), Hpasaung Hospital (3), Demoso (2), Loi Lin Lay (2), Mese (1), and Shardaw (1).

First choice referral sites are selected for the following reasons: Nearby (10) and convenient for transportation (2), more equipment (1) and more modernized equipment (1), save cost (2); Have Doctor (1) or more qualified and adequate staff (1); more comprehensive (1) and higher quality (1) services, patient request (1) or have relatives there (1), minor cases (1), or because medical/food/TA charges are provided by CHDN (1).

Second choices for referral were fairly similar as the list of first choice facilities, and only 17 facilities named a second choice referral site. Second choice facility sites included Loikaw Hospital (10), Loikaw Military Hospital (1; note: is this the same as Loikaw Hospital?), Hpruso Hospital (1), Hpasaung Hospital (1), Shardaw Hospital (1), Demoso (1), Moe Byae (1), Nay Pyi Yaw (1). All first and second choice referral sites are in the government sector. The range of transportation/treatment costs for the referred patient across the facilities ranged from 0 (for the 1 facility where CHDN covers all patient costs) to 250000 MMK, with an average of 77,560 MMK per patient.

Essential Medicines

Most but not all (90%, 19/21) facilities have the essential medicines list, which covers some of the drugs described below. None of the facilities had simvistatin or any other statin, preventing any of them from offering 100% of the essential medicines. The best stocked drugs were: paracetamol (21 facilities) amoxicillin syrup (21),

amoxicillin tablet (20), ibuprofen tablet (20), omeprazole tablet or an alternative proton pump inhibitor (20), zinc sulphate tablet or syrup (20), oral re-hydration solution (19), ceftriaxone injection (19), gentamicin injection (19), ampicillin powder for injection (18), salbutamol inhalers (15), and elalapril tablet or alternative ACE inhibitor (14).

The poorest stocked drugs included: simvastatin tablet or other statin (0 facilities), fluoxetine tablet (1), glibenclamide tablet (1), insulin regular injection (1), metformin tablet (2), amitriptyline (4), beclometasone inhaler (4), and amlodipine tablet or alternative calcium channel blocker (7). A quarter (24%, 5/21) have experienced a stock out within the previous 6 months. During stock outs, 2 facilities report stock-outs by phone and 1 facility reports by both phone and by filling out a requisition form. Over half (57%, 12/21) of facilities reported that they did not have enough space currently to store medicines. The practice of using drugs differed by facility. Most facilities used only 1 method, but 1 facility used 2 different methods. Most facilities (16) used "first expired first out" only; 4 facilities used "last expired first out," and 1 facility used "mixed: first expired first out and first in first out."

Figure 3

HIGH

Amoxicillin syrup	100 %
Amoxicillin tablet	95 %
Ampicillin	86 %
Ceftriaxone	90 %
Gentamicin injection	90 %
Ibuprofen	95 %
Omeprazole	95 %
Oral rehydration solution	90 %
Paracetamol	100 %
Salbutamol inhaler	71 %
Zinc sulphate	95 %

MEDIUM

Enalapril	67 %

LOW

Amitriptyline	19 %
Amlodipine	33 %
Beclometasone inhaler	19 %
Fluoxetine	5 %
Glibenclamide	5 %
Insulin regular injection	5 %
Metformin	10 %
Simvastatin	0 %

Health Promotion

Across CHDN, facilities provided services related to health literacy for a number of programs, including family planning (20), prevention and control of malaria (21), prevention and control of TB/MDR-TB (12), home-based care for newborns and children (16), child immunization (9), HIV/AIDS and STIs (9), nutrition & lifestyle (16), WASH (18), Eye/ENT/Oral health, and NCDs, among others.

Human Resources for Health

At the facility level, there was variation in the staffing structure across the 21 surveyed facilities. For all 21 facilities, there was a total of 201 staff, including 17 Emergency Obstetrics Care Workers (EmOC), 11 midwives, 18 pharmacists, 54 medics, 8 Health Assistants (HA), 44 Maternal and Child Health Worker (MCH) workers, 3 laboratory technicians, 44 community health workers, 1 village health worker, and 1 clinic-in-charge. The average staffing structure was <1 EmOC, <1 midwife, 1 pharmacist, 2.7 medics, <1 HA, 2.2 MCH workers, <1 lab tech, and 2.2 Community Health Workers (CHW) per facility.

Table 1

Human Resources for Health						
Doctors	EmOCs	Midwives	Phamacist	Medics	MCH Workers	Total
0	1	15	1	12	6	35

[note: some facilities mentioned more than one JD is assigned]. 5 facilities have a specific person who is in charge of the financial management, and this is the clinic- in-charge at all 5 facilities.

4 facilities have a specific person who is assigned to logistics management, but only 3 of the 4 have a specific job description for these responsibilities. 7 facilities have a specific person who is assigned to physically checking stocks at the facility, which is the Supervisor (1 facility), Clinic-in-Charge (2), Pharmacy staff (1), and CHW (2). Only 1 facility has a specific person who is assigned to data collection and reporting (no specific job description given). 18 facilities have a specific person who is assigned to physically checking reports, which is the Supervisor (13) and field supervisor (2), clinic-in-charge (1), health coordinator (1), deputy director (1), and HIS manager (1).

When asked if facility staff had adequate training to provide high-quality services, only 4 facilities responded yes, 3 responded that they had "some" training but not enough, but 14 said "no." 62% (13/21) of facilities responded that staff received periodic continuing education, such as CME (5 facilities), BBG (3), Malaria (3),

EmOC (3), TB (2), Pharmacy (2), Medic (1), Management (1), Diseases (1), GPS (1), and EPI (1).

Only 3 facilities had staff who were trained to manage logistics (1 pharmacy and 2 CHW trainings), and only 2 of facilities reported that this training was adequate for managing logistics. Similarly, only 2 facilities reported that retraining was available for logistics management.

Only 6 facilities reported that training on managing Health Information System (HIS) is available. 2 facilities reported that training on managing HIS is available monthly, 2 facilities said such training was available annually, and 1 facility said that such training was available occasionally. Over half (13) of the facilities reported that the person responsible for data collection and reporting has received training for this role.

Quality Control

Supervisory visits from higher levels can play an important role in quality control. CHDN appears to provide frequent supervisory visits. Half of the facilities (11/21) had received a supervisory visit in the past month and 3 facilities reported that their most recent supervisory visit occurred within the past 3 months. However, 3 facilities reported that their most recent supervisory visit took place more than 3 months ago, 1 facility said that they didn't know when the last visit occurred, and 3 facilities said that they had never received a supervisory visit. During the supervisory visit, the supervisor tended to check the pharmacy (12) and the data (15), with checks on staffing (7), health service delivery (5), and the clinic environment (2) occurring less frequently. However, three quarters (76%, 16/21) of facilities responded that they felt that they did not receive adequate supervision to provide high-quality services; only 5 facilities responded that they received enough supervision to ensure high quality service delivery. None of the facilities has any criteria or mechanism to check the quality of drugs.
Only a quarter (24%, 5/21) of facilities collect very basic information about the problems that staff think should be addressed to improve their working situation and services. One quarter (24%, 5/21) of facilities reported having adequate supervision to ensure high-quality service provision. Surveyors observed that most (71%, 15/21) facilities routinely carried out some quality assurance activities (e.g., review or reports or QA meeting minutes, supervisory checklist, mortality review, audit of records/ registers, etc.).

An additional 5 facilities responded that they carried out such quality assurance activities, but this could not be observed/ verified. Half of facilities (11/21) said that

data are never used by facility staff to improve service coverage or quality; other facilities said that data are used for such purposes monthly (3), quarterly (2), or once per year (5). Data were checked for quality frequently at the facility level: monthly (19) or quarterly (2).

None of the facilities had a mechanism for checking drug quality. Almost all (90%, 19/21) facilities have infection precaution guidelines. Most but not all (81%, 17/21) facilities have referral guidelines/SOPs in place; 2 additional facilities reported that they had referral guidelines but these could not be observed/verified on the day of the assessment.

Clinic Managment Procedure

At the facility level, almost all (90%, 19/21) facilities reported holding routine facility management meetings. There was high consistency across facilities in terms of how frequently facility management meetings were

held, and meetings were held relatively frequently. Specifically, 17 out of the 19 facilities that held routine meetings held meetings monthly or more frequently; 1 facility held meetings every 4 to 6 months; and 1 facility held meetings less frequently than every 6 months. For facilities that hold routine facility management meetings, only one third (6/19) keep formal records of the meeting minutes; another 6 facilities said that they keep formal records but these could not be observed/verified on the day of the survey. Most of the facilities that hold routine meetings (74%, 14/19) say that they make decisions or taking follow-up actions based on what was discussed at the facility managementmeetings.

Clinic Finances

24% (5) of facilities surveyed had a financial system. 5 out of 6 facilities reported who was in charge of the financial system at the facility level, and this person was the Clinic-In-Charge at all 5 facilities. There was some variation in how often financial reports are sent: monthly at 3 facilities, quarterly at 1 facility, and every 6 months at 1 facility.

There was some variation in where financial reports are sent. Financial reports are sent to a clinic committee at 3 facilities, headquarters at 1 facility, and the district/township office at 1 facility. Almost all (4 out of 5) facilities faced difficulties in sending financial reports on time, and cited money (1), transportation (2), and both money and transportation (1) as the reason for delays in sending financial reports.

Data Management

The types of log books kept by facilities included: ANC (20 facilities), Delivery (20), PNC (20), Family care (17), Pharmacy (18), Outpatient registry (12), Inpatient

registry (11), General morbidity (20), and Malaria (1). All facilities kept between 5 and 8 different types of log books. For log books, 12 facilities kept 8 different types of logbooks; 2 facilities kept 7 different types of log books, 4 facilities kept 6 different types; and 3 facilities kept 5 different types (average 7 different types of logbooks per facility). Forms are paper-based for almost all facilities (20/21), and both paper-based and electronic for 1 facility.

Almost all (19/21) facilities said that they had to prepare reports according to specific schedules/deadlines, with most (18) facilities preparing reports monthly, 6 facilities preparing reports quarterly, 5 facilities preparing reports every 6 months, and 7 facilties preparing reports annually. In addition, one facility said that they prepared reports "whenever asked."

Note that facilities often had to submit reports at multiple frequencies - up to 4 different schedules per facility (e.g., monthly, quarterly, 6-monthly, and annually). Most (86%, 18/21) facilities had guidelines for managing the health information system. Only 6 facilities (29%) had designated staff to check data accuracy, and no facilities had any mechanism to check data accuracy and quality.

Community Engagement

Two thirds (67%, 14/21) of facilities hold routine meetings about facility activities or management that include community members. Only 4 of the 14 facilities maintain an official record of these meetings; an additional 1 facility reported that they kept such records, but these could not be observed/verified. 29% (6/21) facilities have at least one system for determining clients' opinions about the health facility or its services, including official meetings with community leaders (2), informal discussions with clients or the community (3), and letters from clients/community (4; note: this is unusual. need to verify).

No facilities used suggestion boxes, client survey forms, or client interview forms. Only 9.5% (2/21) of facilities have a procedure for reviewing or reporting on clients' opinions; 2 additional facilities said that they had such procedures but this could not be observed/verified on the day of the assessment.

Strengths & Limitation of Assessments

Because the SARA was designed as part of a rapid situational analysis of individual EHO health systems, several simplifications to the standard WHO tool were made to increase feasibility within a limited timeframe for data collection.

The simplified questionnaire focused on provision of care, which is a foundational building block for service accessibility and quality, but does not represent the full picture of health system performance.

The questionnaire did not assess several key aspects of service availability and readiness such as capacity of individual trained HRH to perform individual services, quality of care via patient observations, experience of care via patient interviews, or verification of detailed service statistics. However, the questionnaire provided a comprehensive assessment of the most important key indicators of service provision for the basic EHPS for information that can be useful to EHO program and policy leads at all levels.

The rapid assessment meant that data collectors could reach a full census of an EHO's facilities or a large representative sample of facilities, and that the results could immediately feed into POA development.

In addition to the simplifications, the questionnaire was also adapted to the basic EPHS for Myanmar as well as to the local context of service provision by EHOs. Although WHO methodology encourages local adaptation of the standard data collection tool to increase its relevance for decision-making, any modifications will limit comparability of the results to national and international SARA assessments.

The cross-sectional nature of the facility assessment cannot capture changes in service availability and readiness at the facility over time, nor explore relationships between contextual factors and long-term service availability and readiness, such as low patient demand.

However, use of standardized tools like the SARA questionnaire means that the assessment can be easily repeated in the future to show changes over time.

Finally, the sampling frame was limited to the health facilities identified by partners to CPI, and may have excluded facilities in more restricted, hard-to-reach areas. As for any health facility assessment, there was the potential for observer error or inability to observe all equipment, infrastructure, and procedures at the clinic. Data collectors were trained and monitored to promote data accuracy and completeness during data collection, and the emphasis on direct observation in the SARA data collection tool enhances the objectivity of the assessment.

Plan of Action

Objective

The core objective of the Plan of Actions (POA) is to develop detailed activities with the approach meeting the identified objectives for the next three-year period (2021). It also aims to strengthen the health system of the organization to achieve Universal Health Coverage (UHC).

The POA is formulated with supportive strategies to deliver essential primary health care services for achieving UHC in the implementing areas. The supportive and collaborative functions and roles of the CHDN, which align with the Myanmar National Health System, are clearly laid out in the POA. Therefore, the POA provides a substantive plan to support UHC in Myanmar by 2030.

The POA provides enough direction so that each building block of the health system can develop objectives and strategies that will guide the day- to-day operations of the existing and upcoming healthcare projects. It also helps strengthen active policies and guidelines and helps develop new policies needed for uniformity in implementing activities throughout the entire organization.

The POA also improves capabilities to network with local, governmental and global implementing partners towards UHC; thus, it helps reduce duplication of efforts within the targeted geographic areas. Developing the POA will help steer the staff in making decisions, prioritizing effective allocation of resources, and increasing impact on the community. This plan helps the CHDN achieve its mission more effectively, focuses health financing, human resource for health, health infrastructure and supplies essential health care services towards specific agreed-upon goals. The plan establishes benchmarks to measure the short-term goals of the organization's program and services. Moreover, it reveals the advantages of ethnic health organizations (EHOs), community-based organizations (CBOs), civil society organizations (CSOs), Ministry of Health and Sports (MoHS) and international non- governmental organizations (INGOs) working together on a common goal, and thus sustaining a sense of organizational identity.

The organization will conduct a review session every year to monitor and evaluate the implementation and completion of the POA. A monitoring and evaluation framework is identified to track the progress of the planned activities; any outstanding actions will be included in the upcoming year's annual plan.

Planning Process

The POA was based on the qualitative and quantitative research conducted in cooperation with CPI. Data collection commenced in the beginning of January 2018 by using focus group discussions and health facility assessments. The leadership interview was conducted on March 28th, 2018 and covered the organizational background, infrastructures, HR systems, logistic systems, health information systems and financial systems of CHDN. The research report was finalized in June 2018 by integrating findings at the clinic and system levels. A two-day workshop was conducted to develop the Annual Operation Planning which was held in Loikaw, Kayah State, starting from July 4 through July 5, 2018 and was attended by facilitators from CPI, senior and middle management staff, program support staff and field staff of CHDN.

The health services information from the previous year was reviewed and discussion sessions were made to collect multiple perspectives from the frontline through management level staff. Every component of the POA was included in the discussions and presentations and the final decisions and consensus were made grounded on the discussion results.The contents that were initially covered include UHC, six building blocks of health system strengthening, a Strength, Weakness, Opportunity, Threat (SWOT) analysis and identifying strategic objectives and activities. Subsequently, development of the detailed annual operation plan, implementation strategies, targeted output, responsible persons, estimated costs and identification of possible funding resources took place. Afterwards, a risk analysis was conducted to determine the risk factors that can limit the organization to carry out the planning, followed by drawing up a risk mitigation action plan. Finally, a monitoring and evaluation framework was developed to track the progress of the POA.

STRATEGIC OBJECTIVES (2018-2021)

Health Service Delivery

CHDN aims to improve health service delivery by focusing activities on standardizing health policy, increasing coverage, access and quality at both village and community levels.

To improve quality of services, CHDN will prioritize the establishment of a central Monitoring and Evaluation (M&E) unit within the network and adopt a mechanism to gather, evaluate and implement feedback from the community served. It will improve coordination between all health partners and initiate a referral network of care providers to expand health services to a larger population.

Human Resources for Health

A sufficient number of well-trained health workers and program support staff is key for CHDN to meet its service delivery and organizational goals. CHDN will focus human resource activities on building a qualified and accredited workforce at all levels of care delivery for full coverage of its service area. CHDN will develop a comprehensive human resources strategy including the creation of a workforce database and an HR recruitment plan based on staffing gaps. CHDN will conduct relevant trainings at all levels to fill workforce gaps and will address high staff turnover by utilizing strategies for staff retention. In addition, CHDN will continue certification trainings and advocacy to MOHS for accreditation of the EHO workforce.

Health Infrastructure

CHDN aims to establish the infrastructure, equipment and supplies required to meet their health care service goals that meet clear and uniform standards. CHDN will improve its current health infrastructure by concentrating on facilities and equipment, health information and communication. A standard quality guideline will be developed, and a thorough assessment of all existing facilities will be conducted for compliance. A common health information system will be established, and pertinent trainings will be available to CHDN staff.

Health Financing

CHDN will target health financing activities by developing a transparent financial policy, systematic fundraising and the strategic use of funds. Given the changing financial and political circumstances of Myanmar's health care system, CHDN will focus on both internal and national health financing structures. Internally, CHDN will clarify and improve financial policy and practice, focusing on increasing sustainable financing and resource mobilization. In addition, CHDN will develop and implement a pilot project to test a purchaser-provider split payment model in coordination with donor organizations and in close communication with MoHS.

Strategic Partnerships

Establishing and preserving partnerships is integral to successful implementation of POA. The organization functions in partnership with NGOs and INGOs that provide financial and technical assistance. CHDN is committed to to maintaining these meaningful partnerships by effectively and efficiently administering resources to ensure they reach undeserved areas and people in need.

PLAN OF ACTION (2018-2021)

The activities are organized into ve pillars of health systems strengthening strategies which are consistent with UHC. Activities are prioritized based on a scale of 1 5, which were designated through the discussion process. Highest priority (1) actions are those with secured funding and existing commitments from CHDN, and 2 5 are those without funding and with declining importance or feasibility.

Work Plan

STRATEGY	PRIORITY	Method	ESTIMATED COSTS	Responsibility
Objective: Service Delivery **Outcome: Standard package of quality basic health care services is ready and available to deliver to community members in the coverage areas** **Outcome: The people are able to access qualified primary health care service package in the targeted areas.**				
Strategy: Monitoring and Evaluation (M&E) System Development				
ACTION I : Conduct M&E training (record keeping and reporting) for 4 CHDN M&E Teams and 27 Supervisors	1	1 time		M&E Team
ACTION II : Develop M&E tools	1	1 time		
ACTION III : Plan monthly M&E activities	2	monthly		M&E Team
ACTION IV : Strengthen data collection system by reviewing the existing templates at monthly program review meeting	3	monthly		Program Team, Health Information System (HIS) Team
ACTION V : Strengthen data flow by reviewing current data system	4	1 time		HIS Team
ACTION VI : Develop supervisor check list	5	1 time		HIS Team
ACTION VII: Conduct regular and ad-hoc site visits	1	24*4= 96 times (4 times for each clinic per year)		M&E Team
Strategy: Standardization of Health Education Package				
ACTION I : Conduct health education Methodology Training (ToT) for 79 Field in-charges	1	2 times		Program Team
ACTION II : Develop health education guidelines for trainee and trainer (TB, Malaria, HIV and other communicable and non-communicable diseases)	1	1 time		Program Team
ACTION III : Conduct regular Health Education Sessions in the community	4	monthly at every village		Field Staff
ACTION IV : Produce IEC materials (Pamphlet and Video in local dialect)	5	1 time workshop		Program Team

STRATEGY	PRIORITY	Method	ESTIMATED COSTS	Responsibility
Strategy: Providing Essential Health Service Package				
ACTION I : Standardize minimal health care package for Health Posts, Back Pack Team, Village health volunteer by conducting workshop	1	1 time (2 days workshop)		Program Team
ACTION II : Pool resources for medical supplies	2	1 time		SMT Team and Program Team
ACTION III : Standardize essential drug list among health posts	3	1 time workshop to finalize the standardized drug list		CHDN Program Team
ACTION IV : Develop guideline for essential drug	3	1 time workshop		CHDN Program Team
Strategy: Coordination				
ACTION I : Quarterly coordination meeting with MoHS	3	4 times at state and township levels		Program Team and Supervisor
ACTION II : Conduct community engagement meeting	2	27 times		Supervisor
Objective: Health Financing **Outcome: A standardized financial policy and guideline helps promote efficient and effective utilization of financial resources that enhances the credibility and accountability of the organization**				
Strategy: Formation of VHC (Priority 1)				
ACTION I : Training for supervisor to form VHC groups	1	1 time		Program Team
ACTION II : Form VHCs at the village level	2	40 times		Supervisors
ACTION III : Quarterly VHCs meeting for supervision and monitoring	3	75*3=225 times		Supervisors
Strategy: Fundraising				
ACTION I : Advocacy to partners' mother organizations to increase financial support to health care activities	4	2 times		SMT Team
ACTION II : Establish a network within the Karenni community	4	1 time		SMT Team
ACTION III : Organize proposal development workshop to raise funding from the international donors	1	2 times		SMT Team
ACTION IV : Advocacy meeting with the local enterprises for fund raising	4	2 times		SMT Team
ACTION V : Advocacy meeting with the partner organizations to identify potential funding sources	5	2 times		SMT Team
Strategy: Strengthening Financial Policy and Procedure				
ACTION I : Review and revise financial policy of the network	1	1 time		Finance Team
ACTION II : Conduct staff orientation session on financial policy, and standard operation procedure	2	1 session		Finance Team

STRATEGY	PRIORITY	Method	ESTIMATED COSTS	Responsibility
Objective: Human Resource For Health **Outcome: A standardized financial policy and guideline helps promote efficient and effective utilization of financial resources that enhances the credibility and accountability of the organization**				
Strategy: Staff Coordination (Priority 1)				
ACTION I : Regular coordination meeting for office and field staff	1	42 times at regular CME session		Operation Team
Strategy: Strengthen HR Policy and Procedure				
ACTION I : Review and revise CHDN staff policy	1	1 time		HR Team and SMT Team
ACTION II : Raise CHDN staff awareness of policies, rules and regulations	2	1 time		HR Team
ACTION III : Review and update job description of CHDN staff	3	1 time		HR Team
ACTION IV : Develop standardize HR structure at the health posts	5	2 time*2-day workshop		HR Team and SMT Team
Strategy: Improving the competency of the health care workers				
ACTION I : Develop training plan and curriculums for staff capacity building	2	1 time workshop		Training Team and SMT
ACTION II : Provide training according to the developed plan and curriculums	3	Continual Process		Training Team and SMT
ACTION III : Conduct Medic Training for newly recruitment staff	2	1 time		Program Team
ACTION IV : Financing new staff recruitment at Clinics for standardized structure	3	Continual Process		SMT
Objective: Enabling Environment (Leadership and Governance) **Outcome: Forming an accountable, transparent, equitable and inclusive governance and leadership structure**				
Strategy: Coordination (Priority 1)				
ACTION I : Organize annual meeting at CHDN birthday	2	1 time per year		SMT
ACTION II : Conduct AEI training at leadership level	3	1 time		Program Team
ACTION III : Develop feedback mechanism among staffs by conducting Annual Review Meeting	2	1 time		HR Team
ACTION V : Staff Retreat	3	1 time		HR Team

STRATEGY	PRIORITY	Method	ESTIMATED COSTS	Responsibility
Objective: Health Infrastructure **Outcome: Standard health care facilities and related infrastructure installation has been equipped to meet the minimum regulatory standards**				
Strategy: Allocating the required resources				
ACTION I : Set up pharmacy management team	1	1 time		SMT
ACTION II : Establish 3 sub warehouse	2	4 warehouses		Program Team
ACTION III : Develop medical waste management guideline	3	2 times workshop		Program Team
ACTION IV : Provide training for medical waste management to pharmacy management team	4	1 time		Program Team
ACTION V : Review and analyze existing logistic and supply chain management system at different levels	5	2 times at review workshop		Program Team
ACTION VI : Set up the infrastructure for water supply at the facility level	5	3 facilities		Program Team
ACTION VII : Awareness raising for procurement and pharmaceuticals management procedures at the facility level	5	monthly village tract meeting		Program Team

Risk Management

The major risks for delivering operational plan were assessed based on their potential impact to the program and probability of occurrence. High impact, high probability risks include a changing health policy and challenging political landscape, mobile targeted population, insufficient program data and IT resources. Risks will be actively managed by the following risk mitigation activities.

Risks

- Budget limitation
- Security threats to the program because CHDN program area is located in both Government and non-government controlled areas of Kayin and Kayah State
- Frequent breaking in bilateral ceasefire agreement between the military and EAOs Poor community participation
- Diverse network structure (which constitutes six EAOs with different political backgrounds)
- Difficult to access to the villages due to poor transportation
- CHDN Legal Registration Status (non-register)

Risk Mitigation Activity

- Identify sustainable financing mechanism and strategic fundraising
- Frequent negotiation with Ethnic Armed Organizations (EAOs) and government with the support of partner funding agencies
- To form the local ethnic committee and collect feedback. Participate actively in the process of National Cease Fire Agreement process.
- Form village health committees, develop seasonal calendar for project activities by inviting local community
- Regular advocacy with the partners
- Develop supply chain management system for natural disasters. Utilize seasonal calendar Coordinate more with partners, donor agencies and the government for better cooperation and communication.

Monitoring & Evaluation

As described in the workplan, a central M&E unit has already been created by CHDN. The M&E unit and other operational departments will work together to consolidate monitoring and evaluation activities across the organization to improve efficiency. A continuous monitoring system will be developed by the M&E team, including a standardized checklist and on-site trainings for staff.

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