SHAN STATE DEVELOPMENT FOUNDATION

Plan of Action
2018 - 2021

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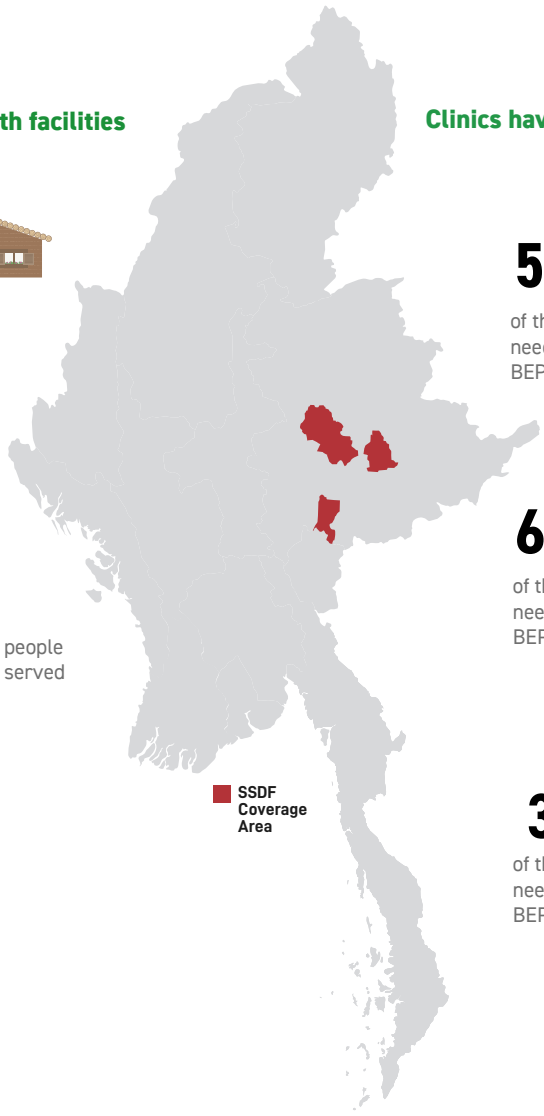
SSDF Assessment Findings - March 2018

Total number of health facilities

9 clinics operated

14,000 people served



Clinics have on average:

57 % of the basic amenities needed to provide BEPHS

67 % of the basic equipment needed to provide BEPHS

38 % of the diagnostic tools needed to provide BEPHS

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ACRONYMS

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

EXECUTIVE SUMMARY

Background

Shan State Development Foundation (SSDF) is an CSO that was founded by the merger of three organizations in 2012 which have been serving the people of Shan State for more than twenty years: the Shan Health Committee, the Shan Relief and Development Committee and the Shan Education Committee. The aim of the organization is working towards a just, democratic and sustainable society in Shan State.

SSDF is based in Chiang Mai, Thailand and Taunggyi, Myanmar. At present, the Taunggyi office is supporting nine clinics through the support of various donors. Among the nine clinics, five receive medicine and other supplies from EHSSG. Four clinics are fully operated in Mauk Mai and Laihka Townships. All staffs are clinic-based and consist of medics, AMWs and CHWs.

SSDF's key partners are Relief International, CPI and PSI. In addition, they cooperated closely with township Ministry of Health and Sports officials.

Mission Statement

SSDF is working towards a just, democratic and sustainable society in Shan State. It aims to provide emergency relief assistance, primary health care services, and basic education and community development programs to IDPs and the most vulnerable population inside Shan State.

One of the SSDF's priority missions is to improve the health situation of the people in Shan state by giving health training, treatment and basic health knowledge to the people. In particular, it aims to provide health care to internally displaced Shan villagers in Shan State as well as Shan refugees in the border areas of Thailand.

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 SSDF'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 SSDF, 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, SSDF 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, SSDF 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 SSDF'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 SSDF to develop its Plan of Action.

SSDF are typically serving over one thousand and five hundred people per clinic, offering a range of services but with strengths in basic obstetric care, family planning and malaria services. They have some of the closest links to the communities seen measured by community meetings, and clinics are usually staffed by a number of Medics leading a team of Community Health Workers with some additional staff with different training.

Most of the facilities described themselves as village tract health centers and the remaining were health posts.

The most common features across the facilities were brick and wood construction materials, a solar system as the primary source of electricity, and the primary water source as either a spring or water piped directly into the facility. On average, each facility had 3.6 functioning patient beds.

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

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

As a preparation for this, the service availability and readiness assessment of SSDF'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 and medicines. 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

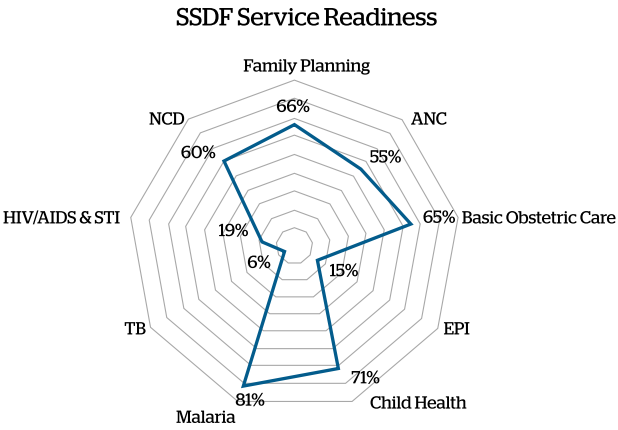
In March 2018, data collectors surveyed 9 health facilities in Shan State, including Kunhing, Nansang, Mawk Mai, Laihka, Ke-Hsi, and Mong Kaing townships. The facility assessment was adapted from the WHO Service Availability and Readiness Assessment and the draft basic Essential Package of Health Services (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 SSDF's Plan of Action (POA).

Service Readiness And Availability

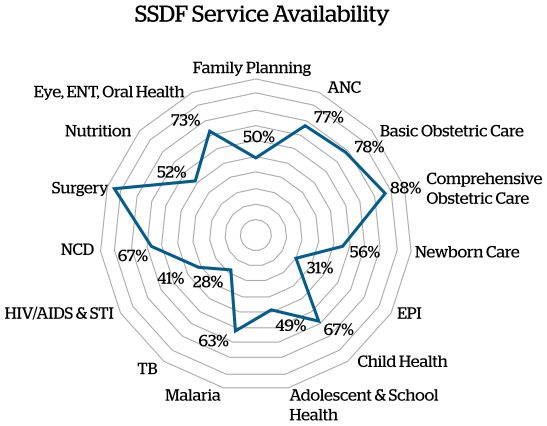
According to standardized infrastructure indices, SSDF facilities had an average score of 57.1% (range: 28.6% to 78.6%) for basic amenities, 66.7% (16.7% – 100%) for basic equipment, and 37.5% (12.5% – 75.0%) for diagnostic capacity (See Appendix Table X). In addition to the summary infrastructure figures for how prepared SSDF clinicswere, 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 facilities supported by SSDF (n=8).



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 facilities supported by SSDF (n=8) for all services included in the draft BEPHS.



Infrastructure

Eight health facilities supported by SSDF were surveyed during the assessment where five facilities were Village Tract Health Centers and the rest were health posts. In terms of building materials, one facility was constructed from brick; three were constructed from brick and wood; two were constructed from wood; and two were constructed from wood and bamboo.

In terms of general building conditions, three were classified as "good, no need to repair;" two were classified as "good, only minor repairs needed," one was classified as "not good, need major repairs; and two were classified as "not good, need to build a new one." Based on data from assessed health facilities, all facilities were between 1 and 3 years old (1.86 years old on average). Seven of the eight facilities were available 24 hours per day, and one facility was available for 4 hours or less per day. None of the facilities had a room with either audio-visual privacy.

One facility had a labor room and two facilities had a medical storeroom. No facilities reported having a laboratory, operating theater, or vaccine cold room. Across all eight facilities, there were a total of 25 beds (average 3.5 beds per facility) and two dedicated maternity beds, and all beds were reported to be functional. Only two facilities had dedicated maternity beds (i.e. one maternity bed at each of the two facilities). Only 75% (6/8) facilities had functioning latrines.

Each facility had between one and three latrines, all of which were pit latrines. Latrines were located 15 to 3,220 meters from the water source, with an average of 504 meters. Two facilities reported that their facility had been affected by armed conflict within the past six months by intimidation of health workers and creating an atmosphere of insecurity that discourages travel.

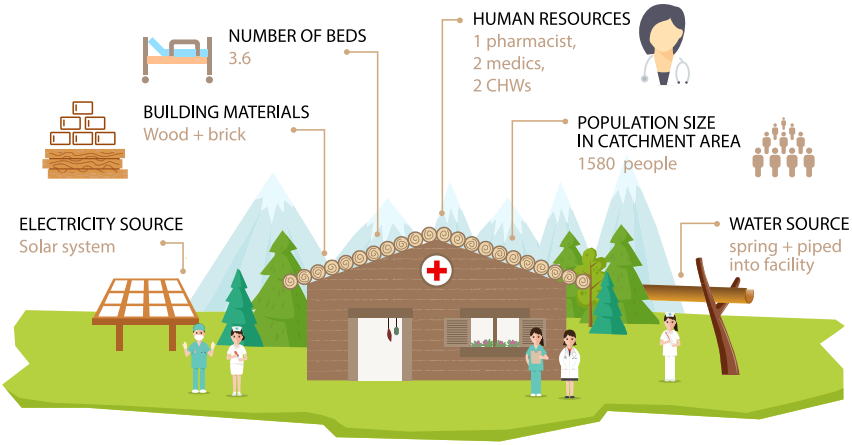
75% (6/8) facilities had electricity. Of the six facilities that had electricity, five facilities said that they had enough electricity for all of their needs, and one facility said that they had only enough electricity for lights and communication. Of five facilities that responded, three reported that they had power for 24 hours/day and two facilities responded that they had power for 5-8 hours per day based on the past week.

Five facilities relied on solar power as the main source of electricity, and one facility relied on the national/community grid as their main source. All five facilities that relied on solar power had a functioning solar power system on the day of the survey. Three facilities also had a backup source of power; two from a generator and one from hydro power. For the two facilities

that relied on a generator for backup power, both were functional on the day of the survey but only one reported having fuel available.

The half (4/8) of facilities reported having access to the internet for communication purposes. Three facilities had access to a functioning computer. Four facilities had access to a functioning phone line; a fifth facility had access to a phone line but it was not functional on the day of the survey.

Typical Facility



Most (n=5) of the facilities described themselves as village tract health centers and the remaining 3 were health posts, with an average catchment population of 1,580 people per facility. The most common features across all 3 facilities were brick and wood construction materials, a solar system as the primary source of electricity, and the primary water source as either a spring or water piped directly into the facility. On average, each facility had 3.6 functioning patient beds.

Service Provision

For the seven facilities that reported population coverage estimates, the total population covered summed to 11,031, with a range of 669 to 2,242 per facility, and an average of 1,576 patients per facility.

Six of the eight facilities provided utilization data for ante-natal care (ANC), deliveries, and out- patient department (OPD) services. For ANC, these six facilities provided a total of 102 ANC services in the previous year, ranging from 6 to 52 ANC services per facility, with an average of 17 ANC services per facility.

For deliveries in the previous year, SSDF provided a total of 33 deliveries, ranging from 0 to 17 per facility, with an average of

5.5 deliveries per facility. SSDF provided a total of 20,619 OPD services in the previous year, ranging from 1101 to 10,903, with an average of 3,437 OPD services per facility.

Referrals

To reach the primary place of referral takes an average of 90 minutes by motorbike (range 60- 180), 105 minutes by truck/car (range 45-240), and 173 minutes by tractor (range 90-360). Travel time is higher for secondary places of referral. Specifically, travel to secondary places is 2-5 hours by motorbike and 3-3.5 hours by truck/car.

25% (2/8 facilities) reported having a standard operating procedure (SOP)/ guidelines for referral. 88% (7/8 facilities) reported having an approval mechanism for referral outside clinic hours (though these seven facilities reported being available 24/7).

Four facilities reported that they always had access to at least one functioning vehicle for emergency transportation, and three facilities reported that they sometimes had access to a functioning vehicle. 63% (5) of facilities had access to a tractor, 75% (6) of facilities had access to a truck/car, and 75% (6) of facilities had access to a motorbike.

All referral facilities are in the government sector. Reasons for selecting referral facilities include: nearby/convenient for transportation, more equipment, adequate staff, good quality, and in the case of one facility, that a donor (RI) has agreed to fund all referral transportation costs to that facility. The only additional reported reason for selecting a secondary referral facility was for X-ray services. Note that the range of transportation/treatment costs across 6 facilities is 0 (RI-supported) to 400,000 MMK, with an average of 245,000 MMK per patient.

Essential Medicines

Only half (4) of facilities had the essential medicines list, which covers the following drugs. 100% of facilities were observed to have the following drugs in stock: amoxicillin syrup/suspension or dispersible tablet, ampicillin powder for injection (one facility reported available but could not observe), enalapril tablet or alternative ACE inhibitor, gentamicin injection, ibuprofen tablet, metformin tablet, omeprazole tablet or alternative, paracetamol tablet, zinc sulphate tablet or syrup.

Seven facilities had the following drugs in stock: oral rehydration solution, salbutamol inhaler. Six facilities had the following drugs in stock: amlodipine tablet or alternative calcium channel blocker. Five facilities had the following drug in stock: ceftriaxone injection. Four facilities had the following drug in stock: glibencalmide tablet. Three

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

Five (63%) of facilities reported experiencing a stock out within the previous six months. Of the five facilities who responded, all five indicated that they communicated about stockouts by phone.

63% (5/8) facilities had defined procedures for managing the supply chain. For guidelines for logistics management, only three facilities reported having any documented guidelines: two had procurement guidelines/flow charts; one had supply chain management guidelines/ flow charts; one had an Asset & Inventory Management Guidelines/flow chart; and all three had Warehouse Management Guidelines/flow charts.

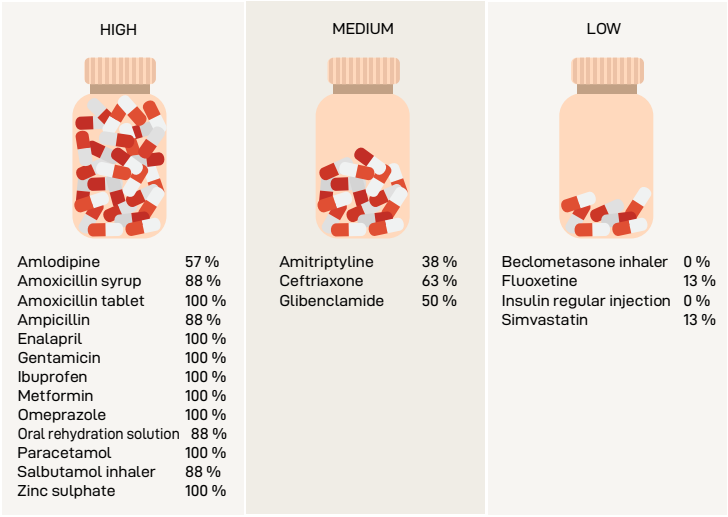
Of the three facilities that responded, two facilities initiated requisitions and one facility reported that upper levels deliver without any requisition.

One facility reported the need to occasionally procure and pay for goods themselves (without reimbursement). In terms of responsibility for ordering drugs, four facilities reported that the clinic-in-charge is responsible, two facilities reported that the pharmacy manager is responsible, one facility reported that the medic is responsible, and one facility reported that the team was responsible.

Drugs come from headquarters for five facilities, donors for one facility, and a combination of Headquarters/NGOs/ Donors for one facility. Across the eight facilities, it takes between one and forty-five days (average 20) between reporting a stockout and receiving the requested drugs/equipment.

Most (7 out of 8) facilities reported that they did not have enough space currently to store medicines. The practice of using drugs differed by facility, and some used a combination of practices. Three facilities used "first expired first out" only; three facilities used "mixed: first expired first out" and "first in first out;" and two facilities used "first expired first out" and "last in first out."

Figure 3 shows medicine availability across all 9 facilities supported by SSDF. 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 facilities supported by SSDF, services provided relate to health literacy for a number of programs, including family planning (100%; 8), prevention and control of malaria (100%, 8), prevention and control of TB/MDR-TB (88%, 7), home-based care for newborns and children (63%; 5), HIV/AIDS (63%, 5), nutrition & lifestyle (63%, 5), WASH (63%, 5), occupational health (50%, 4), Eye/ ENT/Oral health, and NCDs.

Human Resources for Health

At the facility level, there was variation in the staffing structure across facilities. On average, each facility had less than emergency obstetric care worker (EmOC), less than one pharmacist, two medics, and between one and two community health workers (CHWs).

Table 1

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

For all eight facilities surveyed, there were 35 staff in total, including one EmOC Worker, fifteen medics, one MCH worker, twelve CHWs and six AMWs. Based on the responses, there were no doctors, midwives, HAs, pharmacist, or laboratory technicians.

One facility had a person (clinic-in-charge) assigned to financial management. Seven clinics had a person (clinic in charge or medic) assigned to data reporting.

When asked if facility staff had adequate training to provide high-quality services, only one facility said "yes" while the other seven facilities reported that they had "some" training but not enough. 75% (6/8 facilities) reported that staff received periodic continuing education, such as Medic Refresher, Pharmacy, Malaria, TB, MCH, AMW, CHW, and EmOC.

One facility reported the need for training in basic surgical care. 38% (3/8) facilities reported that training was available for managing HIS at the facility. However, only two of these facilities reported that the staff who were responsible for data collection and report preparation were actually trained in HIS.

Quality Control

Supervisory visits from higher levels can play an important role in quality control. Three facilities reported that they had never received a supervisory visit, one facility reported that the most recent supervisory visit occurred over three months ago, and four facilities reported that they had received a supervisory visit within the past threemonths.

During the supervisory visit, one facility reported that the supervisor assessed the pharmacy; one facility reported that the supervisor assessed staffing; one facility reported that the supervisor assessed data; and two facilities reported that the supervisor assessed service provision. None of the facilities had any criteria or mechanism to check the quality of drugs. 63% (5/8) facilities had infection precaution guidelines. 25% (2/8) facilities had referral guidelines.

Surveyors observed that three 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.). Five facilities reported that they carried out such activities but these activities could not be observed. Only one facility reported having a mechanism for assuring data quality/accuracy.

Clinic Managment Procedure

At the facility level, 100% (8/8) facilities reported holding routine facility

management meetings. Five facilities held these meetings monthly or more frequently, while three facilities held these meetings once every two to three months. Only 50% (4/8) facilities keep formal records of the meeting minutes, and 88% (7/8) facilities reported making decisions or taking follow-up actions based on what was discussed at the facility management meetings.

Clinic Finances

At the facility level, only one out of the eight facilities reported having a financial system. At this facility, the clinic in-charge was responsible for finances and reported financial data monthly, yet when asked to whom the financial data were reported, the response was "to no one."

Data Management

Six facilities are using paper-based forms and two facilities are using both electronic and paper- based forms for data collection. Of the seven facilities who responded, 6 facilities send health data to SSDF headquarters and one facility sends health data to Kan Ann.

The types of log books kept by facilities included: ANC (4 facilities), Delivery (3), PNC (2), Family care (5), Pharmacy (6), Outpatient registry (8), Inpatient registry (5), General morbidity (2), Dressing Logbook (1). For log books, one facility kept eight different types of logbooks; one facility kept seven different types; one facility kept six different types; one facility kept five types; one facility kept four types; one facility kept two; one facility kept three types; and one facility kept one type (average 4.5 different types of logbooks per facility).

Seven out of eight facilities said that they had to prepare reports according to specific schedules/deadlines. Seven out of eight facilities had staff specifically designated to complete the reports, which was the clinic-in-charge at four facilities and the medic at three facilities.

Community Engagement

100% (8/8) facilities hold routine meetings about facility activities or management that include community members. 75% (6/8) facilities maintain an official record of these meetings. 75% (6/8) facilities have at least one system for determining clients' opinions about the health facility or its services, including official meetings with community leaders (3 facilities), informal discussions with clients or the community (2 facilities), and client interviews (2 facilities). 38% (3) facilities have a procedure for reviewing or reporting on clients' opinion. No facilities reported using suggestion boxes, client survey 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 details SSDF's planned activities, intended outcomes and measures of success for the coming year. SSDF is focused on activities that support strategic goals for health systems strengthening, both locally and nationally. The POA describes SSDF'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 SSDF'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 SSDF's strategic goals. In addition, it will highlight opportunities for cooperation amongst EHOs, CBOs, CSOs, MoHS and INGOs while preserving SSDF leadership and maintaining organizational focus.

At the end of the year, SSDF will review the successful completion of activities enumerated in the POA and activities still left to be completed. Responsible staff will report progress to SSDF 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 SSDF 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, SSDF leadership, mid-level management teams and program implementation teams. A review of annual data for community-based health services supported by SSDF 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

The overarching aim of the SSDF health program by 2021 is to cover 50,000 of the population with a Basic EPHS based on the local burden of disease. To do this, they will increase communication with communities so that people understand the health services that are available to them. They will also coordinate with MoHS township authorities to understand where gaps in services are, so that these can be filled, potentially with temporary mobile clinics to reach all villages in SSDF catchment areas. To ensure all of this is carried out effectively, they aim to have quarterly clinical supervisions and audits, to supplement quarterly and bi-annual coordination meetings between clinics and headquarters. This greater communication will enable better management, so that new focuses can be effectively carried out, including the aim to deliver monthly health education services if funds allow.

Human Resources for Health

SSDF aim to develop standard job descriptions by end of 2019, and then want to focus on are the training of the clinic staffs in coordination with both MoHS and Mae Tao Clinic, so that all staff can effectively provide a Basic EPHS by 2021. They also aim to ensure that the recently produced Finance and HR policies are translated into the Shan and Myanmar languages of their staff are finalized by end of 2020. The other area they are focusing on is strengthening their internal communications systems, through more systematic monthly and quarterly action plans and documentation of meetings and guidelines.

Health Infrastructure

Logistics management will be the focus of health infrastructure developments for SSDF: from a fully functioning LMIS system with standardized reporting formats and clinic equipment lists, to ensuring there are proper medicine storage areas in each clinic. With these developments they aim to ensure there are no further stock-outs by 2021. In addition, they aim to provide all clinics with electrical power for at least 12 hours per day and the internet to enable electric record keeping and better communication.

Health Financing

SSDF have developed a Health Financing Strategy, but central to the effective implementation of the plan are three things they hope to achieve by 2021. Firstly, there is a need for greater funding, for which they intend to increase advocacy with the donor community. Secondly, translation of the report into local languages so all staff understand the aims. Thirdly, systematic evaluations of previous budgetary performance to improve for upcoming years.

Creating an Enabling Environment

In 2021, SSDF aim for their HR Policy, Finance Policy, Child Protection Policy, HSS Policy & Guidelines and Procurement Policy to all be fully implemented across the organization. They also aim for better community contribution and participation, better community involvement during referral cost-sharing and referral forms to be readily available at each clinic.

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 SSDF, 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.

STRATEGY	PRIORITY	TARGETED OUTPUT	ESTIMATED COSTS	RESPONSIBILITY
Health System Level				
Human Resource for Health				
ACTION I : Finding available funding source for Information and Publication Officer	3	1 x Internal Meeting 1 x Meeting with Donor	150 USD x 1	Management Team
ACTION II : Monthly and quarterly inter-departmental workplan meeting	2	12 x HSS Meeting 4 x Program Meeting	50USD x 12 1000 USD x 2 (exchange visit) 100 USD x 4	Health Program Manager (HSS) Deputy Director
ACTION III : Capacity building for Admin and HR Officer to strengthen recruitment plan, policy and practice,	3	6 x Workshop	150 USD x 6	Management Team
ACTION IV : Update SSDF Financial Policy and HR Policy into both Myanmar and Shan language	1	3 x Workshop	150 USD x 3	Management Team & Finance Team
ACTION V : Internal meeting for advocation to donors for funding to organize SSDF Annual Meeting	4	2 x Internal Meeting		Deputy Director
ACTION VI : Assess the capacity of health workers in SSDF	3	1 x Assessment	150 USD x1	HIS Officer
ACTION VII : Coordinate with Mae Tao Clinic, MoHS for training opportunity and capacity development of all health workers and funding advocacy to donors for trainings	1	1 x Internal Meeting 1 x Meeting with QI Team 2 x Donor Meeting	200 USD x 1 500 USD x 1 400 USD x 2	Management Team & Quality Improvement Team

STRATEGY	PRIORITY	TARGETED OUTPUT	ESTIMATED COSTS	RESPONSIBILITY
ACTION VIII : Development of Meeting Records Forms. Mobile Clinic and Health Education Guideline Development for better internal coordination practice	2	1 x HIS Workshop 1 x Follow up Workshop	1500 USD x 2	Management Team
ACTION IX : Internal meeting to discuss the need for Human Resource for Health Master Strategy	5	1 x Meeting with HR Experts	500 USD x 1	Health Program Manager (MNCH) & Admin & HR Officer
Health Infrastructure				
ACTION I : Collect information from Community and Local Authority for Standard Infrastructure Design	3	Phone Call		Deputy Director & HIS Officer
ACTION II : Collect information from government official about electrical supply to clinics	4	2 x Meeting		Admin & HR Officer
ACTION III : Finding available funding source to set up the Skynet for internet accessibility	4	2 x Donor Meeting	150 USD x 2	Health Program Manager (MNCH)
ACTION IV : Develop inventory lists and assess the gap from the inventory list in each clinic	2	1 x Meeting 1 x Follow-up	100 USD x 1 100 USD x 1	Admin & HR Officer & Logistic Officer
ACTION V : Train all SSDF staff for basic computer skills and Find available funding sources for those training	4	1 x Training	1500 USD x 1	Admin & HR Officer
ACTION VI : Standardized reporting formats and discuss with donors about the new standardized reporting formats	1	1 x Workshop 1 x Follow-up Workshop	600 USD x 2	Health Program Managers & HIS Officer
ACTION VII : Find available funding source to set up computerized reporting system	4	2 x Donor Meeting	150 USD x 2	Management Team
ACTION VIII : To discuss with EHSSG for LMIS and Development of Operation plan for Pharmaceutical Management	2	1 x Workshop 1 x Follow-up Workshop	600 USD x 2	Health Program Manager (HSS) & Quality Improvement Team

STRATEGY	PRIORITY	TARGETED OUTPUT	ESTIMATED COSTS	RESPONSIBILITY
Health Service Delivery				
ACTION I : Update Essential Drug List	1	Link with HSS Monthly Meeting		Health Program Manager (HSS) & Quality Improvement Team
ACTION II : Advocate to community for increase population coverage and discuss with Township Health Department to find out where are the uncovered areas are	2	2 x Internal Meeting		Management Team
ACTION III : Systematic review of local burden of disease, and creating data collection tools for new data of accidents, chemical use and other increasing local burden of disease	3	1 x Systematic Review in HQ 1 x Data Collection	150 USD x 1	Management Team
ACTION IV : Workshop for Clinical Supervision	2	1 x Workshop	2000 USD x 1	Health Program Manager (HSS) & Quality Improvement Team
ACTION V : Cross Exchange visits with Township Health Department	3	2 x Clinic Visit	2000 USD x 2	Health Program Manager (HSS) & Quality Improvement Team
ACTION VI : Advocate to Donors about the need for quarterly and bi-annually coordination meeting and find available funding source	4	1 x Internal Meeting		Management Team
ACTION VII : Advocate to donors about the need for HMIS expert and hire HMIS expert	5	1 x Internal Meeting		Management Team
ACTION VIII : Collection Standard Clinical guidelines according to Basic EPHS and assess the barrier for the clinic staff to follow the clinical guidelines in health workers	4	1 x Workshop	1500 USD x 1	Health Program Manager (MNCH) & HIS Officer

STRATEGY	PRIORITY	TARGETED OUTPUT	ESTIMATED COSTS	POTENTIAL FUNDING SOURCES
HEALTH FINANCING				
ACTION I : Conduct Health Financing Strategy Workshop in SSDF and participate in EHSSG Health Financing Strategy	4	1 x Workshop	1500 USD x 1	Financial Officer
ACTION II : Review meeting for last year budgeting practice	1	1 x Internal Meeting + QIT	500 USD x 1	Financial Officer & Accountant + QIT
ACTION III : Meeting with Management Team about the need to advocate more donor funding.	2	1 x Internal Meeting		Management Team
ACTION IV : Advocacy meeting with the donors for increase funding allocation to SSDF	2	2 x Donor Meeting	150 USD x 2	Management Team
Creating Enabling Environment				
ACTION I : Translate Financial Policy and Human Resource Policy into (Myanmar and Shan)	5	1 x Internal Meeting		Management Team
Health Facility Level				
Accessibility				
ACTION I : Assess SSDF catchment areas and discuss where to open temporary clinics	5	12 x Temporary Clinic	50 USD x 12	Clinic-in-charge
ACTION II : Advocate to the donor about the need for mobile clinics, need for medicine, need for sufficient Travel Allowance	3	2 x Donor Meeting		Management Team
ACTION III : Coordinate with Township Health Department and Pharmacy Companies to donate medicine	3	Phone Call		Health Program Manager (HSS)
ACTION IV : Quarterly community engagements to share about Basic EPHS during VTHC Meeting	1	4 x VTHC Meeting	800 USD x 4	Clinic-in-charge
ACTION V : Advocate to the public about health workers achievements and challenges during quarterly village meeting	1	4 x VTHC Meeting	50 USD x 4	Clinic-in-charge

STRATEGY	PRIORITY	TARGETED OUTPUT	ESTIMATED COSTS	RESPONSIBILITY
Availability (Service Delivery)				
ACTION I : Capacity building of health worker according to Basic EPHS	4	1 x Workshop 1 x Training	1500 USD x 1 7000 USD x 1	Health Program Managers & Quality Improvement Team
ACTION II : Arrange training for Leadership and Management Skills	3	1 x Training	3000 USD x 1	Admin & HR Officer
ACTION III : Arrange internal experience sharing session to reduce the gaps between available services and burden of diseases and arrange internal cross exchange visit	3	1 x Cross-ex-change Visit	3000 USD x 1	Health Program Manager (MNCH)
ACTION IV : Meeting to standardize 10 Forms, arrange Clinical Super-vision Workshops and Applica-tion of 10 Forms accurately and consistently to estimate the use of medicine monthly to prevent stock out	1	1 x Workshop 1 x Follow-up Workshop	1500 USD x 2	Health Program Manager (HSS) & Quality Improvement Team
ACTION V : Monthly health education to the public	2	12 x HE Cam-paign	50 USD x 12	Clinic-in-charge
Availability (HRH)				
ACTION I : Update Standard Clinic Structure	2	2 x Clinic Meeting	100 USD for Vinyl Printing	Clinic-in-charge
ACTION II : Update job descriptions of health workers in each clinic	1	2 x Clinic Meeting		Clinic-in-charge
ACTION III : Coordination meeting with Local Authorities to discuss about regular stipend and allow-ance	3	Link meeting with Local Authority for Standard Clinic Design		Deputy Direc-tor & Clinic-in-charge
ACTION IV : Monthly Clinic Staff Meeting	2	12 x Clinic Meeting		Clinic-in-charge
ACTION V : Training of health worker ac-cording to local burden of disease and for proper data collection according to guideline	3	4 x Training	100 USD x 4	Clinic-in-charge

STRATEGY	PRIORITY	TARGETED OUTPUT	ESTIMATED COSTS	RESPONSIBILITY
Availability (Infrastructure)				
ACTION I : Advocate quarterly during village meeting for community contribution towards the maintenance of health facility	2	Link with VTHC Meeting		Management Team & Clinic-in-charge
ACTION II : Advocate for better coordination with MoHS for referral process and advocate quarterly during village meeting for referral cost and educate the community about referral process	5	Link with VTHC Meeting		Management Team & Clinic-in-charge
ACTION III : Internal coordination meeting to discuss about creating proper medicine storage areas in each clinic	1	8 x VTHC Meeting	1000 USD x 8	Management Team
Acceptability				
ACTION I : Training and follow up to clinic workers to have proper record keeping practice during community engagement meetings and make decision with those records	3	8 x 2 days training	250 USD x 8	Health Program Manager (MNCH) & Clinic-in-charge
ACTION II : Training and follow up to clinic workers to have proper record keeping practice during ANC and OPD	3	Link with above training		Health Program Manager (MNCH) & 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

- Security 1: No document for health worker and clinics in case of requests from Union military forces
- Security 2: For logistics and outreach services, it is easy to meet military troops en route
- Funding could stop as only ever guaranteed for a short period at a time
- Registration of organization has not been possible – unclear what will be outcome.
- Renting house so expensive could be forced to move out of offices

Risk Mitigation Activity

- Joint with Township Health Department, Relief International have now issued documents for health workers and clinics for 4 clinics in 2 townships as well as for those approaching the other five clinics (but remains to be tested). Same as above.
- No apparent solution
- Need to prepare a Fundraising Strategy, or 5- year plan
- Need to do homework, research and collect information
- Should buy a land and build own house. Will approach to Private donors

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