Joint Initiative on Maternal Newborn and Child Health

Annual Report 2010

JI-MNCH

UNOPS

ACKNOWLEDGEMENTS AND DISCLAIMER

We would like to thank Australia, Norway and the United Kingdom for their kind contributions to improving maternal, new-born and child health among some of the poorest and hardest-to-reach communities in Myanmar's Ayeyarwady Delta. Their support to the Joint Initiative on Maternal New-born and Child Health (JI-MNCH) is gratefully acknowledged.

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ACRONYMS

AMW	Auxiliary Midwife
BHS	Basic Health Staff
CHW	Community Health Worker
CSG	Community Support Group
CTHP	Coordinated Township Health Plans
DOH	Department of Health
EPI	Expanded Programme of Immunization
FMO	Fund Management Office
H2R	Hard to Reach
HMIS	Health Management Information System
INGO	International Non-Governmental Organization
IP	Implementing Partner
JI-MNCH	Joint Initiative on Maternal, New-born and Child Health
JTHP	Joint Township Health Plan
M&E	Monitoring and Evaluation
MS	Medical Superintendent
MW	Midwife
MOH	Ministry of Health
MUAC	Mid-upper arm circumference
NGO	Non-Governmental Organization
RHC	Rural Health Centre
SH	Station Hospital
SOP	Standard Operating Procedure
THO	Township Health Officer
TMO	Township Medical Officer
VHC	Village Health Committee
VHW	Voluntary Health Worker

CONTENTS

1 EXECUTIVE SUMMARY

2010 saw the Joint Initiative on Maternal, Newborn and Child Health establish its essential structures, sign service agreements with the Government of Myanmar and several implementing partners and begin to support the provision of essential health services to poor and hard-to-reach populations in parts of the country's Ayeyarwady Delta.

The Initiative aims to improve both the quality and quantity of maternal and child health care provision through both public health services and non-governmental organizations and with support from UN agencies. Its innovative programme is based on integrated township level planning and supported by a comprehensive monitoring framework.

By the end of 2010, the Initiative had pledged almost US$4.5 million from three donor countries (Australia, Norway and the United Kingdom). Of that sum, a little more than half was spent in the course of the year, primarily in grants to three implementing partners (Merlin, IOM and Save the Children).

Based on a joint assessment of health needs in Labutta and Bogale Townships in 2009, partners in the Initiative worked out health plans for those areas. After the establishment of the JI-MNCH Fund Management Office in Yangon, activities were launched in May 2010 in Labutta and Bogale Townships.

In little over six months, the Initiative can report some important achievements in areas including coordination, training and service delivery.

A comprehensive coordination mechanism was established. Monthly township coordination meetings were held with township health authorities, basic health staff and Implementing Partners. From July, monthly meetings were also held in Rural Health Centres.

A total of 43 new auxiliary midwives and 74 new community health workers completed their training in an effort to strengthen service delivery in village where no Basic Health Staff were based. In addition, essential drugs and clean delivery kits have been supplied to health facilities and Voluntary Health Workers.

With the programme's support, health workers carried out well over 1,000 outreach visits, including to many hard-to-reach areas and populations, and handled nearly 200 emergency referrals for pregnant women and sick children.

The programme also began to revitalize Village Health Committees and to select and train Voluntary Health Workers in order to strengthen community-level awareness and engagement in health issues.

At the management level, a consultant with relevant experience drafted a set of Operational Guidelines. Once approved by the Steering Committee, the guidelines are to form the basis for the effective management of the JI-MNCH fund and its partnerships.

Implementing the programme's activities has met with several challenges. These include access to particularly hard-to-reach areas, a shortage of midwives and other health workers and the effectiveness

of Village Health Committees. The latter can be an issue in villages with many migrant workers, for example, where it has proved difficult to select Volunteer Health Workers, with negative impacts on the referral system.

Other challenges included unfilled vacancies for township health officials, which negatively affected coordination and implementation in both townships. In addition, vacancies for Basic Health Staff placed a heavy burden on those in the field.

Implementing the programme also made plain the need to develop improved operating procedures and guidelines to ensure effective service delivery and equitable allocation of resources.

The programme also faced several risks, some of which will endure into 2011. For example, health care provision was hampered by a lack of investment in infrastructure, and providing comprehensive services in hard-to-reach areas is an enduring challenge.

Documenting the impact of the programme and the lessons learnt during its implementation will be crucial to strengthening the initiative and to securing continued funding of its activities. The Monitoring and Evaluation Framework developed in 2010 leans on multiple sources of data as well as monitoring visits.

To strengthen this process, baseline surveys were scheduled for 2011. In addition, close supervision is needed to improve the quality of data collected in the field, and monitoring visits should also get under way in 2011.

Pictured above: An 18-month-old boy holds his completed immunization record after receiving his second shot of measles vaccine. The immunization was carried out by a midwife during an outreach visit to Leik Kone, a village in the Bine Daunt Chaung Village Tract of Labutta Township

Efforts to measure the programme's output more exactly will coincide with its expansion into new geographical areas and a push for it to cover all six of its initial objectives: maternal and child health, nutrition, psychosocial health, disease control, health emergency preparedness and response and demand-side initiatives.

While the task ahead remains substantial, the management team of the JI-MNCH is heartened that, after a successful launch, the work of the initiative continues to enjoy the goodwill and trust of its donors, the Ministry of Health and of its implementing partners.

2 INTRODUCTION

2.1 Background

The Joint Initiative on Maternal Newborn and Child Health, or JI-MNCH, is a collaborative programme that brings together partners in the former Health Cluster and the Government of Myanmar's Ministry of Health (MOH). It aims to increase access to essential maternal and child health services amongst hard-to-reach (H2R) populations in areas most affected by Cyclone Nargis.

The cyclone struck the Ayeyarwady Delta and neighbouring areas of Southern Myanmar in May 2008, killing an estimated 140,000 people and affecting the lives of a further 2.4 million. Since that time, despite some improvements in health service access and health outcomes, problems persist in areas including low service coverage for maternal health, sub-optimal nutrition, and pockets of vey low health service access in H2R areas.

JI-MNCH is an innovative partnership which takes a comprehensive approach to health service delivery at the township level. It aims to deliver an essential package of low-cost, high-impact maternal and child health interventions through a number of service delivery partners including public health services and NGOs. The programme is based on Joint Township Health Plans and a monitoring framework. In addition to resources from MOH, UN and NGOs, the initiative draws on a pool fund supported by three donors to finance eligible actions in the plan. The programme builds on the successful post-Nargis coordination between partners in the Health Cluster and with MOH at township, divisional and central level. It uses a common results framework based on international health indicators, and rests on a service-commissioning rather than project grant-making approach to funding.

The proposed three-year programme began in May 2010 and by the end of the year implementation had begun in three project areas in the Labutta and Bogale Townships of Ayeyarwady Division. The Implementing Partners (IPs) were: Merlin (Labutta Township, excluding Middle Island), IOM (Bogale Township) and Save the Children (Middle Island).

2.2 End of Tripartite Core Group

The programme was initially conceived in the light of the Post-Nargis Recovery and Preparedness Plan (PONREPP), a framework for assistance to cyclone-affected areas that was approved by the Tripartite Core Group in 2008.

In 2010, the Tripartite Core Group, a body comprising the Government of Myanmar, ASEAN and UN partners set up to coordinate the response to Nargis, was dismantled and the recovery phase officially declared over.

As a consequence, the Steering Committee, in consultation with key stakeholders, has changed the programme's name from 'Health PONREPP' to 'Joint Initiative on MNCH' in order to better reflect government policy as well as the programme's focus on the health of mothers, newborns and children.

2.3 Objectives

The core objective of the programme is to increase access to essential maternal and child health services amongst H2R 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 among the affected populations also will be met whilst mitigation of future risks will be achieved through a focus upon emergency preparedness.

2.4 Design of JI-MNCH

The 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 package of services is aligned with guidance regarding minimum maternal and child health services including high-impact child survival interventions identified in the Lancet 2003 series. Additional interventions will address the psychosocial needs of cyclone survivors and better protect them against future disaster risks through community-based disaster preparedness and response activities.

The areas of work eligible for funding under the JI-MNCH have been prioritized by Health Cluster partners and are in line with the Government of Myanmar's National Health Strategy.

2.5 Donors and budget

The JI-MNCH Fund, administered by UNOPS, is a multi-donor fund of 12 million US$ over a three-year period from 2010-2012. It was established by 3 key donors: the Governments of Australia, Norway, and the United Kingdom.

2.6 Fund flow

The programme is being implemented under the framework of the EU Common Position on Myanmar. In line with the existing practice of the 3 Diseases Fund, funds flow directly to UNOPS and IPs in order to support health activities at the township level and below.

3 GOVERNANCE

3.1 Governance structure

The 3 donors formed a **Donor Consortium**. Norway chairs the group.

A **Steering Committee** was formed to oversee the implementation of the JI-MNCH. The committee consists of one representative from the donors, one representative from each of two UN agencies (WHO and UNICEF), the nominated MOH Focal Point for JI-MNCH, an independent public health expert, and one representative of INGOs involved in the programme. The chairmanship of the committee is held by WHO.

An **Advisory Group** was established as the main forum for consultation and coordination among all the stakeholders and partners in the Joint Initiative. The Advisory Group consists of the MOH Focal Point, bilateral and UN agencies, and former NGO Health Cluster members.

UNOPS was designated as the **Fund Manager**, with the principal functions of holding and disbursing funds, administering grant allocations, receiving proposals and undertaking performance monitoring.

Reflecting its own activities in the health field, UNICEF was made responsible **for 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 and the MOH Focal Point, through their membership of the Steering Committee, were to provide a **policy link** between the Steering Committee and the Ministry of Health in Nay Pyi Taw.

3.2 Establishment of the JI-MNCH Fund Management Office

UNOPS established a Fund Management team under an interim officer based in Yangon and supported by a Portfolio Management team in Bangkok (with the Portfolio Manager visiting Yangon regularly). The vacancy for a National Fund Director was advertised in March 2010. However, the only candidate who met the panel's requirements was disqualified after a review of their credentials and references. In order not to slow down project activities, an interim National Fund Director, an interim M&E Officer and an interim Assistant were recruited to manage the programme activities. This resulted in the setting up of an effective M&E Framework and the launch of activities in Labutta, Bogale and Middle Island. Permanent staff members were to be in place in January 2011. The JI-MNCH organizational chart is included in Annex 1.

UNICEF assisted in the management of the programme by providing technical support in reviewing Coordinated Township Health Plans (CTHPs) and supporting operations at the township level. One health officer and one nutrition officer from UNICEF took on these advisory roles.

4 KEY MILESTONES

- **Township Health Assessments**
  Based on joint assessments of the health needs of the townships carried out in 2009, health partners (township health officials, NGOs and UN) developed CTHPs for Labutta, Bogale and Dedaye townships

- **Service Agreement between UNOPS and MOH**
  A Service Agreement between the Department of Health, Ministry of Health and UNOPS was signed on 19th May 2010

- **Monitoring and Evaluation Framework**
  An M&E Framework was developed and approved by the Steering Committee on 19th May 2010

- **Service Agreements with Implementing Partners**
  Service agreements between UNOPS, Merlin and IOM were signed in May 2010 and between UNOPS and Save the Children in November 2010

- **First Semi-Annual Report**
  The first JI-MNCH semi-annual report covering the period from January to September 2010 was drafted and was to be submitted for approval to the Steering Committee in January 2011 prior to distribution to donors and stakeholders.

5 PROGRAMMATIC ACHIEVEMENTS

The following are some of the key achievements of the programme in Labutta (excluding Middle Island) and Bogale townships from May to December 2010:

- 14 township monthly coordination meetings held with township health authorities (7 in Labutta and 7 in Bogale townships)
- Township monthly coordination meeting held with BHS (6 in Labutta and 6 in Bogale townships)
- Monthly meetings organized in all RHC's since July 2010
- Completed the training of 43 new AMWs and 74 new CHWs
- Supported 1,120 outreach visits conducted by MWs
- Supported 265 outreach visits to H2R areas conducted by MWs
- Supported emergency referral of 39 children aged under 5 for child care and 153 women for obstetric care
- Provided emergency health care drugs in all station hospitals (SHs)
- No RHC with a stock-out of essential drugs

Some of the steps implemented to deliver high-impact services and increase coverage are listed below:

- Selection and training of voluntary health workers (VHWs) and revitalization/constitution of VHCs to strengthen community involvement for health
- Delivery of essential package of high impact maternal and child health interventions through RHCs and sub-RHCs, and outreach delivery of primary health care services in the communities by VHWs (CHWs and AMWs)
- BHS field visits to outreach and H2R areas to provide essential services for H2R populations and vulnerable groups
- Emergency health care drugs for SHs, drug kits for RHCs, sub-RHCs and VHWs are being provided, and clean delivery kits distributed
- An innovative referral mechanism for women and children has been formulated to ensure timely and effective emergency referrals
- Coordination among all stakeholders from the central level down to the village level has been clearly established
- Coordination between BHS, NGOs and the community, and policy dialogue with MOH

6 MONITORING AND EVALUATION

6.1 M&E Framework

The first Advisory Group meeting to develop a monitoring log-frame was held on 30th March 2010. The meeting produced a preliminary monitoring framework, indicators and data sources to be used for implementation of Joint Township Health Plans (JTHPs). In close consultation with DFID, the outputs of the meeting were used to prepare the JI-MNCH monitoring log-frame.

The preliminary framework was jointly reviewed and improved at workshops in Labutta and Bogale by IPs, INGOs, Local NGOs, UNICEF, UNOPS and Township Health Teams. The framework was presented to the Advisory Group, and then submitted to and finalized by the Steering Committee. The approved M&E Framework is used as a township-level framework in Labutta and Bogale townships.

6.2 Progress by the end of 2010

The M&E Framework for 2010 was developed under the DFID log-frame format and was used until the end of 2010 Annex 1. The framework was based on 1 goal indicator, 9 outcome indicators and 14 output indicators. The list of indicators used in the framework is mentioned in Annex 2.

There were 3 main data sources at the township level for the development of indicators. The first data source is the Health Management Information System (HMIS) which provides population data, vital data and project outcome data such as immunization, antenatal care, skilled birth attendants, etc. Most of the health outcome and impact data will be collected through this system. The second data source is Quarterly Technical Progress Reports submitted by the IPs. These reports provide project output data and qualitative information. The third data source is population-based surveys planned for early 2011 and late 2012. The surveys will provide data on areas such as exclusive breastfeeding and diarrhoea and oral rehydration therapy. Results produced by the surveys will also be used for triangulation of data gained from other sources.

Data items to be collected through HMIS, progress reports and surveys are mentioned in Annex 2.

Field monitoring visits were to be carried out by the Fund Management Office (FMO) in order to validate data and information from the HMIS and Quarterly Technical Progress Reports. The FMO uses field monitoring checklists (see Annex 3) to collect data and information from the field. Based on the information obtained from technical progress reports, field monitoring visits and routine information systems, the FMO prepares half-yearly Progress Reports and Annual Consolidated Reports. These reports will pass through the Township Coordination Committee, Advisory Group and Steering Committee to ensure wider stakeholder participation and accountability.

An independent evaluation may be conducted at the end of 2012 under the aegis of the Steering Committee as part of overall program monitoring and evaluation. The evaluation will focus on program effectiveness, efficiency, impact, sustainability, coverage (particularly in terms of social inclusion/exclusion), coherence and coordination.

6.3 Issues and constraints

Baseline surveys planned for the end of 2010 could not be carried out because of several constraints. In particular, the FMO was overburdened with preparatory work for the extension of the programme to additional townships, fund management, participation of coordination and technical meetings and M&E work. The surveys were re-scheduled for 2011.

HMIS is the main source that provides most of the data for output and outcome indicators. However, because of the workload facing BHS staff, some HMIS activities such as supervision and validation of data submitted to RHCs and Township Health Departments could not be carried out. Therefore, there are discrepancies and mismatches in the monthly RHC reports.

In 2010, field monitoring visits could not be performed by the FMO because of limited manpower in the office as well as problems in obtaining Travel Authorization.

6.4 Recommendations

As baseline surveys are a critical first step toward measuring the project, they should be carried out in each township within the first year of project implementation. The surveys should also be well prepared to ensure the validity of data collected. Before conducting a survey, a proposal should be prepared and reviewed by peer groups. The proposal should include the formation of a working committee, survey objectives, sample design, sampling methods, sample size determination, data collection methods, enumerators, supervisors, survey instruments (questionnaires), dummy tables and a timeframe.

In order to improve the quality of data produced by HMIS, there should be supervision of the collection, reporting and validation of the data. Supervisors should be Health Assistants working at the RHCs and they should work together with IPs on supervision as well as validation.

Field monitoring visits are important to assess the quality of services and to validate reported data. Therefore, field monitoring visits should be well planned with the partners and carried out in 2011.

Training conducted at the township level should have technical inputs from training teams both from divisional level (Pathein) and central level (Department of Health (DOH)) so that technical inputs and guidelines can be provided to BHS and IPs in the townships. In addition, clarifications can be sought from central level DOH project staff if required.

7 IMPLEMENTATION STATUS FOR LABUTTA (MERLIN) AND BOGALE (IOM)

7.1 Capacity-building for health workers

To enhance health care coverage, especially in areas which are beyond the reach of BHS, CHWs and AMWs were selected according to the set criteria and trained using the curriculum developed by the DOH.

7.1.1 Training of AMWs

In Labutta, of the 50 AMWs planned to be recruited and trained, the first 25 AMWs completed their full 6 months of training and began working independently in their home villages. The remaining 25 AMWs completed their training at the township hospital and were undertaking their period of supervised work experience with the BHS facilities in the field. The new AMWs come from some very hard-to-reach areas, including coastal islands cut off for part of the day by tides. Training the AMWs is crucial to ensuring that the population in these isolated communities can access primary health care, obstetric care and emergency obstetric referrals.

Pictured above: Auxiliary midwives assigned to the Pyinsalu Rural Health Centre holding their certificates at the end of a training course. A total of 43 auxiliary midwives were trained with support from the JI-MNCH in 2010.

Also in Labutta, a total of 116 existing AMWs (about three-quarters of the total in the township) attended one of the four two-day refresher courses held in July by the Township Health Department.

In Bogale, where the planned target was for 60 new AMWs, the training of an initial group of 18 was completed.

7.1.2 Training of CHWs

In Labutta, 51 new CHWs were recruited and attended a 30-day training course after which they were assigned to their respective villages (100% implementation rate).

In addition, a total of 310 CHWs attended one of a series of 3-day refresher course at RHCs in Labutta Township. The courses were coordinated by the Township Health Department. The attendees included 45 AMWs also working as CHWs. (65% implementation).

In Bogale, 23 new CHWs were recruited, trained and assigned to their villages (17% implementation rate). Refresher training of 48 CHWs also was carried out.(40% implementation).

7.1.3 HMIS training for BHS

In Bogale, in order to strengthen the reliability and validity of the HMIS data collected in the field, 84 BHS staff received training on HMIS practices and procedures (84% implementation).

7.2 Outreach and 'Hard-to-Reach' activities

In Labutta, 310 villages were identified as outreach villages and 103 as H2R villages. During the reporting period, MWs carried out a total of 1,238 outreach sessions. Activities included antenatal care, postnatal care, immunization, health education and deliveries (23% implementation). For the hard-to-reach areas, a total of 409 visits were supported, including at least one visit per month to each village.

In Bogale, 1,620 outreach sessions were conducted (46% implementation) by MWs with support from the IP and 324 visits were made to cover H2R villages (46% implementation).

7.3 Drug availability at health facilities and in the community

In Labutta, by the last quarter of 2010, Merlin had distributed RHC drug kits to all 11 RHCs and Sub-RHC drug kits to 48 sub-RHCs as well as drugs to CHWs and AMWs, enabling them to conduct their activities in the villages. There were no stock-outs during the reporting period.

An examination of the drug consumption rates provided by CHWs/AMWs found that they appear to correlate well with morbidity data. This kind of monitoring helps IPs to ensure that drug prescriptions match the diagnoses made by the CHWs/AMWs.

Also in Labutta, a total of 461 CHWs have been provided with CHW kits and a total of 153 AMWs have received AMW kits.

In Bogale, medical supplies were mostly distributed in July. Five SH drug kits (42% implementation), 18 RHC drug kits (100% implementation) and 45 Sub-RHC drug kits and 500 Clean Delivery Kits have been distributed, ensuring adequate supply of essential drugs at the health facilities in the rural areas.

Also, 69 CHW kits were provided to CHWs to help them carry out their activities in their assigned villages (23% implementation).

In both townships, drugs were provided by UNICEF up to October 2010. Subsequently, drugs were provided by the JI-MNCH programme through its IPs

Plans were being laid to deliver cold storage boxes and solar refrigerators to health facilities by early 2011.

7.4 Health education

In Labutta Township, CHWs and AMWs carried out a total of 2,280 health education sessions at the village level during the reporting period.

Another 171 health education sessions were carried out in Bogale. (10% implementation).

7.5 Coordination meetings

Since July, township health authorities together with IPs have held monthly township coordination meetings in Labutta and Bogale. The meetings have been attended by regular JI-MNCH coordination committee members and representatives of township authorities, UNICEF and UNDP, and NGOs/INGOs.

Monthly meetings of BHS at the district or township level were organized to cover the JI-MNCH implementation. In Labutta, 825 BHS (38.19% of target) participated in these meetings during 2010. Some BHS staff from hard-to-reach areas, as well as some SH staff, were unable to attend due to their work commitments. In Bogale, 469 BHS staff attended these meetings (48.85% implementation).

Monthly RHC meetings were held in all the 11 RHCs in Labutta during the reporting period. The attendance rates for CHWs and AMWs were 95% and 72%, respectively. In Bogale, a total of 51 monthly RHC meetings were held (35.42% implementation).

The RHC meetings were seen as a valuable forum for sharing experiences, identifying challenges and finding solutions. Community support groups, fire brigade members, local officials and village elders also participated.

7.6 Emergency referral of obstetric and child cases

In Labutta, a comprehensive Standard Operating Procedure (SOP) for emergency referrals was drafted in collaboration with the Township Medical Superintendant and the DOH. A total of 49 cases were supported to receive emergency referral services, comprising 34 pregnant women, three children and 12 other patients whose condition was judged life-threatening. The operating procedure was to be further refined in the light of feedback from stakeholders.

In Bogale, a total of 155 emergency referrals took place based on interim referral guidelines approved by the Township Medical Superintendent. The total comprised 119 obstetric emergencies and 36 seriously ill children.

7.7 Joint monitoring and supervision

District- or township-level health department personnel and IP staff conducted joint monitoring visits to inspect and supervise the implementation of project activities and to get a first-hand view of conditions at the village level. During the year, 8 such trips were conducted in Labutta and 10 in Bogale.

7.8 Support to Village Health Committees

IOM has supported the mobilization of VHCs in a significant number of villages that previously lacked or had dysfunctional VHCs. The IP sought to build trust by bringing local village authorities and BHS together and sensitizing them to the advantages of having a functional VHC.

In Bogale, out of a total of 553 villages, 114 villages formed VHCs without outside assistance. IOM encouraged the formation of VHCs in several hundred more. It also has developed a checklist for assessing how well VHCs are functioning.

7.9 Maternal and child mortality follow up

In Labutta, Merlin was finalizing mechanisms to establish a maternal and child mortality review schedule for field implementation.

In Bogale, follow-ups by a joint team got under way and 3 cases of maternal mortality and 15 cases of child mortality were reviewed.

7.10 Nutrition

In Labutta, a support fund for community-based management of malnutrition will not be established until the extent of any malnutrition problem is quantified through screening. Screening will be done by active case detection through the measurement of MUAC (mid-upper arm circumference) by CHW/AMWs and confirmed by BHS.

At the 11 RHCs within Labutta Township, a series of 2-day workshops on basic nutrition awareness were carried out for schoolteachers. The RHCs provided the trainers and coordinated the workshops. A total of 337 participants from 318 of the township's 358 schools attended these sessions. Some 70% were women and 30% men.

The training is designed to enable teachers to provide nutrition education to their students, and to recognize and refer suspected cases of malnutrition to BHS or CHW/AMWs. The efficacy of this strategy was to be discussed further through the JI-MNCH management structure.

In Bogale, IOM deployed two Mobile Nutrition Teams in September 2010 to address nutrition issues for pregnant mothers and children under 5 in cooperation with BHS. The Mobile Nutrition Teams conducted 4 monthly trips (33.33% implementation rate) and visited 47 villages, where they screened 3,185 children. In that process, they identified 75 Global Acute Malnourished (GAM) children, 9 Severe Acute Malnourished (SAM) children, 66 Moderate Acute Malnourished (MAM) children and 405 children at risk. The team followed DOH guidelines and the SAM children were provided with Ready to Use Therapeutic Food (RUTF) called plumpy nut and BP5. Along with nutrition screening and monitoring, the teams also conducted several health education sessions. Topics included MUAC, balanced diet, exclusive breastfeeding, weaning diet, immunization and birth spacing. They also conducted individual health education and counselling sessions for the mothers with malnourished children.

Pictured above: A Community Health Worker in Kone Gyi village, Labutta Township, entering patient details into a daily register. More than 400 new or existing CHWs received training supported by the JI-MNCH in 2010.

In December 2010, IOM also facilitated nutrition awareness training for 310 teachers in Bogale. (96.57% implementation status)

7.11 Psychosocial health

Activities to address psychosocial health needs in Labutta and Bogale townships were not carried out in 2010. These activities were expected to begin in 2011.

7.12 Disease control

In Labutta, procurement of equipment including 6 solar refrigerators for RHCs and SHs, cold storage boxes and vaccine carriers was ongoing in 2010. Distribution of the equipment was planned for early 2011.

8 IMPLEMENTATION STATUS FOR MIDDLE ISLAND (SAVE THE CHILDREN)

As Save the Children started its implementation only on 15th November, its activities in 2010 consisted largely of making preparations and coordinating with the relevant central, divisional and township authorities for the implementation of the project activities.

In the last week of November, the JI-MNCH JTHP was officially presented to the Township Authority as well as other government departments and agencies. Save the Children recruited, trained and deployed JI-MNCH specific staff to the field by 23rd December. Orientation and work plan sessions with BHS and Township Health Team members began on 31st December.

Save the Children was already operating a revolving fund system for emergency referral in more than 50 villages, and planned to replicate this system in 59 villages of Middle Island.

9 IMPLEMENTATION CHALLENGES

9.1 Reaching H2R areas

Areas may be designated as hard-to-reach (H2R) for a variety of reasons, including: difficult physical access; low availability and high costs of transportation and communication; low socio-economic status of residents; absence of BHS and VHCs, and lack of health infrastructure. These factors impede the regular and effective delivery of essential health services.

Many MWs encounter difficulties in carrying out health activities like immunizations, antenatal care, attending births, and nutrition care to those living in H2R areas. MWs shoulder the main burden of organizing and executing the transport of medicines and equipment to these places, though some can count on assistance from AMWs, CHWs and some local helpers.

The followings measures will help overcome these challenges and improve access to essential services for populations in H2R areas. Some have been implemented, while others are included in a second phase:

- Support the transportation and micro-planning for MWs related to Expanded Programme of Immunization (EPI)
- Support MWs who are trying to expand services into areas where the position of MW is vacant, particularly in EPI, antenatal care and postnatal care
- Encourage DOH to fill vacant positions for BHS
- Support referral services
- Train more AMWs to ensure access to clean and safe delivery everywhere
- Train CHWs and provide essential PHC services
- Harmonize with EPI programmes in selected areas to reduce the cost and ensure all-time availability of essential services
- Establish and build the capacity of VHCs

- Involve employers and husbands/fathers of pregnant women and children to increase access for programme activities

9.2 Non-functioning VHCs in villages with many seasonal migrant workers

IOM found that some villages in Bogale Township (especially in the Mone Taing Gyi and Kyein Chaung Gyi village tracts) have many migrant workers. These villages often lack a functioning VHC and it has proved difficult to select volunteers from these villages, with likely negative impact on the emergency referral system. IOM intended to support the formation of VHCs and, through these, to try to identify candidates for training as AMW/CHWs.

9.3 Reaching H2R and vulnerable populations

People living in H2R areas may be H2R populations. They might have physical challenges to access essential services but not all have economic and/or socio-cultural challenges.

Access to essential services for people living in H2R areas is improving through the support given to BHS and the involvement of the communities.

There are many H2R people living in the project areas. Most of these families are mobile, manual labourers working in the fishing or salt industries or in firewood/ charcoal production.

As these people are poor and have little knowledge of health issues, when they are busy, they often ignore schedules for immunization and for antenatal, delivery and nutrition care. Employers also show little interest and provide poor support for the health care of these groups. Therefore, it is very difficult to achieve good coverage of health care to these vulnerable populations

Many of them have little or no access to essential health services, including those related to maternal, new born and child health. While they may be eligible for benefits through the emergency referral system, these people may not be aware of the system's existence.

The followings are suggested as means to overcome the challenges and to improve access to essential services for H2R and vulnerable populations. Some have already been introduced and others will be implemented in phase 2 plans:

- Provide technical assistance in identifying H2R populations and planning service delivery
- Encourage IPs to focus on H2R populations
- Establish and build capacity of VHCs
- Involve employers and husbands/fathers
- Raise awareness among H2R populations of the availability of services
- Coordinate with other assistance programmes

9.4 Changes in administrative boundaries and arrangements

Administrative restructuring in Labutta and Bogale townships impacted they way in which support was provided to public health facilities and in which some activities were implemented under the JI-MNCH JTHP.

Merlin reported that the restructuring resulted in the re-designation of catchment areas for health facilities and affected the number of VHWs attending meetings at some RHCs. Some VHWs were unable to attend the meetings regularly due to the cost and time needed for transport. Merlin was addressing this challenge through a review of travel subsidies.

IOM reported that the administrative resulted in the transfer of the area of Ka Done Ka Ni from Pyapon Township to Bogale Township. Ka Done Ka Ni has a population of approximately 30,000, a SH, a RHC and five sub-RHCs. In order to be able to support this additional area, a budget revision for the Bogale JTHP was being reviewed.

9.5 Vacant MOH positions in the townships

The position of Township Health Officer (THO) was still vacant in both townships. This vacancy affected the type of joint public health activities carried out under JI-MNCH. While Medical Superintendents (MSs) have additional responsibilities for managing hospitals and in administration, the appointment of THOs focused on public health issues can facilitate effective coordination and implementation.

In addition, some positions for BHS, especially MWs, are vacant, notably in H2R villages. Merlin notes that some of those BHS staff already in the field felt overburdened by the new activities and responsibilities outlined in the JTHP. The IP said it was seeking ways of motivating BHS staff and improving their sense of ownership of the plan.

IOM noted how the sub-RHC at Kyein Chaung Gyi, Bogale Township, was upgraded to a RHC and its geographical coverage expanded, resulting in a need for more staff. However, the RHC has only 3 staff. As an interim measure, HMIS data collection, EPI and other activities were being carried out with staff from nearby Ma Gu RHC.

9.6 Unauthorised practitioners

Unauthorized ‘quack’ practitioners represent an ongoing challenge to the project. Many community members prefer them over trained medical staff for various reasons, including familiarity, custom and cost. This preference is a barrier to the delivery of health services in the community and the collection of reliable health data. Many unauthorized practitioners, village pharmacies and traditional healers are active in the project areas. IOM has raised this issue with local health officials.

9.7 EPI micro plans

Plans for visits to outreach and H2R areas based on EPI micro plans need to be reviewed and improved in order to provide essential services effectively and efficiently.

IOM observed that while most MWs generally organize EPI activities well and manage to reach villages according to their plan, around 30% do not carry out visits according to a micro plan. The MWs who have difficulty in following their plans are predominantly those working in H2R areas and/or areas with many internal migrants.

9.8 Lacking or inadequate policy, SOPs and guidelines

As an innovative programme based on partnerships, the JI-MNCH has introduced some new activities and others with which some stakeholders were not familiar. At the same time, it has sought to find a common approach for all of its partners in order to ensure effective coverage of services and equitable allocation of resources. Though some policies, standard operating procedures and guidelines are in place, these have proved inadequate or impractical for the implementation of some activities, including in nutrition and psychosocial support. All stakeholders, including IPs, are encouraged to identify policies, operating procedures and guidelines required for effective implementation and to inform DOH so that improved procedures can be developed.

9.9 Coordination

Coordination among health actors at township level is the key to achieving good public health outcomes. All health actors should actively participate in the joint assessments, development of the CTHPs and coordination meetings. The role of the Head of the township health authority is of paramount importance. Coordination should be strengthened both vertically and horizontally. A good coordination among partners and programme managers will lead to the use of common approaches.

10 GOOD PRACTICES

10.1 Using existing village structures

IOM noted that many of the villages where it was implementing JI-MNCH activities had pre-existing Community Support Groups (CSGs). These groups were formed by the Department of Health with the support of JOICEF (Japan)/UNFPA prior to the JI-MNCH intervention, to address and support reproductive health issues Typically, there was one CSG for every 30 households. In coordination with the MS and Health Assistants from the relevant RHC, IOM has successfully encouraged the groups to connect with BHS and volunteers to ensure support for JI-MNCH activities at village level.

10.2 Emergency referrals

Emergency referral is one of the important activities of the programme. Though DOH has guidelines for referrals, they should be adapted for the JI-MNCH programme. Merlin has been developing SOPs with the DOH and there is a need to refine and harmonize such procedures further with all stakeholders.

IOM started to facilitate and support emergency referrals focusing on mothers and children as well as lifesaving referrals for all persons, as it is considered unethical not to ensure that everyone suffering from a life threatening, non-chronic condition is included in this arrangement.

In 2010, IOM supported 36 emergency referrals of children aged under 5 and 119 obstetric emergencies.

Merlin began supporting emergency referrals on 1st November. SOPs include the definition of clinical cases to be referred, an administrative process and a financial guide for reimbursement of patient costs. Merlin and health authorities in Labutta Township have developed a procedure whereby financing will be handled collaboratively by Village Health Committees, Village Tract Health Committees and Merlin staff. This process is transparent, open and fair, and provides clarity for all partners.

This referral system started well, with, 49 cases referred through the system, including 34 emergency obstetric cases and 3 involving children under 5.

10.3 Rural Health Centre meetings

IOM noted that RHC meetings were gaining momentum, with improved attendance. The meetings provide opportunities for sharing experiences as well as for identifying challenges and exploring solutions. Open and fair discussions encouraged more participation. Attendees included BHS, CHWs, AMWs, and CSGs and other invitees. Some meeting conducted health education sessions, with topics chosen according to local needs.

10.4 Strengthening Village Health Committees

JTHPs envisage the involvement of communities through VHCs, community based schemes/demand-driven initiatives as well as emergency preparedness planning for health.

IOM reported that 114 villages set up VHCs using their own funding. Other villages started collecting funds to support the formation of VHCs. IOM initiated discussions on using a revolving fund for referrals and some VHCs established this practice.

Pictured above: a Community Health Worker in Ma Gyi Gyaung, a village in Labutta Township, being mentored by a Merlin project officer on managing the treatment of childhood illnesses.

In addition, IOM, the MS and BHS developed a checklist for assessing the functioning of VHCs. The key indicators are:

- Regular attendance at monthly RHC meetings
- Regular VHC meetings
- Good coordination and cooperation with BHS for activities such as EPI
- Ability to organize health emergency referrals
- Establishment of emergency funds

10.5 Outreach

Merlin reported that, for provision of essential services in the 310 outreach villages and 103 H2R villages in Labutta Township, the monthly coverage was close to 100%. As examples of areas where improvements were clear, Merlin noted referrals (referrals and life-saving institutional deliveries dramatically increased), immunization (helped by transportation support for MWs) and VHW coverage.

10.6 Ability to programme in new areas

Merlin reported that 51 villages in the catchment areas of Kyone Kue and Kyauk Chaung SHs previously had neither CHWs nor access to health facilities of any kind. Fifty-one new CHWs have been trained for these villages, meaning there will be 100% coverage in the two catchment areas.

In addition, through the monthly JI-MNCH township coordination meetings, health agencies have been able to coordinate with other departments. For example, In one meeting, Merlin convinced divisional and township representatives of the worth of scheduling CHW training before the November elections, with direct knock-on effects on health service provision. The early completion of the training has enabled CHWs to begin serving their communities with less lead time. Most importantly, the new CHWs come from parts of Labutta which include H2R areas. Phaung Doe sub-centre covers 6 villages where access to the nearest hospital is extremely challenging. Villagers can travel first by sea for 2.5 hours, which is very risky during the monsoon season, and then by motorcycle. The total journey time is at least 7 hours. Alternatively, they can walk through the forest for 6-8 hours and then continue by motorcycle. The newly trained CHWs are a great boost to these villages.

The joint monitoring and supervision of public health employees has also been agreed. Whilst the activity itself should not be complicated, the approval process goes a long way towards improving transparency and accountability at the township level. The supervision checklist was designed and agreed by the Township Health Department. Supervision visits started in October.

10.7 Population-based survey

A Knowledge, Practice and Coverage (KPC) survey was completed by Merlin with its own funding in this period, after obtaining approval from the DOH. This population-based survey is intended as a base line for the core programme indicators. The survey sampled 360 households in 30 villages across 8 RHC catchment areas. It was carried out using four Focus Group Discussions with mothers of children under 5 and discussed emergency obstetric care, mother and child health, and tuberculosis. Because they act as service providers, interviews also were carried out with CHWs. Findings were to be reported in the next quarterly report following consultation with DOH in January 2011.

11 MANAGEMENT ACHIEVEMENTS

11.1 Coordination mechanisms

- JI-MNCH provides valuable opportunities to strengthen coordination between the public health sector and the private sector (between the MOH and NGOs), based on the experiences of the Health Cluster
- Coordination among all stakeholders at all levels, from the central level down to the village level, is clearly established and many VHCs have been revitalized or newly constituted, thus promoting community involvement
- At the central level, the Steering Committee approves funding and oversees the implementation of the funded plans, and the Advisory Group consults and coordinates with all stakeholders and partners by conducting regular meetings
- At the regional level, coordination meetings bring together the MOH, regional health authorities, Township Medical Officers (TMOs)/MSs, UN agencies, the FMO and IPs to jointly oversee progress and solve problems
- At the township level, two types of coordination meetings are held: Township Coordination Committee meetings with health actors working in the township and BHS chaired by township authorities; and meetings between BHS and IPs to evaluate progress, solve problems and plan for the following months
- At the RHC level, monthly meetings are held with BHS and VHWs
- At the village level, VHC meetings are held. Though most of the VHCs could not arrange regular meetings, meetings are held when issues for coordination arise.

11.2 Operational guidelines

As there was a need to develop Operational Guidelines for JI-MNCH, a consultant who had already worked on the development of such guidelines for the Livelihoods and Food Security Trust Fund (LIFT) was recruited. The Terms of Reference for this consultancy were developed in consultation with DFID.

The main output of the assignment is a set of Operational Guidelines which will be in-line with the requirements of the Donor Consortium, the Steering Committee and UNOPS. The Operational Guidelines include Introduction and Purpose, Overview and Objectives of JI-MNCH, Code of Conduct between IPs and JI-MNCH, Donor Requirements for IPs, Dispute Resolution, Grant Selection and Approval, Grant Amendments, Fund Disbursement to IPs, Closing or Termination of Grants, Financial Management and Reporting, Technical Reporting, Inventory Management and Reporting, Auditing, Record Management, Procurement, Risk Management, Monitoring and Evaluation and necessary General Procedures to achieve the objectives of the JI-MNCH programme.

The final draft will be shared with Steering Committee and once approved by the committee it will be communicated and shared with all JI-MNCH staff and IPs. These Operational Guidelines will be a living document and will thus be regularly updated by the Fund Manager. They will form the basis for the effective management of the JI-MNCH fund and its partnerships.

11.3 Contracting/service agreements

A Letter of Service Agreement was signed between the DOH, MOH and UNOPS on 19th May 2010. UNOPS signed service agreements with IOM on 24th May 2010, Merlin on 28th May 2010 and Save the Children on 15th November 2010.

On December 10 2009, UOPS signed a Grant Agreement with the Government of Norway for a contribution of NOK9.5 million. A day later, it signed Memorandums of Understanding with DFID and AusAID for contributions of GBP2.88 million and AUS$1 million, respectively.

12 LESSONS LEARNT

12.1 Collaboration with health committees and local health personnel

The experience already gathered by IPs during Nargis recovery activities facilitates the endorsement and decision-making for JI-MNCH activities at the township level. In both Labutta and Bogale townships, several meetings were organized and the roles and responsibilities of IPs in the project were stipulated.

12.2 Township-level coordination meetings

Coordination meetings are another example of good collaboration among IPs and relevant stakeholders at the township level. Many experienced staff members from MOH, Township Health Teams, Divisional Health Team, UN agencies and NGOs participated in the meetings, where experiences, views and ideas were exchanged and important decisions taken. Discussions have focused on coordination, operational issues and M&E.

Pictured above: A midwife administering vaccinations during a visit to Khar Kwin village in Labutta Township.

12.3 Monitoring and evaluation

While the M&E framework was developed, issues remain regarding the availability of data from different sources and its utilization by IPs. The establishment of databases for both Labutta and Bogale townships also has begun. It is expected that any issues that arise will be discussed, and appropriate action taken through meetings of the Advisory Committee and Township Coordination Committees.

12.4 JTHP unit rates

There is a need for the FMO to remain vigilant on tracking the JTHP unit rates (e.g. the cost of training an AMW) and ensure that any proposed change is agreed upon with the DOH and the FMO.

13 RISK ASSESSMENT

13.1 Lack of competition to become IPs

Three calls for Expression of Interest have been made under the JI-MNCH Fund and it is noted that in each case, only one proposal was received. This shows that there is little competition among candidates to become involved in the programme. One of the main reasons for the low participation of NGOs is surely the small number of NGOs working in the Delta during the post-Nargis recovery period.

13.2 Change in Government of Myanmar policy after end of TCG

With the end of the TCG in July 2010, government policy on post-Nargis recovery activities changed. The Government was of the view that the recovery effort was complete and needed to conclude. This policy affected ongoing programs to a certain extent. To help avoid adverse effects on the JI-MNCH programme, its name was changed with the agreement of the Steering Committee and key members of the Advisory Group in May 2011. The new name is Joint Initiative on Maternal, Newborn and Child Health (JI-MNCH).

13.3 Myanmar political transition

The high density of political transition activities taking place in the project areas in 2010 delayed the execution of project activities because of restrictions on access for international staff during this period.

13.4 High turnover of personnel within township health teams

High turnover and insufficient human resources among township health departments and health teams represent a risk for the timely implementation of project activities. The strategy for mitigating this risk is for the IPs to provide strong support when required. With the collaboration of TMOs/MSs, IPs may inform DOH about the vacancies and dropouts through the coordination committee meetings in Pathein and Steering Committee meetings in Yangon and Nay Pyi Taw. DOH has agreed in principle to strengthen human resources and possibly to fill the vacant posts within months, especially Township Health Officer posts. To improve health coverage, it was suggested to DOH at the Annual Review Meeting to create positions especially in H2R areas in line with GAVI-HSS. Some activities, including AMW and CHW training, and data collection and compilation, can be delegated to IPs when there are temporary vacancies among BHS staff.

13.5 Lack of funding for health infrastructures

There are a number of activities in the CTHPs which were not funded. For some activities, this is because it was known that they can be 'piggy-backed' on other activities. However, some other activities, such as the construction of RHCs and sub-RHCs was not considered for implementation as a result of a lack of funds and the stance of donors' on infrastructure development.

As these activities are necessary for the achievement of development goals for maternal, newborn and child health in the townships, ways and means should be explored to finance these activities. In some

cases, collaboration between partners or piggy-backing of the activities may be the solution. MOH is reallocating the budget for renovation and construction of RHCs and Sub-RHCs according to the priorities. This may convince donors to provide more funding for renovation and construction.

13.6 Limited availability and validity of some data

Although M&E frameworks have been finalized for both townships, there are limitations on the availability and validity of some of the data collected in the field. In order to improve the situation, population-based surveys are to be carried out at the end of each year.

13.7 Management of emergency referral boats

The management of emergency referral boats is an area of ambiguity in the implementation of the referral system. Although these boat services were established with the intention of facilitating emergency referrals to the Township Hospital with zero cost for the beneficiaries, there is some evidence that these boats are no longer appropriately used by communities. Therefore, there is a need to review the experience of past implementation before extending further support.

13.8 Access to essential services for H2R populations

Services providing outreach and visits to H2R populations should be reviewed and improved as the activities implemented so far are mainly EPI. There are some barriers to deliver all the activities included in EPI-plus, such as antenatal care and the provision of iron supplements to pregnant women.

13.9 Coordination/harmonization with existing systems and structures

Some VHCs have their own funds for the referral of emergency cases to hospitals. The cases referred are not only those requiring life-saving care. Referred patients have to repay the cost to the VHC in instalments. The criteria and system of funding are quite different from the referral system of the JI-MNCH programme.

13.10 Standardization of policies and strategies

As an innovative programme based on partnerships, the programme has introduced some new activities and others which have not previously been widely implemented. Though some policies, SOPs and guidelines exist, they may not be adequate or practical for the implementation of some activities, especially the community-based management of Severe Acute Malnutrition, the provision of psychosocial support, and the referral system. There is a need for more detailed guidelines and procedures.

13.11 Coordination with other health actors in the townships

Some activities in the JI MNCH are being implementing by other partners: Disaster Risk Reduction (DRR) by Myanmar Red Cross Society and World Concern; and Training of CHWs by Save the Children and World Concern. Before implementing JI-MNCH activities, IPs should think about how to use the human resources already available (CHWs) and what they should do to build that capacity. JI-MNCH and LIFT

should work closely together as both programmes focus on vulnerable groups and H2R populations. Likewise, IPs should coordinate closely with the 'cash for work' activities of livelihoods projects.

Information-sharing and meetings with INGOs, NGOs and CBOs for detailed coordination and planning and the sharing of practices are crucial. The goal should be to harmonize their efforts to maximize the benefits.

14 FINANCIAL STATUS AS OF 31ST DECEMBER 2010

The total amount of funds received as of 31st December 2010 was US$4,487,630. This figure comprised US$926,620 from AusAID, US$1,881,460 from DFID, US$1,669,273 from Norway and US$10,277 from interest earned.

Fund expenditures consisted of US$153,391 for the operations of the FMO, US$32,147 for facilities and administration, US$858,661 for grants to IOM Geneva, US$237,637 for grants to Save the Children and US$1,099,894 for grants to Merlin. Total expenditure was US$2,381,730.

Hence, the funds available (balance) at the end of the year were US$2,105,900.

15 ABSORBTION RATE

At the end of December, the FMO noted that the absorption rate of the JTHP budgets in Labutta and Bogale were low in comparison with the programme management budgets. The main reasons were:

- The political transition in the country led to some delays in implementation
- Implementation of the work plans requires a considerable amount of coordination and advocacy, especially in the initial phase
- The capacity of human resources in the Township Health Authorities was insufficient and there was a risk of overburdening BHS
- Some activities (e.g. the procurement of some equipment) were implemented at a cheaper cost than budgeted.
- Some important budget lines will be spent only in late 2010 and in 2011 (e.g. procurement of drugs)
- Insufficient capacity and guidelines to establish Village Food Banks
- Delays in the implementation of the referral system due to insufficient guidelines and SOPs.

16 CONCLUSIONS

- The programme has been launched successfully, complete with an integrated approach that has seen health authorities and IPs jointly assess the health situation at township level, then draw up and begin to implement the resulting work plans.

- The work of the JI-MNCH continues to enjoy the goodwill and trust of its donors, the MOH and its IPs, and donors remain interested in and committed to continuing their support.

- While many important objectives have been reached (e.g. coordination mechanisms have been established at all levels and a monitoring system for all IPs set up), the work plans for the first year did not cover all the objectives.

- In the second phase, the programme will try to cover all six objectives: maternal and child health, nutrition, psychosocial health, disease control, health emergency preparedness and response, and demand-side initiatives.

- Establishing this innovative program has been a learning process and partners have expressed their wish to document the lessons learnt in order to strengthen health services, especially for H2R and vulnerable populations.

- Documenting this process and assessing the impact of the programme will be crucial also for the continued funding of the activities.

- Experience gained from implementing the Initiative will also inform the next phase of the Three Diseases Fund, beginning in 2012, to the extent that it highlights new ways of addressing health issues with a joint programme focused at the township level.

ANNEX 1 SUCCESS STORIES

Saving two lives through EmOC Referral

Ma Phyu Phyu[1] a pregnant woman living in Bine Daunt Chaung village of Labutta Township, felt a pain in her abdomen. A few days later, the pain became sharper and longer. An AMW living in their village and supported under the JI-MNCH programme deemed the problem serious and referred her urgently to the obstetrician at the District Hospital in Labutta town.

The midwife explained to the family that financial support would be available to cover all the transport and medical costs. She wrote a referral slip, gave it to the husband and emergency transportation by boat to Labutta was organized.

The patient was admitted to hospital the same evening and a healthy baby boy was delivered by emergency Caesarian section.

The next day, the obstetrician told the family that, if they hadn't arrived so quickly, both the mother and the unborn child would have been in danger.

Ma Phyu Phyu's husband was already aware of the programme of supported emergency referrals, because another family in the village used the scheme in January 2011. "I knew that everything would be free," he said.

In the first four months of the emergency referral programme, over 150 patients have benefitted from the full support package. Almost 60 percent of them were women who developed complications during pregnancy or childbirth.

[1] The name has been changed to protect the person's identity.

Identify high-risk and refer timely

When **Ma Theingi**[2], aged just 17, went into labour with her first child, the pain was so intense that she fell unconscious.

"When I woke up I was in Labutta hospital. I was told that my child had been delivered by Caesarean section. My child had to go for blue photo (a local term for phototherapy used to treat jaundice). After nine days in the hospital, I was discharged. Now both my baby and I are healthy because I was timely referred to hospital by the AMW.

The pregnancy of Ma Theingi, who lives in Aung Phone, a village in Labutta Township, was being monitored by an AMW trained and supported under the JI-MNCH programme. The AMW had already identified Ma Theingi's pregnancy as high-risk because she had been suffering from hypertension and recommended that she deliver in hospital.

A day after the AMW had begun organizing her referral, she heard that Ma Theingi had had a seizure and lost consciousness.

"With the help of the Village Health Committee, I Immediately referred the mother to Labutta hospital and I accompanied the patient. When we arrived, the obstetrician said an emergency Caesarean section was needed to save both lives," the AMW said.

The operation was successful, though and Ma Theingi only regained consciousness after three days," she said. "Now, both mother and baby are healthy and living happily in the village.

[2] The name has been changed to protect the person's identity.

Providing Health Services to hard to reach populations

Midwife **Ma Thuzar**[3] faces a daunting task to provide health services to the families of migrant workers laboring on dozens of salt farms in the Gway Tauk Gyi area of Middle Island, in Labutta Township.

The workers arrive from northern Myanmar in mid-September and work through the dry season until May the following year. Different years bring different families. None are officially registered, and they are unaware of local health services or of where they should turn for help with child deliveries.

Previously, the cost of travelling back and forth between the many farms by boat meant that Ma Thuzar could provide only "very limited" maternal and child health care to these families. Women were bearing children without receiving tetanus vaccination, for instance. Mothers and infants risked infection due to poor health knowledge, she said.

Save the Children, the IP for the JI-MNCH in Middle Island, has now begun meeting the travel costs for midwives providing maternal and child health services in the area.

"I felt so satisfied to provide full services in my coverage areas, especially in hard-to-reach Gway Tauk Gyi," said Ma Thuzar, who is based at the Chaung Wa Sub-Rural Health Centre. "I can visit pregnant mothers at all of the salt farms and give full immunization to mothers and children. I don't need to feel bad or worry about boat fees because of the transportation allowance from Save the Children. I can spend enough time on health education so that they know how to follow healthy life practices. I am able to monitor the improvements during monthly visiting and health education sessions."

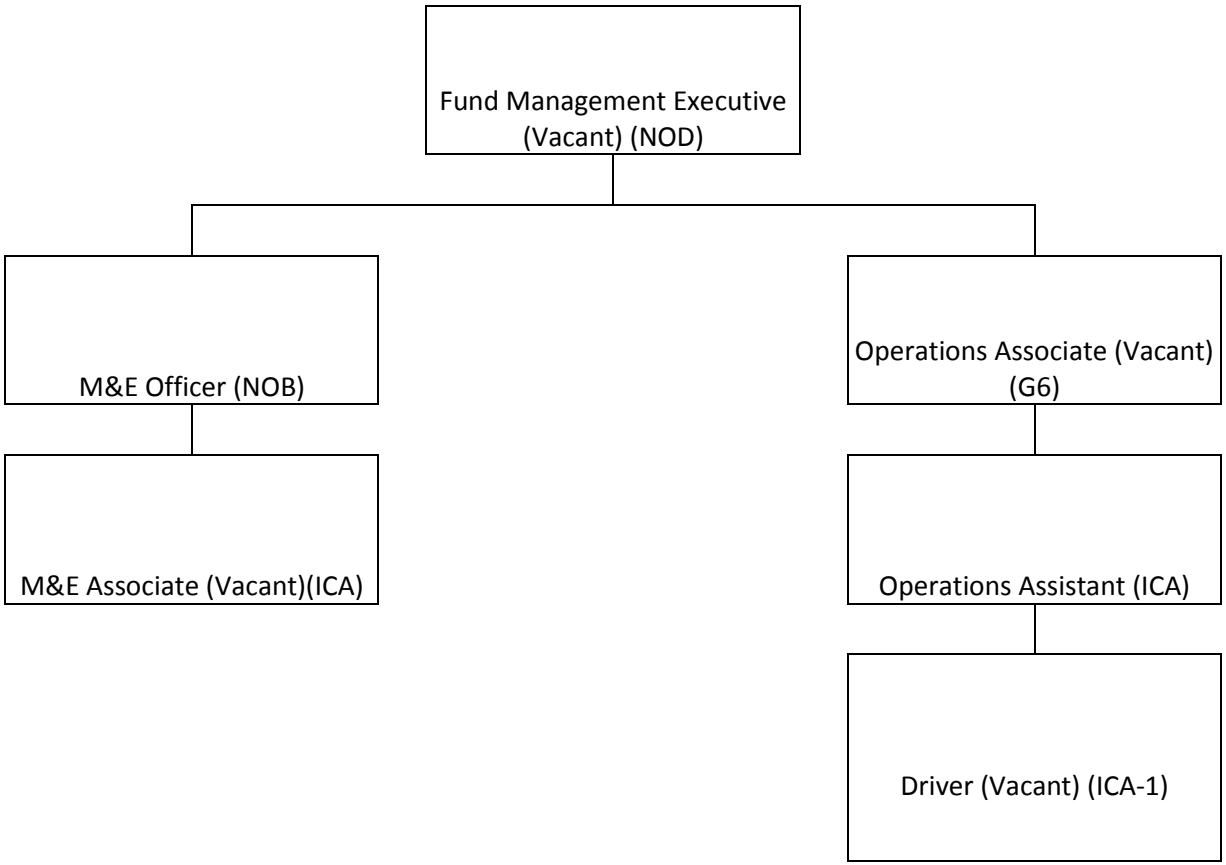
"I also receive great assistance from the Village Health Committee, which was strengthened by Save the Children. We are now planning how to improve the referral of pregnant mothers showing signs that they are at risk."

"Even though I am about to retire, I still have the drive to improve these services. I would be pleased to hand over systematic and well planned maternal and child health services to my successor."

[3] The name has been changed to protect the person's identity.

ANNEX 2 JI-MNCH FMO ORGANISATIONAL CHART

JI-MNCH FMO ORGANISATIONAL CHART



ANNEX 3 JI-MNCH INDICATOR ACHIEVEMENTS FOR 2010

	Labutta (MERLIN)			Bogale (IOM)			Laputta-Middle Island (Save The Children)		
Goal : Improve maternal and child health in the townships most affected by Cyclone Nargis									
Indicators	Target 2010	Actual 2010	% achieved	Target 2010	Actual 2010	% achieved	Target 2010	Actual 2010	% achieved
Proportion of malnourished children between 6 month to 5 year of age (Global Acute Malnutrition)	2%	survey not done	N/A	2%	Survey not done .	N/A	2%	Survey not done .	N/A
Purpose : Increase access to essential maternal and child health services in the townships most affected by Cyclone Nargis									
Indicators	Target 2010	Actual 2010	% achieved	Target 2010	Actual 2010	% achieved	Target 2010	Actual 2010	% achieved
Percentage of births attended by skilled and/or trained personnel	53% , 3076 by MWs, 15% , 870 by AMWs	47 % , 2727 by MW , 15 % , 870 by AMW	89	50 % , 2005 by MWs, 20% , 802 by AMWs	41 % , 1692 ,by MW , 17 % , 733 by AMW	82	53% , 471 by MWs, 15% , 133 by AMWs	47 % , 417 by MW , 15 % , 133 by AMW	89

Proportion of one year olds vaccinated against Diphtheria, Pertussis and Tetanus (DPT3)	85% , 11033	83% 10756 ,	98	85% , 6931	92% , 7453	108	85% , 1717	83% , 1676	98
Indicators	Target 2010	Actual 2010	% achieved	Target 2010	Actual 2010	% achieved	Target 2010	Actual 2010	% achieved
Proportion of one year olds vaccinated against measles	80% , 10384	80% , 10384	100	80% , 6524	91% , 7204	114	80% , 1616	80% , 1616	100
Proportion of pregnant women vaccinated against tetanus toxoid	85% , 11700	81% , 11175	99	85% , 7836	89% , 8231	105	85% , 1873	84% , 1851	99
Outpatient visits per capita per year	0.5	0.25	50	0.5	0. 12	24	0.5	0.25	50
Proportion of children under 5 year with diarrhea receiving oral rehydration therapy	60%	55%	92	60%	55%	92	60%	55%	92
Output 1 : Maternal and Child Health									
Indicators	May 2010 to June 2011	Actual 2010	% achieved	May 2010 to June 2011	Actual 2010	% achieved	May 2010 to June 2011	Actual 2010	% achieved
Percentage of Pregnant Women who received AN care one or more times	80% , 11012	79 % , 10874	99	85% , 7836	85 % , 7836	100	80% , 1763	79% , 1741	99
Proportion of RHCs / SRHCs with no stock out of antibiotics and ORS during last six months	100%	100%	100	100%	100%	100	NA	NA	NA
Township supervision of RHCs by the supervisory team	48	8	17	36	10	27.8	24	0	0
Number of referrals for EOC and ECC	308	49	12	336	155	37	198	0	0
Coordinated Township Health PONREPP Plan in place	Yes	Yes	100	Yes	Yes	100	Yes	Yes	100

Township Health PONREPP Coordination Committee meeting conducted and follow up on actions	7	7	100	7	7	100	2	2	100
Indicators	May 2010 to June 2011	Actual 2010	% achieved	May 2010 to June 2011	Actual 2010	% achieved	May 2010 to June 2011	Actual 2010	% achieved
Monthly Township Health PONREPP meeting conducted with BHS	7	7	100	7	7	100	2	2	100
Monthly RHC meetings with BHS and Volunteer Health Workers (VHW)	132	64	48	144	51	35	48	0	0
New Auxiliary Midwives (AMW) trained	23	25	109	28	18	64	42	0	0
New Community Health (CHW) Worker trained	83	51	61	132	23	17	46	0	0
Proportion of NGO service providers attend quarterly township health PONREPP coordination committee meeting	300	133	44	960	469	49	264	22	8
Provision of emergency health care drugs for Station Hospital (SH)	6	6	100	12	5	42	NA	NA	NA
Provision of clean delivery kits to RHCs and SRHCs	7020	4405	63	1200	500	42	2700	0	0
Provision of RHC drug kits	11	11	100	18	18	100	8	0	0
Provision of SRHC drug kits	52	48	92	35	45	129	40	0	0
Conduct Maternal death follow up visits and report	25	0	0	24	3	13	10	0	0
Conduct Child death follow up visits and report	25	0	0	24	15	63	50	0	0
Conduct Routine Outreach visits (EPI Plus) (5 visits per month X 12 months X no of midwives)	5280	1238	23	3540	1620	46	1200	0	0
Conduct Hard to Reach Outreach visits (1 visit per month X 12 months X no of midwives)	1248	409	33	708	324	46	240	0	0

NB. The implementation of the programme in Labutta and Bogale started in May 2010 and the implementation in Middle Island in November 2010.