Plan of Action
2018 - 2021
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KDHW Assessment Findings - March 2018

Total number of health facilities

68 clinics operated

Clinics have on average:

66% of the basic amenities needed to provide BEPHS

89% of the basic equipment needed to provide BEPHS

43% of the diagnostic tools needed to provide BEPHS

350,000 people served

1,808 staff members
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<td>Acquired Immunodeficiency Syndrome</td>
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<td>ANC</td>
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<td>Auxiliary Midwives</td>
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<td>Burma Border Guidelines</td>
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<td>BEPHS</td>
<td>Basic Essential Package of Health Services</td>
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<td>CBO</td>
<td>Community-based Organization</td>
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<td>CHW</td>
<td>Community Health Worker</td>
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<td>Community Partners International</td>
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<td>Essential Package of Health Services</td>
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<td>Health Management Information System</td>
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<td>Headquarters</td>
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<td>Human Immunodeficiency Virus</td>
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<td>Internally Displaced Person</td>
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<td>ICMV</td>
<td>Integrated Community Malaria Volunteer</td>
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<td>INGO</td>
<td>International Non-Governmental Organization</td>
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<td>Information Technology</td>
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<td>KDHW</td>
<td>Karen Department of Health &amp; Welfare</td>
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<td>Logistics Management Information System</td>
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<td>Monitoring and Evaluation</td>
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<td>Out-Patient Department</td>
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<td>Plan of Actions</td>
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<td>Quality Improvement Team</td>
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<td>Rapid Diagnostic Test</td>
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<td>Standard Deviation</td>
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<td>Strengths, Weakness, Opportunities, and Threats</td>
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<td>Village Tract Health Center</td>
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EXECUTIVE SUMMARY

Background
Karen Department of Health & Welfare (KDHW) is an Ethnic Health Organization (EHO) which has served the health needs of the Karen population for over 50 years. The organization was founded in 1965 to provide primary health care to the ethnic Karen living in regions without government-sponsored health care services and limited access to health resources of any kind.

The current delivery system is community-based, with at least one Village Tract Health Center (VTHC) per village and at least one Village Health Worker (VHW) on site. KDHW provides comprehensive primary health care to a population of more than 350,000 in remote and conflict-affected areas in Karen State, some parts of Mon State, Tanintharyi and East Bago regions.

Mission Statement
The aim of KDHW is for all people within KDHW service areas to have access to quality healthcare services without financial hardship.

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 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 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 KDHW’s health facilities was conducted to identify areas for improvement, further investment and strengthening.

Following the assessments conducted in summer 2018, CPI teams discussed the findings with KDHW, 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, KDHW 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, KDHW 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 sampled 17 of KDHW’s facilities across Kayin, Tanintharyi, Bago and Mon, in addition to conducting leadership interviews and holding Focus Group Discussions to evaluate the readiness of KDHW to deliver the Basic Essential Package of Health Services to its communities.

KDHW typically serves over four thousand people per clinic, offering a range of services, with particular strengths in obstetric care and malaria services.

Thirteen of the seventeen sampled clinics hold regular meetings with their communities. Clinics are usually staffed by one medic leading a varied team of Community Health Workers, Maternal and Child Health Workers and sometimes a pharmacist.

Sixteen of the seventeen facilities described themselves as village tract health centers, while one was described as a township clinic.

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 7.7 functioning patient beds.

According to standardized infrastructure indices, KDHW facilities had an average score of 66.4% (range: 35.7% to 100%) for basic amenities, 89.2% (66.7% - 100%) for basic equipment, and 42.6% (12.5% - 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.

Equipment to deliver the BEPHS was consistently present, but there was considerably more need for support in terms of both basic amenities and diagnostic capacity. Further detail is contained in the report, breaking these down to disease level, showing what the average clinic for KDHW 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 Universal Health Coverage by 2030 so 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 (EPHS) 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 KDHW’s health facilities was conducted to know the area to improve, investment and strengthen.

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, medicines, and commodities.

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 March and April 2018, data collectors surveyed a random sample of 17 KDHW facilities in Kayin State, Tanintharyi Region, and Bago Region, including, Myitta, Dawei, Kyarinseikkyi, Kawkareik, Myawaddy, Hlaing Bwe, Thaton, Moe, and Than Daung townships.

The facility assessment was adapted from the WHO Service Availability and Readiness Assessment and the draft 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 (HR), and service delivery, in order to inform the development of KDHW’s Plan of Action (POA).
Service Readiness And Availability

According to standardized infrastructure indices, KDHW facilities had an average score of 66.4% (range: 35.7% - 100%) for basic amenities, 89.2% (66.7% - 100%) for basic equipment, and 42.6% (12.5% - 75.0%) for diagnostic capacity (See Appendix).

During the assessment, the readiness of the clinics to provide a range of specific service include in BEPHS was probed. Service readiness was defined as the presence of functional equipment, drugs or diagnostics tools for each health service on the day of assessment.

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.
Infrastructure

A random sample of 17 KDHW facilities were surveyed in the following townships in Kayin State, Tanintharyi Region, Bago Region, and Mon State: Ler Mu Lay (1); Matta (2); Dawei (1); Kyar Inn Seik Kyi (2); Kawkareik (2); Myawaddy (4); Hlaine Bwe (2); Tha Htoon (1); Moe (1); and Than Daung (1).

Of the 17 KDHW facilities, most (16) were village tract health centers, and 1 was a township clinic. Across all 17 facilities, the average age of the building was 10.9 years (range 0.3 to 42 years). In terms of building materials, 11 were constructed from brick and wood, 2 were constructed from wood, 3 were constructed from both wood and bamboo, and 1 was constructed from bamboo and thatch.

In terms of general building conditions, about one third (6) were classified as “good, no need to repair;” over half (9) were classified as “good, need minor repairs;” 1 was classified as “not good, need major repairs,” and 1 was classified as “not good, need to build a new one.” There was high variation in how many hours per day the facility was available. Over half of facilities (10) were available 24 hours per day; 3 facilities were available 9-16 hours per day; and 4 facilities were available 5-8 hours per day. Only 4 facilities had a room with both audio and visual privacy.

6 facilities had visual privacy (but not audio privacy) and 7 facilities did not have any rooms with any privacy. 2 facilities had a functional laboratory, 9 facilities had a functional medical store room and 5 facilities had a medical store room that needed repairs, 4 facilities had a functional labor room and 1 facility had a labor room that needed repairs, and 1 facility had a functional operating theater. No facilities reported having a vaccine cold room.

Across the 17 facilities sampled, there were 134 beds in total available, of which most (131) were functional. Individual facilities had between 0 and 16 functioning beds each, with an average of 7.7 functioning beds per facility.

Only 2 facilities had a dedicated maternity bed, of which only 1 maternity bed was functional. Only 13 of the 17 facilities had functioning latrines. Each facility had between 0 and 6 latrines, with an average of 2.1 latrines per facility. All 13 facilities with functioning latrines had pit latrines. Latrines were located between 16 and 3200 meters (average 581) from the water source. 1 of the 17 facilities reported that they had been affected by armed conflict within the past 6 months. For that facility, conflict had occurred four times in the past 6 months and occurred between different ethnic arm groups. This conflict resulted in intimidation of health workers.
Most (82%, 14/17) facilities had electricity. Most (12/14) of these facilities with electricity said that they had enough electricity for all of their needs, while the remaining two facilities said that they had only enough electricity for lights and communication.

Of the 10 facilities that responded, 4 reported that they had power for 5-8 hours per day, 2 facility reported that they had power for 9-16 hours per day, and 4 facilities reported that they had power for 24 hours per day, based on the past week. Most facilities relied on a solar system as their main source of electricity (11); other facilities relied on hydro power (1), and generators (2). Only 4 of the facilities had a backup source of power, which was a generator for all 4 facilities with a back-up source.

In total, 6 facilities relied on a generator as the main or backup power source. Of these 6 facilities, the generator was functional at only 5, and fuel was available at only half (3). For the 11 facilities that relied on solar power as the main power source, all 11 had functional solar systems on the day of the assessment.

Half (9/17) of the sampled facilities reported having access to the internet for communication purposes. Only a quarter (4/17) of the sampled facilities had access to a functioning computer. Over half (10/17) of facilities had access to a functioning phone line.

**Typical Facility**

Most facilities (n=16) described themselves as VTHCs and 1 as a township clinic, with an average catchment population of 4,120 people per facility. The most common features across all 17 facilities were brick and wood construction materials, a solar system as the primary source of electricity, and the primary water source piped directly into the facility. On average, each facility had 7.7 functioning patient beds.
Service Provision

Out of 17 sampled facilities, 16 facilities reported any population and service utilization data. Out of 16 reporting facilities, the total population covered is 65,960, ranging from 1809 to 6541 people, with an average population size of 4123 people per facility. Only 12 facilities provided information on number of ANC1 services delivered in the previous year, which ranged from 0 to 240 ANC1 services per facility (average 49).

11 facilities provided delivery services in the previous year, which ranged from 2 to 66 deliveries per facility (average 21). Only 2 facilities provided any DTP3/Pentavalent services in the previous year, which ranged from 31 to 39 services (average 35).

For 8 facilities that reported outpatient service delivery, the average number of OPD services per facility per year was 777, ranging from 121 services to 1678.

Referrals

Across all 17 sampled facilities that had access to trucks/cars for emergency transport, to reach the primary place of referral takes an average of 2.5 hours (148 minutes) by car, ranging from 20 minutes to 6 hours. For 12 facilities that had both a primary and a secondary place of referral by car, the travel time to the second place of referral was 3 3⁄4 hours (227 minutes), ranging from 20 minutes to 1 day. Across 11 facilities that had access to motorbikes for emergency transport, to reach the primary place of referral takes an average of 2.5 hours (153 minutes), ranging from 20 minutes to 6 hours.

For 5 facilities that had both a primary and a secondary place of referral by motorbike, the travel time to the second place of referral was almost 7 hours (414 minutes), ranging from 1 hour to 1 day. For 7 facilities that had access to a boat for emergency transport, to reach the primary place of referral takes an average of 2 3⁄4 hours (163 minutes), ranging from 5 minutes to 15 hours. 1 facility reported having access to a tractor for emergency transport to the nearest primary place for referral, which takes 5 hours. 1 facility reported that it was possible to walk to the nearest primary place for referral, which takes 12 hours.

About 10% (2/17) facilities have an SOP/guidelines for referral. 65% (11/17) of facilities have an approval mechanism for referral outside clinic hours. 71% (12/17) of facilities report that they always had access to at least 1 functioning vehicle for emergency transportation and the remaining 5 facilities reported that they sometimes had access to a functioning vehicle; no facilities reported that they did not have any access. 17 facilities had access to a truck/car; 12 facilities had access to a motorbike; 9 facilities had access to a boat; and 1 facility had access to a tractor.
First choices for referral were Myiek (1 facility), Kaleinaung Hospital (1), Dawei (2), Noe Bo (1), Mae Tao Clinic (4), Daw Na Clinic (1), Mae Ra Mark (2), Hlaing Bwe Hospital (1), Kawkareik hospital (1), Mae La Camp Hospital (1), Tha Ra Daw Phae (1), and Kler La (1).

First choice referral sites are selected for the following reasons: nearby (9), convenient/save cost for transportation (8), free of charge for medical services (5), good relationship/communication (4), good quality (3), and ability to take general cases.

Second choices for referral were Kanchanaburi Hospital in Thailand (2 facilities), Wang Ka Hospital in Thailand (1), Dawei (1), Kawkareik (2), Myawaddy (1), Mae La Camp (1), Kou Ko (1), War Pa Clinic (1), Mae Sot Hospital (1), Tha Htoon Hospital (1), and Taw Oo (1).

Second choice referral sites are selected for the following reasons: can manage more severe cases (6), emergency and EmOC cases (2), convenient to travel to despite high transportation costs (2), nearby (4), free of charge for medical services (3), and good relationship (1).

Most primary and secondary referral sites are managed by the government sector, but 2 are UNHCR camp-based clinics, 4 are community-based clinics, and 1 is managed by EHOs.

Based on data from the 17 sampled facilities, the range of transportation/treatment costs across the facilities was 0 to 490,000 MMK, with an average of 96,100 MMK per patient referral.

**Essential Medicines**

Only a quarter (4/17) facilities have the essential medicines list, which covers some of the drugs described below. No facility had 100% of the essential medicine list because no facility had amitriptyline, fluoxetine tablets, or insulin injections. The best stocked drugs were: Amoxicillin tablets (17 facilities), paracetamol tablets (16 facilities), ibuprofen (14 facilities), ceftriaxone injection (13 facilities), amoxicillin syrup/suspension (13 facilities), omeprazole tablet (13 facilities), oral rehydration solution (12 facilities), and gentamicin injection (11 facilities).

The poorest stocked drugs included: amitriptyline (0 facilities), fluoxetine tablets (0 facilities), insulin injections (0 facilities), simvastatin tablet or other statin (1 facility), beclometasone inhaler (2 facilities), glibenclamide tablets (2 facilities), enalapril tablet or alternative ACE inhibitor (5 facilities), metformin tablet (5 facilities), and salbutamol inhaler (5 facilities). Most facilities (82%, 14/17) had experienced a stock out within the previous 6 months. Methods of reporting stock outs include submitting a requisition form (8 facilities),
calling by phone (7 facilities), reporting in person (4 facilities), and telegraph (1 facility).

Over half (10/17) of facilities reported that they did not have enough space currently to store medicines. The practice of using drugs differed by facility, and 1 facility used two different practices. Most facilities (16) used “first expired first out” only; 2 facilities used “mixed: first expired first out” and “first in first out.”

13 facilities had a specific staff member who was assigned to manage logistics: 9 clinic-in-charge, 1 medic, 2 township health in-charge, and 1 logistician.

However, only 3 facilities included logistics responsibilities in the specific job description for that staff member, and only 3 of the 13 facilities which had a dedicated logistician role reported receiving any training on logistics procedures. Only 2 of the 17 sampled facilities had defined procedures for managing logistics.

Of these 2 facilities with defined logistics procedures, 1 facility had Procurement Guidelines and 1 facility had (unspecified) guidelines which were developed at the district level; no facilities had Supply Chain Management Guidelines, Asset and Inventory Management Guidelines, or Warehouse Management Guidelines.

For pharmaceuticals, all 17 facilities had defined procedures to manage the supply chain of pharmaceuticals.

For these 10 facilities, individual facilities used between 1 and 3 different methods to procure pharmaceuticals, including initiating requisitions (10 facilities), directly purchasing pharmaceuticals at the facility level (3 facilities), and receiving pharmaceuticals from the upper level without any requisition (7 facilities).

The person responsible for ordering the drugs: the clinic-in-charge (11 facilities), pharmacy staff and medics (2), township health in-charge (2), district health in-charge (1), and program staff (1). Drugs are supplied by headquarters for 10 facilities, donors for 6 facilities, local markets and shops for 5 facilities, District and Township offices for 3 facilities, and NGOs and partner organizations for 3 facilities. The amount of drugs to be supplied is decided by headquarters for 9 facilities, the facility itself for 5 facilities, the district or township office for 4 facilities, and a health subcenter by 2 facilities. It takes between 1 and 180 days from the beginning of ordering to receiving drug, with an average of 79 days.
Figure 3. Medicine availability across a sample of 17 KDHW facilities. The percentage reflects the percent of clinics where the drug was available on the day of the survey. Drugs in the “high” category were well stocked across all facilities, whereas drugs in the “low” category were poorly stocked across all facilities.

Health Promotion

Across KDHW, all facilities provided services related to health literacy for a number of programs, including antenatal care (15), prevention and control of malaria (17), prevention and control of TB/MDR-TB (9), HIV/AIDS and STIs (8), nutrition & lifestyle (13), WASH (15), 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 17 surveyed facilities. There was a total of 141 staff, including 1 EmOC, 3 midwives, 9 pharmacists, 30 medics, 1 HA, 23 MCH workers, 2 laboratory technicians, 1 eye operation specialist, 54 community health workers, 10 Village Health Workers/Malaria Health Workers, 6 cleaners or general helpers, and 1 unspecified.

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Table 1
13 facilities have a specific person who is assigned to logistics management, but only 3 of the 13 have a specific job description for these responsibilities. Only 2 of the 13 facilities had staff who had received relevant training for logistics management (the assigned person in 1 facility had received logistics training, and the assigned person in the other facility had received pharmacy training). None of the facilities said that they had received adequate training for logistics management. 9 facilities have a specific person who is assigned to physically checking stocks at the facility. 11 facilities have a specific person who is assigned to data collection and reporting: District Health In-Charge (1); Township Health In-Charge (2); Clinic In-Charge (6); BP Team In-Charge (1); EmOC (1), Helper (1), MCH (1) Medic (1). 12 facilities have a specific person who is assigned to checking reports: District Health In-charge (3); BP Health In-Charge (2); Clinic In-charge (4); Supervisor (1); Medic (1) and CHW/clinic staff (1). None of the facilities have a specific person who is in charge of the financial management (clinic-in-charge at 5 facilities, financial manager at 1 facility).

When asked if facility staff had adequate training to provide high-quality services, about a third (6) of facilities responded yes and most (11) responded that they had “some” training but not enough. Most (12/17) of facilities responded that staff received periodic continuing education, such as refresher trainings for EmOCs, CHWs, and MCH workers; topics like malaria, TB, GBV, and HIV; and clinic procedures related to the pharmacy and lab. 11 facilities have a specific person who is responsible for data collection and report preparation. Only 4 of the 11 facilities reported that person responsible for managing health information at the facility had been trained for this position, and this training was available monthly at 1 facility, every 6 months at 1 facility, and annually at 2 facilities.

**Quality Control**

Supervisory visits from higher levels can play an important role in quality control. 2 facilities reported that they had received a supervisory visit within the past month, 7 facilities between 2 and 3 months ago, 5 facilities between 4 and 6 months ago, and 3 facilities responded that they had never received a supervisory visit. For facilities that received supervisory visits, during the most recent supervisory visit at the time of the assessment, the supervisor assessed the pharmacy was assessed at 8 facilities, staffing at 8 facilities, data at 7 facilities, services at 5 facilities, infrastructure at 4 facilities, and waste management at 1 facility.
However, only half (10/17) of facilities responded that they felt that they received adequate supervision to provide high-quality services. None of the facilities had any criteria or mechanism to check the quality of drugs.

Over half (11/17) of facilities collect very basic information about the problems that staff think should be addressed to improve their working situation and services. Surveyors observed that only 2 out of 17 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.). Most facilities (15/17) said that data are used by facility staff to improve service coverage or quality; with such data reviews occurring monthly (8) or every 6 months (7). However, 2 facilities reported that data are never used by facility staff. There was variation in how often data were checked for quality at the facility level: monthly (2), every 3 months (1), every 6 months (6), once a year (5), and never (3). None of the facilities had any mechanism for checking drug quality.

Clinic Management Procedure
At the facility level, most (16/17) facilities reported holding routine facility management meetings. There was high variation across facilities in terms of how frequently facility management meetings were held. 7 facilities held these meetings monthly or more frequently; 3 facilities held these meetings once every 2-3 months; 1 facility held these meetings once every 4-6 months; and 5 facilities held these meetings less frequently than every 6 months.

For facilities that hold routine facility management meetings, 5 keep formal records of the meeting minutes which were verified during the assessment, and 5 facilities reported keeping formal records but these could not be observed/verified during the assessment. Most (14/17) of the facilities that hold routine facility management meetings reported making decisions or taking follow-up actions based on what was discussed at the facility management meetings.

Clinic Finances
None of the 17 sampled facilities had a financial system.

Data Management
The types of log books kept by facilities included: ANC (11 facilities), Delivery (11), PNC (11), Neonatal Logbook (2), Family care (10), Pharmacy (6), Outpatient registry (4), Inpatient registry (1), General morbidity (16), Nutrition (1), Malaria (4), TB (1), and Referral (1). For log books, 1 facility kept 8
different types of logbooks; 4 facilities kept 7 different types of logbooks, 2 facilities kept 6 different types, 2 facilities kept 5 different types, 3 facilities kept 4 different types, 2 facilities kept 2 different types, and 2 facilities kept 1 type (average 4.6 different types of logbooks per facility). 13 facilities said that they had to prepare reports according to specific schedules/deadlines, with 4 facilities preparing reports monthly, 5 facilities preparing reports quarterly, 10 facilities preparing reports every 6 months, and 2 facilities preparing reports annually.

None of the facilities had guidelines for managing the health information system. Most (11/17) of facilities had staff specifically designated to collect data and prepare reports, but only 4 of the 11 facilities reported that they had trained staff for data collection and report preparation. Only 1 facility had a specific mechanism for checking data accuracy, which was “communicating with the data collector,” but 4 facilities reported that they had designated staff to make sure that data are correct. For data collection, most facilities (15/17) keep paper-based forms while 2 facilities keep both paper-based and electronic records. For facilities that send data forms/records, reports were sent to KDHW headquarters of KDHW or KMCC (9), District office (5), METF/SMRU (2), donors (2), Kou Ko Office (1); higher level clinic (1), nowhere (due to no current programming (1)).

Community Engagement

Most (13/17) facilities hold routine meetings about facility activities or management that include community members. Only 2 of the 13 facilities maintain an official record of these meetings; an additional 5 facilities reported that they kept such records, but these could not be observed/verified. About half (9/17) facilities have at least one system for determining clients’ opinions about the health facility or its services, including, client interview forms (1), official meetings with community leaders (4), and informal discussions with clients or the community (9). No facilities reported using suggestion boxes, client survey forms, or letters from clients or the community. Approximately one quarter (4/17) of facilities have a procedure for reviewing or reporting on clients’ opinions.
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 Plan of Action details KDHW’s planned activities, intended outcomes and measures of success for the coming year. KDHW is focused on activities that support strategic goals for health systems strengthening, both locally and nationally. The POA describes KDHW’s role in supporting and aligning with the Myanmar National Health System and its plan to move towards providing an essential package of quality health services within KDHW’s service area as part of the shared goal of reaching universal health coverage (UHC) in Myanmar by 2030.

The POA aims to guide the day-to-day implementation of new and ongoing projects and the creation and promotion of new and existing policies to encourage consistency throughout the organization and improve cooperation with local, governmental and global partners.

To that end, the POA will guide players at all levels within the organization in prioritization and decision-making to effectively target resources, maximize program impacts and maintain steady progress towards KDHW’s strategic goals.

In addition, it will highlight opportunities for cooperation among EHOs, CBOs, CSOs, MoHS and INGOs while preserving KDHW leadership and maintaining organizational focus.

At the end of the year, KDHW will review the successful completion of activities enumerated in the POA and activities still left to be completed. Responsible staff will report progress to KDHW leadership, and uncompleted tasks will serve as a foundation for future planning.

Planning Process

Development of the POA took place during a series of three workshops conducted at KDHW headquarters in Hpa-An, beginning in April 2017 and concluding in August 2017. Participants in these workshops included INGO-partner facilitators, KDHW leadership, mid-level management teams and program implementation teams.

A review of annual data for KDHW health services programming for the previous year was completed and brainstorming sessions were conducted to gather input from front line and leadership staff.

Each step of the planning process was inclusive, and all aspects of the POA were discussed and decided upon by the group, including the planned activities, implementation strategies, performance indicators, risk management mitigation activities, timelines for completion and staff responsible for completion.
STRATEGIC OBJECTIVES (2018-2021)

Health Service Delivery
KDHW 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, KDHW will prioritize the establishment of a central monitoring and evaluation (M&E) unit within the organization and adopt a mechanism to gather, evaluate and implement feedback from the community. It will develop a BEPHS, 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 KDHW to meet its service delivery and organizational goals.

KDHW will focus HR activities on building a qualified and accredited workforce at all levels of care delivery for full coverage of its service area.

KDHW will develop a comprehensive HR strategy including the creation of a workforce database and an HR recruitment plan based on staffing gaps. KDHW will conduct relevant training at all levels to fill workforce gaps and will address high staff turnover by utilizing strategies for staff retention. In addition, KDHW will continue certification training and advocacy to the MoHS for accreditation of the EHO workforce.
Health Infrastructure
KDHW aims to establish the infrastructure, equipment and supplies required to meet their health care service goals with clear and uniform standards. KDHW 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 (HIS) will be established and pertinent training will be available to KDHW staff.

Health Financing
KDHW will target health financing activities on 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, KDHW will focus on both internal and national health financing structures. Internally, KDHW will clarify and improve financial policy and practice, focusing on increasing sustainable financing and resource mobilization. In addition, KDHW 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
Building and maintaining collaborative partnerships are key to the success of the KDHW POA. KDHW partners with many NGO and INGO organizations, which provide crucial financial and technical support for current and future operations. KDHW will maintain these partnerships by prioritizing deliverables for current commitments. In addition, the organization will focus efforts on improving coordination and communication between all partners, including NGOs, INGOs, CBOs, CSOs and MoHS to fill service and funding gaps, create a strong referral system and build an efficient, sustainable and transparent financial structure.
PLAN OF ACTION
(2018-2021)

The activities are organized into four pillars of health systems strengthening strategies which are consistent with the four pillars of the Myanmar National Health Plan (NHP) and the Karen Ethnic Health Organizations’ Health Strategy towards 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 KDHW, and 2-5 priorities are based on criteria including alignment with the NHP, standardization of organization policies and impact on health service delivery.

Workplan

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>PRIORITY</th>
<th>Method</th>
<th>Funding Status</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective: Service Delivery Outcome: Standard package of quality basic health care services is ready and available to deliver to community members of Karen Ethnic Area</td>
<td></td>
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<tr>
<td>Strategy: Quality of Care</td>
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<tr>
<td>ACTION I : Develop and finalize Basic EPHS</td>
<td>2</td>
<td>2 Meetings</td>
<td>Technical and financial support needed</td>
<td>Training Coordinator, Project Manager (SPP) and program coordinators CPI (Technical Assistance)</td>
</tr>
<tr>
<td>ACTION II : Review and integrate Basic EPHS into existing curricula and update Standard Treatment Guidelines accordingly; develop reporting forms</td>
<td>3</td>
<td>2 Meetings</td>
<td>Technical and financial support needed</td>
<td>EPI Program Manager, TB/HIV Program Manager KDHW Program coordinators, training coordinators, technical staff</td>
</tr>
<tr>
<td>ACTION III : Awareness raising activity for UHC, NHP, EPHS, THWG, ITHP</td>
<td>1</td>
<td>1 workshop</td>
<td>CPI</td>
<td>Assistant Director (Health Program), OD Manager Program leads, technical staff</td>
</tr>
<tr>
<td>ACTION IV : Training of health care providers on EPHS Standard treatment guidelines (in service refresher training)</td>
<td>1</td>
<td>2 (12 ++ Planned) Through refresher trainings and CME</td>
<td>Current funding</td>
<td>MCH Program Coordinator, Training Coordinator Program leads, skilled trainers, health care providers, technical staff</td>
</tr>
<tr>
<td>ACTION V : Establish central M&amp;E unit</td>
<td>1</td>
<td></td>
<td>PACT Additional financial support needed</td>
<td>Project Manager (SPP)</td>
</tr>
<tr>
<td>ACTION VI : Develop Continuous Monitoring System 1. Develop supervision checklist 2. Supervisor Skill-up training</td>
<td>1</td>
<td>2 Meetings</td>
<td>PACT</td>
<td>Project Manager (SPP), Malaria Project Coordinator, HIS Manager Program leads, M&amp;E and HIS managers</td>
</tr>
<tr>
<td>ACTION VII : Continuous Monitoring and Supportive Supervision with Standardized Check List (on-job training)</td>
<td>5</td>
<td>Quarterly per clinic</td>
<td>Financial and technical support needed</td>
<td>Project Manager (SPP), Malaria Project Coordinator, HIS Manager Program leads, M&amp;E manager</td>
</tr>
</tbody>
</table>
**Strategy: In-service trainings**

| ACTION I | Review curriculum for VHW and VBA training | 2 | 1 meeting | Financial and technical support needed | Assistant Director (Health Program)/ Medical Care Manager, Medic trainer, Clinic in Charge |
|ACTION II| Continuous Medical Education (including VHW training) | 2 | Once a year at district and monthly at clinic level | Financial and technical support needed | One by HSS, One by CPI/SDC |
|ACTION III| Pharmacy Management Training/ Medical stock management training | 2 | Two batches | Financial and technical support needed | VTHC Coordinator, HSS Coordinator |
|ACTION IV| Health Facility Management Training | 2 | One training | Linkage with university, MOHS, technical and financial support needed | Assistant Director (Health Program), Medical Care Manager, Medic trainer, Clinic in Charge |
|ACTION V| OD trainings (Admin, HR, Procurement, Logistics, Financial trainings) | 1 | Trainings | PACT OD team | Assistant Director (Admin & Finance, OD Manager) |

**Strategy: Coordination**

| ACTION I | Coordination meeting with other Karen EHO and CBO (Health) | 1 | 2 Meetings | CPI | Secretary, TB/HIV program coordinator, KDHW key personnel |
|ACTION II| Coordination meeting within KDHW | 1 | 7 district meetings | CPI | Director, Deputy Director, Secretary, KDHW Key Personnel, KDHW District Leaders |
|ACTION III| Coordination Meeting with MoHS (Township) | 2 | 15 meetings | Financial support, facilitators needed | TB/HIV program manager, EPI program manager, KDHW key personnel |
|ACTION IV| Coordination Meeting with MoHS (States and Region) (Bago, Taninthary, Mon, Kayin) | 2 | 4 meetings | Financial and technical support needed | Senior Executive Officer, Assistant Director (Health program), TB/HIV program manager, EPI program manager, KDHW key personnel |
|ACTION V| Coordination Meeting with MoHS (Central) | 1 | 1 meeting | CPI, IRC, IOM based on type of meetings | Senior Executive Officer, Assistant Director (Health Program), KDHW key personnel, CPI |
|ACTION VI| Coordination with Thai MOPH | 1 | 1 meeting | IRC, Mae Tao Clinic | Secretary, Deputy Director, Assistant Director, VTHC Coordinator, EPI Program Coordinator |
### Strategy: Referral

<table>
<thead>
<tr>
<th>ACTION</th>
<th>Description</th>
<th>PRIORITY</th>
<th>Method</th>
<th>Funding Status</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTION I: Develop emergency/ non-emergent referral guidelines; develop referral forms</td>
<td>1</td>
<td>1 Workshop</td>
<td>CPI and SDC</td>
<td>Field Assistant, Counterpart Liaison Officer, RCH team leads, VTHC coordinator</td>
<td></td>
</tr>
<tr>
<td>ACTION II: Referral site and network mapping</td>
<td>4</td>
<td>1 workshop</td>
<td>Financial and technical support needed</td>
<td>Training Coordinator RCH team leads, VTHC coordinator</td>
<td></td>
</tr>
<tr>
<td>ACTION III: Establish referral network</td>
<td>4</td>
<td>1 coordination meeting 4 meetings with respective referral sites and CSOs</td>
<td>Financial, facilitation and technical support needed</td>
<td>Training Coordinator KDHW central senior staff Referral site representatives, CSO, MoHS, Thai MoPH</td>
<td></td>
</tr>
</tbody>
</table>

### Strategy: Health Education

<p>| ACTION I: Develop health education methodology and design; create guideline booklet for trainee and trainer | 3        | 2 | Technical and financial support needed | Assistant Director (Health Program), Training Manager, EPI Program Manager, TB/HIV Program Manager Senior program lead, technical person, health training team |
| ACTION II: Health education methodology training (ToT) | 3        | 2 trainings | Technical and financial support needed | Assistant Director (Health Program), Training Manager, EPI Program Manager, TB/HIV Program Manager Health training team, ToT trainee |</p>
<table>
<thead>
<tr>
<th>STRATEGY</th>
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<th>Method</th>
<th>Funding Status</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTION III: Health education sessions</td>
<td>1</td>
<td>Quarterly to each targeted village</td>
<td>Current funding through existing health programs IEC materials, incentive supports needed</td>
<td>Program leads, Clinic in Charge</td>
</tr>
<tr>
<td>ACTION IV: Production of IEC materials (pamphlet, poster, Competition/video clips/Concert/school based activities)</td>
<td>1</td>
<td>Develop in workshop</td>
<td>Current funding through existing health programs IEC materials, incentive supports needed</td>
<td>WASH Program Coordinator&lt;br&gt;Training team and program leads</td>
</tr>
</tbody>
</table>

**Strategy: Community engagement and community feedback mechanism**

| ACTION I: Preparation and development of methods to collect community feedback (Methods - Suggestion box (post-ready envelope), religious leaders, Village Health Committee, community meeting, home visit, community scoring cards, FGD) | 1        | Workshop for UHC/NHP/THWG<br>During KDHW annual meeting | CPI and SDC<br>Focal - OD manager<br>OD manager/M&E manager/VTHC coordinator | Focal - OD manager<br>OD manager/M&E manager/VTHC coordinator |
| ACTION II: Establishment of Community feedback mechanism (including community awareness raising on Community feedback mechanism) | 1        | Following Action I<br>CPI and SDC Functioning VHC and VTHC | OD manager/M&E manager/VTHC coordinator | OD manager/M&E manager/VTHC coordinator<br>CPI and SDC Functioning VHC and VTHC |
| ACTION III: Analysis and response on community feedbacks and re-programming as needed | 1        | Following Action II<br>CPI and SDC | OD manager/M&E manager/VTHC coordinator<br>CPI and SDC | OD manager/M&E manager/VTHC coordinator<br>CPI and SDC<br>VTHC guidelines<br>RCH team, Malaria, TB/HIV team |
| ACTION IV: Establishment of VHC | 1        | In every village in KNU area<br>CPI and SDC VHC guidelines | RCH team, Malaria, TB/HIV team | RCH team, Malaria, TB/HIV team |
| ACTION V: Community consultation and engagement meetings through VHC to promote the ownership of community on health and health facilities | 1        | Community consultation engagement meeting<br>CPI and SDC VHC guidelines | VHC | VHC |
## Objective: Human Resources for Health

### Outcome: Sufficient number of qualified and accredited health workforce has been installed

### Strategy: Human Resources Development System Development

<table>
<thead>
<tr>
<th>Action</th>
<th>Priority</th>
<th>Method</th>
<th>Funding</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACTION VI</strong>: Facilitate VHC to participate in social, health and welfare activities in village according to the guideline</td>
<td>1</td>
<td>Program monitoring site visits</td>
<td>CPI and SDC</td>
<td>RCH team, Malaria, TB/HIV team</td>
</tr>
<tr>
<td><strong>ACTION VII</strong>: VHC assessment training using PLA tools, social mapping (ToT and multiplier)</td>
<td>1</td>
<td>One TOT, Three multiplier</td>
<td>CPI and SDC, PLA tool trainings</td>
<td>EPI Program Coordinator, EPI Program Officer</td>
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## STRATEGY PRIORITY METHOD FUNDING STATUS RESPONSIBILITY

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<tr>
<th>STRATEGY</th>
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<th>METHOD</th>
<th>FUNDING</th>
<th>STATUS</th>
<th>RESPONSIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTION I : Finalization of organogram of KDHW clinic level health workforce; review with EHOs</td>
<td>1</td>
<td>2 Meetings</td>
<td>CPI and SDC</td>
<td>KDHW Hpa-an office</td>
<td></td>
</tr>
<tr>
<td>ACTION II : Registration of health workforce; develop, maintain and update health workforce database</td>
<td>1</td>
<td>Registration and giving ID cards from central to field level clinic staffs</td>
<td>Financial and technical support needed</td>
<td>Senior Executive Officer, Assistant Director (Admin &amp; Finance), CPI (technical support)</td>
<td></td>
</tr>
<tr>
<td>ACTION III : Raise KDHW staff awareness of policies, rules and regulations</td>
<td>3</td>
<td>During annual meeting</td>
<td>Financial support needed</td>
<td>KDHW policies</td>
<td></td>
</tr>
<tr>
<td>ACTION IV : Review and update Provider-Population Ratio and Facility-Population Ratio; HR mapping and explore gap based on Provider-Population Ratio (For entire health cadre)</td>
<td>1</td>
<td>Eg. One CHW covers 200 PP</td>
<td>Financial and technical support needed</td>
<td>Training Coordinator, Assistant Director (Admin &amp; Finance), HR Manager</td>
<td></td>
</tr>
<tr>
<td>ACTION V : HR recruitment plan based on gaps identified in HR database</td>
<td>2</td>
<td>Technical and financial support needed</td>
<td>Training Coordinator, Assistant Director (Admin &amp; Finance), HR Manager</td>
<td></td>
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<tr>
<td>STRATEGY</td>
<td>PRIORITY</td>
<td>Method</td>
<td>Funding</td>
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<tr>
<td>ACTION VII: Recruitment of required health workforce based on determined need</td>
<td>1</td>
<td>HR recruitment procedure with district and township leaders</td>
<td>Depending on the gap and available resources</td>
<td>HR Manager, Program Managers</td>
<td></td>
</tr>
<tr>
<td>ACTION VIII: Strengthen the practice of regular reporting from supervisee to supervisor</td>
<td>3</td>
<td>Timely reporting and information sharing on meetings/workshops/trainings attended and emergency situations</td>
<td>Reporting guidelines/monitoring mechanism needed</td>
<td>SMT and respective supervisors</td>
<td></td>
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</tbody>
</table>

**Strategy: Production of qualified workforce (pre-service trainings)**

| ACTION I: Medic training | 1 | One time per year at Taw Naw & Mae La Camp | Hope for the World | Medic trainer |
| ACTION II: CHW training | 1 | Five batches (Nyaung Lay Bin, Bleet Da-wei, Dopepla, Mutraw, Pa An) | Financial and technical support needed | KDHW Hpa-An -2, KDHW MS -2, KDHW MSR -1, Qualified trainers |
| ACTION III: MCHW training | 1 | Two batches | CPI and SDC | KDHW Hpa-An office, KDHW Mae Sot Office |
| ACTION IV: VHW training (TOT) | 1 | One time | Financial and technical support needed | AD (Health Programs, CPI) |
| ACTION V: VHW training (Multiplier) | 1 | 7 times/district (with district level CME workshop) | Financial and technical support needed | Community Child Health Program Lead |
| ACTION VI: TTBA training | 1 | Will organize in the areas of newly trained MCHWs (above two batches) | CPI and SDC | RCH Senior Program Manager |
| ACTION VII: Nurse training (Win Ka Clinic) | 1 | One time Will coordinate with MAM | MAM (tentative) | Deputy Team Leader, Win Ka Clinic |
| ACTION VIII: Physician Assistant Training (Kyauk Kyi) | 1 | 1 training | EMA | External |
**Strategy: Higher Education**

| ACTION I: | Advocacy to Parliament and MOHS for higher education (Sending students for education in health professions) | 2 | Advocacy meetings | Financial and coordination support needed | SMT of KDHW |
| Strategy: Improve Staff Retention |

| ACTION I: | Develop staff performance evaluation system | 3 | Meetings | Financial and technical support needed | HR manager |
| ACTION II: | Clarify and review job descriptions | 1 | Meetings | Financial and technical support needed | HR manager |
| ACTION III: | Staff capacity building (services and clinical skills) | 1 | Existing and additional skill training National curriculum and guidelines | Technical and financial support needed | Training Team |

**Strategy: Recognition and Accreditation**

| ACTION I: | Advocacy to MOHS/Government to recognize and accredit the EHO health workforce | 1 | Advocacy meetings | CPI and SDC | SMT, KDHW, MoHS, MMC, MNMC |
| ACTION II: | Continue the certified trainings together with MOHS Eg. BEmONC, IMCI trainings | 1 | Trainings | JHPIEGO, CPI and SDC | SMT, KDHW, MoHS, MMC, MNMC |

**Objective: Establishment of Health infrastructure and Supplies**

**Outcome:** Standard health care facilities and related infrastructure installation has been equipped to meet the minimum regulatory standards

**Strategy: Health Infrastructure**

<p>| ACTION I: | Develop and finalize standard infrastructure guideline for health facilities (VTHC); create assessment checklist | 2 | Meetings | Technical and financial support needed (Ref: UNHCR and SARA) | Deputy Team Leader (Win Ka Clinic), VTHC Coordinator |</p>
<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>PRIORITY</th>
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<th>Funding Status</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTION II: Assessment of current health facilities</td>
<td>3</td>
<td>Review available data from UNHCR, balance score card, SARA, HSS baseline data and experience</td>
<td>CPI technical support, financial support needed</td>
<td>M&amp;E Manager with program leads</td>
</tr>
<tr>
<td>1. VTHC target populations</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. HR active, level of skills, position, workload</td>
<td></td>
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<td></td>
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<tr>
<td>3. Service &gt; &gt; programs</td>
<td></td>
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<tr>
<td>4. Health facility assessment (privacy, delivery room, water, electricity, staff housing)</td>
<td></td>
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<tr>
<td>5. Common d/s in area</td>
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<tr>
<td>6. Medical supply and storage management</td>
<td></td>
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<td>7. Community input</td>
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<td>8. Health facility location and accessibility</td>
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<td>9. Referral accessibility</td>
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<td>10. VTHC management structure</td>
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<td>11. Financial payment to health workers</td>
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<td>12. Fiscal space analysis</td>
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**Strategy: Procurement, storage, supply distribution and waste disposal management**

| ACTION I : Establishment of procurement, storage, supply distribution and waste disposal system (including sub-township warehouse) | 2 | Technical staff meeting | Financial and technical support needed | Thara Shwe Htoo, Thara Sky, Thara Saw Ko Soe |
| ACTION II : Database Training | 1 | One time | CPI and HSS | HIS Manager (MS), Tharamu Lay Lay Khine, Thara Pierson, CPI |
| ACTION III : Establishment of common database of whole KDHW - Mapping (HR, Service, Health Facility) | 1 | Meeting, workshop, continue feedback from pilot | CPI and HSS | M&E Manager |
| ACTION IV : Development and establishment of information sharing rule and regulation | 1 | Technical staff meeting | CPI and HSS | AD (Health Programs) & AD (Admin/Finance) |

**Strategy: Health Information System**

**Strategy: Strengthening the communication system**

| ACTION I : Advocacy to KNU leaders at central, district and township level for better communication | 2 | Meeting | - KDHW central |

**Strategy: Research and Development**

| ACTION I : Eastern Burma Retrospective Mortality Survey | 1 | Together with partners | HSS Consortium | Training Coordinator, HIS Manager |
### Objective: Health Financing

**Outcome:** Effective financing and resource management mobilization mechanism has been developed through good governance system with full accountability

### Strategy: Strengthen financial policy and practice

| ACTION I : Review & revise financial policy | 1 | Workshop | PACT | KDHV financial team (Assistant Director (Admin & Finance, Finance Manager, OD Manager)) |
| ACTION II : Conduct financial policy training for field staff | 2 | Workshop | Financial and technical support needed | KDHV financial team (Assistant Director (Admin & Finance, Finance Manager, OD Manager)) |
| ACTION III : Distribute the statement letter of good practice at all level | 2 | | | Head of KDHW |
| ACTION IV : Conduct financial compliance monitoring visit | 4 | Field trip | Financial and technical support needed | M & E team |

### Strategy: Upgrade to sustainable financing and resource mobilization mechanism

| ACTION I : Desk review of KDHV annual overall budget and develop annual master budget plan (to link with health account) | 3 | Meeting | Financial and technical support needed | Assistant Director (Health Programs) |
| ACTION II : Develop comprehensive KDHV health financing strategy | 3 | Workshop | Financial and technical support needed | Assistant Director (Health Programs) |
| ACTION III : Develop KDHW Health Account | 1 | Close technical group workshop | CPI | Assistant Director (Admin & Finance), Finance Manager |

### Strategy: Reform health financing structure through pilot project

| ACTION I : Review and revitalize essential drug list | 2 | Workshop | Financial and technical support needed | Assistant Director (Health Programs), VTHC Coordinator |
| ACTION II : Pilot design workshop: M&E, implementation research, determine provider payment mechanism | 1 | Workshop | CPI and PACT | Senior Executive Officer, Training Coordinator |
| ACTION III : Develop advocacy and informational relationship with MoHS, local authorities | 3 | Workshop | Financial and technical support needed | Senior Executive Officer, |
| ACTION VII : Training of health workers at selected project areas, Scale up training | 3 | Training | Financial and technical support needed | Liaison Coordinator, OD manager |
| ACTION VIII : Implementation of pilot project in selected areas | 3 | | Financial and technical support needed | VTHC Coordinator |
| ACTION IX : Ongoing pilot M&E | 3 | | Financial and technical support needed | M&E team |
| ACTION X : Communication with stakeholders, public | 3 | | Financial and technical support needed | Secretary, Field Assistant |
Training

The production of a sufficient and qualified health workforce is key for KDHW’s ability to meet health service delivery goals. To build staff capacity and skill, KDHW will conduct both routine and specific training for new and current staff throughout the year.

KDHW will improve information technology (IT) and administrative capability by providing training targeting health information systems (HIS), HR and database creation and management. It will build cooperation between staff and improve operations by conducting staff training on existing and changing organizational policies.

Finally, KDHW will increase the pool of trained health care workers available by offering multiple clinical training for medics, nurses, physician assistants, VHWs, maternal and child health workers, village birth attendants and community health workers.

Responsibility and timelines for conducting the number of training throughout the year is detailed below:

KDHW will prioritize the establishment of a central monitoring and evaluation (M&E) unit within the organization and adopt a mechanism to gather, evaluate and implement feedback from the community. It will develop a BEPHS, improve coordination between all health partners and initiate a referral network of care providers to expand health services to a larger population.
Timeline

1/18  2/18  4/18  5/18  7/18  9/18  10/18  12/18

- VH/W training (TOT)
  *AD (Health programs, CPI)

- VH/W training (multiplier)
  *Community Child Program Lead

- Financial Policy training
  *Saw Jenery Htun, New Shur Htut Htun, Saw Sky

- Health education methodology training (TOT)
  *Dr. Thin Myat Khine, Thara Doht Doht, Dr. Htet Ko...

- Continuous medical education (district)
  *Dr. Thin Myat Khine, AD (Health Program), Medical...

- Continuous medical education (clinic)
  *Dr. Thin Myat Khine, AD (Health Program), Medical...

- Pharmacy management/medical stock management
  *HSS/CPI/SDC

- Health facility management
  *Thara Phoe Kyaw, Thara Hei Gay Htoo

- OD trainings
  *Thara Jenery Htun, Thara Sky Htoo

- Medec training
  *Medec trainer

- CHW training
  *KDHW Hpa-an, MS, MSR

- MCIW training
  *KDHW Hpa-an, MS

- TTBA training
  *RCH Senior Program Manager

- Physician Assistant training
  *External

- Certified trainings with MoHS
  *SMT, KDHW

- HMIS training
  *HIS manager (MS), Thamma Lay Lay Khine, Thara...

- Database training
  *HIS manager (MS), Tharamu Lay Lay Khine, Thara...

- Health care providers on EPHS guidelines
  *Thaum Thaun Tin Tin Yi, Thara Doht Doht, Thara Eh Paoh

- VHC assessment training (multipler)
  *Thara Kapaw Lay, Thara Nay Tha

- Nurse training (Win Ka clinic)
  *Saw Ko Soe, Deputy Team Leader

- Pilot project training for selected area health workers
  *Sah Moo Eh, Saw Sky
Monitoring & Evaluation Framework

As described in the work plan, a central monitoring and evaluation (M&E) unit will be created within KDHW to consolidate monitoring and evaluation activities across the organization to improve efficiency and reduce redundancy. A continuous monitoring system will be developed by the M&E team, including a standardized checklist and on-site training for staff.

All people in Karen Ethnic Area have access to quality health care services without financial hardship by 2021.

SERVICE DELIVERY
Standard package of quality basic health care services ready and available to deliver to Karen community.

HUMAN RESOURCES
Sufficient number of qualified and accredited health workforce established.

INFRASTRUCTURE
Standard health care facilities and related infrastructure established and equipped to meet minimum regulatory standards.

FINANCING
Effective financing and resource mobilization mechanism developed through transparent process with full accountability.

GOAL

INTERMEDIATE RESULTS

STRATEGIES
• Improve quality of care.
• Expand community health care services.
• Provide capacity-building in-service training.
• Increase coordination and establish referral system.
• Develop community engagement and feedback mechanism.
• Produce adequate health workforce and increase rural retention.
• HR, Management System Development

• Establish MoHS recognition and workforce accreditation.
• Develop health infrastructures and academic institutions.
• Logistic and supply chain management system strengthening.
• Develop M & E and Health Information System.
• Research and Development.
• Develop disaster management and disease surveillance mechanism.

• Strengthen financial policy and practice.
• Upgrade to sustainable financing and resource mobilization mechanism.
• Reform health financing structure through pilot project.
**Risk Management**

Key risks to delivering the plan of action were assessed for potential impact and probability of occurrence.

High-impact, high probability risks include a changing national health policy, challenging political landscape, a mobile population and insufficient existing data and IT resources.

Risks will be actively managed using the following mitigation activities.

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**Risks**

- Changing national health policy
- Insufficient data and information
- Limited technical and financial resources
- Service area demarcation
- Nationwide Ceasefire Agreement
- Financial regulations
- Overlapping activities and activity gaps
- Funding grant / design changes
- Migration pattern changes
**Risk Mitigation Activity**

- Collaboration with partners for IT capacity-building training
- Active advocacy and coordination with government
- Convergence of KDHW and government health programs
- Development of strong internal policy
- Development of Standard Health Information Systems
- Strategic fundraising
- Negotiation with EAOs and government
- Make contract with USD
- Development of unrestricted backup funds in anticipation of risks in exchange rate fluctuations
- Some degree of financial autonomy in memorandum of understanding (MOU)
- Coordination of meetings
- Strengthening of humanitarian aid policy
- Standard POA implementation
- Development of strong policy, active planning and strategizing
- Communication and coordination with partners for health care continuity
Results

Health Services

- Development of standardized basic EPHS and treatment guideline for providers at different levels.
- Development of village-based quality health care services through village-based health workers and village-based advisers (VHWs/VBAs).
- Coordination meeting with stakeholders to raise awareness of KDHW's goals regarding UHC. Upgrading standard referral guideline and strengthening referral networks and usage. Development of standard health education guidelines and related information, education and communication (IEC) materials.
- Establishment of Village Health Committee and empowerment of community feedback mechanisms.

Human Resources

- Recruitment of health workforce in accordance with standard organization structure.
- Advocacy to Parliament and MOHS for higher education for KDHW's existing health workforce.
- Strengthening of Organization Development and capacity-building to meet KDHW's goals and objectives.
- Establishment of a standard Health Information System including health management information system (HMIS), human resources management information system (HRMIS) and logistics management information system (LMIS) policy and guidelines.
Health Infrastructure

- Development of standard procurement, logistics and supply chain management systems at different levels.
- Installation of minimum standards of health infrastructure including buildings, medicines and equipment in accordance with developed guidelines.
- Development of a central Monitoring and Evaluation system to track the progress of implementation on KDHW's annual operational plan and strategic plan.
- Upgrading HR policies, practices and mapping. Strengthen the administrative management structure and vitalize line of supervision.
- Regular and periodic research and surveys e.g., Enterprise Back-up, Recovery and Archival System, EBRMS.

Health Financing

- Development of a financial policy and establishment of a KDHW Health bank account.
- Development of a KDHW annual budget plan and comprehensive financing strategy.
- Development of a convenient purchaser payment mechanism through implementation research on a purchaser-provider split model.
- Capacity-building and training on financial management for KDHW's respective staff.