Post Nargis Recovery and Emergency Preparedness Plan (PONREPP)

Implementation and Management Arrangements
Health PONREPP

"Description of the Action"

October 30,2009

TABLE OF CONTENTS

TABLE OF ABBREVIATIONS

AMW: Auxiliary Midwife
ASEAN: Association of South East Asian Nations
BCC: Behaviour Change Communication
BHS: Basic Health Staff
CDC: Communicable Disease Control
CHW: Community Health Worker
DHF: Dengue Haemorrhagic Fever
DTP3: Diptheria, Tetanus, Pertussis 3
EOC: Emergency Obstetric Care
EPI: Expanded Programme of Immunization
GAM: Global Acute Malnutrition
GAVI: Global Alliance Vaccine Initiative
HepB: Hepatitis B
HSS: Health System Strengthening
IEC: Information Education Communication
LLITN: Long-Lasting Insectide Treated Bednet
MCH: Maternal and Child Health
MUAC: Mid-upper arm circumference
MW: Midwife
NHSC: National Health Sector Coordinating (Body)
NGO: Non-Governmental Organization
OPV: Oral Polio Vaccine
ORS: Oral Rehydration Solution
PHC: Primary Health Care
PONJA: Post-Nargis Joint Assessment
PONREPP: Post Nargis Recovery and Preparedness Plan
RHC: Rural Health Centre
Sub-RHC: Sub-Rural Health Centre
TCG: Tripartite Core Group
TMO: Township Medical Officer

Summary

Background: The Nargis Cyclone in May 2008 affected the lives of 2.4 million people with an estimated loss of 140,000 lives. Since that time, despite some improvements in health service access and health outcomes, there are persisting problems of low service coverage for maternal health, sub-optimal nutritional status, and pockets of very low health service access in hard to reach areas. In December 2008 the Tripartite Core Group (Government of the Union of Myanmar, ASEAN and UN partners) approved the Post Nargis Recovery and Preparedness Plan (PONREPP). Chapter 4 of the plan, section 4.1 outlined the recovery plan for health in 11 townships most affected by Cyclone Nargis.

Objectives: The core objective of the proposed 3 year "Health PONREPP" programme is to increase access to essential maternal and child health services amongst hard-to-reach populations in areas most affected by Cyclone Nargis. The programme will result in enhanced provision of, and access to, quality basic maternal and child health care services (including nutrition and immunization). Psychosocial needs of affected populations will be met whilst mitigation of future risks will be achieved through a focus upon emergency preparedness.

Prioritization: The "Health PONREPP" programme has been prioritized in the following ways:

- A focus on the needs of pregnant women and children under 5 years
- Agreement by all partners on a core minimum set of essential services focused on primary and community level of care which will meet the health needs of the targeted beneficiaries
- A common approach by all partners to ensure effective coverage of services
- Selection of most affected townships and ranking of these townships according to current needs based on data regarding Cyclone damage, deaths and existing levels of service coverage
- Ensuring equitable allocation of resources across a geographical area affected to varying degrees of severity by Cyclone Nargis. Provision of an irreducible core package of services will be initiated in townships most severely affected by Cyclone Nargis with sequential implementation across townships, based upon ranking of severity of impact of Nargis amongst townships as well as existing needs.
- Within each township, identification of most hard-to-reach populations through a joint assessment

Programmatic design: The "Health PONREPP" programme has been designed in line with approaches recommended as being most effective and efficient in delivering enhanced maternal and child health outcomes. The core minimum (irreducible) package of services is aligned with guidance regarding minimum maternal and child health services, including high impact child survival interventions as identified in the Lancet 2003 series[1]. The minimum package of services described in the "Health PONREPP" is consistent with the package of interventions for maternal and child health as agreed in the recent international *Consensus on Maternal and Newborn Health* (2009)[2]. Additional to the package are interventions which will address the psychosocial needs of survivors of Cyclone Nargis as well as better protect them against future risks, through a focus upon emergency preparedness. The package of services was reviewed at a MOH/Health

[1] Jones G *et al*. How many child deaths can we prevent this year? Lancet, 2003, 362: 65-71
[2] The Global Campaign for the Millenium Development Goals. Leading by Example. Protecting the Most Vulnerable during the Economic Crisis (2009)

PONREPP Coordination meeting conducted on October 26 and 27 2009 in Nay Pi Taw, with modifications subsequently being made based on policy recommendations of the Ministry of Health departmental and program directors.

Scope of Work: The work undertaken by the MoH and Health Cluster between the period May 2008 until June 2009 averted disease outbreaks and levels of malnutrition usually associated with the aftermath of natural disasters. This was possible through a collaborative and joint approach to providing health services between the Ministry of Health and other agencies working through the Health Cluster. The MoH has requested that health agencies undertake recovery activities through the same coordinated approach. This programme builds on the effective coordination of the health response to the Cyclone, particularly at township level:

1. A joint assessment and planning of services with township medical officers and MoH, and other health stakeholders in the township will ensure efficient and effective delivery of services and no duplication of effort to maximize impact.
2. An agreed *programme* rather than *project* approach across each township will ensure that basic core services are delivered consistently across partners
3. Emphasis on coverage of services with priority to populations who are hard to reach because of their distance from health facilities or because they face other barriers. This needs assessment will be conducted jointly by township medical officers and agencies in each township as well as drawing on the findings of Periodic Review II.
4. Providing support to Basic Health Staff and expanding Volunteer Community Health Workers and Auxiliary Midwives to maximize vaccination campaigns undertaken by MoH and provision of essential medicines and health promotion in line with the technical guidelines set by MoH.

It is proposed that in each township, a Health PONREPP Joint Work Plan will be developed encompassing a maternal and child health scope of work to be conducted under the leadership of the Township Health Authorities and communities in partnership with Implementing Partners (NGOs and international agencies). The work plan should reflect all inputs in the Township relating to the scope of work. This scope of work will be guided by Ministry of Health policies and guidelines for service delivery, essential drug and equipment lists and health management. This work plan will be based on a situation analysis of Township health needs conducted by the TMO and health partners, and the plan will be developed with policy guidance from the Division Health Director and MOH and with the technical support of UNICEF and WHO. Service delivery will prioritize primary health care at rural health centre, sub-rural health centre and community level. This approach will ensure a structured and coordinated response to the most pressing health needs of the most vulnerable of the Cyclone survivors.

Beneficiary selection: pregnant women and children under 5 years have been prioritized as beneficiaries to be targeted under this township programme and the package of services has been designed to reduce preventable causes of morbidity and mortality amongst these groups. Comprehensive township assessments will furthermore identify and prioritize the 'hard-to-reach' areas and populations within each township. There will be an analysis of barriers limiting access to health care. Pilots will be initiated in order to address financial barriers being faced by those unable to afford the costs associated with illness.

Expected Outcomes*:* The Results Framework reflects the maternal and child health focus of Health PONREPP. As well as describing maternal and child health program baselines, the results framework also identifies health system outputs in such areas as health service delivery, human resource development and emergency preparedness. Expected health outcomes include improved

access to professional birthing services by mothers, improvements to immunization and ante natal care coverage, and reduced rates of malnutrition. As a measure of the shift from emergency care to longer term recovery efforts, there will be a focus upon increased capacity for delivery of an essential package of MCH services, improved availability of essential drug supplies, establishment of community based financing schemes and strengthened Township NGO coordination mechanisms at the Township level.

During the initial 12 months of project implementation, expected results include:

- 48,700 children under one year vaccinated against measles
- 40,000 children vaccinated against Diphtheria, Pertussis and Tetanus
- 24,700 pregnant women give birth whilst receiving care from a skilled birth attendant
- 1,200,000 people provided with essential health care
- A 10% increase above baseline of pregnant women given tetanus toxoid vaccinations
- An increase from a baseline of 51% to a target of 60% of all under fives appropriately treated with oral rehydration solution for diarrhoea
- 26,700 mothers exclusively breastfeeding their infants
- 2,800 malnourished children treated with a reduction of levels of GAM from 2% to 1%

Expected outputs for subsequent years of programme implementation will be detailed during the process of setting achievement targets for year 2 and 3 implementation goals.

Governance and Management Arrangements*:* Areas of work, eligible for funding under the Health PONREPP, have been prioritized by Health Cluster partners and are in line with the National Health Strategy. A Health PONREPP Steering Committee consisting of one representative of bilateral donors, one representative from each of two UN agencies (WHO & UNICEF), the nominated MoH Focal point for Health PONREPP, an independent public health expert[3] as well as one representative of INGOs will oversee the implementation of the Health PONREPP. A Health PONREPP Advisory Group will be the main stakeholder consultation and coordination forum for all partners of the PONREPP. The Advisory Group will consist of the MOH Focal Point for the Health PONREPP, bilateral and UN agencies, and former NGO Health Cluster members. A Fund Management Agency will be established by UNOPS, with the principal functions of holding and disbursing funds, administering grant allocations and receiving proposals and undertaking performance monitoring. In line with UNICEF's current activities, UNICEF will assist in technical support to the Fund Manager regarding maternal and child health programming as well as procurement mechanisms to ensure quality standards and policy guidelines are maintained. WHO, along with the MOH Focal Point, through membership of the Steering Committee will provide a policy link between the Steering Committee and the Ministry of Health in Nay Pyi Taw.

Approval Mechanisms*:* Initial design and start up funds will be provided to WHO. The organization in collaboration with the Department of Health will assist the targeted townships to conduct a health needs assessment and develop a Health PONREPP JointWork Plan. The Township Health PONREPP JointWork Plan will reflect MCH resource inputs from all sources. The plan will then be technically assessed by the Health System Strengthening Technical Working Group at the Ministry of Health. A meeting will be convened with the TMOs and Divisional Health Directors and interested implementing partners to review and assess the plan.

[3] The independent public health expert will be a public health expert without any institutional affiliation to Health PONREPP partners.

Following review and technical approval, the plan will then constitute the basis for a funding request to the Fund Manager with funding approval provided by the Steering Committee. Following response to advertised "expressions of interest" to support Health PONREPP implementation, the Steering Committee will grant the successful Implementing partner the opportunity to implement activities contained within the Health PONREPP Joint Work Plan. This mechanism is similar to the Global Fund mechanisms after approval from the country Coordination Mechanism.[4] On plan completion and following technical review and approval, a Service Agreement will be negotiated between the Fund Manager and Implementing Partner for the period of available funding.[5]

Implementation and Coordination Arrangements: In terms of implementation, funds approved by the Steering Committee will be channeled to service "Implementing partners" through the Fund Manager. A Service Agreement will be signed between UNOPS (Fund Manager) and the implementing partner specifying organizational obligations, payment mechanisms and audit, and procurement and reporting arrangements. Deliverables in the Service Agreement will be based on the eligible activities within the MOH approved Health PONREPP Joint Work Plan for the Township. The service Implementing Partner (NGO, UN agency / international organization or consortiums including several UN agencies/NGOs/CBOs would be eligible for funding) will be responsible for technical and financial support to implementation and monitoring of the activities of the Health PONREPP Joint Work Plan for the Township. Pending development of standard operational procedures for financial management at Township level (under development through GAVI HSS) and fiduciary risk assessment, it may be feasible for Township Health Authorities at a subsequent date to also submit expressions of interest to the Fund Manager. As a matter of procedure, the TMO and township implementing partners will be signatories to township plans; specific partnership and coordination arrangements will also be detailed in the township Health PONREPP Joint Work Plan.

Budget and Timeline The cost of implementation of Health PONREPP over a three year timeframe was estimated in the February 2009 PONREPP document as being $43.5 million (excluding facility restoration). Costing estimates for health PONREPP were undertaken by an independent public health financing expert whose secondment ??to the Health Cluster in November 2008 was organized by ASEAN. Costing estimates were made using financial budgeting information made available by organizations currently implementing similar core packages of intervention in Myanmar. Costings were also based upon international guidance. This sum of money covers outcomes 1a, 1b, 2, 4, 5, 6, and 7 as detailed in the Monitoring and Evaluation Framework (see Annex 12). Mechanisms for facility restoration are not within the scope of work detailed within this document, which describes management and implementation arrangements for delivery of a core package of services[6].

The amount of funding to be sought for the Health sector under the planned ASEAN-led Post-Nargis Assistance Conference (PONAC) is $12.43 million. This is intended to cover funding for PONREPP health service delivery ($11.6 million) for the initial 9 months out of its total 36

[4] Following endorsement by the Ministry of Health of Township Health Planning Guidelines, implementing partners and Townships will be able to apply a consistent planning methodology with consistency in costing guidelines.

[5] A detailed plan with objectives, activities and costs will only be required for 1 year.

[6] Facility restoration was initially budgeted at $10.3 million however this figure has been revised downwards to $755,000 based upon prioritization of remaining unreconstructed health facilities using data provided by MoH. Funds to cover these costs will be sought under the planned ASEAN-led Pledging Conference.

month period of implementation. During the PONAC, an appeal will be also made for $ 800,000 for health facility restoration.

The amount of funds planned to be managed by the Fund Manager (UNOPS) and expended over the initial 9 months of implementation of this project are $11.6 million, since this document does not describe management arrangements or funding mechanisms for health facility reconstruction. Currently, funding (3 million pounds sterling) has been committed by DFID for Health PONREPP over a 2 year period, with additional funding opportunities from other donors expected through the planned ASEAN-led pledging conference. The overall cost of implementing the Health PONREPP, for 36 months, as described in this Description of Action document is $43,500,000 which is in line with the budgeted figure in the PONREPP for non-construction activities of $43, 500,000.

The figure of $43,500,000 includes non-service delivery related outcomes detailed in the Results Framework (outcomes 5: Human Resource and Training Plans; outcome 6: Increased access to Health Services by the extremely vulnerable and poor households and outcome 7: Emergency Preparedness and Response Capacity strengthened). The total 3 year planned expenditure on service-delivery related activities is $37,800,000 which is equivalent to a per capita annual expenditure of $5.1/capita/year. The per capita budgeting is in line with that suggested in a large number of recent health financing guidance publications (usually $4-5/capita/year), though none of these publications have addressed or quantified the additional cost of implementing such a programme in the aftermath of a large and complex natural disaster and are not therefore strictly comparable. Many of these per capita calculations exclude administrative costs for grants, whereas the figure quoted here is inclusion of such costs. The figure of $5.1/capita/year outlined as the cost for this programme is a significant saving when compared to other small scale project based approaches to addressing causes of maternal and child health morbidity and mortality and therefore represent significant efficiency savings[7].

Funds committed to this project will be allocated to townships, in line with the ceiling township budgets presented below, sequentially and as funds are made available from donors to the overall programme. Implementation will proceed township by township, as funds are committed. Allocation of funds to townships will be undertaken on the basis of matching available funds to townships in line with the severity of impact of Cyclone Nargis. Initial commitments will be made to townships where the severity of impact of Nargis on the health of the population and damage to the health system has been greatest. Published data strongly supports an approach of delivering a core package of services in order to reduce maternal and child health morbidity and mortality[8].

This approach therefore takes into consideration both equity and efficiency. Maximal efficiency depends on fully funding a core package of services across an entire township as opposed to funding a partial package over many townships. Equity is addressed in this proposal by allocating funds as they are made available using a methodology which ranks townships as having been differentially affected by Nargis.

[7] Investing in Maternal, Newborn and Child Health. The Case for Asia. http://www.adb.org/Documents/Brochures/Maternal-Child-Health/Investing-Maternal-Child-Health.pdf Signatories to this document included ADB, AusAID, CIDA, JICA, DFID, USAID, UNICEF, WHO,
[8] Investing in Maternal, Newborn and Child Health. The Case for Asia. http://www.adb.org/Documents/Brochures/Maternal-Child-Health/Investing-Maternal-Child-Health.pdf

Ranking of severity of effect of Nargis	Township	Population covered under PONREPP plan	Cost of initial 9 month implementation period[9] (USD)	Costs over 3 year implementation period (USD)
1	Labutta	390,000	1,800,000	6,750,000
2	Bogalay	286,000	1,350,000	5,062,500
3	Dedaye	213,000	1,000,000	3,750,000
4	Mawgyun	270,000	1,270,000	4,762,500
5	Ngaputaw	332,000	1,550,000	5,812,500
6	Kyaitlatt	177,000	850,000	3,187,500
7	Pyapon	239,000	1,125,000	4,218,750
8	Kungyangone	114,000	565,000	2,118,750
9	Twante	202,000	960,000	3,600,000
10	Kawhmu	125,000	610,000	2,287,500
11	Kyauktan	104,000	520,000	1,950,000

Table 1: Planned financial expenditures per township. These figures include overall expenditures for outcomes 1a, 1b, 2, 4, 5, 6, 7 as detailed in the Monitoring and Evaluation Framework (see Annex 12).

Total number of townships covered	Total population covered under PONREPP plan	Total costs of initial 9 month implementation period (USD)	Cumulative costs of implementation for months 0 – 36 (USD)
11	2,452,000	11,600,000	43,500,000

Table 2: Planned overall financial expenditures. These figures include overall expenditures for outcomes 1a, 1b, 2, 4, 5, 7, 8 as detailed in the Monitoring and Evaluation Framework (see Annex 12).

Conclusion: This "Description of the Action" was developed in consultation with the Health Cluster (the now renamed Health PONREPP Advisory Group). Based on this consultation and written drafts, a discussion paper was developed and reviewed with the Ministry of Health in Nay Pyi Taw on September 10 2009. As an outcome of these discussions, amendments were made to the draft and expanded into this "description of the action" document. The document is divided into 4 sections: (1) Summary, (2) Rationale, (3) Description and (4) Procedural Annexes. The procedural annexes detail terms of reference of stakeholder groups, draft service agreements and expressions of interest, essential packages of services and a monitoring & evaluation framework.

PART 1 Rationale

Country and Development Context

A National Health Policy was developed in 1993, of which the main objectives include achieving "health for all" goal, using primary health care approach, producing sufficient as well as efficient human resources for health, expanding health services not only to rural but also to border areas so as to meet overall health needs of the country, and augmenting the role of the private sectors and non government organizations in delivery of health care in view of the changing economic system.[10]

The National Health Plan developed more specific objectives for the 2007 – 2011 period addressing most of the health objectives outlined in the National Health Policy above, but also including a focus on mother, newborn and under 5 child health,[11] reducing under 5 mortality rate, infant mortality rate and neo natal mortality rate by one third of existing rate by 2011,[12] providing health services through an integrated approach, and accelerating health development activities with stronger linkages with National and International NGOs.[13]

The National Health Plan describes the significant progress made in recent years in hospital expansion, curative care, technology introduction and private sector expansion. However, there are persisting high rates of communicable disease and high infant and maternal mortality rates. This is attributed to fundamental weaknesses in the health care system, particularly in rural areas. In the last planning cycle, there was inability to expand the number of rural health centres as planned and provide essential drugs and equipments to facilities. This situation is exacerbated by high rural health staff turnover or insufficient staff numbers, financial limitations, and high out of pocket expenditures on health by the population.[14]

The Nargis Disaster and Health Impacts

The cyclone in May 2008 affected the lives of 2.4 million people with estimated loss of 140,000 lives. A recent (second) Periodic Review has documented persistent outstanding and unmet needs, especially in hard-to-reach areas. Livelihoods are still insecure, and 74% of the population still has inadequate shelter. 58% of the population relies on agriculture for livelihood, and 46% on casual labour. There are pockets of severe food shortages particularly in the hardest hit areas of Labutta and Bogalay. Currently, 32% of the population treat their water inadequately, and 43% use adequate sanitation facilities.

Cyclone Nargis had a severe impact on the health system and its capacity to deliver essential services, with the destruction of 130 health facilities and significant damage to another 500 facilities. At the same time, the cyclone increased healthcare needs and decreased the ability of families to pay for treatment,[15] especially amongst families living in the 11 most severely affected

[10] Ministry of Health National Health Plan 2007 - 2011
[11] Objective 3.1 National Health Plan Pg 59
[12] Objective 3.1 National Health Plan Pg 79
[13] Objective 2.6 National Health Plan Pg 23
[14] National Health Plan Pages 1 – 3. Also GAVI Health System Strengthening proposal. 2008
[15] In 2005 almost 90% of health expenditure was accounted for by out-of-pocket costs to families while the public sector accounted for just over 10% (WHO: National Health Accounts data base (2008). A visit to a Sub-Health center averaged K1,000, and a mid-wife charges about K10,000 per delivery (Ministry of Health, 2008)

townships included under this plan. There has been a significant reduction in access to village level basic health services and an increased need for better ambulatory health care (colds, fever, diarrhoea and respiratory problems). Trauma and injury accentuated by the cyclone accounted for 8 percent of facility visits in the immediate aftermath of the cyclone.

In terms of health care access, only 32% of deliveries are attended by trained health personnel with 87% deliveries at home. Although household respondents to Periodic Review II reported that most health clinics were well staffed and supplied with adequate medicines, in some coastal areas access remains a problem with more than 1 hour travel required to reach facilities. Distance, use of household remedies and financial barriers are cited by the population as the most common causes for not accessing facilities.[16] The consultation rate of 1.9 contacts per household head has met the target of the health cluster, however periodic Review II points out that it falls short of the optimal standard set in the SPHERE humanitarian standards guidelines for an average of 4 new consultations per person per year among populations in an unstable context. [17]

Nutritional status has improved from Periodic Review 1, with Global Acute Malnutrition (MUAC < 125mm) declining from a mean of 5% to 2% in sample areas. For the category "malnourished" or "at risk of malnutrition" (MUAC < 135mm) the result is 13%, although there are wide variations in villages from 0% to 40%. [18] The incidence of fever in children in the last 14 days had declined from 40% in Periodic Review 1 to 21% in Periodic Review 2 (i.e. within 1 year). Incidence of diarrhoea remains unchanged, with 1 in 5 children between the ages of 6 months and 5 years having diarrhoea in the last 14 days as reported by their care giver, with 51% of those affected being treated with ORS. Measles immunization coverage remains high at 88% (1 vaccination) but once again there are wide variations in coverage in the target area with village coverage ranging from 36% to 100%.

Finally, although 23% of respondents had a family member with (or had observed) psychological problems arising from Cyclone Nargis, only 11% of those with problems reported having received treatment.

Post Nargis Recovery Efforts

Three weeks after Nargis, a Health Cluster was formally convened by WHO and co-chaired by Merlin. Ministry of Health appointed a Focal Point Dr Kyan Nyunt Sein, Deputy Director-General for Disease Control in order to ensure that relief efforts were maximally coordinated.

In December 2008 the Tripartite Core Group (Government of the Union of Myanmar, ASEAN and UN partners) approved the Post Nargis Recovery and Preparedness Plan (PONREPP). Chapter 4 of the plan, section 4.1 outlined the recovery plan for health in the 11 townships most affected by Cyclone Nargis. An important development in this plan is the transition from emergency assistance post disaster to longer term humanitarian assistance. Harmonization of PONREPP with government recovery planning was an important objective of PONREPP, to which all stakeholders subscribed. These overall recovery objectives are mirrored in Phase II of the Myanmar Government "Programme for Reconstruction of Cyclone Nargis Affected Areas and Implementation Plans for Preparedness and Protection from Future National Disasters." This plan outlines in detail the multi sector needs for reconstruction and recovery, including infrastructure

[16] PONREPP 2nd Periodic Review 2009 Page 11
[17] PONREPP 2nd Periodic Review 2009 Page 11
[18] PONREPP 2nd Periodic Review 2009 Page 13

and equipment needs of the health sector in the delta area. The Ministry of Health has also developed a "Post Nargis Recovery Plan of Action" which outlines 13 main activities for recovery.

This Health Cluster has now evolved into a group responsible for ensuring efficient implementation of longer-term recovery plans. On the 5th June 2009, the MOH appointed a focal point for this Health Recovery Planning Group responsible for PONREPP implementation (Deputy Director General for Disease Control) and agreed to implementation of the health PONREPP over the next 3 years.

The Health PONREPP and its coordination arrangements relates to a wider multi sector post Nargis PONREPP governance framework that is outlined elsewhere,[19] and that will not be the subject of this paper. This document details the implementation and governance arrangements for the Health PONREPP that are specific to the health sector. Following consultations undertaken with the Ministry of Health in Nay Pyi Taw from Sept 9 to 11, and subsequently with development partners (WHO, UNICEF, DFID, UNOPS, 3D Fund, Health Cluster) from September 14 – 18, consensus was reached on the recommendations for implementation and governance arrangements, which permitted a more detailed design of this "Health PONREPP Management Arrangements" document, (elsewhere referred to as the "Description of the Action") that will in turn guide implementation of the Health PONREPP beginning in the final quarter of 2009 and for a total duration of 3 years.

Lessons Learned from Early Implementation

The health PONREPP builds on lessons learnt during the relief response to Cyclone Nargis, concerning the importance of coordination in the delivery of aid, as well as the need for the full participation of affected communities in the planning, implementation and monitoring of programs. The response to Cyclone Nargis benefitted from effective coordination through ASEAN and the TCG, OCHA and the Cluster system. The Health Cluster brought together the agencies involved in the health relief effort, promoting communication and coordination. The health PONREPP will continue working through the coordination mechanisms shown to be successful during the relief period, adapted to fit the early recovery phase. Additionally, more recently, consultations with the MOH have highlighted the need to strengthen coordination linkages not only between NGOs and Township Health Authorities, but also between developments in Health PONREPP planning and initiatives in health system strengthening currently being undertaken by the Department of Health in Nya Pyi Taw.

The aftermath of Cyclone Nargis also demonstrated the resilience of the affected villages and the capacity of communities to help themselves and implement relief activities. At the village level traditional social welfare support systems all played a role, and new self-help groups were formed spontaneously by survivors. The numerous initiatives that emerged in the initial stages following the cyclone continue to contribute to recovery and reconstruction. The participation and involvement of village and township communities will therefore be an essential guiding principle for the implementation of the health PONREPP. Participation is also important as global best practice, and because the diversity of villages in the Delta demands a local approach. Due to the

[19] Tri Partitie Core Group Post Nargis Recovery and Preparedness Plan 2008

large number of actors involved in the relief effort, the degree of participation has varied. This suggests that agreeing on common approaches is very important. Coordinating health recovery work through the health PONREPP will facilitate the implementation of common approaches across Townships.

PART 2 Description

Objectives

Activities carried out under the health PONREPP will focus on improving maternal and child health care, thus contributing towards the achievement of Millennium Development Goals 4 & 5.

The core objective of the proposed programme is to ensure restoration and appropriately enhanced provision of and access to quality basic primary health care services (including nutrition) with a strategic emphasis on improved maternal and child health outcomes.

It is proposed that access to primary health care should be restored through both supply side interventions (better quality health services) and demand side interventions (including surveillance and subsidies for hard to reach and vulnerable populations).

The ability of hard-to-reach populations to access health services is at the forefront of health response planning and programming. To that end, key priorities include the development of:

(i) Essential services for maternal and child health delivered through rural health centres, sub centres and community health workers
(ii) Referral system including for emergency obstetric care
(iii) Training for basic health staff and community health workers
(iv) Psychosocial support and nutrition interventions in response to the specific needs of the population
(v) Disaster risk reduction through village training on emergency health preparedness and an integrated disease surveillance system
(vi) Joint township needs assessment, prioritisation of hard-to-reach populations and coordinated work planning
(vii) Pilots to increase access to services for vulnerable populations

All parties have agreed that as a matter of principle there should be one integrated implementation plan, drawing on pooled funds to the extent possible and that there is a need to sustain and enhance current coordination and information sharing arrangements at the township level between delivery agents, communities, technical agencies, and the MoH.

The design and implementation of these activities will take place in close consultation with the Department of Health, Division Health Directors, Township Health Managers, Basic Health Staff, communities, as well as with NGOs and the private sector.

Cross Cutting Issues

The programme will meet the needs of the most vulnerable, in terms of restoring and enhancing provision of and access to quality basic primary health care services through both supply side and demand side interventions. Hard-to-reach populations will be identified through comprehensive needs assessments that will assist to prioritize service provision in the Health PONREPP Joint Work Plan. The programme will promote equal access to healthcare, including interventions to ensure that financial constraints do not limit opportunities to access health services.
Health PONREPP is based on the following guiding principles: effectiveness, transparency and accountability, self-sufficiency and capacity-building, a focus on the most vulnerable groups,

strengthening communities, the need to determine at which level decision-making is best undertaken and how best to support and promote better decision-making and oversight.

As outlined in the country and sector context in the rationale section, the health PONREPP aims to align with Ministry of Health policies and initiatives. This is seen as a crucial entry point for delivering effective maternal and child health services. Basic Health Staff are employed as well as salaried by MoH and are responsible for maternal and newborn care. However prior to Cyclone Nargis, there had been very few possibilities for international actors wishing to improve MCH service delivery through support to health clinics and staff. Health PONREPP offers a significant opportunity for doing this. For this reason, Health PONREPP will attempt at all times to align as close as possible to health sector policies and developments in health planning and financing[20] and to Government of the Union of Myanmar and Ministry of Health Post Nargis Plans [21] and strategies for strengthening health systems,[22] as well as to the broader multi sector PONREPP arrangements.[23]

Services to Provided (Scope of Work)

The scope of work was agreed in the 2008 PONREPP document and has been refined based on discussion in the health cluster , a review of MOH plans, with reference to the MOH "Post Nargis Recovery Plan of Action" 2008 (see Table 3 below).

It should be noted that the Health PONREPP proposes an emphasis on community level activities supporting referral and improved access for the poor, particularly in matters relating to maternal and child health. There are also some areas of emphasis where Health PONREPP does not cover, such as school health and water and sanitation and placement of health staff. In other areas, as can be seen in Table 3, Health PONREPP complements the MOH Post Nargis Plan.

It is proposed that a Health PONREPP Joint Work Plan be developed encompassing the scope of work (see Table 3 below) to be conducted under the leadership of the Township Health Authorities and communities in partnership with implementing partners. The work plan should reflect all inputs in the Township relating to the scope of work[24]. This scope of work will be guided by Ministry of Health policies and guidelines for service delivery, essential drug and equipment, and health management. This work plan will be based on a situation analysis of Township health needs conducted jointly by the TMO and health partners. The work plan should be developed by the TMO and health partners at the township level under the policy guidance of the Division Health Director and MOH and with the technical support of UNICEF and WHO.

[20] Ministry of Health National Health Plan 2007 - 2011
[21] Ministry of Health "Post Nargis Recovery Plan of Action"
[22] MOH Health Sector Working paper 2008, Health System Strengthening proposal 2008 GAVI
[23] Tripartite Core Group PONREPP Plan
[24] See procedural Annex which outlines suggested contents of the Coordinated Township Health Plan)

The work plan should reflect all inputs in the Township relating to the scope of work. Implementing partners will be required to finance and technically support activities that are reflected in the work plan.

Table 3 - Health PONREPP Scope of Work (Services to be provided)

Post Nargis Recovery Plan of Action" 2008 MOH	**Health PONREPP Scope of Work (services to be provided)**
ACTIVITY 1 Mobilization of health personnel to affected areas	**Management** and coordination strengthening (planning, supervision, surveillance, M & E, referral systems for obstetric care) (meetings, training programs, transport, accommodation) Conducting of **capacity building** programs for community health workers, auxiliary midwives and basic health staff (travel and accommodation costs, training materials)
ACTIVITY 2 Reconstruction and Renovation of damaged facilities	**Infrastructure** renovation[25] and logistics procurement including transport capital
ACTIVITY 3 Restoration and replacement of health staff	-
ACTIVITY 4 Replenishment of equipment, logistics, medicines and supplies to health facilities	Procurement of **essential drugs and equipment** (procurement of essential MOH/UNICEF standardized MC drug and equipment kits)
ACTIVITY 5 Strengthening of early detection and Rapid response of disease outbreaks	Supporting provision of **minimum essential services** for MCH, including nutrition, EPI and CDC at all levels of the Township Health System
ACTIVITY 6 Immunization	As Above for essential services
ACTIVITY 7 Dengue prevention and control	-
ACTIVITY 8 Protein energy Malnutrition Control	As Above for essential services
ACTIVITY 9 Reproductive Health	As Above for essential services
ACTIVITY 10 Restore and maintain programs such as TB, HIV AIDS and leprosy	-
ACTIVITY 11 Mental Health	Psychosocial support in response to the specific needs of the population
ACTIVITY 12 Water and Sanitation	-
ACTIVITY 13 School Health	-
PART B Comprehensive Plan for Future Disaster	Comprehensive **emergency planning** for future disasters
	Developing and implementing small scale **demand side initiatives** for improving access to MCH services for the very poor (village health funds, support for referral systems, strengthening village health committees) Providing logistics and operations support for **health outreach** programs (transport and logistics, operational costs, equipment drugs and supplies) Providing support for **health education** and community participation activities (communication meetings, IEC materials, CHW kits, AMW kits, clean delivery kits)

[25] Funding for health facility restoration will occur through mechanisms outside of management and implementation arrangements overseen by UNOPS as Fund Manager and detailed in this document

Expected Results

The health PONREPP has a Results Framework, which has been agreed by the Tripartite Core Group. The M & E framework and baseline will be contained in each Coordinated Township Health Plan, and will form a component of each proposal for Health PONREPP funding to the Steering Committee. The M & E targets for 2010 and 2011 will be updated based on the results of further analysis of the Second Periodic Review. The Results Framework is annexed in detail in the Expected Results in the Procedural Annex. The Results Framework reflects the maternal and child health focus of Health PONREPP. As well as describing maternal and child health program baselines, the Results Framework also identifies health system outputs in such areas as health service delivery, human resource management, infrastructure development and emergency preparedness.

Stakeholders

Hard-to-reach and vulnerable populations living in cyclone-affected areas will be the final beneficiaries of the health PONREPP, in particular pregnant women and children. The main stakeholders will be Ministry of Health and technical government staff at central, township (including Township Coordination Committees) and community levels, local NGOs, private sector providers and communities and INGOs, community based organizations and UN and bilateral funding agencies

Ministry of Health: Priorities were identified in close consultation with the MOH and are fully consistent with the strategic focus of the Ministry's Post-Nargis Recovery Plan of Action. The Ministry of Health has appointed a Focal Officer for the further development of the implementation plan for the health PONREPP. Final discussions took place with Ministry of Health Departments in Nay Pyi Taw on September 10 2009 to reach consensus on management and implementation arrangements. A role was specified for the Health System Strengthening Technical Working Group at the MOH to facilitate technical review and approval of Health PONREPP Joint Work Plan.

UN agencies: WHO has been co-lead of the Health Cluster whilst UNICEF has led the Nutrition Cluster. Both agencies have provided Cluster leadership at township/hub levels during the Cluster lifetime. WHO has been co-lead of the Early Recovery sub-group whilst UNICEF has provided key inputs to the Health PONREPP based upon its expertise in the field of child health programmes. Inputs to the plan have been provided by UNFPA and IOM for the elaboration of the health PONREPP. UNOPS has been consulted regarding its capacity to act as a Fund Manager.

NGOs: Merlin has been co-lead of the Health Cluster as well as the Early Recovery Sub Group for the development of the Health PONREPP. There has been ongoing consultation with NGOs concerning the development of the health PONREPP, existing needs and programmatic issues through the Cluster mechanism.

Donors: Donors have been consulted through the Cluster mechanisms and have provided input to the Health Cluster and Early Recovery Group discussions.

Local NGOs and private sector providers: Discussions will be carried out at township level in order to ascertain the capacity of local organisations to contribute to PONREPP, as well as to

engage with them on the needs in their communities. The MoH has agreed to a role for Community Based Organizations within Health PONREPP, including under a partnership arrangement through NGOs.

Communities: Communities will be involved in the health PONREPP though Village Health Committees, community based financing schemes/demand-side initiatives as well as emergency preparedness planning for health.

Beneficiaries and Target Areas

The beneficiaries of the health PONREPP will be hard-to-reach and vulnerable populations living in cyclone-affected areas within 11 selected townships (see table 4 for details). Township health assessments will identify hard-to-reach-areas and populations, which will be prioritised for service delivery. Service delivery will be based on minimum essential health services at rural health centre, sub rural health centre and community levels, and there will also be pilots to test new demand side approaches for those without financial reserves to ensure that financial barriers do not hinder their access to healthcare. Planning will promote an integrated approach with an effective referral system. Both Government and non-government health service providers will be included in the township health plans.

An overarching principle for the implementation of the health PONREPP is the full involvement of village and township beneficiary populations in all stages of the recovery process, from conception and planning, to implementation and monitoring. Such participation is essential as the diversity of villages in the Delta demands a local approach. In addition, the aftermath of Cyclone Nargis has already demonstrated the resilience of the affected villages and their capacity to help themselves and organize and implement relief and recovery activities.

The Health PONREPP will reflect these principles through focussing on maternal and child health, community health, psychosocial care and emergency preparedness.

Target Areas: The Health Cluster (UN/NGO grouping), in collaboration with the Ministry of Health Focal Point for PONREPP implementation, has prioritized the list of Townships for investment with the MOH based on various criteria of deaths/missing, health centre damage, PHC coverage (BHS per pop), MCH coverage (MW/AMW per pop) and cost for EPI support. Labutta, Bogalay and Dedaye were prioritized 1 and 2 and 3 respectively based on these criteria.

Table 4 - List of Townships in order of prioritization

TOWNSHIP	POPULATION	DEATHS/MISSING	FINAL OVERALL RANKING OF SEVERITY
Labutta	394,553	81808	1
Bogalay	285,909	37852	2
Dedaye	211,353	4130	3
Mawgyun	267,989	7377	4
Ngaputaw	330,058	4188	5
Kyaitlatt	177,339	12	6
Pyapon	240,091	1268	7
Kungyangone	114,771	1446	8
Twante	200,954	25	9
Kawhmu	124,311	130	10
Kyauktan	103,299	13	11

Ngaputaw township will in the future be included within the MoH GAVI program. Changes to some administrative boundaries are currently being planned. Middle Island which is currently under the administration of the Ngaputaw TMO, will in the future be incorporated within Laputta township. It is proposed that due to its geographical isolation, activities being currently undertaken in Middle Island by health agencies need to be maintained and should be funded under the Health PONREPP. A Health PONREPP Joint Work Plan could be developed covering Middle Island alone as a sub plan of Labutta Health PONREPP Joint Workplan.

Governance Structures

Figure 2 outlines the governance arrangements for Health PONREPP. Main governance structures and relationships are summarized in the following section, and are detailed in draft terms of reference in the procedural annexes.

STEERING COMMITTEE

A Health PONREPP Steering Committee to include one representative of bilateral donors, one representative from each of two UN agencies (WHO & UNICEF), the nominated MoH Focal point for Health PONREPP, an independent public health expert as well as one representative of INGOs drawn from amongst agencies not implementing Health PONREPP will review costed work plans, against eligible activities to be funded by PONREPP, as well as selection of implementing partners. The steering committee would be the main body to oversee the implementation of the health PONREPP.

FUND MANAGER

A Fund Management Agency will be established at UNOPS, with the principal function of fund manager (holding, disbursing and monitoring the performance of the Fund). The Fund Manager will issue call for expressions of interest and will receive proposals. The Fund Manager will evaluate proposals and make recommendations to the Steering Committee. Following successful grant awards, the Fund Manager will be responsible for administering grant allocations, auditing

and fund monitoring, and receiving proposals and undertaking performance monitoring in coordination with those responsible for programme monitoring and evaluation.

Funding from some donor sources managed through the UNOPS pool fund are provided within the EC Common Position or similar frameworks of support. Activities eligible for funding under this pool arrangement are defined in Annex 11. Cash handling and reporting will be in line with current arrangements for the Three Diseases Fund. Donors to the pool fund will need to jointly agree procedures for the release of funds. This may entail an approval mechanism for release of disbursements.

IMPLEMENTING PARTNERS

In terms of *implementation*, funds approved by the Steering Committee will be channeled to service implementing partners through the Fund Manager. The Implementing partners will submit expressions of interest to the Fund Manager (for approval by the Steering Committee). A Service Agreement will be signed between UNOPS (Fund Manager) and the implementing partner specifying services to be provided and organizational obligations, annual work plan, detailed budget, payment mechanisms and audit, procurement and reporting arrangements. Deliverables in the Service Agreement will be based on the eligible activities[26] within the MOH approved Health PONREPP JointWork Plan for the Township. The service implementing partner (NGO, UN/international organization, or consortiums including two or more out of UN agencies/international organization/NGOs/CBOs would be eligible for funding) will be responsible for technical support to the TMO and Township Health Coordination Committee as well as for management, implementation and monitoring of the PONREPP activities of the Health Work Plan for the Township.

TOWNSHIP HEALTH SYSTEM & MINISTRY OF HEALTH

The MOH Focal point will be the main point of liaison between the program and decision makers in the Ministry of Health in the areas of disease control, public health and health planning.

To ensure health system coordination and aid effectiveness, efforts will be made to technically link implementing partners resourcing and activities with the Township Health System. Several mechanisms will be applied to achieve this aim and will include the following:

1. Development of a Health PONREPP JointWork Plan between the TMO and stakeholders reflecting all resource inputs in the Township for the proposed scope of work.
2. Technical approval of the Health PONREPP JointWork Plan by the HSS Working Group (MOH) in Nay Pyi Taw. It is proposed that the process for technical review and approval would involve participation of implementing partners, TMOs, and Divisional Health Directors in a meeting with the HSS Working Group.
3. Regional coordination meetings every three months between the TMO health team and implementing partners under the chairmanship of the MOH Focal Point for Health PONREPP to jointly oversee implementation progress and problem solving.
4. Joint mid year and annual program reviews to review progress of the Township health PONREPP Joint Work Plans.

[26] Defined in the scope of work and approved by the Health PONREPP Steering committee

TECHNICAL PARTNERS

A *Health PONREPP Advisory Group* (formerly known as "the Cluster" consisting of funders, implementers and managers) will be the main consultation and coordination forum for all partners of the health PONREPP. Advisory Group membership will include the MOH Focal Point for the Health PONREPP, bilateral and UN agencies, and NGO Health Cluster members. Participation will be voluntary and open to all partners of the Health PONREPP.

WHO and UNICEF have provided *technical support* to the design of the health PONREPP and this will continue throughout the implementation of the PONREPP. WHO will provide overall technical guidance on policy and will be represented on the Health PONREPP Steering Committee. It will continue to provide the main technical link to the Ministry of Health on matters of policy and health system strengthening.

UNICEF will provide technical input on implementation. UNICEF is already a technical implementing partner in the Health PONREPP Townships. This organization is well placed to support UNOPS in ensuring that implementation is technically aligned with best practice guidance in the field of MCH public health approaches. UNICEF can also provide technical input to service implementing partners and Township Health authorities, particularly with respect to maternal and child health, immunization, logistics and procurement services. In line with UNICEF's current activities, UNICEF can assist in procurement mechanisms to ensure quality standards and policy guidelines are maintained.

Implementation steps

STEP 1 Joint Health Assessment

Although the scope of work has already been identified, a Joint Health Assessment will need to be implemented in order to (a) identify hard to reach areas (b) establish priority needs for psychosocial support and emergency preparedness (c) identify funding gaps for MCH health programs (d) define the Township level monitoring and evaluation baseline.

Technical support will be provided by WHO, UNICEF and the Department of Health to undertake this assessment. The scope of work for the Joint Health Assessment is included in the Procedural Annex.

STEP 2 Township Health PONREPP Joint Work Plan

Technical Approval: Health PONREPP will be one source of funding for the Health PONREPP JointWork Plan. Other available resources include UNICEF, 3DF, the Government of the Union of Myanmar as well as funding secured by INGOs from sources outside of Health PONREPP funding. Care will need to be taken there is no overlap with existing health plans and resources. This being the case, the MOH planning system will identify where Health PONREPP fits into the overall pattern of resourcing and activity in the Township.

The TMO and support staff will play a key role in plan development. A Health PONREPP Joint Work Plan will be based upon a township health needs assessment. The assessment and work

plan will be elaborated over one week through a process which will involve the relevant inputs of township health authorities as well as all agencies and stakeholders active within the township. MoH and UNICEF will provide technical support. Subsequent implementation of the work plan and coordination with all stakeholders will occur through technical, financial and any necessary management support from the implementing partner.

The MOH, through the Township management, with partners, will therefore need to technically review and approve Health PONREPP Joint Work Plan through existing health system mechanisms.

The Health PONREPP Joint Work Plan should comprise the following information:

- A brief situation analysis describing the health situation and gaps in service provision in the Township
- A description of objectives and activities covering the scope of work
- A costing (or estimate of costs) of these activities up to the township budget limit outlined on page 8.
- A description of the financial gaps that Health PONREPP will finance
- A monitoring and evaluation framework
- The coordination mechanisms at Township level

The procedural annex provides more details on the expected contents of the Health PONREPP Joint Work Plan. The plan will be assessed by the HSS Working Group at the Ministry of Health. A meeting will be convened with the TMO, Division Directors and interested implementing partners to review and assess the plan. As a matter of procedure, the TMO will be a signatory to all Health PONREPP Joint Workplan.

Following review and technical approval, the plan will then constitute the basis for call for expression of interest by the Fund Manager (UNOPS).

STEP 3 Expression of Interest Evaluation

The award of Health PONREPP funding grants to service implementing partners will be by expression of interest (EOI). The EOI documents will be prepared and issued by the Fund Manager (UNOPS) under the guidance of the Steering committee and with technical review by public health experts. NGOs, UN agencies, international organizations or consortiums including two or more out of UN agencies/NGOs/CBOs would be eligible for funding. Consideration may be given to the possibility at a later stage of Health PONREPP implementation to soliciting expressions of interest from township health officials for advance payments for designated Health PONREPP Joint Work Plan activities (see fund flow section for more detail on this option). This option would depend upon clarification at a later date on fund flow and management mechanism in townships and fiduciary risk assessments.

Figure 1 - Criteria for Expression of Interest

Criteria for Evaluation of Expressions of Interest

1. Does the EOI address identified gaps in health care provision as demonstrated in the Health PONREPP Joint Workplan?
2. Is the EOI consistent with guidelines on scope of work as described in the Health PONREPP Management Arrangements?
3. Has the service implementing partner demonstrated the capacity to implement in coordination with Township Health Authorities?
4. Is the coordination mechanism or strategy with the Township Health Authority and other township level stakeholders well described?
5. Are the financial management and reporting systems consistent with guidelines as described in the Health PONREPP Management Arrangements?
6. Is there evidence of agreement to work in Myanmar by the Implementing partner?
7. Reasonableness of costs/budgets

As a matter of procedure, the TMO will be a signatory to all Health PONREPP Joint Work Plan in order to ensure partnership and coordination arrangements are endorsed by all parties to the agreement.

The procedural annex provides details on the call for expression of interest. EOIs will be evaluated by the Fund Manager against pre-set criteria. The Steering Committee will appoint the Implementing Partner (or consortium of partners) for each health PONREPP plan.

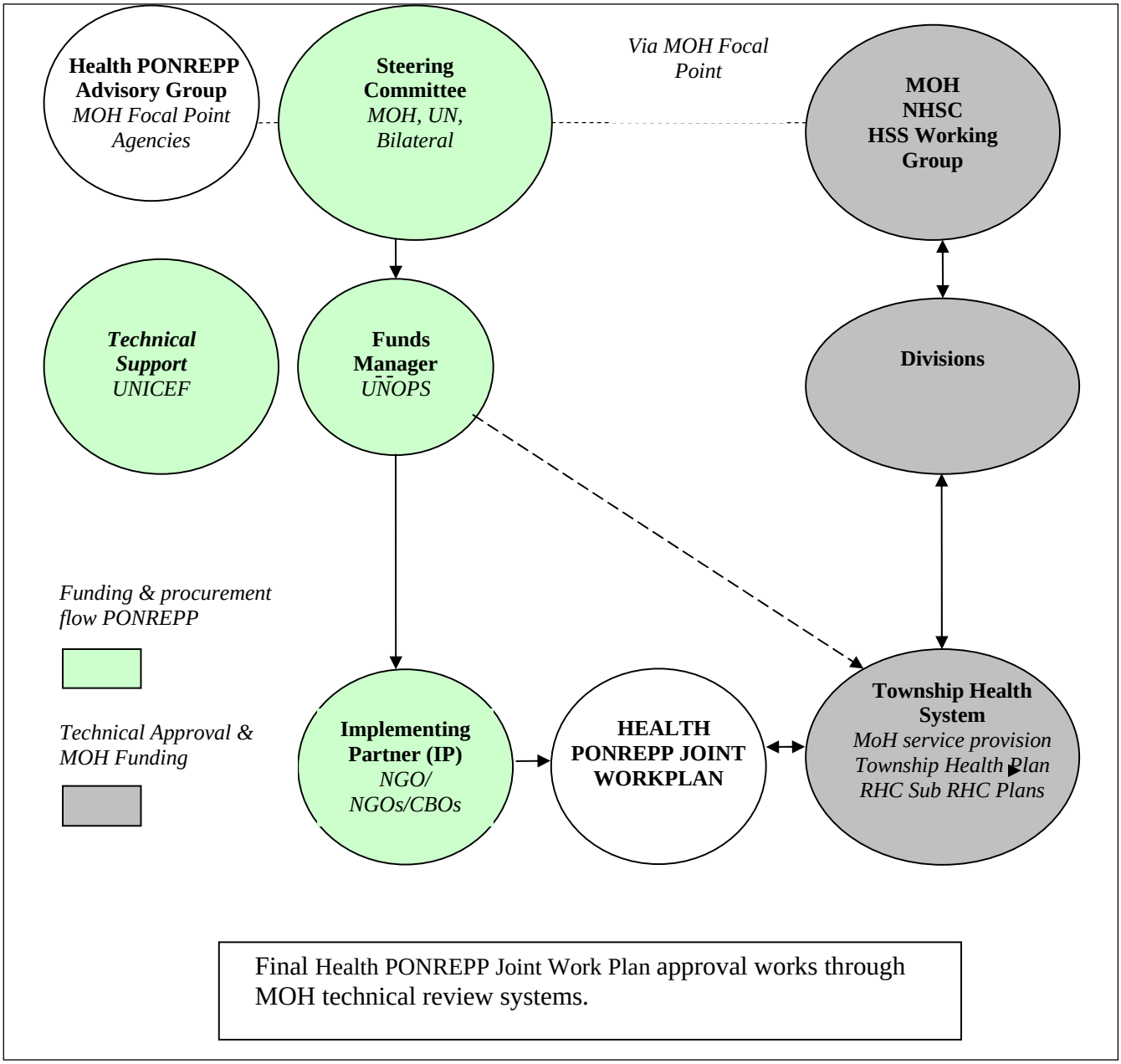
Following appointment, a Service Agreement will be negotiated between the Fund Manager and Implementing Partner against the period that funds are available. The Service Agreement (detailed in the procedural Annex) will specify the following:

- Services to be provided (support for inputs to annexed Coordinated Township Health Plan)
- Monitoring and Evaluation requirements (impacts, outcomes and system outputs)
- Expectations of support to the implementation of health PONREPP plan (TMO, Implementing partners, Community Based Organizations, RHC, Sub RHC)
- Payment mechanisms, audit & procurement systems and reporting arrangements.
- Detailed annual work plans of implementing partners

STEP 4 Health PONREPP Fund Approvals and Funds Flow (see Figure 2)

As stated above, funding approval for the eligible actions of the PONREPP within the approved Health PONREPP Joint Work Plan will operate through the Steering Committee.

Figure 2 - Management & Implementation Arrangements



* IMPORTANT NOTE: Signatories to the Service Agreement will be the Fund Manager and Implementing partner. It is important to note that *at this stage* the TMO is not a Funds Recipient from the Fund Manager. However, the signature of the TMO with the annexed Coordinated Township Health Plan will represent agreement to technical endorsement of the plan. The Implementing partner as co signatory is signifying responsibility for technical support for plan implementation and funds management of Health PONREPP Funds.

Funding Modalities: Fund flowing from the Fund Manager to the Implementing Partner will be most usually utilized through one of the following funding modalities:

(1) Direct disbursement – this involves zero cash flow. The service implementing partners finance officers provide direct disbursements to participants during meetings, during services or during training
(2) Reimbursement – This is a system of submission of claims to be reimbursed for such recurrent activities as transport, supervision, etc and
(3) Procurements – Direct provision of in kind materials or products (drugs and supplies etc) (according international procurement standards)

Initial service agreements may be for up to an initial 1 year period (the lifetime of the annual Health PONREPP Joint Work Plan) with provision approvals for subsequent years dependent on the successful implementation of the agreement and availability of funds. The methods and timing of fund disbursements will be identified in the Service Agreement between the Fund manager and the Implementing partner.

Other funding modalities may be considered at a later date following further policy and procedural discussion to be undertaken between the donors, other health PONREPP partners and MOH regarding the documented standard operating procedures and legalities of direct cash payments to Township Health Authorities.

For programme funds managed by UNOPS, funding flow may need to proceed through the left hand column in Figure 2, and for funding from other external sources (e.g. GAVI) will be able to proceed through government channels to Townships, provided there is sufficient MOH legal and procedural detail to facilitate this. GAVI HSS will design standard operating procedures for financial management of cash grants at Township level for implementation of Health PONREPP Joint Work Plan. The Steering Committee, in collaboration with the Ministry of Health and health PONREPP partners, will review these developments during implementation.

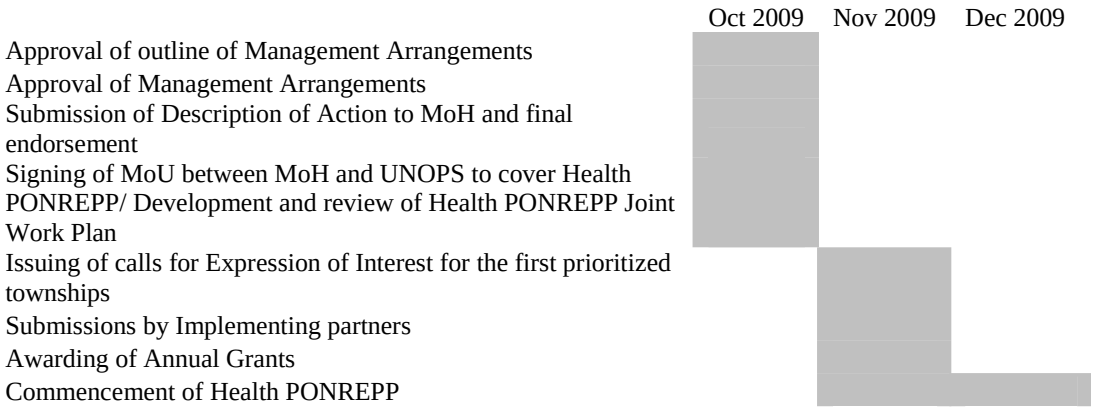
Budget and Timeline

Funding: Currently, funding (3 million pounds sterling) has been committed by DFID for Health PONREPP over a 2 year period, with additional funding opportunities from other donors expected through a proposed ASEAN-led pledging conference. The cost of implementation of Health PONREPP over a three year timeframe was estimated in the February 2009 PONREPP document as being $43.5 million (excluding facility restoration). This sum of money covers outcomes 1a, 1b, 2, 4, 5, 6 and 7 as detailed in the Monitoring and Evaluation Framework (see Annex 12). Mechanisms for facility restoration are not within the scope of work detailed within this document, which describes management and implementation arrangements for delivery of a core package of services[27]. Funds totaling $12.43 million are currently being sought to cover the costs of the initial 9 months of implementation of this 3 year programme (across all prioritized 11 townships) through the proposed ASEAN-led Pledging Conference. The figure of urgently required funds of $12.43 million, as compared to the overall 3 year requirement of $43.5 million,

[27] Facility restoration was initially budgeted at $10.3 million however this figure has been revised downwards to $755,000 based upon prioritization of remaining unreconstructed health facilities using data provided by MoH. Funds to cover these costs will be sought under the planned ASEAN-led Pledging Conference.

is proportionate to the 9 month timeframe of funding being sought through the proposed ASEAN-led pledging conference. These funds will be phased amongst the 11 townships included within the PONREPP, aiming at a global funding in proportion to the overall population of each township and the gaps identified in the Joint Work Plans. These funds will be additional to the existing Government of the Union of Myanmar funding for reconstruction. Additional sources of funding for PONREPP areas will also emerge through commencement of GAVI HSS as well as existing UNICEF programs for maternal and child health.

Table 5 - Timeline for Commencement of Health PONREPP (pre-implementation step and first Townships implementation)



Township Health System and NGO (Implementing partner) Coordination Mechanisms

Health PONREPP provides a valuable opportunity to strengthen coordination between NGOs and the Township Health System. This coordination is seen as essential for MCH programming. The basic principles of coordination are as follows:

(1) As partners in development, regular communication is required between the Township Health System and Implementing partners to ensure equitable and effective allocation of resources

(2) Township Health Systems are funded from multiple sources. Coordination mechanisms (through and led by the TMO and Township health team) have been in existence throughout the Nargis response and have played a vital role in targeting all government and non government resources in the Township for the benefit of the Township population.

The following strategies will be applied by Health PONREPP in order to strengthen coordination mechanisms:

1. The Health System Strengthening Technical Working Group at the DOH will technically review and approve Townships Health PONREPP Joint Work Plans with interested partners. This will include review of the proposed coordination mechanisms.
2. The Health PONREPP Joint Work Plans will reflect government and non government resources inputs, in order to demonstrate maximum efficiency and coordination in resource allocation (MCH, Nutrition, EPI, Psychosocial health)
3. Annual program and 6 monthly reviews (led by the central MOH) with wider stakeholder participation are encouraged in order to achieve effective program coordination amongst stakeholders as well as information sharing in regard to programme direction.

4. 4 Monthly *Division Coordination meetings* will be conducted by the Division with TMOS and Implementing partners (with central MOH participation) to evaluate progress, problem solve issues of implementation, and receive updates on health policy and planning
5. 1 monthly *Township coordination meetings* (or more often if required) will be conducted by the TMO (chair) with Township Health team and Implementing Partners to evaluate progress, problem solve issues of implementation and plan the following months activities.

Performance Monitoring and Evaluation

Baseline *Health Outcome* Indicators reflect the MCH focus of Health PONREPP and include:

- Outpatient visits per year
- Immunization coverage (measles, DPT3, TT2)
- Delivery by skilled health personnel
- Exclusive Breast Feeding rates
- Appropriate treatment of diarrhoea
- Nutritional status of children (Global Acute and Severe Acute)
- % of RHC and sub RHC with drug stock outs

Figures for expected outcomes during the first year of programme implementation across the 11 selected townships are described on page 6.

The results framework also describes *health system outputs*, which are summarized below:

- Health services delivery (essential services package and medium term health plan)
- Strengthened Referral Systems
- National program implementation
- Human resource capacity building
- Demand side initiatives
- Emergency preparedness planning

Performance monitoring at field level for technical programming will be central to the plan's success. This will be undertaken at the sub Township level by the implementing partner and TMO Health team through supportive supervision programs. The Fund Manager's Office, through UNICEF MCH Technical Advisor, will ensure that implementation remains in line with approved plans.

The Services Agreement established between the Fund Manager and the Implementing partner will stipulate the monitoring and evaluation reporting mechanisms and timeframes. It is expected that a mid year review and an annual report will be produced by each township and consolidated by the Fund Manager.

A joint Annual Review will be conducted by through the Health PONREPP Advisory Group. It is hoped that this overall Annual Review could be prededed by township level reviews led by the TMO, with support by the Implementing Partners.

Financial management monitoring will be undertaken by the Fund Manager. The basis for monitoring will be agreed roles and functions in financial management as specified in the Service Agreement and the standard operating procedures for funds management developed by the Fund manager and provided to the implementing partner. The Implementing Partner will agree to provide an annual statement of expenditures to the Township Health Authority so that these expenditures can be included in the National Health Accounts (identifying funding for Township Health Plans by source) The funds will be identified as having an origin as external overseas aid. The Health PONREPP Steering Committee may commission an independent end-of-programme evaluation or other studies during the implementation of the programme.

Part 3 Annexes

Annex 1 Terms of Reference Health PONREPP Advisory Group

The health PONREPP implementation will be advised by the Health PONREPP Advisory Group, which is a continuation of membership of the "Health Cluster." The Health Cluster between May 2008 and June 2009 served a distinct role during the one year aftermath of Cyclone Nargis in line with its core globally mandated responsibilities including ensuring coordination, accountability and predictability of funding. Cluster participants included UN agencies, INGOs, national NGOs, civil society and MoH representation.

Membership of the Health PONREPP Advisory Group will be:

- Ministry of Health PONREPP Focal Point
- International organizations
- Bilateral Agencies
- Non Government Organizations (national and international)
- Representative of Fund Manager

Membership selection is voluntary. Any partner of the Health PONREPP is eligible for membership.

Terms of reference for the Health PONREPP Advisory Group are as follows:

- Recommend to the Steering Committee on strategies for improving the quality of implementation and coordination of implementation.
- Share updates on implementation and resolving major implementation issues through open discussion
- Jointly review progress of the health PONREPP
- Act as a forum for dissemination of information, best practices, health research and lessons learned from implementation
- Commission, as necessary, sub groups to address specific technical questions in order to feed back recommendations to the main body

Annex 2 Terms of Reference Steering Committee

Membership

The Steering Committee will include the nominated MoH Focal point for Health PONREPP, one representative of bilateral donors, one representative from each of two UN agencies (WHO & UNICEF), an independent public health expert (without any institutional affiliation to Health PONREPP partners) as well as one representative of INGOs (which is not a Health PONREPP partner).

The Ministry of Health Focal Point is appointed by the Ministry of Health.

The independent public health expert is appointed by the remaining steering committee members.

Secretariat function will be implemented by the Fund Manager.

The terms of reference of the Health PONREPP Steering Committee are as follows:

1. Commission and selection of township Implementing Partners
2. Approval of funding for the PONREPP components of Health PONREPP Joint Work Plan
3. Reviewing summarized findings of financial audits
4. Commissioning special studies on evaluation and acting on findings
5. Liaison with the Ministry of Health to ensure that all Health PONREPP activities are in line with MOH policies and standards.
6. Making senior appointments to the Fund Manager
7. Overseeing and approving an annual report on program implementation

Annex 3 Terms of Reference Fund Manager

UNOPS will serve as overall Health PONREPP Fund Manager. The Fund Manager will not be directly involved as an implementing partner.

The Terms of Reference for the Fund Manager will be as follows:

- Provide secretariat support for the PONREPP Steering Committee
- Launch a call for Expressions of Interest for township Implementing Partners, one for each township for approval by the PONREPP Steering Committee.
- Execute Steering Committee decisions
- Preparation and monitoring of service agreements with Implementing Partners.
- Ensure sound procurement and financial management practices and serve as a clearing house for major procurement
- Undertake procurement of commodities or, where appropriate, contract it to independent managing agents
- Contract any consultants needed by the programme
- Receive disbursement instructions (as required) from donors
- Disbursing, monitoring and tracking and reporting of financial flows to Implementing Partner
- Prepare the Annual Report on Programme Implementation

Annex 4 Terms of Reference for Technical Support to Fund Manager

UNICEF will function as the primary technical support for implementation, particularly in matters relating to maternal and child health programming and will also assist programme implementation through its procurement capacity.

- Provide support to the Fund Manager for reviewing the Health PONREPP Joint Work Plan to ensure that activities to be supported by the Health PONREPP are clearly delineated and in line with the agreed scope of work. This would involve joint monitoring missions with the Fund Manager and a monthly meeting to monitor program and financial performance.
- Closely liaise with township authorities and Implementing Partner with respect to technical aspects of the programme. This will involve (a) monthly meeting with implementing partner and township BHS at the monthly coordination meeting (b) supporting and involvement with 4 monthly meetings at the Division level with participating Township and Implementing partners and (c) technical support for an annual program review with DOH, Division and Implementing partners and townships.
- Provide technical support to the Fund Manager and implementing partner on matters relating to procurement of essential drugs
- Where necessary, facilitate procurement through UNICEF mechanisms of health products (after MoH approval) (i.e. from the warehouse list of UNICEF supplies and drugs)
- Provide technical updates to the PONREPP Advisory Group on child survival strategy (in monthly PONREPP advisory group meetings)
- Provide technical advice and recommendations to the Steering Committee on the overall progress of the Health PONREPP Work Plan (through participation in monthly Township coordination meetings and by reviewing of reports submitted by implementing partners)
- Support the Fund Manager (UNOPS) to draft an annual report on program implementation.

Annex 5 Terms of Reference Implementing Partner

A fundamental element to the proposed programme is anchoring its implementation at township level, and identifying an 'Implementing Partner' to work with and support the Township Medical Officer (TMO) and Township Management team and to assist township coordination with other stakeholders. With the technical support of the Implementing Partner, The TMO and Township Health Coordination Committee will jointly develop detailed programme design and planning and for management of the programme including defining procurement needs, and monitoring. It is proposed that the Implementing Partner will have a service level agreement for each township to provide technical and financial support to implementation of relevant activities and programs in the Health PONREPP Joint Work Plans. The Implementing Partner would likely be a INGO (or a UN agency / international organization or consortiums including two or more out of UN agencies /NGOs/CBOs) with relevant experience and capacity (and the ability to scale up capacity) in the township, but other options could be considered. Relevant experience in the township would include the fact that Implementing Partner:

- Participated to the process of joint township health assessment
- Participated to the development (led by the TMO and the Township Health Committee) of the Health PONREPP Joint Work Plan (in close consultation with target populations and stakeholders such as UN agencies, INGOs, NGOs and the private/cooperative sector)

Terms of Reference for the Implementing Partner will be common across townships and will include:

- Technically support the delivery of an essential package of MCH services as described in the procedural annex of the "Management and Implementation Arrangements" (Health PONREPP).
- Support the TMO to coordinate all service providers and non-governmental actors who contribute to the plan through development of joint plans, monthly or more frequent coordination meetings chaired by the TMO, and through mid year and annual review of program implementation
- Report regularly against the Health PONREPP Joint Work Plan to the Fund Manager and to alls stakeholders through reviews
- Technically support the Township Medical Officer for supervision of health facilities, ensuring links to community health workers and village health committees
- Scaling up of community health approaches including community health workers, auxiliary midwives, village health committees and community based insurance
- Tracking expenditure and accounting for health PONREPP funds
- Handling of cash flow for activities funded under the health PONREPP
- Tracking procurement for items funded through the health PONREPP
- Providing narrative and financial reports as specified in the Service Level Agreement with UNOPS
- Provision of financial summary reports to Township Health authorities to enable monitoring of health expenditure (from external sources) at the Township level.

The Implementing Partner will be responsible that health PONREPP funds are held, disbursed and accounted for at township level in a transparent and efficient manner for their intended purpose. The Implementing Partner will work under an overall Service Agreement with the Fund Manager and shall fully comply with the terms of the Agreement (including, amongst others, reporting/M&E, financial management and audit).

Annex 6 – Terms of reference for Health PONREPP for Township Medical Officer & Coordination Committee

At the township level, health PONREPP implementation will be overseen by the Township Medical Officer (TMO) and Township Health Team. Monthly or weekly coordination meetings (chaired by the Township Medical Officer) and comprising the Implementing Partner plus other implementation partners to the Health PONREPP Joint Work Plan will be organized by the TMO. This Township Health Coordination Committee will serve as the forum for coordination between all actors involved in implementation of the health PONREPP at Township level. It will be chaired by the Township Medical Officer with Co-Chairing of the meeting by the approved Implementing Partner.

This structure builds upon successful approaches to coordination and oversight which were developed during the relief and early recovery phase of the post-Nargis response. During the aftermath of Nargis, township level health coordination meetings were chaired by the TMO and attendance at the meeting included UN agencies, INGOs as well as other agencies contributing to health relief and early recovery. These committees enjoyed linkage to the Divisional Level and, for Ayerwaddy division, monthly coordination meetings in Pathein attended by all TMOs as well as health partners contributed towards a standardization of approach as well as information sharing.

The following strategies will be applied by Health PONREPP in order to strengthen coordination mechanisms at all levels:

- An Annual Review of the Health PONREPP will be conducted in Nay Pi Taw with the MOH
- A 6 monthly coordination meeting of the Health PONREPP Advisory group and MOH to review the implementation progress
- 4 Monthly Division Coordination meetings will be conducted by the Division (Chair) with TMOS and Implementing partners with participation of the Central DOH to evaluate progress, problem solve issues of implementation, and receive updates on health policy and planning.
- 1 monthly Township coordination meetings (or more often if preferred) will be conducted by the TMO (chair) with Township Health team and Implementing Partners to evaluate progress, problem solve issues of implementation, and plan the following months activities. As much as possible this meeting will be integrated with the regular monthly health coordination meeting led by TMO to avoid duplication of coordination mechanism.

The Terms of Reference below are suggested in relation to Health PONREPP only and include the following:

- Work with MoH/DoH officials and technical partners in order to undertake a determination of township health needs focusing upon identifying areas where needs are greatest.
- Design and elaboration of a Health PONREPP Joint Work Plan , under the guidance of MoH/DoH officials and technical partners, which is aligned with PONREPP priorities and based upon a township health needs based plan.
- Provide information for health actors within the township in order that they can allocate or re-allocate resources in order to address areas of greatest need.

- Coordinate the actions of health actors within the township in order to maximize allocative efficiency.
- Work jointly with the Implementing Partner within health facilities in order to ensure optimal support, supervision and oversight of Basic Health Staff as agreed in the Health PONREPP Joint Work Plan.
- Facilitate participation of Basic Health Staff in training as agreed in the Health PONREPP Joint Work Plan
- Ensure that health data is shared and used in order to maintain an output based focus during coordination meetings.
- To ensure agreement with the technical endorsement of the plan, TMO should sign the service agreement together with the implementing partner and Fund Manager.
- Engage with and provide information to all other relevant non-health actors within the township in order to ensure that sectoral actors especially WASH agencies can contribute towards the overall health improvement of the population through a focus upon providing water, hygiene and sanitation activities in areas where the need is greatest.

Annex 7 Terms of Reference WHO

WHO has been active in assisting the MOH, Development Partners and Health Cluster with coordination in Nargis affected areas and with various health system strengthening strategy developments. WHO has provided a link between the health cluster and the Department of Health.

For implementation of Health PONREPP, WHO will continue this role and specifically undertake the following activities:

- Assist with the development of health assessments and Health PONREPP Joint Work Plan
- In collaboration with the MOH Focal Point, assist with facilitating policy linkages between the DOH and the Health PONREPP Advisory Group and the Steering Committee, particularly with respect to health planning, health financing, human resource management and partner coordination
- Participate in the Steering Committee to assist this committee to fulfill its specific terms of reference in funding approvals and monitoring and evaluation.
- In partnership with the MOH Focal Point, update the Health PONREPP advisory Group about policy developments in relation to health planning and health financing.

Annex 8 Draft Expression of Interest Form

Calls for Expression of Interest

Technical Support for Post Nargis Health Preparedness and Recovery Planning and Implementation (Health PONREPP)

The cyclone in May 2008 affected the lives of 2.4 million people with estimated loss of life of 140,000. In December 2008 the Tripartite Core Group (Government of the Union of Myanmar, ASEAN and UN partners) approved the Post Nargis Recovery and Preparedness Plan (PONREPP). Chapter 4 of the plan, section 4.1 outlined the recovery plan for health in 11 townships most affected by Cyclone Nargis. The core objective of the proposed programme is to ensure restoration and appropriately enhanced provision of and access to quality basic primary health care services (including nutrition) with a strategic emphasis on improved maternal and child health outcomes. It is proposed that access to primary health care should be restored through both supply side interventions (better quality health services) and demand side interventions (including surveillance and subsidies for hard to reach and vulnerable populations), especially in the areas of maternal and child health, disaster preparedness and psychosocial care.

The Steering Committee for Health PONREPP is now calling for expressions of interest from eligible non government organizations (referred to as "Implementing Partners") to submit EOI to implement Coordinated Township Health Plans in the Townships of……
……..

Eligible organizations are non government organizations (or consortia of NGOs and Community Based Organizations) with evidence of agreements to work in Myanmar.

Expressions of interest will be evaluated according to the following criteria:

- The proposed Implementing partner should demonstrate existing capability and track record and /or intent to implement in coordination with Township Health Authorities and other health partners at township level. The coordination mechanisms with the Township Health Authority and community should be well described.
- The proposed Implementing partner will clearly identify which activities and funding gaps the Implementing partner will support in the health PONREPP plan which has been endorsed by the Township Health Authorities
- The proposed Implementing partner will need to encompass a scope of work including support for maternal and child health care services, emergency preparedness planning and psychosocial care, and as detailed in the Health PONREPP Management Arrangements.
- The proposed Implementing partner will need to provide evidence of financial management and reporting systems that are consistent with guidelines as described in the Health PONREPP Management Arrangements. Financial management capacity should be well described.
- Finally, the Implementing Partner will be required to provide some evidence of

approval to work in Myanmar from the Government of the Union of Myanmar.

The Health PONREPP management and Implementation Arrangements provide detailed terms of reference for the program. For these details, please contact…….
The closing date for submissions is……..
All expressions of interest should be submitted the Fund Manager in a sealed envelope to……

Annex 9 Expected Contents of a Township Health PONREPP Joint Work Plan

Health Assessment

- An introduction with a brief Township profile and description of how the assessment was conducted (1-2 page)
- A Maternal and Child Health Summary (including nutrition) detailing the priority health problems and service gaps (1-2 page)
- A mapping of Hard to reach areas with unreached and difficult to reach populations clearly described
- Identification of main supply side (staffing, equipment, essential drugs, infrastructure and transport) gaps in service provision
- Identification of main demand side gaps in service access (knowledge of population, physical access, financial access)
- A monitoring and evaluation framework, with Township level health indicators based on the Health PONREPP M & E Framework

Health PONREPP Joint Workplan

- Health objectives and activities that relate to the scope of work
- A description and costing of essential drug, equipment and infrastructure needs (funding for health facility restoration will occur through mechanisms outside of management and implementation arrangements overseen by UNOPS as Fund Manager and detailed in this document)
- Costing of the activities and identification of sources of funding from all sources
- An analysis of funding gap and how Health PONREPP funds will fill this gap.

Annexes

- A description of the health coordination arrangements for implementation of the plan, including links to Township Health Systems, the Division Level and other agencies implementing programs in the Township (1 page)
- An outline of health information and financial reporting, and methods of evaluation (2 Page) and system of reporting for the Township, Division and DOH
- A procurement plan, which also outlines methods for quality control

Annex 10 Draft Service Agreements [28]

Draft Service Agreement

Health PONREPP

Date:

This Service Agreement (hereinafter referred to as the "Agreement') is made between the United Nations Office for Project Services ("UNOPS") and ……. duly constituted under the laws of ……. (the "Implementing Partner") in connection with activities further described in Annex A and hereinafter referred to as the "Project" financed by the Health PONREPP Fund ("Health PONREPP Fund"), managed by UNOPS on behalf of the Donor Consortium of the Health PONREPP Fund acting through their Health PONREPP Steering Committee.

WHEREAS the Donor Consortium has established and provided funding to the Health PONREPP Fund, which aims to improve maternal and child health outcomes, improve disaster preparedness and assist populations experiencing the psychosocial impacts of the Nargis Disaster in 11 Townships. Activities will be undertaken to improve access to maternal and child health care services, emergency preparedness and psychosocial support as outlined in the Health PONREEP Joint Work Plan attached as Annex C.

WHEREAS the Health PONREPP Steering Committee, to which the Donor Consortium has delegated the authority to select and approve projects and allocate funding, has, at a meeting held on …….., approved the Project, details of which are set out at Annex A – the Description of Action, Annex B – the Budget, Annex C – the Health PONREPP Joint Work Plan, and agreed to the allocation of funds to the Implementing Partner (the "contribution").

WHEREAS the Implementing Partner is ready and willing to accept such funds from the Health PONREPP Fund through the administration of UNOPS for the above mentioned Project on the terms and conditions set out herein and has agreed that it shall be undertaken without discrimination, direct or indirect, because of race, ethnicity, religion or creed, nationality or political belief, gender, sexual orientation, disability or any other circumstances.

WHEREAS UNOPS has appointed the Chief Executive Officer, Health PONREPP Fund (the "CEO") as its representative for all day-to-day matters concerning the administration of the Health PONREPP Fund programme in Myanmar.

NOW, therefore, the parties hereto agree as follows:

1. Responsibilities of the Implementing Partner

[28] Based on 3D Fund Memorandum of Agreement (MOA), updated with Health PONREPP terminology, and with additional clauses relating to coordination between Implementing Partner and the Ministry of Health and Township Health Authorities

a. The Implementing Partner hereby agrees to undertake the activities described in the Project Proposal (according to the Health PONREPP Joint Work Plan) which has been approved by the Health PONREPP Steering Committee and is attached as Procedural Annexes which form an integral part of this Agreement.

b. None of the funds provided pursuant to this Agreement may be used for any purposes other than those expressly set forth in Annex A. Without prejudice to the generality of the foregoing, in any case no funds may be used:

i. to make payment to Government agencies' bank accounts.
ii. for the following charges: customs duty for procurement, previous obligations, bad debts, fines and penalties, land and property, construction or reconstruction of infrastructure of public health structures, hospitality, international travel to conferences, trainings, workshops or any other activity outside the country not directly related to project implementation and political or religious propaganda, depreciation charges or rental of implementing partner's assets.

c. It is the exclusive responsibility of the Implementing Partner to ensure that it has evidence of authorization to carry out the Project in Myanmar. UNOPS will not extend any assistance nor will it accept any responsibility for any such registration or authorization process, or failure thereof. The Implementing Partner and its sub-contractors shall not interfere with the political and religious affairs of the Union of Myanmar and shall abide by the laws and regulations of the country.

d. The Implementing Partner hereby agrees to adhere to all guidelines, Standard Operating Procedures and other documentation of the Health PONREPP Fund as they may be published from time to time by the Fund Manager, including but not limited to procurement, carried out with funds from the Health PONREPP Fund.

e. The Implementing Partner agrees to implement the eligible actions in the health PONREPP Township Health Plan with the Township Health Authority and other partners.

f. The Implementing Partner agrees to provide an annual summary of expenditure to the Township Health Authority so that these expenditures can be included in the National Health Accounts (identifying Township Health Funds by external source).

2. Responsibilities of UNOPS

UNOPS agrees to provide payment of funds as specified in Article 4 below. UNOPS commitments and liability is limited to funds availability.

3. Duration

This Agreement will come into effect on signature by both parties and activities shall be completed by … , subject to the extension of the MOU between the Government of The Union of Myanmar and UNOPS. Should any party wish to extend the duration of this Service Agreement, it should inform in writing the other party accordingly and provide justification at least two months before this Service Agreement ends. Any extension is subject to a formal amendment to this Service Agreement.

4. Payments

a. UNOPS shall provide funds to the Implementing Partner in a maximum amount of up to USD ……. (United States Dollars ……) according to the planned schedule set out below, subject to the Implementing Partner's submission of timely and accurate reports:

Notwithstanding the foregoing, if UNOPS shall conduct procurement services on behalf of the Implementing Partner, USD _____ (United States Dollars _____) of the total funds mentioned above shall not be disbursed to the Implementing Partner, instead shall be withheld and utilised by UNOPS to cover procurement costs of the Project.

Maximum USD amount in figures and in words Deliverables Target Date
USD .
(United States Dollars ……..) upon signature of the Agreement by both parties and submission of an invoice ……
USD
(United States Dollars ….....) Upon certification by the CEO of receipt and acceptance of the relevant due reports as listed in Article 6.a.i. and Article 6. a.ii. on the use of funds together with an invoice…….
USD
(United States Dollars ….....) Upon certification by the CEO of receipt and acceptance of the relevant due reports as listed in Article 6.a.i. and Article 6. a.ii. on the use of funds together with an invoice …….
USD
(United States Dollars ….....) Upon certification by the CEO of receipt and acceptance of the relevant due reports as listed in Article 6.a.i. and Article 6. a.ii. on the use of funds together with an invoice ……..
USD
(United States Dollars ….....) Upon certification by the CEO of the final technical report and final financial report on the use of funds and acceptance of all prescribed documentation upon closure as listed in Article 5. and 4.g. together with an invoice……

Notwithstanding the above mentioned amounts, and without prejudice to articles 4.g and 6.e, UNOPS reserves the right to adjust upcoming installments by the amount of the balance, if any, resulting from funds already transferred by UNOPS and funds expended by the Implementing Partner, and to reduce proportionally the overall amount mentioned in article 4 a) without thus incurring any liability of any kind under this agreement.

b. All amounts in this Article 4 are expressed in US dollars. Payment amounts shall be made to the Implementing Partner in accordance with the planned payment schedule set out in article 4. The Implementing Partner's bank account details are as follows:

Bank name:
Bank Postal Address:
Name of Account:
Bank Account Number:
Currency of Bank Account:

c. The maximum amount of payment of such funds is not subject to any adjustment or revision because of (price) currency fluctuations.

d. No disbursements under this Agreement will be made to Government agencies bank accounts.

e. All in country payments to national partners will be made in local currency.

f. Under this Agreement, the Implementing Partner can claim up to 6 % indirect costs of the final costs.

g. The Implementing Partner may vary the budgeted cost of any single input in the budget funded by the Health PONREPP Fund, provided that (a) the variation is, cumulatively, not more than ten percent (10%) of the major budget heading (see UNOPS chart of accounts); (b) the variations are within the scope of the work plan, not new or unplanned activities; and (c) the total amount approved by UNOPS is not exceeded. Any variation exceeding ten percent (10%), or which involve new, unplanned activities outside as defined in Annex A, B, C and D requires prior written request and consent of the UNOPS and submission of a detailed justification and an appropriately revised budget.

h. All progress reports required to be submitted pursuant to this article 4 shall be in the form set out in Annex E. All financial reports shall be in the form set out in Annex F.

5. Audit

a. The Implementing Partner shall have the Financial Statements related to the fund audited in accordance with the International Standards on Auditing.

b. UNOPS will appoint external auditors to satisfy itself that the financial control systems of the Implementing Partner are sound and that the accounting returns are true records.

c. In addition to the audit report on Financial Statement, the auditors shall provide the Implementing Partner and UNOPS with a management letter addressing the adequacies of the accounting and internal control systems.

d. The Terms of Reference of audits will be drawn by UNOPS.

e. Adverse and disclaimer opinions will result in suspension of any further disbursement to the Implementing Partner by UNOPS until the Implementing Partner satisfactorily demonstrates that issues identified have been resolved.

f. UNOPS may suspend disbursement of funds until such time the audit report has been received, terminate the contract and/or issue recovery orders.

g. UNOPS may, at any time, check the Implementing Partner's accounts or order a further audit of financial records by a reputable audit firm chosen by UNOPS. The terms of reference of audits will be drawn by UNOPS. The cost of such audits will be charged to the Contribution.

h. In any instance, the Implementing Partner shall furnish, compile and make available at all times to UNOPS and/or its auditors any records or information, oral or written, which either UNOPS or its auditors may reasonably request in respect of the funds received by the

Implementing Partner. Upon receipt of a request by email or any other form of written communication from UNOPS and/or its auditors, the Implementing Partner shall, within 10 working days, forward to UNOPS and/or its auditors such records or information as so requested.

i. Where activities are completed in accordance with the agreed project duration as per Article 3 - Duration or where this Agreement is otherwise terminated in accordance with items j, k, l and m of Article 9 – General Provisions, the Implementing Partner shall have the Financial Statement related to the fund audited in accordance with Article 5 a, b, c and d within 6 months from the date of completion of activities or from the date of termination of the Agreement after the qualification.

6. Records and Reports

a. Reporting obligations by the Implementing Partner are as follows. The Implementing Partner will draw up mid year and annual narrative and financial reports. These reports shall cover the Project as a whole, regardless whether or not parts thereof are funded from other resources than the Health PONREPP Fund. If the Implementing Partner fails to supply UNOPS with adequate and timely reports, UNOPS may terminate this Service Agreement in accordance with article 9m), and recover the amounts not substantiated.

i. Technical / narrative progress reports (Annex E)

The Implementing Partner shall transmit to UNOPS in the form set out in Annex E mid year technical reports on the progress of the activities financed by the contribution as per Article 4.a. Such reports must be received as per below schedule.

Period Covering Not later than

Annual Technical Report

ii. Financial reports (Annex F)

Financial reports of receipts and expenditures shall be provided to UNOPS in the form set out in Annex F The reporting of expenditures shall also include the administrative cost as indirect cost of the activity. Such reports must be received as per below schedule.

Period Covering Not later than

iii. Final technical / narrative reports

Within 6 months after completion of the Project activities or early termination, the Implementing Partner shall provide UNOPS with a final report on the project in the form set out in Annex E, indicating the progress made toward the goals of the activities undertaken.

iv. Final Financial reports

Within 6 months after completion of the Project activities or early termination, the Implementing Partner shall provide UNOPS with a final report on the project in the form set out in Annex F with respect to all income and expenditures made from the Contribution. The reporting of expenditures shall also include the administrative cost as indirect cost of the activity.

v. The Implementing Partner shall submit any additional reports as may reasonably be required by UNOPS in connection with its obligations to submit reports to the donors.

vi. The. Implementing Partner shall submit an inventory list of non expendable equipment as of 31st December of each year together with the financial report covering the same date, in the format as provided by the Health PONREPP Fund which can be found in the Standard Operating Procedures for procurement with grants from the Health PONREPP Fund.

vii. The Implementing Partner shall submit a final inventory list of non expendable equipment and the list of drugs unused and other non-pharmaceutical health items procured with the funds provided under this agreement upon completion of the Project or upon termination of this Agreement together with the final financial report due 6 months after completion of the project or of any termination of this agreement, in the format as provided by the Health PONREPP Fund which can be found in the Standard Operation Procedures for procurement with grants from the Health PONREPP Fund .

b. All reports must be provided in English and be as per the formats set out in the abovementioned Annexes.

c. The Implementing Partner shall maintain clear, accurate and complete records in respect of the funds received under this Agreement. The Implementing Partner's books and records shall be maintained in such a manner that the receipts and expenditures relating to such funds will be shown separately on such books and records in an easily accessible and transparent form. In addition, the Implementing Partner shall maintain a comprehensive file in respect of the Contribution, including but not limited to:

i. the initial proposal submitted by the Implementing Partner, and any documentation relating to the process leading up to an amended and final proposal;
ii. the final proposal;
iii. a copy of this Service Agreement, signed by both parties;
iv. any amendments to the Service Agreement;
v. copy of interim technical reports submitted to the CEO;
vi. copy of interim financial reports on the use of funds;
vii. any correspondence with the CEO, etc., and
viii. final reports to be submitted in accordance with paragraph a) above.

d. Any income earned from implementation of activities granted under this Agreement shall be returned to the Fund or used for purposes as set forth in the approved work plan.

e. All funds which remain unutilized after completion of activities funded by the Contribution shall be returned by the Implementing Partner to UNOPS.

f. The Implementing Partner shall maintain complete and accurate records of supplies, equipment and other property purchased with Health PONREPP Fund funds and shall take periodic physical inventories of all equipment, property and non-expendable materials and supplies. The partner institution shall provide UNOPS with records on such equipment, property and supplies at such time and in such form as UNOPS may reasonably request.

g. Non expendable equipment purchased by the Implementing Partner with Fund resources shall remain the property of the Fund unless otherwise provided for in Annex A. An inventory of non expendable equipment – i.e. items valued at US$500 or more and other attractive items – must be maintained by the Implementing Partner. Attractive items include, but are not limited to tangible properties with a value of less than US$500,such as cameras, mobile phones, PDAs,

projectors or other items which are both highly moveable and desirable and therefore at risk of theft.

h. UN operational rates of exchange must be applied in all financial reporting. Ref. http://www.un.org/Depts/treasury/

7. Information and Communications

a. The Implementing Partner shall keep the CEO informed of all activities pertaining to the Project and shall consult with the CEO as circumstances arise which may have a bearing on the status of the Implementing Partner in Myanmar or may affect the achievement of the Project objectives, with a view to reviewing the Project Description and Budget (annexes A and B) and the implementation of the Project.

b. The Implementing Partner authorizes UNOPS to communicate or publish its name, the maximum amount of the grant, and a description of the activities funded under this Service Agreement. A derogation to this clause may be discussed with UNOPS should the communication or the publication of such information present a danger to privacy of the beneficiaries of the activities, to security, or to the ability of the Implementing Partner to deliver its task. UNOPS takes the final decision.

c. All correspondence and reports regarding the implementation of this Agreement shall be in the English language and should be addressed to:

d. All correspondence regarding disputes or termination of this Agreement, or changes in the implementation schedule should be addressed to:

8. Procurement, equipment and assets

a. Procurement within Myanmar, whether for supplies or services, must be made from the private sector exclusively. Restrictions may be imposed by the Donors. As is common practice, no salaries, consultancy fees or honoraria can be paid to employees of the State.

b. In its procedures for the procurement of goods, services or other requirements with funds made available by the Health PONREPP Fund as provided for in the Budget under this Service Agreement, the Implementing Partner shall ensure that, when placing orders or awarding contracts, it will safeguard the principles of highest quality, economy and efficiency and that the placing of such orders will be based on an assessment of competitive quotations, bids or proposals, unless otherwise agreed to by UNOPS. The Implementing Partner undertakes to take all necessary precautions to avoid conflicts of interests, favoritism, or corrupt practices in the execution of this Service Agreement.

c. Equipment purchased by the Implementing Partner with funds supplied by the Health PONREPP Fund shall be the property of the Health PONREPP Fund and shall be used for the purpose indicated in Annex A throughout the period of this Agreement. At the end of the period covered by this Agreement, UNOPS will decide upon the disposal of such equipment in consultation with the Implementing Partner.

d. In cases of total damage, theft or other loss of property made available to the Implementing Partner, the Implementing Partner shall provide UNOPS with a comprehensive

report, including a police report where appropriate, and any other evidence giving full details of the event leading to the loss of the property.

e. Essential drugs and non-pharmaceutical medical supplies to be procured under the Health PONREPP Fund must meet internationally recognized quality criteria.

f. Procurement action shall take place in the first 12 months of the project – unless agreed otherwise with UNOPS prior taking such action.

All medicines to be placed on the market in Myanmar must be registered by the Food and Drug Administration of Myanmar after an evaluation of scientific documentation. Such evaluation and laboratory testing are mandatory regardless of being registered and used in other countries with stringent regulatory requirements.

Locally procured medicines must be registered with the FDA. All Around 9,000 products are currently registered in Myanmar. The Food and Drug Administration is also responsible for inspection of pharmaceutical manufactures to assess compliance with Good Manufacturing Practices (GMP) and for inspection of pharmacies.

9. General Provisions

a. This Agreement and the Annexes hereto shall form the entire Agreement between the Implementing Partner and UNOPS, superseding the contents of any other negotiations and/or agreements, whether oral or in writing, pertaining to the subject of this Agreement.

b. The Implementing Partner acknowledges that UNOPS and its representatives have made no actual or implied promise of funding except for the amounts specified in this Agreement. The Implementing Partner furthermore commits itself to promptly inform UNOPS should the Implementing Partner access or in anyway uses funds from other sources than the Health PONREPP Fund for the implementation of the activities subject of this Service Agreement as described in Annex A. If any of the funds are returned to UNOPS or if this Agreement is rescinded, the Implementing Partner acknowledges that neither the Health PONREPP Fund nor UNOPS will have further obligations to the Implementing Partner as a result of such return or rescission.

c. The Implementing Partner shall carry out all activities described under Annex A with due diligence and efficiency. Subject to the express terms of this Agreement, it is understood that the Implementing Partner shall have exclusive control over the administration and implementation of the activities referred to in Annex A and that UNOPS shall not interfere in the exercise of such control. However, both the quality of work and the progress being made toward successfully achieving the goals of such activities shall be subject to review by UNOPS. If at any time UNOPS is not satisfied with the quality of work or the progress being made toward achieving such goals, UNOPS may in its discretion (i) withhold payment of funds until in its opinion the situation has been corrected; (ii) require the return of all or any goods and/or equipment purchased by the Implementing Partner with the funds provided pursuant to this Agreement; (iii) declare this Agreement terminated by written notice to the Implementing Partner as described in paragraph m) below; and/or (iv) seek any other remedy as may be necessary. UNOPS' determination as to the quality of work being performed and the progress being made toward such goals shall be final and shall be binding and conclusive upon the Implementing Partner insofar as further payments by UNOPS are concerned.

d. The Implementing Partner shall be responsible for the implementation of the Project in close cooperation with UNOPS. The Implementing Partner shall not be considered, for any purposes whatsoever, as having a legal status connected with or dependent upon the United Nations or UNOPS.

e. UNOPS or its representatives undertake no responsibilities in respect of life, health, accident, travel or any other insurance coverage for any person which may be necessary or desirable for the purpose of this Agreement or for any personnel undertaking activities under this Agreement. Such responsibilities shall be borne by the Implementing Partner.

f. The rights and obligations of the Implementing Partner are limited to the terms and conditions of this Agreement. Accordingly, the Implementing Partner personnel and sub-contractors performing services on its behalf shall not be entitled to any benefit, payment, compensation or entitlement except as expressly provided for in this Agreement.

g. The Implementing Partner's Personnel shall neither seek nor accept instructions from any authority external to UNOPS concerning their activities under the Agreement.

h. The Implementing Partner shall be solely liable for claims by third parties arising from the Implementing Partner's acts or omissions in the course of performing this Agreement and under no circumstances shall UNOPS or its representatives be held liable for such claims by third parties.

i. The Implementing Partner shall not assign, transfer, pledge, subcontract or make other disposition of the Agreement or any part thereof, or of any of its rights, claims or obligations under the Agreement except as foreseen in Annex A or with the prior written consent of UNOPS. The engagement of a sub-contractor of implementing partner by the Implementing Partner shall not relieve the Implementing Partner of any of its obligations under this Service Agreement.

j. For the purpose of the present Agreement, "force majeure" shall mean acts of nature, war (whether declared or not), invasion, revolution, insurrection or other acts of a similar nature or force.

k. In the event of and as soon as possible after the occurrence of any cause constituting force majeure as defined in paragraph j) above, the parties to this Agreement shall give each other notice and particulars in writing of such occurrence if the party (parties) affected is (are) rendered unable, wholly or in part, to perform its (their) obligations or meet its (their) responsibilities under the Agreement. The parties shall consult on the appropriate action to be taken, which may include suspension of the Activities or, without prejudice to paragraph m) below, termination of the Agreement with either party giving to the other party at least seven (7) days' written notice.

l. The Implementing Partner represents and warrants that it has taken all appropriate measures to prevent sexual exploitation or abuse of anyone by its employees or any other persons engaged by the Implementing Partner to perform services under this Agreement. For these purposes, sexual activity with any person less than eighteen years of age, regardless of any laws relating to consent, shall constitute the sexual exploitation and abuse of such person. In addition, the Implementing Partner represents and warrants that it has taken all appropriate measures to prohibit its employees or other persons engaged by the Implementing Partner from exchanging any money, goods, services, employment, or other things of value, for sexual favours or activities, or from engaging in any sexual activities that are exploitative or degrading to any person.

m. This Agreement may be suspended or terminated by either party by giving thirty (30) calendar days written notice to the other party, and the Implementing Partner shall promptly return any unutilized funds to UNOPS within 30 days from acceptance of final reports in accordance with section 6 art a (iii, iv, vii) and section 9 art c. In case of suspension or termination, the Implementing Partner shall continue to provide such information as may be reasonably requested by UNOPS, including detailed reports, and shall endeavour to protect all assets acquired under the present Service Agreement.

n. No modification of or change in this Agreement, waiver of any of its provisions or additional contractual provisions shall be valid or enforceable unless approved in writing by the parties to this Agreement in the form of an Amendment Agreement duly signed by the parties hereto.

o. Any controversy or claim arising out of, or in connection with this Agreement or any breach thereof, shall unless it is settled by direct negotiation, be settled in accordance with the UNCITRAL Arbitration Rules as at present in force. Where, in the course of such direct negotiation referred to above, the parties wish to seek an amicable settlement of such dispute, controversy or claim by conciliation, the conciliation shall take place in accordance with the UNCITRAL Conciliation Rules as at present in force.

p. The parties shall be bound by any arbitration award rendered as a result of such arbitration as the final adjudication of any such controversy or claim.

q. Nothing in or relating to this Agreement shall be deemed a waiver of any privileges and immunities of the United Nations or UNOPS.

IN WITNESS WHEREOF, the undersigned, duly appointed representatives of UNOPS and of the Implementing Partner, respectively, have on behalf of UNOPS and of the Implementing Partner signed in two originals the present Service Agreement on the dates indicated below their respective signatures, each party retaining one original.

On behalf of UNOPS:

On behalf of the Implementing Partner:

Annex 11 Details of Essential Services Package for MCH [29]

Maternal and Reproductive Health					
Activities	**Township/Station hospital**	**RHC + Sub-RHCs**	**AMW**	**CHW**	
Supplies of Midwifery kits/Basic medical equipment		X	X		
Supplies of Clean delivery kits		X	X		
Supplies of Essential Drugs including FeSO4/Folic Acid and Vitamin B1		X	X		
Supplies of drugs for postpartum hemorrhage (Misoprostol)		X (Prevention, management and referral)			
Training of Basic Health Staff on Emergency Obstetric Care	X	X			
Provision of Comprehensive Emergency Obstetric Care	X				
New Training of Voluntary Health workers (AMW/CHW) according MOH guidelines (CHW/AMW 1:1 of each/village)			X	X	
Refresher and on job training of voluntary health workers (AMW/CHW)			X	X	
Provision of Basic Obstetric Care (including antenatal/postnatal)		X	X (Nornal delivery and referral of complicated labour)		
Birth spacing	X (IUD, Injection, pills, condom)	X (IUD, Injection, pills, condom)	X (Pills and condom)	(Condoms)	
Management of Unsafe abortion		X	Detection and referral		

[29] Source Health Cluster Document, based on broad definition of essential service package in Health Sector Working paper MOH 2008

Management of locally endemic diseases (malaria, DHF, STI, TB…)		X	X	X	
Reproductive health promotion/BCC		X	X	X	
Strengthen effective and stepwise referral systems	X	X	X	X	

Child Health					
Activities		**RHC + sub-RHC level**	**AMW**	**CHW**	
New Born Care					
Basic New Born Care including promotion of early exclusive breastfeeding		X	X	Counseling and referral	
Management of new born complication		Basic resuscitation + referral	Detection, first aid, referral	Referral	
Training on essential New Born Care		X	X		
Supply of medical equipment/consumables for new born resuscitation		X	X (mouth suction)		
Common Childhood Illnesses					
Community Case Management of Childhood Illnesses		X	X	X	
Training of Community health worker on Child Health management				X	
Supplies of drugs including for diarrhea and pneumonia management (ORS, Zinc, ATB)/Basic medical equipment		X (2 ATB)	X (1 ATB)	X (pre-referral treatment)	
Management of locally endemic disease (DHF, malaria)		X	Detection, treatment and referral	Detection, treatment and referral	
Promotion of use of LLITN		X	X	X	
Health education / BCC on child health and prevention of communicable disease		X	X	X	
School health		X (RHC level only)			

EPI				
Activities		**RHC level + SHC**	**AMW**	**CHW**
Planning and supervision of EPI activities including transportation means	X	X		
Cold Chain equipment and ice supply		X		
Outreach EPI-Plus/Reaching Every Community for hard to reach areas		X		
Childhood immunization including measles, DTP3, OPV, HepB, BCG *		X	Promotion + referral	Promotion + referral
Tetanus Immunization of pregnant women		X	Promotion + referral	Promotion + referral
Community mobilization/BCC		X	X	X

*Vaccines should be supplied by Department of Health and UNICEF

Nutrition				
Training of health staff on malnutrition		X	X	X
Malnutrition Surveillance with MUAC		X	X	X
Community based Management of acute malnutrition including provision of supplies – village foodbank, community based management (with supervision from MW)		X	X	X
Vitamin B treatment (emergency life-saving cases)		X		
Micronutrient supplementation of pregnant and postpartum women (including Vit B)		X	X	X
Vit A supplementation		X	Promotion and referral	Promotion and referral
Deworming of child 2-5y and pregnant mothers (after 1st trimester)		X	promotion	promotion
Exclusive Breastfeeding and adequate Nutrition Promotion/BCC	X	X	X	X

Psychosocial Support					
Activities		**RHC level + SHC**	**AMW**	**CHW**	**Comm-unity**
Community level awareness for psychosocial support including training of CHWs/AMWs		X	X	X	X

Capacity building/training of Township mental health teams	X				
Training of BHS in MHPSS concepts and basic management techniques		X	X		
Detection and referral of psychological/mental health disorders		X	X	X	X

Health Emergency Preparedness and Response including environmental health			
Activities		**RHC level + SHC**	**Community level (VHC, CHW, AMW)**
Design emergency disaster response and preparedness plan by TMO and partners	X	X	X
Dissemination of health emergency disaster response and preparedness plan		X	X
Integrated Diseases Surveillance and Response (EWARS)	X	X	X
Training on First Aid		X	X (CHW/AMW)
Village Health committee training on emergency preparedness (risk mapping, community level response)		X	X
Environmental and Medical Waste Management	X	X	X

Demand side interventions			
Activities		**RHC level + SHC**	**Community level (VHC, CHW, AMW)**
Strengthening of Village Health Committees			X
Strengthening of effective and stepwise referral systems	X	X	X
Joint MOH/PONREPP study on financial barriers at township and grass roots level and proposals on pilot financing strategies to respond	X	X	X
Township initiative for community financing of emergency treatment and referral (co-financed by trust fund)	X		
Pilot projects to increase access to primary healthcare for vulnerable groups, to include initiatives to overcome financial barriers to care and referral	X	X	X

Annex 12 Monitoring and Evaluation Framework 30 (to be updated for July 2009 onwards following completion of review of PERIODIC REVIEW 2 DATA)

Outcomes	Baseline	Achievements (May – Nov. 2008)	Expected outputs January-June 2009	Expected outputs July-December 2009	Expected outputs January 2010-December 2011
Base line and Target Indicators for Proposed Programme	**Indicators** *(Actual)* 1) Outpatient Visits Per capita/year: Not Known 2) Births attended by skilled personnel No. (30%) (2007) 3) One year olds vaccinated against: (i) measles: No..60,955 (75%) (ii)DPT 3 No. 70,333 (91%) (2007) 4) Proportion of pregnant women vaccinated with TT2+ Not known 5) Child malnutrition: Global Acute: 13%	**Indicators** *(Actual)* 1) Outpatient Visits Per capita/year: 0.35. 2) Births attended by skilled personnel No. (35%) 3) One year olds vaccinated against: (i) measles: No. (76 %) (ii) DPT 3 No. (82%) 4) Proportion of pregnant women vaccinated with TT2+ 94 % 5) Child malnutrition: Global Acute: 12%	**Indicators** *Target:* 1) Outpatient Visits Per capita/year: 0.5. 2) Births attended by skilled personnel No. (37%) 3) One year olds vaccinated against: (i) measles: No. (80 %) (ii) DPT 3 No. (85 %) 4) Proportion of pregnant women vaccinated with TT2+ 95 % 5) Child malnutrition: Global Acute: 11%	**Indicators** *Targets:* 1) Outpatient Visits Per capita/year: 1.0. 2) Births attended by skilled personnel No. (40%) 3) One year olds vaccinated against: (i) measles: No. (80%) (ii) DPT 3 No. (90%) 4) Proportion of pregnant women vaccinated with TT2+ 95% 5) Child malnutrition: Global Acute: 10%	**Indicators** *Targets:* 1) Outpatient Visits Per capita/ year: 1.5. 2) Births attended by skilled personnel No. (50 %) 3) One year olds vaccinated against: (i) measles: No. (85 %). (ii) DPT 3 No. (90 %) 4) Proportion of pregnant women vaccinated with TT2+ 95 % 5) Child malnutrition: Global Acute: 8%

[30] Source Health PONREPP Plan 2008, updated with results from Periodic Review II 2009

	Severe Acute 2 % 6) Percent of < five children treated with ORS after diarrhoea episode in last month: Not known 7) Proportion of mothers exclusively breast feeding child for first 6 months 15 % 8) Number and % of SHC and HC reporting stockout of essential drugs of .2 weeks in last 6 months.	Severe Acute 2 % 6) Percent of < five children treated with ORS after diarrhoea episode in last month: Not known 7) Proportion of mothers exclusively breast feeding child for first 6 months 15 % 8) Number and % SHC/HC with 2 week stockout of essential drugs in last 6mn	Severe Acute <2% 6) Percent of < five children treated with ORS after diarrhoea episode in last month: Not known 7) Proportion of mothers exclusively breast feeding child for first 6 months >15 % 8) Number and % SHC/HC with 2 week stockout of essential drugs last 6 mn. RHCs. No: < 20 % Sub-RHCs: No < 25 %	Severe Acute 1% 6) Percent of < five children treated with ORS after diarrhoea episode in last month: 60% 7) Proportion of mothers exclusively breast feeding child for first 6 months 20 % 8) Number and % SHC/HC with 2 weeks stockout of essential drugs last 6mn. .. RHCs. No: < 15 % Sub-RHCs: No < 20 %	Severe Acute <1% 6) Percent of < five children treated with ORS after diarrhoea episode in last month: 80% 7) Proportion of mothers exclusively breast feeding child for first 6 months 30 % 8) Number and % SHC/HC with 2 week stockout of essential drugs in last 6mn. RHCs. No: < 10 % Sub-RHCs: No < 15 %
<u>Health Services Delivery</u>: 1a. **Minimum essential health services package** delivered township down with a focus upon MCH and community-based approaches to primary health care (including key medical	1a. Essential services very significantly disrupted particularly at sub-centre and health centre levels. 1b. Before Nargis no Township plans in	1a. significant service delivery restoration through INGO and makeshift health facility based and mobile services.(see outcomes above) 1b. Agreement to use township planning approach as basis for	1a. focus on (i)delivery of basic health services through village based volunteer health workers and (ii) health facilities supported through training[31] and medical supplies with focus on MCH & nutrition 1b. Agree: (i) TOR for township focal points (FP); (ii) planning	1a. scale up programme -See targets above 1b. Finalize initial township expenditure plan, outcomes and	1a. Implement program and focus on implementing sustainability strategies See targets above 1b. Continue planning review, and update in

[31] Including HIV messaging and referral for care and treatment

supplies). 1b. **Medium Term Plan and** at Township-level area to form basis of program funding.	cyclone affected areas.	establishing one plan.	framework guidelines; & (iii) select FPs -Planning initiated	budget. - Including financing plan.	light of implementation progress.
Total cost estimates	*US$ 34.8 million*		*US$ 5.9 million*	*US$ 9.7 million*	*US$ 19.2 million*
2. **Ensure referral system** in place including access to Emergency Obstetric Care (EOC).	1) Not Applicable	1) Pilots underway to ensure referral of seriously ill and for EOC.	1) Rapid evaluation of pilots and develop community based plans for referrals and access to EOC as part of Township area plans.	1) Scale up community based referral systems and monitor their effectiveness.	1) Scale up community based referral systems and monitor their effectiveness.
Total cost estimates	*US$ 3 million*		*US$ 500,000*	*US$ 500,000*	*US$2 million*
3. ***Facility Restoration***[32] Note: Priority to restoration of sub health and health centers. An allocation in the facility restoration costs of US$3	1) Initial documentation of facility destruction (PONJA Report) 2) Number of facilities damaged/destroyed: No -% destroyed)	1) Continued documentation of destruction and planning for designs and construction standards. 2) Number of health facilities restored:	1) Agreement on facility configuration in towns 2) finalize designs and briefs for contracting 3) Initiate contracting 4) Number of health facilities restored:	1) Finalization all designs and expand contracting for construction effort. 2) monitor construction progress and quality 3) Number of health facilities: (a) restored:	1) Manage and adjust implementation of construction program. (incorporated in area health plans) 2) Number of health facilities: (a) restored:

[32] Funding for health facility restoration will occur through mechanisms outside of management and implementation arrangements overseen by UNOPS as Fund Manager and detailed in this document.

Million has been included to: (a) judicially expand facilities in program townships; (ii) ensure all health centers in other townships are restored; and /or); (iii) used to restore hospitals <25 and essential EOC facilities.	Sub-RHCs:No 300-30%) RHCs. No:60-25%) Hospitals <25 beds: No. 25-35%) (PONJA Report data base)	S/RHCs:: Not known RHCs. Not known Hospitals <25beds: Not Known	S/RHCs:: No 92 RHCs. No: 12 Hospitals <25beds: No. 0	S/RHCs:: No 150 RHCs. No: 25 Hospitals <25beds: No. 1	S/RHCs:: No 250 RHCs. No: 60 Hospitals <25beds: No. <10
Total cost estimates	*US$ 10.3 million*		*US$ 1 million*	*US$ 2.5 million*	*US$ 6.8 million*
4. **Update/establish technical policies** and protocols for priority public health interventions	1) GAVI/MOH agreed township area planning approach.	1) Health Cluster has began work and initiated MOH consultations.	1) Core list of technical polices agreed and work initiated. (includes essential drugs list).	1) Drafts completed and implications incorporated in township area plans	1) Policies formally approved 2010 and their implementation monitored
Total cost estimates	*US$ 400,000*		*US$ 100,000*	*US$ 100,000*	*US$ 200,000*
5. **Human Resource and Training Plan** developed and implemented linked to township area plans.	1) Need updating &/or established	1) Initial discussions	1) Agree scope of staffing needs & core focus and scale of training plan with MOH and initiate training	1) Finalize training plan, including targets, and scale up training and its evaluation	1) Continue training and monitor effectiveness in changing service provider behaviour and results.
Total cost	*US$ 500,000*		*US$ 100,000*	*US$ 100,000*	*US$ 300,000*

estimates					
6. **Demand side**: ensure the extremely vulnerable and poor have financial resources to access health. (see PONJA Report)	1) Not applicable	1) Not applicable 2) Disease early warning system established	1) TA to design pilot community based interventions & demand-side financing schemes.	1) Implement pilot programs and monitor results. Finalize design and implement agreed demand side financing scheme.	1) Implement, monitor and evaluate operations and targeting. 100
Total cost estimates	*US$ 4.5 million*		*US$ 100,000*	*US$ 400,000*	*US$ 4 million*
7. **Emergency Preparedness and Response**	1) No preparedness strategy in place 2) Limited capacity in Place. 3) Build Infrastructure with improved cyclone resistance – facilities largely not built to any cyclone resistant standards	1) Agreements reach on standards of "build-back better"	1) Planning for strategy initiated (TORS) 2) Strengthen system and monitor shifts in disease burden and nutrition status; respond to emerging challenges 3) Ensure technical standards are reviewed and documented for inclusion in all construction design briefs financed under this program.	1) Draft consultation strategy developed 2) Sustain 3) Ensure standards are enforced and monitored under area planning framework	1) Sustain 2) Sustain
Total cost estimates	*US$ 300,000*		*US$ 100,000*	*US$ 100,000*	*US$ 100,000*
Total Sector Cost	***US$ 53.8 million***		***US$ 7.8 million***	***US$ 13.4 million***	***US$ 32.6 million***

Annex 13 References

1. Post Nargis Recovery Plan of Action MOH 2008
2. Tripartite Core Group Post Nargis Recovery Plan December 2008
3. Government of Myanmar "Programme for Reconstruction of Cyclone Nargis Affected Areas and Plans for Preparedness and Protection from Future National Disasters" 2008
4. Tripartite Core Group Coordination Arrangements For Post-Nargis Recovery (Handbook)
5. Delta Basic Services Recovery Working Group (Health & Nutrition)
6. Draft Paper on Management Arrangements Health Cluster August 17 2009
7. Discussion Paper Management and Implementation Arrangements Health PONREPP Sept 9 2009
8. Standard Operating Procedures 3D Fund and supporting documents (MOA)
9. Health PONREPP 1st Periodic Review 2008
10. Health PONREPP 2nd Periodic Review 2009
11. Health Sector Working Paper MOH 2008
12. Health System Working Paper MOH 2008
13. GAVI HSS Proposal MOH 2008