



Mon National Health Committee

ဌာနပရေင်ထတ်ယုက်-ဗဟို



Plan of Action 2018 - 2021

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MNHC Assessment Findings - March 2018

Total number of health facilities



15 clinics
operated

Clinics have on average:

59%

of the basic amenities
needed to provide
BEPHS

60,000 people
served

73%

of the basic equipment
needed to provide
BEPHS

22%

of the diagnostic tools
needed to provide
BEPHS

MNHC
Coverage
Area

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ACRONYMS

AIDS	Acquire Immunodeficiency Syndrome	IRC	International Rescue Committee
ANC	Ante-Natal Care	LMIS	Logistics Management Information System
AMI	Aide Médicale Internationale	M&E	Monitoring and Evaluation
BBC	British Burma Consortium	MCH	Maternal and Child Health
BBG	Burma Border Guidelines	MHD	Mon Health Department
BCC	Behavioral Change Communication	MNEC	Mon-National Education Committee
BPHWT	Backpack Health Workforce Team	MNHC	Mon-National Health Committee
CD	Communicable Diseases	MoHS	Ministry of Health and Sport
CHD	Community Health Development	MSF	Médecins Sans Frontières
CHW	Community Health Worker	NCD	Non Communicable Diseases
CPI	Community Partners International	NMSP	New Mon State Party
ELISA	Enzyme Linked Immunosorbent Assay	PHC	Primary Health Care
ENT	Ear, Nose and Throat	POA	Plan of Actions
EPHS	Essential Package of Health Services	SARA	Service Availability and Readiness Assessment
EPI	Expanded Program on Immunization	SD	Standard Deviation
HIS	Health Information System	SRH	Sexual and Reproductive Health
HIV	Human Immunodeficiency Virus	STI	Sexually Transmitted Infection
HR	Human Resource	TB	Tuberculosis
HRH	Human Resource for Health	TBBC	Thai Burma Border Consortium
IDP	Internally Displaced Person	VHC	Village Health Committee
IEC	Information, Education, and Communication	WHO	World Health Organization

EXECUTIVE SUMMARY

Background

The Mon National Health Committee is a non-profit health organization founded in 1992. MNHC serves communities along the Thai-Burma border, deeper inside of Mon state and some areas of Kayin State and Tanintharyi Division.

MNHC is the main provider of primary health care to internally displaced persons (IDPs) living along the Thai-Burma border in Mon State.

On the border MNHC operates nine clinics and two village health facilities, while there are a further four clinics inland.

MNHC targets its health care to approximately 60,000 Internally Displaced People (IDPs) between its health facilities and outreach services, serving on average around 10,000 people per year.

Mission Statement

Better health and better life through locally acceptable health systems with full community participation and working closely with the community itself to understand the needs of the community.

MNHC target to provide quality health care services to the people in Mon regions and nearby places. MNHC plans to prevent and

promote local health priorities with the support of the government, international and local organizations.

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 MNHC'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 MNHC, 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, MNHC 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, MNHC 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 February and March 2018, data collectors surveyed all 15 of MNHC's facilities in Mon State, Kayin State, and Tanintharyi Region, including Ye, Yebyu, and Kyarinseikkyi 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 MNHC's Plan of Action (POA). MNHC are typically serving 1,580 people per clinic, offering a range of services but with strengths in basic obstetric care, child health and malaria services. They have close links to the communities they serve, strengthened by community meetings, and clinics are usually staffed by a variety of Medics, Midwives and Community Health Workers.

All facilities described themselves as health posts, with an average catchment population of 920 people per facility. All 15 facilities were made of wood and bamboo/thatch 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 3.5 functioning patient beds.

According to standardized infrastructure indices, MNHC facilities had an average score of 58.6% (range: 21.4% to 85.7%) for basic amenities, 73.3% (33.3% to 100%) for basic equipment, and 21.7% (12.5% - 37.5%)

for diagnostic capacity (See Appendix Table X). In addition to the summary infrastructure figures for how prepared MNHC 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.

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 MNHC'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 encompassed basic amenities, basic equipment, standard precautions against infection, diagnostic and other laboratory capacity, medicines, and commodities.

Service-specific readiness encompassed 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 all 15 of MNHC’s facilities in Mon State, Kayin State, and Tanintharyi Region, including Ye, Yebyu, and Kyarinseikkayi 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).

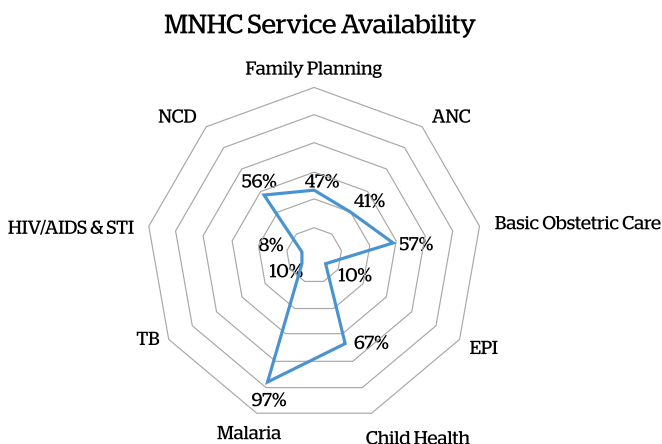
In line with the WHO SARA aims and methodology, the objective of this assessment was to generate reliable, systematic data on tracer indicators for key health systems components, including infrastructure, human resources, and service delivery, in order to inform the development of MNHC’s Plan of Action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

Service Readiness And Availability

According to standardized infrastructure indices, MNHC facilities had an average score of 58.6% (range: 21.4% to 85.7%) for basic amenities, 73.3% (33.3% to 100%) for basic equipment, and 21.7% (12.5% - 37.5%) for diagnostic capacity (See Appendix Table X). In addition to the summary

infrastructure figures for how prepared MNHC 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.

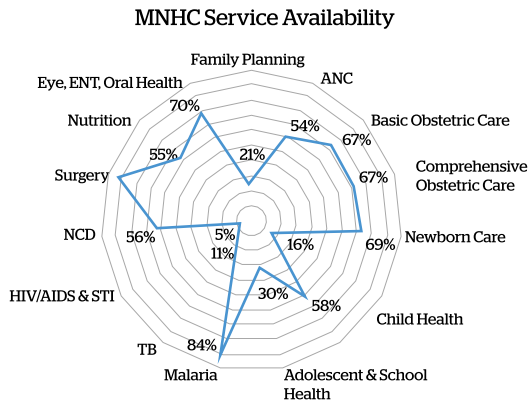
Figure 1. Average facility service readiness index scores at MNHC facilities (n=15).



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 MNHC facilities (n=15) for all services included in the draft bEPHS.



Infrastructure

15 health posts were surveyed. In terms of building materials, 1 was constructed from bamboo and thatch; 5 were constructed from bamboo and wood; 2 were constructed from wood; 5 were constructed from brick and wood; and 2 were constructed from brick. In terms of general building conditions, 1 was classified as “good, no need to repair;” 9 were classified as “good, only minor repairs needed,” 4 was classified as “not good, need major repairs; and 1 was classified as “not good, need to build a new one.” Based on data from 10 facilities, all facilities were between 5 and 27 years old (17.4 years old on average).

All 15 facilities were available 24 hours per day. 67% (10/15) of the facilities did not have any private room for patients. Only 1 facility had a room with both visual and audio privacy. 3 facilities had a room with visual privacy only, and 1 facility had a room with

audio privacy only (meaning?). 14% (2) facilities had a functioning labor room and 1 facility had a labor room that required repairs. 47% (7) facilities had a functioning laboratory, and 2 facilities had a laboratory that required repairs. 7% (1) facility had an operating theater. 33% (5) of facilities had a functioning medical storeroom, and 6 facilities had a medical storeroom that required repairs. No facilities had a vaccine cold room.

Across all 15 facilities, there were a total of 54 beds not including dedicated maternity beds, and almost all beds (52/54) were reported to be functional. The number of functional beds per facility ranged from 1 to 12, with an average of 3.47 per facility. 4 facilities had a dedicated maternity beds (i.e. 1 maternity bed at each of the 4 facilities), but only 3 were reported to be functional. 73% (11/15) facilities had functioning latrines. Each facility had between 1 and 4

latrines (average 1.7 per facility), all of which were pit latrines. Latrines were located 6 to 170 meters from the water source, with an average of 54 meters. No facilities reported being affected by armed conflict within the past 6 months.

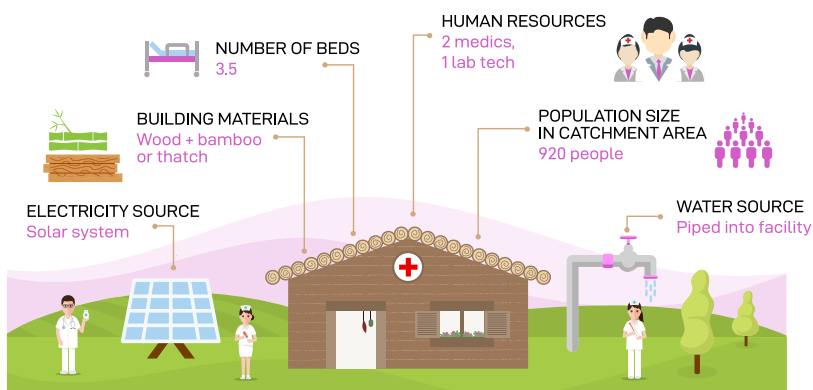
Almost all (93%; 14/15) facilities had electricity. Of the 14 facilities that had electricity, 50% (7) facilities said that they had enough electricity for all of their needs, and 50% (7) facilities said that they had only enough electricity for lights and communication. Of 6 facilities that responded, 1 reported that they had power for 5-8 hours per day, 3 facilities had power for 9-16 hours per day, and 2 facilities had power for 17-24 hours per day based on the past week.

Most (11) facilities relied on solar power

as the main source of electricity, and 3 facilities relied on the national/community grid as their main source. 27% (4) facilities also had a backup source of power; 1 from a generator (which was observed to be functional), 2 from solar power, and 1 national/community grid. For facilities that used solar power as their main or backup source of power, 73% (11) had a functioning solar power system on the day of the survey, and 2 additional facilities reported that the solar power system was functional but could not be observed.

33% (5/15) of facilities reported having access to the internet for communication purposes. No facilities had access to a functioning computer. 20% (3) facilities had consistent access to a functioning phone line and 7 facilities sometimes had access to a functioning phone line.

Typical Facility



All facilities described themselves as health posts, with an average catchment population of 920 people per facility. All 15 facilities were made of wood and bamboo/thatch 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 3.5 functioning patient beds.

Service Provision

None of the facilities reliably reported total population numbers in their catchment area. For the 5 facilities that reported target population sizes, the total ranged between 800 and 1000 people per clinic. Based on numbers of OPD services delivered in the previous year, actual number of OPD services delivered ranged between 375 and 1300 - which likely reflects unique visits rather than population size, though this indicates that some facilities may not be reaching their target patient load. Utilization numbers were not reliably reported across all 15 facilities. For ANC1, individual facilities provided between 0 and 7 ANC1 services in the previous year; 0 and 2 deliveries in the previous year; and 375 and 1300 OPD services in the previous year.

Without improving data quality, it will be difficult to draw conclusions about utilization of services.

Referrals

To reach the primary place of referral takes an average of 100.5 minutes by motorbike, car, or truck (range 25-240 minutes) across all 15 facilities, and 60 minutes by tractor based on 1 facility responding. None of the 15 facilities reported having an Standard Operation Procedure/guidelines for referral. 93% (14/15) facilities reported having an approval mechanism for referral outside clinic hours (though all facilities reported being available 24/7). 60% (9) facilities reported that they always had access to at least 1 functioning vehicle for emergency transportation, and 40% (6) facilities reported that they sometimes had access to a functioning vehicle.

For emergency transport, 100% (15) facilities had access to a truck/car; 87% (13) had access to a motorbike; and 40% (6) had access to a boat. On average, it takes 101 minutes to be transported between the MNHC facility and referral facilities by truck, car, or motorbike. On average it takes 20 minutes to be transported to Joe Kha Prout and 204 min to Ye from the MNHC facility by boat. Facilities referred first to Ye township hospital (7), Kwai River Christian Hospital (3), Three Pagoda Pass Hospital (3), Jhoe Kha Prout (1), and Palaing Japan (1). Reasons for selecting primary places of referral included: Nearby (14), Patient request (3), Save cost (1). 7 facilities reported that they had secondary referral

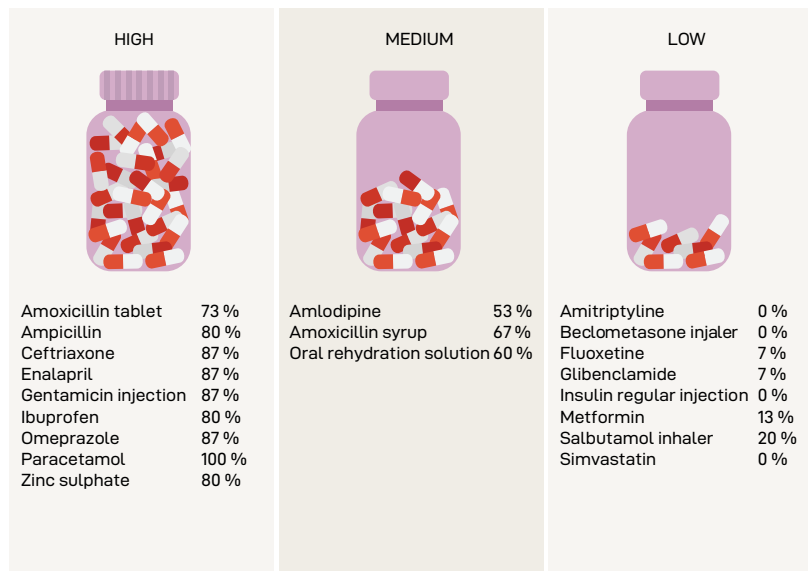
hospitals, which included Ye township hospital (1), Mawlamyaine (1), Three Pagoda Pass Hospital (3), and Kwai River Christian Hospital (2).

Reasons for selecting secondary places of referral included: Nearby (2), Major/Emergency cases (2), More equipment/Instruments (2), and Good quality service (2). Most referral facilities are in the government sector, except for Jhoe Kha Prout (EHO), Palaing Japan (EHO), and Kwai River Christian Hospital (faith-based). Note that the range of transportation/treatment costs across 14 facilities is 4500 to 300,000 MMK, with an average of 95,900 MMK per patient.

Essential Medicines

Only half (47%, 7/15) of facilities had the essential medicines list, which covers the following drugs. 100% of facilities were observed to have the following drug in stock: paracetamol tablet. 13 facilities had the following drugs in stock: ampicillin powder for injection (1 facility reported but could not observe), ceftriaxone injection, enalapril tablet or alternative ACE inhibitor, gentamicin injection, omeprazole tablet or alternative. 12 facilities had the following drugs in stock: ibuprofen tablet, zinc sulphate tablet or syrup. 11 facilities had the following drug in stock: amoxicillin tablet.

Figure 3



10 facilities had the following drug in stock: amoxicillin syrup/suspension or dispersible tablet. 9 facilities had the following drugs in stock: amlodipine tablet or alternative calcium channel blocker, and oral rehydration solution. 7 facilities had the following drugs in stock: oral rehydration solution, salbutamol inhaler.

6 facilities had the following drugs in stock: amlodipine tablet or alternative calcium channel blocker. 5 facilities had the following drug in stock: salbutamol inhaler (2 facilities reported but could not observe). 2 facilities had the following drugs in stock: glibenclamide tablet (1 facility reported but could not observe), and metformin tablet.

1 facility had the following drugs in stock: beclometasone inhaler (1 facility reported but not observed), and fluoxetine tablet. No facilities had the following drugs in stock: amitriptyline, insulin regular injection, and simvastatin tablet or other statin. Two thirds (10/15) of facilities reported experiencing a stock out within the previous 6 months. 6 facilities indicated that they communicated about stockouts by phone, 2 facilities reported stock outs via field assistants, 1 facility reported stock outs via requisition form, and 1 facility communicated about stock outs in person.

Half (27%; 7/15) of facilities reported that they did not have enough space currently to store medicines. With regards to usage

of medicines, all facilities reported that they adhered to the “first expired, first out” procedure, which is the practice of using the medicines which are closest to expiration, first. 93% (14/15) facilities had defined procedures for managing the supply chain. For guidelines for logistics management, only 1 facility reported having any documented guidelines, which were 1) Procurement Guidelines/Flow charts, and 2) Supply Chain Management Guidelines/flow charts.

To obtain supplies, out of 14 responding facilities, 8 facilities initiate the requisition, 11 facilities receive supplies from the upper level without any requisition, and 7 facilities purchase supplies directly at the facility level (with 8 facilities using 2 to 3 strategies). In terms of responsibility for ordering drugs, 7 facilities reported that there was no specific person responsible; 8 facilities reported that there was a specific person responsible with a specific job description for ordering drugs, which were the medic (5 facilities), clinic supervisor (2 facilities), and a combination of the supervisor and 2nd supervisor at 1 facility. Drugs come from headquarters for 15 facilities, donors for 5 facilities, and local shops for 1 facility; 5 facilities reported receiving drugs from 2 to 3 different sources. Across the 8 facilities, it takes between 7 and 30 days (average 21.6) between requesting and receiving the requested drugs/equipment.

Health Promotion

Across MNHC, facilities provide services related to health literacy for a number of programs, including family planning (13%; 2), prevention and control of malaria (87%, 13), home-based care for newborns

and children (13%; 2), child immunization (27%; 4), HIV/AIDS (33%, 5), nutrition & lifestyle (13%, 2), WASH (73%, 11), Eye/ENT/ Oral health, and NCDs. No facility provides health literacy for prevention and control of TB/MDR- TB, or occupational health.

Table 1

Human Resources for Health								
Doctors	EmOCs	Midwife	Pharmacists	Medics	MCH Workers	Lab technicians	CHWs	Total
0	0	0	0	38	1	14	5	58

Human Resources for Health

At the facility level, there was variation in the staffing structure across facilities. On average, each facility had 2.53 medics, 1 laboratory technician, and <1 CHWs. For all 15 facilities surveyed, there were 58 staff in total, including 38 medics, 14 laboratory technicians, 5 CHWs, and 1 MCH worker.

Based on the responses, there were no doctors, EmOCs, midwives, pharmacists, or HAs. In terms of training received, 7 facilities reported receiving medic training, and all 7 facilities reported that the medic training was inadequate. 1 facility reported receiving logistics management training which was perceived to be adequate and that continuous/refresher training was available, but that this continuous/refresher training was inadequate.

None of the facilities reported having access to continuing education. When

asked if facility staff had adequate training to provide high-quality services, no facility said “yes;” the majority (12%) said that they had “some” training but not enough, 2 facilities said “no,” and 1 facility said “don’t know.”

None of the facilities had training for managing HIS at the facility, yet 2 facilities reported that the person responsible for data collection and report preparation were trained in HIS.

53% (8/15 facilities) had a person assigned to logistics management. This person was the medic at 5 facilities, the clinic supervisor at 2 facilities, and both the supervisor and 2nd supervisor at 1 facility. All 15 facilities had an assigned person to check logistics reports. This person was the Logistics Manager (4) or Data Manager (1) from Headquarters or

Headquarters generally (6), and 1 facility reported that this entity was the Health committee (1).

80% (12/15) facilities had a person assigned to physically checking at the facility level. This person was described as the “supervisor” (3) or “clinic supervisor” (9). Physical checks were performed monthly at 11 facilities, quarterly at 1 facility, and every 6 months at 1 facility; other facilities did not report. 53% (8/15) facilities had a person assigned to collecting health data and preparing reports based on data. 67% (10/15) facilities had dedicated staff to check the data quality at the facility level. No facilities had a person assigned to financial management.

Quality Control

Supervisory visits from higher levels can play an important role in quality control. 1 facilities reported that they had never received a supervisory visit, 1 facility reported that the most recent supervisory visit occurred over 3 months ago, 7 facilities reported that they had received a supervisory visit within the past 3 months, 5 facilities reported that they had received a supervisory visit within the past month, and 1 facility did not know the time of the last supervisory visit.

During the supervisory visit, 6 facilities (40%) reported that the supervisor assessed the pharmacy; 3 (20%) reported

that the supervisor assessed staffing; 2 (13%) reported that the supervisor assessed data; 3 (20%) reported that the supervisor assessed service provision, and 1 (7%) reported that the supervisor assessed the clinic compound. 11 facilities were observed to carry out any quality assurance activities, such as audits of reports, QA meeting minutes, supervisory checklists, mortality reviews, audits of records/registers, etc; the other 4 facilities reported that they carried out such activities but none were observed/verified. Only 3 clinics reported that they had adequate supervision to provide high-quality services. Almost all (14/15) reviewed data quality monthly, and the 15th facility reviewed data quality quarterly. None of the facilities had any criteria or mechanism to check the quality of drugs.

67% (10/15) facilities had infection precaution guidelines, and an additional facility reported having such guidelines but could not be observed. None of the facilities had referral guidelines. Surveyors observed that 11 facilities routinely carried out quality assurance activities (e.g., review or reports or QA meeting minutes, supervisory checklist, mortality review, audit of records/registers, etc.). 4 facilities reported that they carried out such activities but these activities could not be observed. Only 2 facilities reported having a mechanism for assuring data quality/accuracy. Data quality

is reviewed monthly at almost all (14/15) facilities and quarterly at 1 facility.

Clinic Management Procedure

At the facility level, 67% (10/15) facilities reported holding routine facility management meetings though 11/15 reported the frequency of their internal meetings. 5 facilities held these meetings monthly or more frequently, and 6 facilities held these meetings once every 2 to 3 months. Only 2 facilities keep formal records of the meeting minutes (with an additional facility who reported keeping formal records, but these could not be observed). Only 5 facilities reported making decisions or taking follow-up actions based on what was discussed at the facility management meetings. 60% (9) facilities collected very basic information about the problems that staff think should be addressed to improve their working situation and services.

Clinic Finances

At the facility level, only 7% (1) of the 15 facilities reported having a financial system. At this facility, no information about the person responsible for financial reports, reporting frequency, or the recipients of financial reports was available.

Data Management

There was inconsistency in the type of log books maintained across the 15 facilities. The types of log books kept by facilities

included: ANC (5 facilities), Delivery (2), Family care (1), Pharmacy (11), Outpatient registry (15), Inpatient registry (10) and Malaria Logbook (3). For number of log books, 2 facilities kept 5 different types of logbooks; 5 facilities kept 4 types; 3 facilities kept 3 types; 3 facilities kept 2 types; and 2 facilities kept 1 type (average 3.1 different types of logbooks per facility). 60% (9/15) facilities said that they had to prepare reports according to specific schedules/deadlines, which were all monthly.

Only 8 facilities had staff specifically designated to complete the reports, but 9 facilities reported that the clinic supervisor/in-charge write the reports. 100% (15/15) facilities are using paper-based forms for data collection. 100% of facilities send health data to MNHC headquarters, and 1 facility sends health data to donors.

Community Engagement

73% (11/15) facilities hold routine meetings about facility activities or management that include community members. 27% (3/11) of the facilities that hold routine meetings keep official records of these meetings, and 2 additional facilities reported that they keep such records but the records were not observed/verified. None of the facilities have any system for determining clients' opinions about the health facility or its services. None of the facilities have any procedure for reviewing or reporting on clients opinion.

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 Activities (POA) details MNHC's planned activities, intended outcomes and measures of success for the coming year. MNHC is focused on activities that support strategic goals for health systems strengthening, both locally and nationally. The POA describes MNHC'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 MNHC's service area as part of the shared goal of reaching universal health coverage in Myanmar by 2030. The POA is 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.

The POA aims to 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 MNHC's strategic goals. In addition, it will highlight opportunities for cooperation amongst EHOs, CBOs, CSOs, MoHS and INGOs while preserving MNHC leadership and maintaining organizational focus. At the end of the year, MNHC will review

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

Planning Process

Development of the POA took place during a workshop conducted at MNHC headquarters in Mawlamyine, beginning in January of 2018 for data collection, focus group discussions, health facility assessments and finalizing in June 2018. Participants in these workshops included INGO- partner facilitators, MNHC leadership, mid-level management teams and program implementation teams. A review of annual data for MNHC health services programming for the previous year was completed and brainstorming sessions were conducted to gather input from frontline and leadership staff. 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 Plan

Subsequent to the Strategic Planning Workshop was conducted in June 2017 in Mawlamyine city. The aftermath is the consensus agreement of three years Strategic Plan for Mon National Health Committee.

It presents the three strategic goals that will guide the work of the MNHC over the next three years (2018 - 2021) with clear the vision and mission statements. The five pillars of the MNHC remain the same namely;

These can be understood as a frame towards which the plan of action is working. This strategic plan explicitly defines the vision and mission of the MNHC.

- Service delivery
- Infrastructure and supply chains
- Financing
- Health Information System
- Human Resource for Health retention planning and development

Strategic Goals		
Goal 1: Becoming a formal ethnic health organization in Myanmar that provides quality health care services to targeted beneficiaries.	Goal 2: Enhancing organizational performance sustainably	Goal 3: Strengthening health care facilities and existing health systems
Strategic Goals	Strategic Objectives	
Becoming a formal ethnic health organization in Myanmar that provides quality health care services to targeted beneficiaries.	<ul style="list-style-type: none"> - To get approval of MNHC strategic plan (from NMSP); - To become an official ethnic health organization in Myanmar with the option agreed by MNHC management body - Together with other ethnic health organizations, to advocate for recognition and getting support from Ministry of Health and other relevant organizations active in Myanmar 	
Enhancing organizational performance sustainably	<ul style="list-style-type: none"> - To review organizational structure and revise policies and procedures - To improve program and operational management of MNHC - To improve health information system of MNHC - To set up effective monitoring and evaluation system 	
Strengthening health care facilities and existing health systems	<ul style="list-style-type: none"> - To develop comprehensive program staff capacity development plan and strengthen capacity - To provide necessary support to local communities to have enough health education in targeted areas - To provide necessary data to the leadership to ensure enough supplies of essential drugs in MNHC health facilities 	

PLAN OF ACTION

(2018-2021)

Service Delivery and Infrastructure

Sr. No	STRATEGY	OBJECTIVES	INTERVENTIONS	PRIORITY (1-5)	Targets	RESPONSIBILITY
1	Improve Health Care services	To increase access for health care services for the local community	Development of Basic EPHS based on the community needs	5	1 for CD 1 for NCD 1 for SRH and MCH	M&E Manager (MNHC)
			Immunization will be undertake as the separated program	5	No plan yet for inside with Government Schedule	Currently immunization program is implementing in Thai Border area with Thailand Schedule.
		To develop standard training curriculum and guideline	Updating process of basic training curriculum will be undertaking chapter by chapter for all types of service providers (Multi purpose)	5	1	M&E Manager (MNHC)
			Development and finalization of essential drug and equipment list (Village level, Health Post Level, District Level)	5	1	M&E Manager (MNHC)
			Development of Emergency Kit list	4	1	M&E Manager (MNHC)
			Development of project management	3	1	CPI and MNHC
			Development of HIS guideline	3	1	
			Development of Treatment Algorithm and reviewing process	3	30 Diseases	Training team
		To promote the quality of care	Conducting refresher training for clinic supervisors and potential clinic supervisor	5	once a year	MNCH
			Development of referral guideline	5	1	MNHC, CPI will share existing referral guideline for financial support

Sr. No	STRATEGY	OBJECTIVES	INTERVENTIONS	PRIORITY (1-5)	Targets	RESPONSIBILITY
2	Comm- unity Engag- ement		Standardize facility population ration or provider population ratio	3	Already	
			Develop basic facility structure and design for health post	2		MNHC
			Renovation of existing health post according to basic infrastructure design	2	based on fund availability	
			Procurement and distribution of medicines and supplies	5	Quarterly	Logistic team
		To establish the community engagement mechanism	Development of village health committee	2	11 VHC in 17 villages	MNHC
			Coordination meeting with village level local authorities	2	ad hoc	MNHC
			Coordination meeting with township health department	2	ad hoc	MNHC
			Community engagement activities through VHC	4	continuous	MNHC
			VHC meeting with volunteers at health post	3	Quarterly	MNHC
			Development of community feedback mechanism	3	Quarterly	MNHC
		To promote preventive and promotive measure	Development of Health Education Manual (how many focus area?)	1	1	MNHC
			Development of BCC/ IEC materials with local language	1	Depends on focus area	MNHC
			Training for village based volunteer for health education	1	Will set the target soon based on VHCs' performance	MNHC
			Providing Health Education through Volunteers	1	Will set the target soon	MNHC
			Development of BCC indicators and assessment	1		MNHC

Human Resource of Health

Sr. No	STRATEGY	OBJECTIVES	INTERVENTIONS	PRIORITY (1-5)	Targets	RESPONSIBILITY
1	HR policy improvement and implications	To set up basic HR requirement	Update the existing HR and Administrative policy to be applicable including recruitment, benefits, etc.	5	1	CPI and MNHC (CPI will assist drafting and MNCH will process for approval)
			Standardize the criteria for performance-based incentivising and punishment mechanism	5	1	CPI and MNHC (CPI will assist drafting and MNCH will process for approval)
			Conducting orientation sessions for all staff to understand the organizational vision and mission	5	1	CPI and MNHC (CPI will assist drafting and MNCH will process for approval)
			Conduct the leadership training for clinic supervisors	5	ad hoc	CPI and MNHC (CPI will assist drafting and MNCH will process for approval)
		To improve HR structural and functional system	Standardization of level of facility with HR structure and facility population ratio	3		
			Review and update the Job Description of different level of position	4	About to finish	
			Development of management flow chart for every position	2		
		To promote organisational relationship	Ensure the current communication channel and provision of basic requirements	3	depends	
			Conducting MNHC conferences for multipurpose	3	2 Yearly	

Health Information System

Sr. No	STRATEGY	OBJECTIVES	INTERVENTIONS	PRIORITY (1-5)	Targets	RESPONSIBILITY
1	Effective use of information for decision making	To establish the functioning M&E mechanism	Development of M&E Plan including core indicators, tools and data management guideline	5		
			Conducting M&E Training to field staff	5		
			Development of Service quality monitoring	3		
			Conducting M&E Training to field staff (Service Quality)	3	Once a year	
			Facility based village coverage mapping		Already	
			Area based village coverage mapping		Already	
			Population coverage update		Already in HRH	
			Facility based service mapping	2		CPI will provide technical assistance
			Area based service mapping	2		CPI will provide technical assistance
			Visualization of locally high incidence and prevalent disease and and establishment of surveillance system for notifiable diseases	5	depends	
2	Improve service readiness	To establish the functioning Logistic Management Information System (LMIS)	Establishment of annul procurement plan for medicine and supply	5		MNHC and CPI
			Installation of systemic supply chain and pharmacy management at different level of facility and head of office	5		MNHC and CPI
			Review and Update Procurement and logistic policy (including performance indicators for logistic)	5		MNHC and CPI
			Conduct workshop to develop core indicators for both logistic and service delivery	5	1	CPI, ARC, MNHC
			Update existing health workforce and develop HR Database	5		MNHC and CPI

Financing

Sr. No	STRATEGY	OBJECTIVES	INTERVENTIONS	PRIORITY (1-5)	Targets	RESPONSIBILITY
1	Strengthening Financial Management	To increase organization's income and performance	Development of annual cash projection and available fiscal space	2		
			Income and Expenditure statement	3	annually	
			Decentralization of financial management system to health post level	2	after finalization of policy and procedure	
			Review and update the organization finance policy	5	1	
			Providing financial management trainings (organization level and Facility Level)	5	one for organization level and not set yet for facility level	CPI will organize the training for organization level
			Preparation of proposal development to raise the revenue	5	ad hoc	



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