



PA-OH

Pa-Oh Health Working Committee



Plan of Action 2018 - 2021

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PHWC Assessment Findings - March 2018

Total number of health facilities

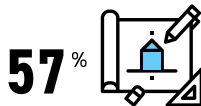


3 clinics operated



5,000 people served

Clinics have on average:



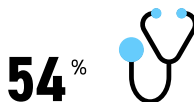
57%

of the basic amenities needed to provide BEPHS



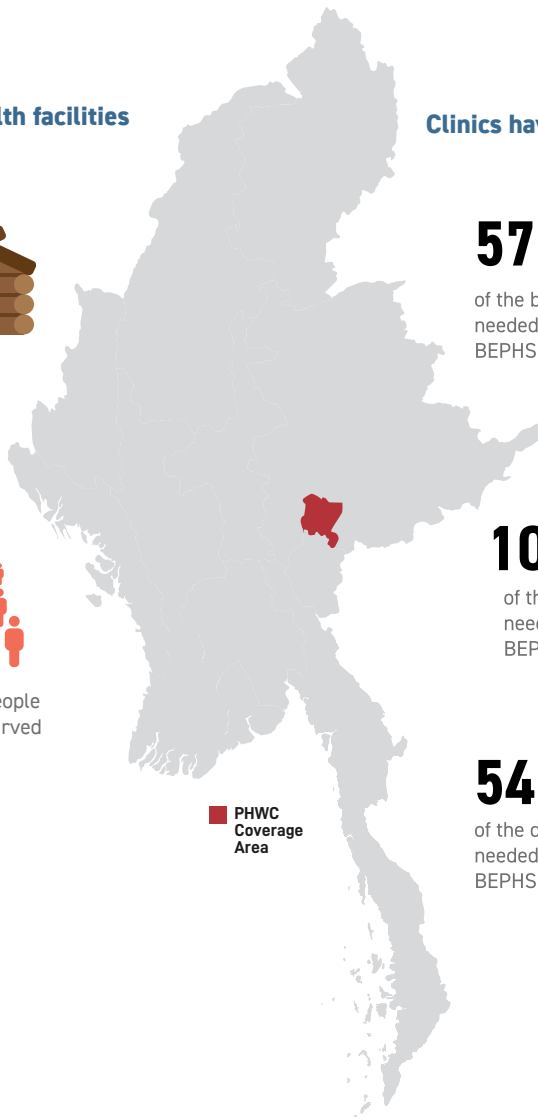
100%

of the basic equipment needed to provide BEPHS



54%

of the diagnostic tools needed to provide BEPHS



■ PHWC Coverage Area

TABLE OF CONTENTS

ACRONYMS	1
EXECUTIVE SUMMARY	2
Background	
Mission Statement	
Purpose of Assessment and Plan of Action	
Key Assessment Findings	
Typical Facility	
ASSESSMENT METHODOLOGY AND RESULTS	4
Methodology	
Assessment Findings	
Service Readiness And Availability	
Infrastructure	
Typical Facility	
Service Provision	
Referrals	
Essential Medicines	
Health Promotion	
Human Resources for Health	
Quality Control	
Clinic Management Procedure	
Clinic Finances	
Data Management	
Community Engagement	
Strengths & Limitation of Assessments	
PLAN OF ACTION	16
Objective	
Planning Process	
STRATEGIC OBJECTIVES (2018-2021)	17
Health Service Delivery	
Human Resources For Health	
Health Infrastructure	
Health Financing	
Creating an Enabling Environment	
PLAN OF ACTION	19
Operation Plan	
Risk Management	

ACRONYMS

3MDG	3 Millennium Development Goal	HSS	Health System Strengthening
AIDS	Acquire Immunodeficiency Syndrome	INGO	International Non-Governmental Organization
ANC	Ante-Natal Care	IT	Information Technology
BBG	Burma Border Guidelines	JD	Job Description
BEPHS	Basic Essential Package of Health Care Services	LMIS	Logistics Management Information System
BMA	Burma Medical Association	M&E	Monitoring and Evaluation
CBO	Community-based Organization	MCH	Maternal and Child Health
CHW	Community Health Worker	MOHS	Ministry of Health & Sports
CPI	Community Partners International	NGO	Non-Governmental Organization
CSO	Civil Society Organization	PNLO	Pa-Oh National Liberation Organization
CV	Curriculum Vitae	PHWC	Pa-Oh Health Working Committee
EAO	Ethnic Armed Organization	RDT	Rapid Diagnostic Test
EHO	Ethnic Health Organization	RHC	Rural Health Centre
EHSSG	Ethnic Health Systems Strengthening Group	SARA	Service Availability and Readiness Assessment
ELISA	Enzyme Linked Immunosorbent Assay	SD	Standard Deviation
EMOC	Emergency Obstetric Care	SOP	Standard Operating Procedure
ENT	Ear, Nose and Throat	STI	Sexually Transmitted Infection
EPHS	Essential Package of Health Services	TB	Tuberculosis
EPI	Expanded Program on Immunization	TORs	Term of References
HIV	Human Immunodeficiency Virus	USD	United States Dollar
HMIS	Health Management Information System	WHO	World Health Organization
HR	Human Resource		
HRH	Human Resource for Health		

EXECUTIVE SUMMARY

Background

Pa-Oh Health Working Committee (PHWC) is an Ethnic Health Organization (EHO) serving the health needs of the Pa-Oh people. PHWC was formed by Central Health Department of Pa-Oh National Liberation Organization (PNLO) on 21st September 2013. The aim of the organization is to provide primary health care to the people living in Pa-Oh regions without government-sponsored health care services and limited access to health resources of any kind.

The current delivery system is community-based, with a primary health care focus. PHWC was founded by its current Director and Deputy Director, Khun Nay Htoo and Khun Si Thu. It is currently headquartered in Taunggyi with three functioning clinics in Mauk Mae (of which only one was purpose built). There are also two designated houses to store medicines in Shi Seing.

In Ho Nan and Ka Toe Gyi, there are 30 CHWs working in the village tract level. There were not sufficient funds in PHWC to provide a stipend, so the leaders coordinate with village leaders to facilitate community support. PHWC was initially funded by PNLO but that source of funding has now ended (though they receive support politically). PHWC had never worked

on a project with a Non-Governmental Organization (NGO) until in 2016 when they began working with Relief International on a 3MDG grant. They work closely with the Ethnic Health Systems Strengthening Group (EHSSG) in Mae Sot, both receiving medicines and contributing to collaborative work.

Mission Statement

The aim of PHWC is that all people within PHWC service areas can access quality health care without financial hardship. It aims to provide primary health care services, and health education to the most vulnerable population in Southern Shan State.

The goal of PHWC is to improve the health situation of the people in Southern Shan state by organizing continuous medical education for their health workers, standardizing treatment guidelines according to national guidelines and promoting basic health knowledge to the public. PHWC closely work with Ministry of Health and Sport in Township Health Coordination Meetings which in turn promote convergence of the health system.

Purpose of Assessment and Plan of Action

The Myanmar Ministry of Health and Sports (MoHS) began implementing the National Health Plan (NHP) (2017-2021) after a formulation period in an effort to promote

participation and inclusiveness from a range of stakeholders including ethnic health organizations (EHOs). The plan specifically acknowledges the key role of EHOs in the implementation process and is focused on improving both the demand and supply for health care services throughout Myanmar.

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

As a preparation for this, the service availability and readiness assessment of PHWC'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 PHWC, 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, PHWC 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, PHWC identified its own risk management plan as well as monitoring and evaluation plan. This is contained as the final sections of this report.

Key Assessment Findings

In early 2018, CPI data collectors surveyed all of PHWC's fully operated clinics to assess their service availability and readiness for delivering the Basic Essential Package of Health Services (BEPHS), as well as conducting leadership interviews and focus group discussions. With the findings of each assessment, CPI technically and financially supported PHWC to develop its Plan of Action.

PHWC 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 staffed by a variety of Medics, Midwives and Community Health Workers.

According to standardized infrastructure indices, PHWC facilities had an average score of 57.1% (range: 42.9% to 71.4%) for basic amenities, 100% (100% to 100%) for basic equipment, and 54.2% (50.0% - 62.5%) for diagnostic capacity. In addition to the summary infrastructure assessment the readiness of the clinics to provide a range of specific service included in BEPHS was

probed. Service readiness was defined as the presence of functional equipment, drugs or diagnostic tools for each health service on the day of assessment. Further detail is contained in the report, breaking these downs to disease level, showing what the average clinic for PHWC 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 (BEPHS) to the whole country by 2020-2021. Therefore, regardless of the health care provider, it is critical to have technical alignment across the board for building and strengthening each type of health care provider's system.

In perpetration for this, preparation for this, the service availability and readiness assessment of PHWC's health facilities was conducted to identify areas for improvement, further investment and strengthening.

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 March 2018, data collectors surveyed all three of PHWC’s facilities in Mauk Mae Township in Shan State (south). The facility assessment was adapted based on the WHO Service Availability and Readiness Assessment and the draft basic Essential Package of Health Services (BEPHS) from the Ministry of Health & Sports (MoHS).

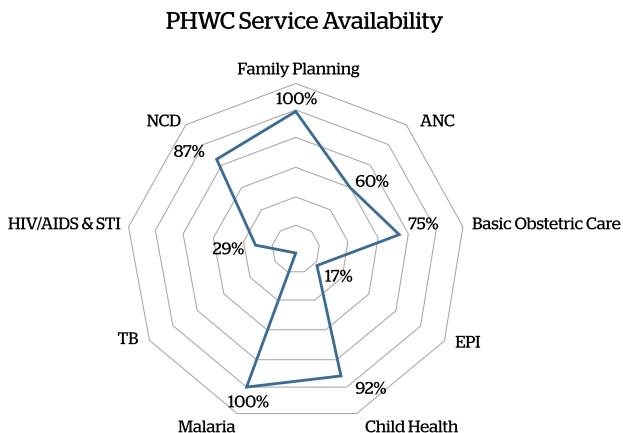
In line with the WHO SARA aims and methodology, the objective of this assessment was to generate reliable and systematic data on tracer indicators for key health systems components, including infrastructure, human resources, and service delivery, in order to inform the development of PHWC’s Plan of Actions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

Service Readiness And Availability

According to standardized infrastructure indices, PHWC facilities had an average score of 57.1% (range: 42.9% to 71.4%) for basic amenities, 100% (100% to 100%) for basic equipment, and 54.2% (50.0% - 62.5%) for diagnostic capacity (See Appendix Table X). In addition to the summary infrastructure.

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.

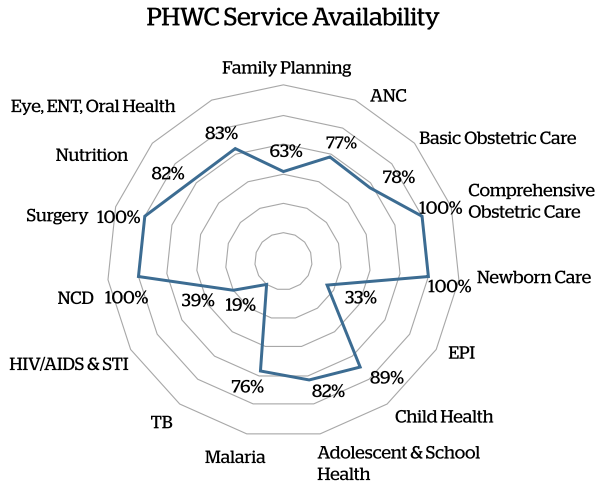
Figure 1. Average facility service readiness index scores at PHWC facilities (n=3).



Additionally availability of facility based services 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, treatments, 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 PHWC facilities (n=3) for all services included in the draft BEPHS.



Infrastructure

3 PHWC health posts were surveyed in Mauk Mae Tsp. In terms of building materials, 1 was constructed from brick and wood, while the other 2 were constructed from wood only. In terms of general building conditions, 2 were classified as “good, no need to repair;” and 1 was classified as “not good, need to build a new one” (one of the facilities constructed from wood only).

All 3 facilities were available 24 hours per day. 1 facility had a room with visual privacy (but not audio privacy), and the other 2 facilities did not have any rooms with audio-visual privacy. 1 facility had a medical storeroom.

No facilities reported having a labor room, laboratory, operating theater, or vaccine

cold room. 1 facility had 3 beds, 1 facility had 2 beds, and 1 facility had no beds; for facilities that had beds, all beds were functional. No facilities had dedicated maternity beds.

All 3 facilities had functioning latrines. Each facility had between 1 and 3 latrines, all of which were pit latrines. Latrines were located 20 to 50 meters (average 30) from the water source. 1 facility reported that they had been affected by armed conflict within the past 6 months.

All 3 facilities had electricity. 2 facilities said that they had enough electricity for all of their needs, and 1 facility said that they had only enough electricity for lights and communication. Of the 2 facilities that responded, 1 reported that they had power

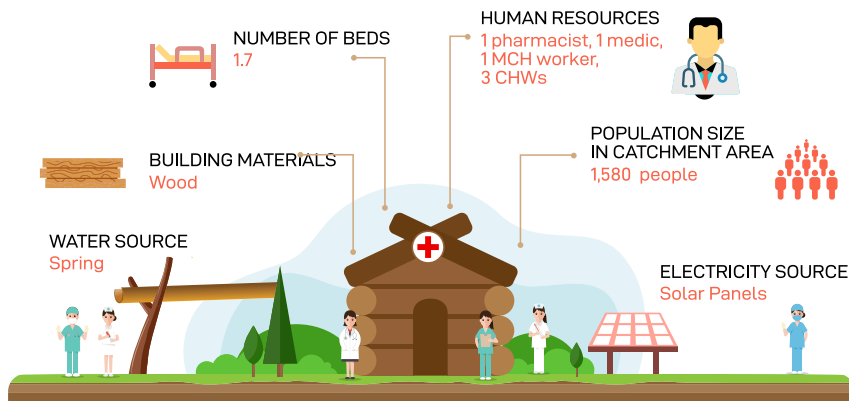
for 5-8 hours per day and 1 facility reported that they had power for 4 hours or less per day based on the past week.

All 3 facilities relied on solar power as the main source of electricity; the solar system was reported to be functional at 2 facilities but could not be observed, and not functional at 1 facility on the day of

the survey. 2 facilities also had a generator for a backup source of power; both were functional on the day of the survey and had fuel available.

Only 1 of the 3 facilities reported having access to the internet for communication purposes. No facilities had access to a functioning computer. 1 facility had access to a functioning phone line.

Typical Facility



All facilities described themselves as clinics, with an average catchment population of 1,580 people per facility. All three facilities were wooden structures with a solar system as the primary source of electricity, and spring water as the primary water source. On average, each facility had 1.7 functioning patient beds.

Service Provision

For the 3 facilities, the total population covered summed to 4752, with a range of

1211 to 1800 per facility, and an average of 1584 patients per facility.

Only 1 of the 3 facilities provided utilization data for ANC1, deliveries, and OPD services. For ANC1, this facility provided 25 ANC1 services in the previous year, 8 deliveries, and 1080 OPD services.

No facility reported providing DTP3/pentavalent services in the past year.

Referrals

Data on distance and transportation between communities and the facility were not collected as part of SARA.

However, data on distance/transportation are available for referral. To reach the primary place of referral takes an average of 2.5 hours by car (range 1.5 to 3 hours). Travel time is higher for secondary places of referral. Specifically, travel to secondary places takes an average of 4 hours by car (range 3 to 5).

1 of the 3 facilities reported having an SOP/guidelines for referral. 2 out of 3 facilities reported having an approval mechanism for referral outside clinic hours. 1 facilities reported that they always had access to at least 1 functioning vehicle for emergency transportation, 1 facility reported that they sometimes had access to a functioning vehicle, and 1 facility reported that they did not have any access. 2 facilities had access to a truck/car and 1 facility had access to a motorbike. First choices for referral were Ho Nam (1 facility) and Hsi Seng (2 facilities) both of which are in the government sector and were selected because they are nearby and convenient for transportation. Second choices for referral included Mauk Mae (2 facilities) and Loikaw Hospital (1 facility). Reasons for selecting secondary referral facilities include that they are nearby, or have adequate equipment and

experienced staff. All 3 facilities referred EmOC cases, and 1 facility also reported referring severe pneumonia for children under 5 years, and severe dehydration. Note that the range of transportation/treatment costs across the 3 facilities was 80000 to 380000, with an average of 126,700 MMK per patient.

Essential Medicines

All 3 surveyed facilities had the essential medicines list which covers the following drugs. 100% (3) of facilities were observed to have the following drugs in stock: amoxicillin syrup/suspension or dispensable tablet, ampicillin powder for injection, ceftriaxone injection, enalapril tablet or alternative ACE inhibitor, gentamicin injection, ibuprofen tablet, omeprazole tablet or alternative, oral rehydration solution, paracetamol tablet, salbutamol inhaler, and zinc sulphate tablet or syrup.

2 facilities had the following drugs in stock: amlodipine tablet or alternative calcium channel blocker, glibenclamide tablet.

1 facility had the following drugs in stock: fluoxetine tablet, and metformin tablet. No facilities had the following drugs in stock: amitriptyline, beclometasone inhaler, insulin regular injection, and simvastatin tablet or other statin.

100% (3) of facilities reported experiencing a stock out within the previous 6 months. During stock outs 1 facility said that they communicated about stock outs by filling out a requisition form, and 2 facilities indicated that they communicated about stockouts by phone.

None of the facilities had defined procedures for managing logistics, including procurement guidelines/flow charts, supply chain management guidelines/flow charts, Asset & Inventory Management Guidelines/flow chart, or Warehouse Management Guidelines/flow charts.

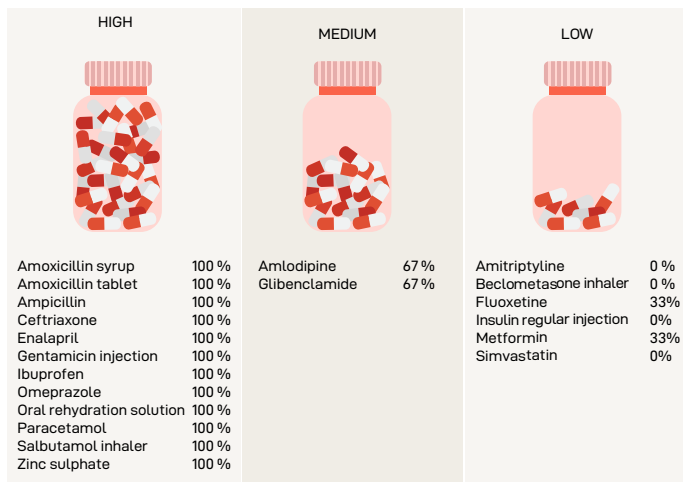
1 of the 3 facilities had procedures to manage the supply chain of pharmaceuticals, which comprised of both initiating the requisition and purchasing the pharmaceuticals directly. Another facility reported that sometimes the medic or the pharmacist would arrive with drugs.

All 3 facilities reported that the clinic-in-charge is responsible for ordering drugs. Drugs were supplied by headquarters, NGOs, and donors for 3 facilities; by local markets for 2 facilities; by sub-centers for 1 facility; Backpack for 1 facility; and HSSWG for 1 facility.

The amount of drugs to be supplied was decided by headquarters for 2 facilities, but the third facility reported that the amount was determined by the facility because it purchased them directly (despite reporting multiple sources of drug supply). Across the 3 facilities, it takes between 7 and 30 days (average 22) between ordering and receiving the requested drugs/equipment.

Most (2 out of 3) facilities reported that they did not have enough space currently to store drugs. The practice of using drugs differed by facility, and some used a combination of practices. 1 facility used “first expired first out” only; and 2 facilities used “mixed: first expired first out” and “first in first out.”

Figure 3. Medicine availability across all three PHWC 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 PHWC, all facilities provided services related to health literacy for a number of programs, including family planning, prevention and control of malaria, prevention and control of TB/MDR-TB, home-based care for newborns and children, child immunization, nutrition & lifestyle, WASH, Eye/ENT/Oral health, and NCDs. 2 facilities provided health

literacy services related to HIV/AIDS (67%, 2). No facilities provide health literacy on occupational health.

Human Resources for Health

At the facility level, there was variation in the staffing structure across facilities. On average, each facility had <1 EmOC, <1 pharmacist, <1 MCH worker, 1 medic, and 3.7 CHWs.

Table 1

Human Resources for Health										
Doctors	EMOCs	Mid-wives	Aux Midwives	Pharmacists	Medics	MCH Workers	Lab technicians	CHWs	Other	Total
0	1	0	3	2	3	2	0	11	1	23

For all 3 facilities surveyed, there were 23 staff in total, including 1 EmOC, 2 pharmacists, 3 medics, 2 MCH workers, 11 CHWs, 3 AMWs, and 1 surgical health worker. Based on the responses, there were no doctors, midwives, HAs, or laboratory technicians.

None of the 3 clinics had a specific person who was assigned to a) financial management, b) checking data quality, or c) data reporting. When asked if facility staff had adequate training to provide high-quality services, all 3 facilities reported that they had “some” training but not enough.

All 3 facilities reported that staff received periodic continuing education, such as Medic, EmOC, MCH, CHW, and AMW refresher trainings. No facilities reported receiving training on logistics or managing health information. That being said, all 3 facilities said that the person responsible for data collection and report writing had been trained in data management.

Quality Control

Supervisory visits from higher levels can play an important role in quality control. 1 facility reported that the most recent supervisory visit occurred over 3 months ago, and 2 facilities reported that they had received a supervisory visit within the past 3 months.

During the supervisory visit, the pharmacy and data were assessed at all 3 facilities; services were assessed at 2 facilities; and 1 facility reported that the supervisor assessed staffing.

None of the facilities had any criteria or mechanism to check the quality of drugs. 2 of the 3 facilities had infection precaution guidelines. 1 facility had referral guidelines. Only 1 facility reported having adequate supervision to ensure high-quality service provision.

Surveyors observed that all 3 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.).

All 3 facilities reported reviewing data quality at the facility level, with 2 facilities reviewing data quality every 3 months and 1 facility reviewing data quality every 6 months. None of the 3 facilities had a mechanism for checking drug quality.

Clinic Management Procedure

At the facility level, 2 out of 3 facilities reported holding routine facility management meetings. 1 facility held these meetings once every 2-3 months, while the other facility held these meetings once every 4-6 months. Both facilities keep

formal records of the meeting minutes, and both reported making decisions or taking follow-up actions based on what was discussed at the facility management meetings.

Clinic Finances

None of the facilities reported having a financial system, despite the fact that 2 facilities procured their own drugs at local markets.

Data Management

All 3 facilities are using paper-based forms for data collection. All 3 facilities send reports to headquarters, 2 facilities send reports to sub-centers, and 2 facilities send reports to donors. The types of log books kept by facilities included: ANC (1 facility), Delivery (1), PNC (2), Family care (3), Pharmacy (3), Outpatient registry (2), Inpatient registry (2), and General morbidity (3).

For log books, 1 facility kept 7 different types of logbooks; 1 facility kept 5 different types; and 1 facility kept 3 different types (average 5 different types of logbooks per facility). All 3 facilities were using exclusively paper-based forms for record keeping.

All 3 facilities said that they had to prepare reports according to specific schedules/deadlines, with 1 facility reporting every 3 months and every 6 months; 1 facility

reporting monthly and every 3 months; and 1 facility reporting monthly. Health data are reported to headquarters for 3 facilities, donors for 2 facilities, and rural subcenters for 2 facilities. None of the facilities had staff specifically designated to complete the reports. 2 out of 3 facilities had guidelines for managing the health information system. Only 1 facility had a mechanism for checking data accuracy, which was done by the clinic supervisor and headquarters.

Community Engagement

100% (3/3) facilities hold routine meetings about facility activities or management that include community members. All facilities maintain an official record of these meetings. All facilities have at least one system for determining clients' opinions about the health facility or its services, including official meetings with community leaders (2) and informal discussions with clients or the community (1). Only 1 facility has a procedure for reviewing or reporting on clients' opinion. No facilities reported using suggestion boxes, client survey forms, client interview forms, or letters from clients/community, all of which require higher literacy from community members.

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 Actions (POA) details PHWC's planned activities, intended outcomes and measures of success for the coming years (2019 -2021).PHWC is focused on activities that support strategic goals for health systems strengthening, both locally and nationally as identified in National Health Plan (2017-2021).

The POA describes PHWC's role in supporting and aligning with the National Health System and its plan to move towards providing an essential package of quality health services within PHWC'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 the organization in prioritization and decision-making to effectively target resources, maximize program impacts and maintain steady progress towards PHWC's strategic goals.

Through identification of resource gaps, this POA aims to effectively engage with wider stakeholders to ensure the needed resources are acquired effectively and efficiently.

In addition, it will highlight opportunities for cooperation amongst EHOs, CBOs, CSOs, MOHS and INGOs while preserving PHWC leadership and maintaining organizational focus. Annually, PHWC will review and evaluate the successful completion of activities enumerated in the POA and activities still left to be completed. Responsible staff will report progress to PHWC 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 PHWC headquarters in Taunggyi, 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, PHWC leadership, mid-level management teams and program implementation teams.

A review of annual data for PHWC 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 OBJECTIVES (2018-2021)

Health Service Delivery

PHWC's aim for 2021 is to provide 15,600 people within Mauk Mai and Hsi Hseng with a BEPHS that are consistently delivered at a high quality.



In order to ensure that this Basic EPHS is as effective as possible, there will be a strong focus in the coming years on understanding the burden of diseases currently faced. This will include full reviews of logbooks to understand what conditions are faced by communities, then strong lobbying to EAO partners to stress the importance of continued or increase support.

When delivering the Basic EPHS, monitoring will be conducted to identify gaps between services provided and SOPs, to ensure that high quality is maintained and enable training to be provided as necessary.

Human Resources for Health

The first priority for human resources is to develop a standardized clinic and departmental structure while identifying minimum HR requirements to deliver BEPHS by 2021.



This can result in updating the existing HR policy, but would then crucially have to be disseminated across clinic level and new staff will be trained according to this new structure. These are all linked in to an aim of formalizing the system more, including paying salaries from the headquarters rather than depending on each community to support the local health workers.

With this shift to increased formalization, they would like to increase communication between central administration and clinics.

Health Infrastructure



PHWC aim to establish and utilize Village Tract Health Committees to ensure local contributions are able to fund the maintenance and ongoing upgrading of each clinic (as well as lobby local EAO support).

They also need to investigate the state of all infrastructure and office equipment and attempt to secure funding to update it.

Health Financing



By 2021, PHWC hopes to find the fiscal space necessary to provide the Basic EPHS to all the population served.

As the first step towards that, PHWC aims to provide three Maternal and Child Health (MCH) services consistently across clinics, for which costing of each service needs to be done.

Creating an Enabling Environment

PHWC aims to become more systematic and evidence based in terms of activity planning and budgeting.

Based on this POA, PHWC aims to produce annual reports containing data about health accounts, burden of diseases, and how PHWC's health services impact on reducing the burden against an M&E plan.



At the clinic level, PHWC intends to collaborate and coordinate with Village Tract Health Committee to ensure functionality, and accountability by keeping a community suggestion bos in place.

PLAN OF ACTION

(2018-2021)

The activities are organized into four pillars of health systems strengthening strategies which are consistent with the six pillars of the WHO's six system building blocks. 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 PHWC, and 2-5 priorities are based on criteria including alignment standardization of organization policies and impact on health service delivery. All activities cannot be completed in the absence of further funding, so this should be viewed as an aspiration operational plan, rather than an action plan against which the performance of the EHO should be judged.

Work Plan

STRATEGY	PRIORITY	TARGETED OUTPUT	ESTIMATED COSTS	Responsibility
HEALTH SYSTEM LEVEL				
HUMAN RESOURCE FOR HEALTH				
ACTION I : Develop a Draft Standard Department Structure internally first. Then meeting with technical team from PHWC Technical Team (with support from CPI). If technical team make changes, another round of internal discussions to finalize preferred department structure.	1	3 Meetings	500 USD x 3	Director
ACTION II : To form an organizational development team including people from PHWC & technical consultants. This group to define TORs.	2	3 Meetings	300 USD x 3	Deputy Director
ACTION III : Analyze the existing TORs. Discuss these TORs with health workers to understand strengths and weaknesses.	2	2 Meetings	200 USD x 3	Deputy Director
ACTION IV : Disseminate updated HR policy to all PHWC staff members. Train new PHWC staff members according to updated HR policy.	1	Link with Action I		Director
ACTION V : Internal meeting to come up with staff motivation and retention plan.	3	1 Workshop	500 USD x 1	Director & Deputy Director
ACTION VI : Work together with experts from BMA and others (including Taunggyi Medical Association and other Pa-Oh doctors) to come up with continuous medical education plan.	3	1 Meeting 1 Workshop	250 USD x 1 500 USD x 1	Deputy Director

STRATEGY	PRIORITY	TARGETED OUTPUT	ESTIMATED COSTS	RESPONSIBILITY
ACTION VII : Advocate to local authorities about importance of cross clinic exchange.	5	2 Workshop	500 USD x 2	Director & Field Coordinator
ACTION VIII : 3 monthly internal coordination meetings with agenda objectives, expected outcomes and meeting minutes	2	4 Meeting	250 USD x 4	Field Coordinator
ACTION IX : Workshop with HRH experts to advise on HRH strategy.	3	1 Workshop	500 USD x 1	Organizational Development Team
HEALTH INFRASTRUCTURE				
ACTION I : Assess the condition of generators currently located in each clinic. Estimate costs of fuel needed to run generator for different amounts of time each day.	3	1 Assessment		Clinic-in-charge
ACTION II : Training all staff members how to use internet to effectively communicate	3	1 Training	500 USD x 1	Organizational Development Team
ACTION III : Assess current condition of IT & office equipment (how much gap at present). Then advocate to donors with list of gaps.	1	1 Assessment		Director & Clinic-in-charge
ACTION IV : Technical training for all staff for communication and coordination mechanisms, Technical training for all PHWC staff about reporting mechanism with support of partners	3	1 Training		Organizational Development Team
ACTION V : Advocate to donors about new reporting mechanism.	2	2 Meetings	250 USD x 2	Director & Deputy Director

STRATEGY	PRIORITY	TARGETED OUTPUT	ESTIMATED COSTS	RESPON- BILITY
SERVICE DELIVERY				
ACTION I : Proper collection of data about the burden of diseases for populations served and analysis of the data. Workshop with experts to draft basic EPHS.	1	2 Meetings 1 Workshop	250 USD x 2 500 USD x 1	Director & Deputy Director
ACTION II : Develop disease treatment guidelines and SOPs. To follow development of Basic EPHS.	2	2 Meetings 1 Workshop	250 USD x 2 500 USD x 1	Technical Team
ACTION III : Expand the current HRH CV database into a more complete version. Explore the use of HR software.	4	2 Meetings	250 USD x 2	Technical Team
ACTION IV : Collect all the necessary guidelines and raise awareness of them to staff with encouragement to use.	2	1 Meeting	250 USD x 1	Technical Team
HEALTH FINANCING				
ACTION I : Now there are 3 MCH services provided in all clinics. Cost those to be able to start budgeting for services. Organize a workshop with partners to prepare first draft of costing.	1	1 Workshop	500 USD x 1	Technical Team
ACTION II : Establish a PHWC master health account for 2017 or 2018. Conduct workshop combined with costing exercise.	2	3 Meeting	250 USD x 3	Finance Officer
ACTION III : Participate in development of EHSSG health financing strategy.	4	2 Meeting	250 USD x 2	Deputy Director

STRATEGY	PRIORITY	TARGETED OUTPUT	ESTIMATED COSTS	RESPONSIBILITY
CREATING AN ENABLING FRAMEWORK				
ACTION I : Advocate to local authorities, donors & INGOs about PHWC POA. Review progress towards POA with CPI.	1	5 Meeting	250 USD x5	Director and Deputy Director
ACTION II : Workshop with CPI in December to set indicators and make plans for PHWC Annual Report.	2	1 Meeting	250 USD x1	Technical Team
ACTION III : Update HR policy in 1st year; draft procurement policy; update finance policy.	2	2 Meeting 1 Workshop	250 USD x2 500 USD x2	Organization Development Team
HEALTH FACILITY LEVEL				
AVAILABILITY				
ACTION I : Advocate to donors the need for another facility in Hsi Hseng	4	Link with Action 1 from Creating Enabling Framework		Director and Deputy Director
ACTION II : Advocate to local authorities, armed groups and community to have an emergency vehicle at every clinic.	4	3 Meeting	250 USD x3	Director, Field Coordinator & Clinic-in-charge
ACTION III : Awareness raising sessions in the community. Routine data collection of the health knowledge of public to reduce the Know-Do Gaps and to increase the community understanding of Health Providers	1	3 Meeting	250 USD x3	Technical Team, Field Coordinator & Clinic-in-charge
AVAILABILITY (SERVICE DELIVERY)				
ACTION I : Advocate to local armed groups and authorities about importance of Basic Package and invite input.	1	2 Meeting	250 USD x2	Director and Deputy Director

STRATEGY	PRIORITY	TARGETED OUTPUT	ESTIMATED COSTS	RESPONSIBILITY
ACTION II : Logbook review to understand better the burden of diseases faced.	2	2 Meeting	250 USD x 2	Technical Team and Clinic-in-charge
ACTION III : Internal meeting to discuss burden of diseases and understand what services could be offered. Meeting with experts to discuss potential additions to MCH services offered to reduce burden.	2	2 Meeting	250 USD x 2	Technical Team and Clinic-in-charge
ACTION IV : Hire pharmacy and logistics staff member at each clinic after training of those people. Advocate for sustainable, reliable, sufficient financing to donors to facilitate this.	4	2 Meeting	250 USD x 2	Technical Team
ACTION V : Internal meeting for development of a checklist to identify the gaps in performance from standard guidelines.	2	2 Meeting	250 USD x 2	Clinic-in-charge
ACTION VI : Workplan workshop internally, then working with technical experts to refine it and come up with implementable health promotion workshop.	3	1 Workshop	500 USD x 1	Technical Team
AVAILABILITY (HRH)				
ACTION I : To assess local HRH situation to feed into HR database.	2	2 Meeting	250 USD x 2	Field Coordinator & Clinic-in-charge
ACTION II : To assess local understanding of JDs and to explain where this is lacking.	1	2 Meeting	250 USD x 2	Field Coordinator & Clinic-in-charge
ACTION III : Assess job satisfaction and needs of staff to encourage them to continue working for PHWC. Analyze this in internal workshop to draft plans for Staff Retention Plan.	4	2 Meeting	250 USD x 2	Field Coordinator & Clinic-in-charge

STRATEGY	PRIORITY	TARGETED OUTPUT	ESTIMATED COSTS	RESPONSIBILITY
ACTION IV : Assess current training levels and identify gaps.	3	2 Meeting	250 USD x 2	Field Coordinator & Clinic-in-charge
ACTION V : Clinical audit to identify gaps in quality service provision.	3	2 Meeting	250 USD x 2	Field Coordinator & Clinic-in-charge
ACTION VI : Training of all health workers to complete logbooks appropriately.	3	1 Training	250 USD x 1	Technical Team
AVAILABILITY (INFRASTRUCTURE)				
ACTION I : Advocacy and awareness raising about community contributions and assistance for clinic maintenance. Formation of Village Tract Health Committees for each clinic to coordinate efforts and make them more effective.	1	Link with 3 monthly coordination meeting		Field Coordinator & Clinic-in-charge
ACTION II : Assess needs for emergency referrals in community.	4	1 Assessment		Field Coordinator & Clinic-in-charge
ACTION III : Training of health workers with regards to HMIS and LMS systems.	2	1 Training	500 USD x 1	Technical Team
ACCEPTABILITY				
ACTION I : Advocate to local leaders and public about the needs for formation of Village Tract Health Committees	1	3 Meeting	250 USD x 3	Director, Field Coordinator & Clinic-in-charge
ACTION II : Training of clinic in charge about need for understanding of health trends and utilization, and ways to provide that as feedback for headquarters.	2	1 Training	500 USD x 1	Technical Team & Organization Development Team
ACTION III : Advocacy to community about the value of community feedback and that they will be anonymous. Put suggestion boxes in facilities.	4	3 Meeting	250 USD x 3	Field Coordinator & Clinic-in-charge

Risk Management

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

High impact, high probability risks include a changing health policy and challenging political landscape, a mobile population and insufficient existing data and IT resources. Risks will be actively managed using the following mitigation activities.

Risks

- Personal Safety in activities
- Political Instability
- Uncoordinated donor engagement





Risk Mitigation Activity

- Information sharing and better coordination with the government and EAOs
- Continue work with PNLO and government
- Advocate to Donors, INGO, LNGO for more long term and PHWC led funding

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