Joint Initiative on Maternal, Newborn and Child Health (JI-MNCH)

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Acknowledgements and Disclaimer

We would like to thank Australia, Norway and the United Kingdom for their kind contributions to improving maternal, newborn 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, Newborn and Child Health (JI-MNCH) is gratefully acknowledged.

This document has been produced with financial assistance from Australia, Norway and the United Kingdom. The views expressed herein should in no way be taken to reflect the official opinion of the governments of Australia, Norway or the United Kingdom.

Acronyms

AMW Auxiliary Midwife

BHS Basic Health Staff

CHW Community Health Worker

CSG Community Support Group

CTHP Coordinated Township Health Plans

DOA Description of Action

DOH Department of Health

EPI Expanded Programme of Immunization

EmOC Emergency Obstetric Care

ECC Emergency Child Care

FMO Fund Management Office

H2R Hard to Reach

HMIS Health Management Information System

INGO International Non-Governmental Organization

IOM International Organization for Migration

IP Implementing Partner

JI-MNCH Joint Initiative on Maternal, Newborn 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

RI Relief International

SH Station Hospital

SOP Standard Operating Procedure

THO Township Health Officer

TMO Township Medical Officer

VHC Village Health Committee

Contents

1 Executive Summary

The first half of 2011 saw the Joint Initiative on Maternal, Newborn and Child Health make substantial gains in the delivery of health care services to poor and hard-to-reach populations across three project areas in the Ayeyarwady Delta. Significant progress also was made in the planned expansion of programme activities into new townships and in the creation of workplans for Phase 2 implementation in existing project areas.

Since the programme began in May 2010, almost US$5 million has been made in grants to four Implementing Partners: Merlin, IOM, Save the Children and Relief International. In May 2011, the contracts for Merlin and IOM were extended until August. However, no extra funding was given because existing grant money was still available. Additional funds for those IPs will be made available in August for the extension of the programme until December 2012.

The success of service delivery in 2011 was based on good coordination and high achievement of health worker training targets.

The coordination mechanism established in 2010 is working effectively. Regular meetings were held at the field level, ensuring that Basic Health Staff and Voluntary Health Workers received the support they needed. Meetings were held between township health authorities and Implementing Partners also.

The first year training targets were close to being met. In the reporting period, 89 new Auxiliary Midwives and 137 new Community Health Workers were trained, bringing the total to 132 and 211, respectively, since the start of the programme in 2010. In addition, 259 Auxiliary Midwives, 498 Community Health Workers and 695 Traditional Birth Attendants received refresher training. From January to the end of June, health workers carried out 4,543 routine visits and 968 visits to H2R areas, a significant increase compared with 2010. Essential drug kits were distributed and monitoring of drug distribution was improved.

The emergency referral systems established by Merlin and IOM last year saw a steady increase in usage. Merlin reported 377 referrals and IOM reported 760. In May 2011, emergency referrals started in Middle Island after 78 Village Health Committees were strengthened. In the first two months, 21 cases were referred. To date, the total number of referred cases across the project areas is 1,158. The survival rate is 99.6%.

Building on the emergency referral systems, maternal and child death follow-up began in Bogale and Middle Island this year. In Labutta, it is expected to begin in September. The follow-up information is discussed at regular field level meetings.

Successful implementation in Bogale and Labutta townships informed the Steering Committee's decision to expand the programme into Dedaye, Pyapon and Mawlamyinegyun townships, which was later approved by the Ministry of Health. Relief International, which started activities in Dedaye Township in June, is welcomed to the programme. In Pyapon and Mawlamyinegyun, joint assessments to identify health needs are on-going and will feed into Joint Township Health Plans.

Documenting lessons learned from the implementation of the JI-MNCH programme will be essential to improving the quality of the programme and providing information on its impact and cost effectiveness. In late May, a consultant was chosen to document such lessons and work is expected to begin in the third quarter of 2011.

The programme recognises the value of a demand side approach to health interventions and is working to build on such efforts as strengthening Village Health Committees and establishing emergency referral systems. Further work is needed to map the variety of health initiatives underway and build consensus among partners.

Significant gains over the past six months have been made but challenges remain. Establishing effective mechanisms to provide health care to hard-to-reach populations is a priority for Phase 2. A need exists also to establish standard operating procedures for key programme activities, such as emergency referrals and village trust funds, as the programme expands.

Despite the availability of funding, little was achieved in the area of psychosocial health because training for Township Mental Health Teams was not organised in time due to ineffective communication.

Similarly, limited progress was made in the area of nutrition. IOM visited 53 villages and screened 3,243 children. IOM and Save the Children each supported culinary demonstrations in villages but on a small scale. Difficulties in implementing nutrition activities such as Village Food Banks led to discussions with IPs, UNICEF and MOH to review and recommend activities that should be part of the Phase 2 health plans for IOM and Merlin, as well as new project areas.

The JI-MNCH programme is achieving its core goal of improving access to basic health care for poor and hard-to-reach populations. Refining existing systems, expanding coverage and making progress on the full range of programme objectives will be challenging but achievable with the continued support of donors, the Ministry of Health and Implementing Partners.

2 Introduction

Background

The Joint Initiative on Maternal, Newborn and Child Health (JI-MNCH) is a collaborative programme that aims to increase access to maternal and child health services among poor and hard-to-reach populations in areas affected by Cyclone Nargis.

JI-MNCH builds on the successful post-Nargis coordination between the former Health Cluster, which was established as part of the Post-Nargis Recovery and Preparedness Plan in 2008, and the Government of Myanmar's Ministry of Health (MOH). In addition to resources from MOH, UN and NGOs, the programme draws on a fund of US$12 million over a three-year period from 2010-2012, which is supported by the governments of Australia, Norway and the United Kingdom. This fund is administered by UNOPS through a Fund Management Office (FMO).

The proposed three-year programme began in May 2010 and by the end of the year implementation had started in three project areas in the Labutta and Bogale townships of Ayeyarwady Division. The Implementing Partners (IPs) are Merlin (Labutta Township, excluding Middle Island), IOM (Bogale Township) and Save the Children (Middle Island). In June 2011, Relief International (RI) joined the programme as the fourth IP. It will carry out project activities in Dedaye Township.

Governance Update

When the Fund Management Office was established by UNOPS, the positions of Fund Management Executive, Monitoring and Evaluation Officer, and Operations Associate were filled by interim staff. The first two positions were filled in January and the final position will be filled in July.

3 Implementation Status

3.1 Health Worker Training

Capacity building for Voluntary Health Workers (VHWs) improves health care coverage in areas that are beyond the reach of Basic Health Staff (BHS). Based on a curriculum developed by the Department of Health, Community Health Workers must complete a 30-day training course and Auxiliary Midwives a six-month programme, which involves three months of hospital-based learning and a further three months of practical field training at Rural Health Centres. The table below summarises the training of VHWs.

Table (1) Training Voluntary Health Workers

Training of Voluntary Health Workers	Merlin (Labutta)			IOM (Bogale)			Save the Children (Middle Island)			All project areas		
	Year 1 Target	Actual (May 2010 to June 2011	Achieved (%)	Year 1 Target	Actual (May 2010 to June 2011)	Achieved (%)	Year 1 Target	Actual (Nov 2010 to June 2011)	Achieved (%)	Year 1 Target	Actual (May 2010 to June 2011)	Achieved (%)
Training of new AMWs	50	50	100	60	40	67	42	42	100	152	132	87
Training of new CHWs	51	51	100	132	114	86	46	46	100	229	211	92
AMW refresher training	153	116	76	93	101	109	55	42	76	301	259	86
CHW refresher training	474	386	81	120	88	73	53	24	45	647	498	77
TBA refresher training	495	472	95	100	113	113	100	110	110	695	695	100

Auxiliary Midwives

The coastal geography of the project areas and reliance on slow, water-based transport serves to isolate many communities. Auxiliary Midwives (AMWs) play a vital role in such communities because they ensure quick access to primary health care, obstetric care and emergency obstetric and child referrals. AMWs work independently in their villages but with support from IPs.


Auxiliary Midwives receive training at a sub-RHC.

In Labutta, 25 AMWs were trained in 2010 and are now working in their villages. Upon completion of the course, each graduate was given a certificate, identity card and AMW kit. A second group of 25 AMWs undertook training at the township hospital in Labutta from January to March 2011 and practical training at Recovery Health Centres (RHCs) from April to June. In Bogale, where the planned target was for 60 AMWs, an initial group of 18 completed their training in 2010 and a further 22 were expected to finish their training in September 2011. In Middle Island, training for 21 AMWs started in March 2011. A second group of the same size are to begin training in July.

From the start of the programme in May 2010 to the end of June 2011, basic training was completed by 68 AMWs. In Bogale and Middle Island, 64 AMWs are expected to complete their training.

In Bogale**,** 101 AMWs received refresher training during the reporting period, exceeding the target of 93. In Middle Island, 42 AMWs undertook refresher training, which was less than the target of 55. However, 25 AMWs were trained on exclusive breastfeeding and supplementary feeding in this project area.

From the beginning of the programme to the end of the reporting period, 259 AMWs participated in refresher training across the three project townships.

Community Health Workers

In Labutta, training of new Community Health Workers (CHWs) did not take place in the reporting period because the 51 new CHWs completed a 30-day training in 2010. In Bogale, IOM supported the training of 91 CHWs during the reporting period. A total of 114 new CHWs were trained from May 2010 to June 2011. In Middle Island, the planned target of 46 new CHWs was met.

From the beginning of the programme to the end of the reporting period, 211 new CHWs were trained in the project areas.

In addition to recruiting new CHWs, refresher courses were given to existing staff. Building on the 310 CHWs who received refresher training in 2010, Merlin reported a further five refresher course days conducted for CHWs at 11 RHCs in Labutta TownshipIn. In total, 386 CHWs attended courses out of a planned target of 474. The 88 CHWs who missed training on IMNCI were followed up individually at the village level.In Bogale, IOM supported refresher courses for 40 CHWs during the reporting period. A totalof 88 CHWsreceived refresher training from May 2010 to June 2011.In Middle Island, Save the Children planned refresher courses for 53 CHWs and had trained 24 by the end of June 2011.

From the beginning of the programme to the end of the reporting period, 498 CHWs received refresher training across the project areas.

Traditional Birth Attendants

To assist Traditional Birth Attendants (TBAs) in their efforts to reduce the number of maternal deaths and identify potential complications early, training in “Do’s & Don’ts” was supported by the programme.

In Labutta, a four-day training course for TBAs was held at 44 sub-RHCs. These courses, which were led by midwives based at the centres, utilised a participatory, pictorial-led approach. 472 TBAs were trained in total, which represents an achievement rate of 95%. In Bogale and Middle Island respectively, 113 and 110 TBAs were trained, exceeding the planned targets.

Linkages between TBAs and BHS were improved in the areas of antenatal care, referrals, use of clean delivery kits and immunization.

In total, 695 TBAs were trained at the three project sites.

3.2 Outreach and Hard-to-Reach Activities

The transfer of support from Malteser to Merlin of 12 Sub-RHCs and 130 villages increased the IP's total coverage to 543 villages, of which 440 are classified as outreach and 103 H2R. Altogether, Merlin now supports 599 Voluntary Health Workers (421 CHWs and 178 AMWs, 61 of which are also CHWs).

Midwives and BHS planned 5280 routine outreach visits and 1248 H2R visits from May 2010 to June 2011 and carried out 3852 (73% of target) and 1023 (82% of target) visits, respectively. In the reporting period from January to the end of June 2011, 2614 routine visits (50% of target) and 614 H2R visits (49% of target) took place. Midwives made monthly routine outreach visits to 440 villages and H2R visits to 103 villages to assist deliveries, provide antenatal care, postnatal care, Expanded Programme of Immunization (EPI) care and health education. A total of 86 Emergency Obstetric Cases were referred as a result of the visits and 206 AMW assisted deliveries took place. Outreach activities carried out in Labutta are shown in the table below.

Table (2) Routine and H2R outreach activities in Labutta (excluding Middle Island)

Outreach Activities	Target (May 2010 to May 2011)	Actual (May to Dec 2010)	Actual (Jan to June 2011)	Actual (May 2010 to June 2011)
Routine Outreach	5280	1238 (23%)	2614 (50%)	3852 (73%)
H2R Outreach	1248	409 (33%)	614 (50%)	1023 (82%)

Midwives and BHS planned 3540 routine outreach visits and 708 H2R visits in Bogale from May 2010 to June 2011 and carried out 3240 (92% of target) and 648 (92% of target) visits, respectively. In the reporting period, 1620 routine visits and 324 H2R visits took place. Outreach activities in Bogale are detailed below.

Table (3) Routine and H2R outreach activities in Bogale

Outreach Activities	Target (May 2010 to May 2011)	Actual (May to Dec 2010)	Actual (Jan to June 2011)	Actual (May 2010 to June 2011)
Routine Outreach	3540	1620 (46%)	1620 (46%)	3240 (92%)
H2R Outreach	708	324 (46%)	324 (46%)	648 (92%)

Midwives and BHS planned 1200 routine outreach visits and 240 H2R visits in Middle Island from November 2010-2011. By the end of June 2011, 309 routine visits (26% of target) and 30 H2R visits (13% of target) had taken place. Midwives were able to immunize in both routine and H2R areas. Rather than wait at checkpoints, they could visit homes to immunize in many cases. The provision of motorbikes and boats by

the programme lessened travel times in Middle Island significantly. Outreach activities carried out in the area are shown below.

(4) Routine and H2R outreach activities in Middle Island

Outreach Activities	Target (Nov 2010 to Nov 2011)	Actual (Nov to Dec 2010)	Actual (Jan to June 2011)	Actual (Nov 2010 to June 2011)
Routine Outreach	1200	0	309 (26%)	309 (26%)
H2R Outreach	240	0	30 (13%)	30 (13%)

3.3 Drug Availability

Merlin supplies Voluntary Health Workers with drugs at monthly RHC meetings held in Labutta. VHWs that do not attend are followed by Merlin within a two-week period and supplied. Merlin teams also carry a full range of drugs and medical supplies with them to resupply villages that are visited on an *ad-hoc* basis. Drug usage is cross-checked with morbidity reports to help IPs check that drug prescriptions match the diagnoses made by VHWs.

The position of Station Medical Officer was vacant in Labutta's Pyin Sa Lu Station Hospital so drug delivery is expected to be postponed until the position is filled.

Save the Children's international procurement of medicines was delayed due to weaknesses in administrative procedure but permission from the Department of Health was finally given and drugs are expected to arrive in three batches in August and September 2011.

Provision of drug kits for hospitals, health centres and VHWs in the project sites are shown in Table 5.

Table (5) Provision of drug kits for hospitals, health centres and VHWs

Drug Kit Provision	Merlin (Labutta)			IOM (Bogale)			Save the Children (Middle Island)		
	Target	Actual (Jan to June 2011)	Achieved (%)	Target	Actual (Jan to June 2011)	Achieved (%)	Target	Actual (Jan to June 2011)	Achieved (%)
RHC Kits (Twice yearly)	22	21	95	18	18	100	8	0	0
Sub-RHC Kits (Yearly)	104	96	92	35	45	129	40	0	0
CHW Kits (existing and new)	948	960	101	306	163	53	99	0	0
AMW Kits (existing and new)	306	335	109	143	119	83	99	0	0
Drug kit/EOC drugs for Station hospitals	12	11	92	12	5	42	Not included in the work plan		

Some station hospitals and Rural Health Centres still have drug supplies that were distributed by UNICEF in October 2010. New drug kits are supplied as necessary by the JI-MNCH programme through IPs.

Sub-RHC drug kits are provided twice yearly but midwife vacancies and the establishment of new sub-RHCs resulted in the uneven achievement of targets across project areas. Furthermore, the selection and training of new VHWs and refresher courses for existing VHWs took time to organise and were carried out in batches. Drug kits were provided to VHWs immediately after their training was completed.

The long drug procurement process resulted in delays to the provision of essential medicines and kits in Middle Island to BHS and VHWs. This is not the first time that such delays have been experienced by IPs so future drug procurement should consider how to reduce lead times.

3.4 Coordination Meetings

Township health authorities together with IPs held regular township coordination meetings in Labutta and Bogale beginning in July 2010, and in Middle Island from December 2010. The meetings were attended by members of the JI-MNCH coordination committee and representatives from township administrative authorities, Medical Superintendents, UN agencies and NGOs/INGOs.

Monthly meetings of BHS at the district or township level were organised to review central and regional government guidelines, programme implementation and provide Continuous Medical Education (CME). By the end of June 2011, 1869 BHS had participated in these meetings in Labutta, 953 BHS in Bogale and 154 BHS in Middle Island.

Monthly RHC meetings were held in all project areas. By the end of the reporting period, 130 meetings (98% of target) were held in Labutta, 105 meetings (73% of target) in Bogale and 24 meetings (50% of target) were conducted in Middle Island.

The RHC meetings were seen as a useful forum for sharing experiences and identifying challenges. The participation of community support groups, members of the fire brigade, local officials and village elders made problem-solving more effective. Health education sessions were conducted on topics determined by local needs. These included diarrhoea and its management, dengue fever, pneumonia, good nutrition, exclusive breast-feeding, birth plans, antenatal care, delivery, and postnatal care. The RHC meetings improved the capacity of village leaders to organise and conduct their VHCs.

A supervision visit.

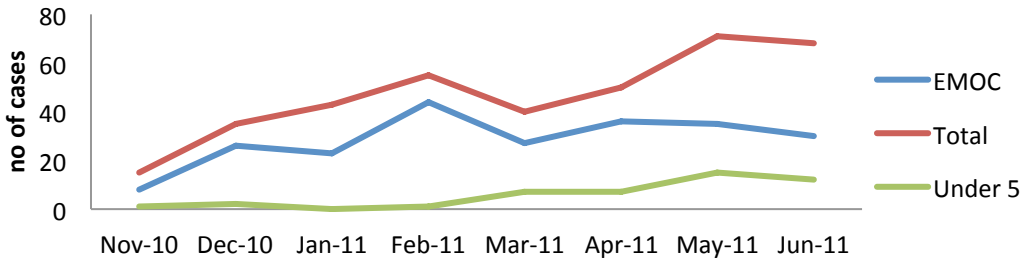
Sub-RHC meetings were conducted in Middle Island and were attended by BHS and VHWs. Discussion covered technical matters, the assignment of tasks and the arrangement of support to villages. Meetings were followed by training courses on exclusive breastfeeding and supplementary feeding for AMWs.

3.5 Emergency Referrals

From the start of the referral system in November 2010 until June 2011, a total of 377 emergency cases were referred and supported by Merlin in Labutta Township. Of these cases, 327 were referred in the reporting period. Of the 377 referrals, 229 were classified as EmOC resulting from eclampsia, prolonged labour, cephalo pelvic disproportion and delayed progress of labour, abortions (Bleeding Per Vagina BPV) and antepartum haemorrhage. 45 ECC referrals involved children under-5 and were caused by severe pneumonia, malnutrition, anaemia, other fevers, and diarrhoea with severe dehydration.

Among referrals, all ECC cases survived. However, despite being seriously ill, one EmOC referral suffering from eclampsia signed herself out of hospital. Another EmOC referral delivered a stillbirth baby due to intrauterine fetal death. The remaining 103 cases were not classified as EmOC or ECC.

Figure (1): Emergency referral cases in Labutta



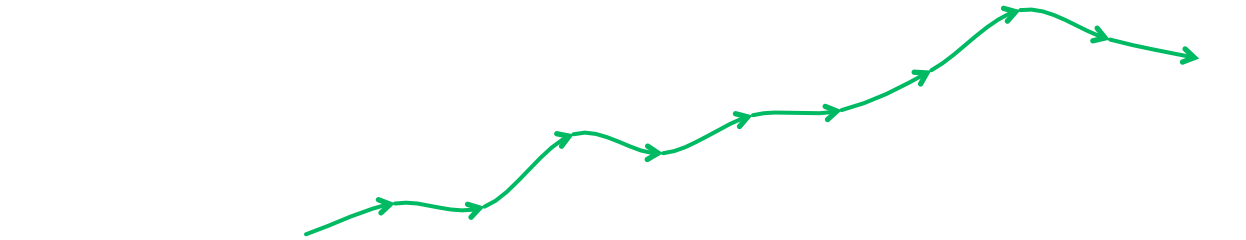
IOM also conducted joint awareness campaigns with BHS staff, addressing the referral service, identification of danger signs and the importance of pre- and post-antenatal care services in RHC meetings.

IOM supported 760 referrals (82% of target) in Bogale from the beginning of the referral system in July 2010 to the end of June 2011. A total of 605 cases were referred in the reporting period.

Based on information gathered from Bogale Township, the leading causes of EmOC referrals were prolonged labour, preeclampsia, antepartum haemorrhage, malpresentation and scarring from previous deliveries by caesarean section. The leading causes of ECC referrals were severe gastroenteritis, severe acute respiratory tract infection, febrile fits and dengue haemorrhage fever.

Among referred cases, a six-month-old boy with severe acute respiratory infection died in January 2011 in Bogale Hospital and a three-day-old infant with febrile convulsions and neonatal jaundice died in March at Set San Station Hospital. Primigravida, a 20-year-old mother, whose child was delivered by a TBA, died of uterine rupture at Set San Station Hospital in April.

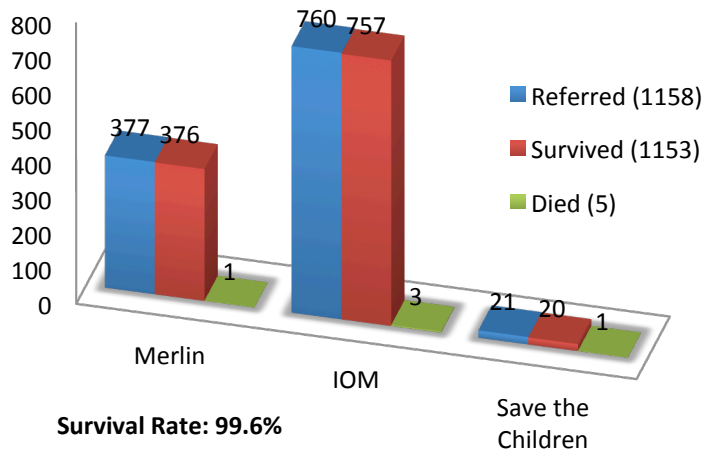
Figure (2) Emergency referral cases in Bogale



	Jul-10	Aug&Sep/2010	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11
Total referral cases	4	22	20	62	51	73	76	99	134	117	106

In Middle Island, 10 emergency obstetric cases and 11 under-5 emergency cases were referred to the Station Hospital. Of the 21 referrals, all survived except one child suffering from multiple-organ failure resulting from pneumonia and severe protein-energy malnutrition (PEM). Diarrhoea and pneumonia with PEM and complications were the main causes of under-5 referrals, the majority of whom were newborns and infants.

Figure (3) Referral outcomes among Implementing Partners



Survival Rate: 99.6%

3.6 Joint Monitoring and Supervision

All IPs made five joint monitoring visits each to RHCs, accompanied by township health staff. In Labutta, Merlin conducted an additional five visits to H2R areas.

3.7 Support to Village Health Committees

Village Health Committees (VHCs) are an essential component of demand side interventions and a useful forum to bring village and village tract authorities closer to BHS, sensitising them to the benefits of functional VHCs. Some village tracts/villages had established VHCs before the programme started. These, together with new VHCs, have been strengthened through capacity building.

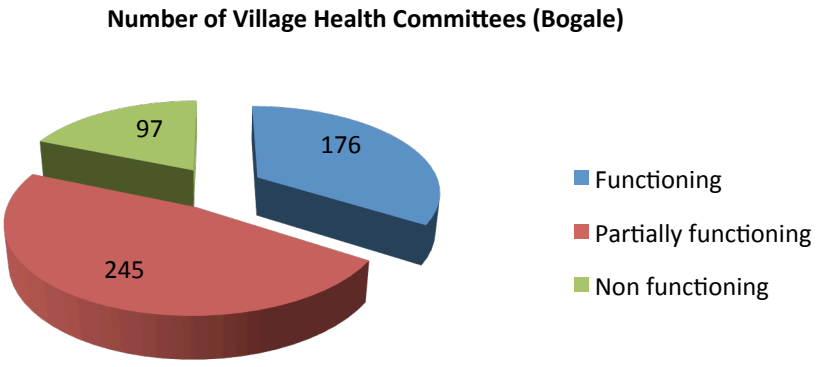
Merlin conducted management training over a two-day period for VHCs and Village Tract Health Committees (VTHCs) in Labutta. Of the 560 villages invited to attend the event, 458 sent participants, an attendance rate of 82%. Voluntary Health Workers were instructed also in how to use a new CPMIS register and monthly reporting format. Field teams were trained in the use of a performance management tool to improve tracking of diagnoses and treatments.

IOM established 61 new VHCs in Bogale Township during the reporting period and now supports 518 VHCs, based on a target of 585 villages. Out of the 518 VHCs, 176 (34%) are functioning well, which is almost double the number reported in the previous quarter; 245 (47%) are partially functioning and 97 (19%) remain non-functional. 262 villages, or just over half of those supported, have established revolving funds to manage health emergency needs.

To establish baseline information on the functional status of VHCs in IOM targeted districts, the following assessment criteria are used:

- Regular attendance at monthly RHC meetings
- Regular VHC meetings
- Coordination and cooperation with BHS for activities such as EPI
- The handling of health emergency referrals from villages to hospitals
- Establishment of emergency funds in villages for health-related issues

Figure (4) Functional status of Village Health Committees in Bogale



In Middle Island, Save the Children provided support to 78 VHCs and an emergency referral system was started in May 2011. To build the capacity of the VHC, training for trainers was given to Save the Children staff from April to June. Multiplier trainings will be coupled with the establishment of revolving funds in the next quarter. VHC members held regular meetings with midwives and improved support at the village level led to an increase in the number of health education sessions conducted.

With the support of Village Health Committees, AMWs received quality practical training experience in their assigned health posts in Middle Island, especially in Pyin Ka Yaing Station Hospital and Thet Kal Thaung RHC. Pregnant mothers from villages falling under the purview of the Station Hospital and RHC were supported to deliver at these health facilities. The first group of AMWs to receive training assisted an average of 15 deliveries.

3.8 Maternal and Child Mortality Follow-up

Maternal and child death follow-up has started in IOM and Save the Children project areas. In Bogale, IOM followed-up five maternal deaths, the causes of which included 2 post-partum haemorrage, 2 uterine rupture and 1 hypovolemic shock due to incomplete abortion. Five under-5 deaths were found to be the result of severe pneumonia, febrile fits, infantile beri-beri and fits with nephrotic syndrome(twins). Eighteen under-5 child deaths were followed-up by Save the Children in Middle Island. No maternal deaths were reported from January to June in Middle Island.

Maternal and child death follow-up was delayed in the Merlin project area but will begin in September once reporting materials are printed.

3.9 Nutrition

Referral of Severe Acute Malnourished cases by VHWs and BHS to the hospital under the emergency referral system was initiated in Labutta Township in November 2010. Merlin reported the referral of nine children from January to the end of June.

During the reporting period, IOM established and supported 10 Village Food Banks (VFBs) to provide sustenance for 100 undernourished children. Cooking demonstrations were conducted also in these villages with the support of the Myanmar Maternal and Child Welfare Association and BHS. The VHWs and VHCs received culinary training, the objective being to educate mothers and caregivers in the preparation of nutritious food for children.

A demonstration on the use of wighing scales, which are distributed to Auxiliary Midwives as part of a kit.

IOM deployed two Mobile Nutrition Teams to screen and monitor the nutritional status of under-5 children in villages. During the reporting period, the team visited 53 villages and screened 3,243 children. Of these children, 515 (16%) were found to be "at risk" of malnutrition, 77 (2.4%) were moderately malnourished and nine (0.3%) were severely malnourished. The percentage of Global Acute Malnourished children was 2.7% (86 children) in the villages visited. The Mobile Nutrition Teams, with the support of BHS, conducted 101 health education sessions promoting good nutrition to some 2,274 participants. The teams combined their monitoring in the communities with health education activities.

In Middle Island, Save the Children supported cooking demonstrations in three villages. However, the establishment of Village Food Banks was not initiated. Discussion among the IPs, UNICEF and UNOPS on how to implement the VFBs is on-going.

3.10 Psychosocial Health

The Fund Management Office and IPs have discussed the possibility of conducting psychosocial training with the head of the Psychiatry Department within the Ministry of Health. Training for Township Mental Health Teams is planned for late 2011.

3.11 Disease Control

Merlin procured six solar refrigerators from April to June 2011 for RHCs and Station Hospitals in Labutta Township. Installation was planned for September following discussion with the Department of Health. The provision of five vaccine carriers was planned but the regional EPI unit suggested that support could come from MOH.

IOM provided the Bogale DOH with 10 cold storage boxes and 20 vaccine carriers from April to June. Immunization coverage increased in Bogale in April, in part because of the inclusion of two additional sub-RHC populations into the township project area. However, in May and June, EPI activities suffered due to heavy monsoon rains that restricted people's movement. There was a shortage of vaccines also, especially Hepatitis B vaccine. Immunization coverage of measles and tetanus toxoid showed some improvement in May because of support for outreach and H2R visits.

Save the Children is expected to provide Middle Island with two solar refrigerators in the first week of July.

4 Implementation Challenges

As the programme enters its second year, the training of VHWs is paying dividends in terms of service provision in outreach and H2R areas, especially in the Bogale and Labutta project areas where implementation started in May 2010. However, a number of challenges remain in the area of practical training experience for VHWs and their coordination with township authorities.

All IPs reported an insufficient number of trainers at the Township Health Authority. In Labutta, this problem was addressed by pooling staff from RHCs. In future, this limitation will be overcome through an improved training methodology and training of trainers courses planned for the programme's second year.

Some new AMWs in Labutta were not witnessing sufficient deliveries during their field training because they were sent to RHCs where only a limited number of deliveries were taking place.

In Middle Island, the initial three-month theory course for AMWs could be improved. AMWs were taught by Township Health Teams but could benefit from the availability of specialists working in the same training/hospital compound. Save the Children noted that Township Training Teams should be strengthened.

A significant number of CHW/AMWs are classed as non-functioning in Middle Island. There were 42 non-functioning CHW/AMWs out of 108 for refresher training in Middle Island. These health workers have been classified as non-functioning for reasons such as inadequate supervision and malpractice. However, Save the Children could not reach its target for CHW/AMW refresher training because of high attrition rates. To solve this problem and maintain high coverage, the target for new VHWs will be increased.

In the accurate assessment of nutritional needs, BHS and AMWs require additional weighing tools in Middle Island to detect low birth weight prevalence among newborns. Currently, MW/AMWs are equipped with weighing tools to monitor mothers and CHWs for under-5 children. In addition, CHWs in Middle Island require additional training if they are to conduct nutrition assessments. Although CHWs have all participated in a 30-day training course, this was not sufficient to enable them to assess nutritional status by MUAC/Weight/Height. The Steering Committee proposed a one-day course in Phase 2.

There is no resource person in Middle Island to provide nutrition and psychosocial training at the township level. The Labutta Township Mental Health Team will receive support from Merlin to increase capacity. Since Middle Island is within the same township, it is expected that health workers in the Save the Children project area will also benefit from increased capacity at the township level. An inadequate number of trainers in psychosocial health care is a problem also in Bogale.

IOM provided seed funding of 100,000 Kyats each to cover the cost of establishing ten Village Food Banks. The remaining funding to make the VFBs functional was to come from the villages. However, approximately 50 per cent of the new VFBs were unable to function effectively because of insufficient funds contributed by the communities.

At the Regional Coordination Meeting in March a decision was made to review the programme's nutrition component. This process began in April and meetings have been held with FMO, UNICEF, IPs and the National Nutrition Centre to develop activities.


Maternal and child death follow-up.

The need to establish a working group to review the emergency referral procedures was also discussed at the Regional Coordination Meeting. Merlin proposed the establishment of this group at the following Advisory Group meeting in October 2011.

Mobile workers living in at least 122 villages in Bogale Township were found to have difficulties accessing health care services due to socio-economic barriers. Since they are mobile, information about their location and numbers are not known clearly.

In Middle Island, heavy rain and storms from May to October made transportation hazardous. This limited the number of outreach visits that could be achieved and also affected the ability of BHS to travel to Labutta for monthly township meetings. An additional limitation on outreach was that some health facilities in Middle Island do not have direct public transportation.

Midwife vacancies in Middle Island limited achievement of outreach targets. Of 20 midwife positions, only 14 are occupied. All outreach and H2R villages were covered by the midwives with no negative impact on service provision.

Existing Township Training Teams are overworked and understaffed. This is particularly evident in Labutta District where two IPs are sharing the same training resources.

5 Lessons Learned

The experience gained by IPs during Nargis recovery has been vital to the effective coordination and implementation of programme activities at the township level. The roles and responsibilities of IPs were clarified during several meetingss organised in the project areas and participated in by MOH staff, Township Health Teams, Divisional Health Teams, UN agencies and NGOs. This collaboration between IPs and stakeholders at the township level is mirrored also by stronger links between BHS and VHWs, whom hold monthly RHC and sub-RHC meetings. In addition to identifying problems and improving service delivery, regular communication between health workers at the field level is believed to contribute to the low attrition rate among volunteers.

The practice of maternal and child death follow-up is proving a useful tool in educating volunteers on the danger signs to watch out for in children, pregnant women and during childbirth. Follow-up information is discussed at the monthly RHC meetings. Analyses of deaths by time, place and cause can guide programme planning, monitoring, and evaluation of the effectiveness of interventions, informing the allocation of future resources. In Bogale, BHS started to provide health education to families, which is expected to help reduce maternal and child deaths in future.

The practice of coupling antenatal care with immunization visits is prioving effective. Home Based Maternal Records are provided that are linked into the emergency referral system, with the support of VHC members. Pregnant mothers were actively seeking antenatal care, which has given rise to increased coverage.


Provision of antenatal care in Kan Seik Village

Although the emergency referral system is now operating effectively in all project areas, its application is uneven. Under the current system, IPs support and facilitate referrals of antenatal, intranatal and postnatal emergencies, as well as cases involving critically ill children under-5. IPs cover drug and medical investigation costs, transportation expenses and provide patients with a subsistence allowance. IOM and Save the Children refer life-threatening cases irrespective of age. Merlin only considers maternal and child cases for referral.

Coordination between project areas could be improved. Currently, the referral system is not flexible enough to allow the provision of emergency health care in hospitals located in townships other than where the initial referral was made, even though in some cases this may be preferable. This shortcoming was identified at the Regional Coordination Meeting in March and will be studied as part of a review of the referral system across all project areas.

Health service providers working at the field level on complementary programmes should improve their coordination to avoid gaps and overlap in activities. The Township Health Authorities should take a leading role in developing truly coordinated township health plans. The SC recommended that Implementing Partners disclose all sources of funding for planned activities in both the Joint Township Health Plans and Service Agreements.

6 Monitoring and Evaluation

M&E is based on mechanisms established by the FMO, IPs and Township Health Departments, with the support of the JI-MNCH Advisory Group and Steering Committee.

When the programme started, planned targets were defined for the period until 2011, in line with funding commitments. The logframe format used for M&E was based on a DFID framework. However, with the extension of the programme until 2012, this logframe was updated with additional gender and commnunity participation indicators by the FMO, Save the Children and BHS. It is in use in Middle Island and will be used by Merlin and IOM for activities implemented in Phase 2.

The logframe output indicators demonstrate programme achievements and are used as a tool by IPs for fund mobilisation

Health outcomes in the project areas are monitored through surveys proposed on an annual basis in each township. A Health Management Information System provides population data, vital data and project outcome data. In addition, IPs submit Quarterly Technical Progress Reports that include project output data and qualitative information.

Field monitoring visits were conducted by the Fund Management Office in Labutta and Bogale townships in March and June, respectively. Information gathered from these trips is combined with that from the routine information systems and Quarterly Technical Progress Reports for use in the half-yearly and annual reports. These pass through the Township Program Coordination Committee, Divisional Coordination Committee, AG and SC to ensure stakeholder participation and accountability.

Baseline and annual surveys are essential in measuring the programme's success and should be conducted in the first and last years in each project area.

Before surveys are conducted a proposal should be prepared by the IPs and reviewed by the AG. 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.

7 Coordination

JI-MNCH Annual Review Meeting

The Annual Review meeting was held on May 6th in Naypyitaw. It was chaired by the Department of Health's Deputy Director General for Public Health, Dr Thein Thein Htay. The meeting was attended by WHO, UNICEF, DOH, Department of Health Planning, donors, IPs and other INGOs.

The objectives of the meeting were to review the process and progress of implementation up until December 2010, amend the programme as necessary and advocate for strengthened coordination at the field level. To achieve these objectives, participants considered the implementation of activities, needs assessment, coordinated township planning and township level recommendations for second year interventions.

Recommendations for IPs and health authorities:

- Identify ways to target vulnerable groups, including mobile populations and those living in H2R areas;
- Township Medical Officers and IPs should develop SOPs for the implementation of activities under the Joint Township Health Plans in parallel with planning exercises such as emergency referrals and outreach visits.

Recommendations for the FMO:

- Develop SOPs to ensure accountable and transparent project delivery;
- Conduct routine support visits to address identified constraints;
- The FMO should have greater flexibility in agreeing health plan modifications when new priorities are identified.

Recommendations for all Health Partners

- The Annual Township Plan should be developed in concert with DOH so that future resource allocation is more effective;
- Linkages with Divisional Health Authorities could be strengthened to improve programme implementation;
- Comprehensive briefing and induction of newly appointed critical staff such as MS/TMO should be undertaken by MOH/DOH as well as IPs;
- External technical support should be used only when DOH support is unavailable.

Regional Coordination Meeting

This meeting was held in Yangon in March 2011 and was attended by 43 representatives from the Department of Health. It including staff from the Regional Health Department and five townships in Ayeyarwady Region, as well as participants from WHO, UNICEF, UNOPS, DFID, IPs and other INGOs, including Medecins du Monde, Marie Stopes International and Relief International.

The purpose of the meeting was to monitor progress, share best practices, discuss ways to strengthen coordination at all levels between stakeholders, advocate policy makers and administrators on ways to improve implementation, and identify challenges and find ways to overcome them collectively.

The following recommendations were made:

- Improve vertical and horizontal coordination within the programme between administrative levels (Central ↔ Regional ↔ Township);
- Conduct Township Health Coordination meetings on a monthly basis;
- Invite Department of Health, Regional Health Department and UNOPS to attend township JI-MNCH Coordination Meetings;
- Conduct technical meetings to develop a systematic referral mechanism. The first stage of this process would be to select indicators to evaluate the existing referral system through a Working Group with the participation of stakeholders;
- Undertake a review of the programme's nutrition activities with the support of the National Nutrition Centre and UNICEF;
- Ensure that maternal and child death follow-up is in line with SOPs for maternal and neonatal death issued by the Ministry of Health and the conclusions shared at the Regional Coordination Meeting;
- Agree upon criteria for the designation of H2R areas within districts and townships, and undertake an in-depth study on barriers to health care access with a view to reducing them;
- Determine criteria to assist in the identification of vulnerable groups living in project areas for the purpose of defining approaches to ensure improved access to health services;
- Encourage all partners to share relevant data to facilitate project impact evaluation;
- Encourage MOH to launch activities that are not included currently in the Coordinated Township Health Plans.

Steering Committee Meetings

The Steering Committee, which is comprised of representatives from MOH, WHO, UNICEF, UNOPS, donors and INGOs, met four times during the reporting period.

The SC decided that the next priority areas in the Ayeyarwady Delta would be Mawlamyinegyun and Pyapon and that the name of the programme would be changed from Health PONREPP to Joint Initiative on MNCH.

In addition, the SC provided guidance and suggestions on a number of technical and financial issues. It recommended that the baseline survey conducted by Merlin in Labutta be replicated in other programme project areas for the purpose of triangulating HMIS data, as well as obtaining data not covered by HMIS. It was recommended also that indicators used by Merlin be reviewed to ensure compliance with MOH policies and standards.

The SC provided approval and oversight for the budgets of the FMO and Implementing Partners. Semi-annual and annual reports, proposals, operational guidelines and requests for additional funding were submitted to the SC for approval.

Advisory Group Meeting

In early March, an Advisory Group meeting was held in Naypyitaw, attended by MOH, INGOs, UNICEF, WHO and UNOPS. Participants discussed child survival strategy and NGO experiences implementing the emergency referral mechanism in project areas.

8 Application for Additional Funding

Additional funding required to extend the programme up to December 2012 is estimated at US$7,079,670. This funding will cover activities in five townships and six project areas.

The planned programme extension focuses on the needs of pregnant women and children under-5 years. It aims to improve access to quality basic maternal and child health services, particularly for vulnerable populations in H2R areas. Psychosocial needs of the affected populations will be met also and mitigation of future disaster risks achieved though a focus on emergency preparedness.

Implementation of the JI-MNCH programme has led to new ways of working at the township level by incorporating a wide variety of stakeholders, one coordinated plan, one pooled fund and one M&E framework. This approach offers a potential new model for health funding in Myanmar and will inform the next phase of the Three Diseases Fund from 2012 and the Global Alliance for Vaccine Initiative and Health Systems Strengthening (GAVI-HSS).

9 Phase 2 Workplans

Contracts with Merlin and IOM expired in May but were extended until August. No additional funding was given because existing funds were not exhausted.

IPs prepared Phase 2 of the programme in their project areas under the leadership of the MS/TMO, making sure the process involved the participation of NGO/INGOs working on health issues and stakeholders at the township level. Activities correspond with those of the essential service package described in the DOA.

The FMO reviewed the planned activities under Phase 2 with the assistance of IPs, WHO, UNICEF and concerned National Project Managers. The Department of Health provided support as requested. Following the review, the FMO submitted the Joint Township Workplan, Operational Budget and Project Implementation Plan for Bogale and Labutta to the Steering Committee. They were approved on 22nd August 2011. The contracts to extend programme activities in Bogale and Labutta townships were signed by IOM and Merlin on 23rd August and 27th August, respectively.

10 Extension into New Townships

Dedaye Township

The JI-MNCH Steering Committee was given responsibility by the Donor Consortium to select and approve projects and to allocate funding as needed.

On 4th May 2010, the SC held a meeting at which the expansion of activities into Dedaye Township was approved. On 29th October, a call for expressions of interest was listed on the UNOPS website and one proposal was received from Relief International on 18th November. In June 2011, official authorisation to work in the township was granted by MOH and a Service Agreement between FMO/UNOPS and RI was signed on 16th June 2011.

Pyapon and Mawlamyinegyun townships

Medical Superintendents from Pyapon and Mawlamyinegyun were invited to the Advisory Group meeting in February, the Regional Coordination meeting in March and the Annual Review meeting in May. Eight INGOs working in the townships were invited by WHO and UNOPS to a meeting on 27th May at the WHO office in Yangon. The purpose of the meeting was to brief the INGOs on the expansion of the JI-MNCH programme and to solicit preliminary statements of interest. IOM and Save the Children will jointly assist implementation of activities in Mawlamyinegyun. In Pyapon Township, Medecins du Monde will take the lead role but will be supported by RI in a joint assessment to identify health needs and baseline data, and the development of a coordinated township health plan that will form the basis of the Joint Township Health Plan.

A meeting In Pathein with the Regional Health authorities and MS/TMO to discuss the programme expansion in the three townships will take place in July.

11 Demand Side Approach

A health approach that focuses solely on providing inputs is unlikely to achieve significant gains because it ignores the diversity of needs within and across communities. The JI-MNCH programme recognises that a demand side approach, which takes account of health-seeking behaviours and patterns of utilisation within communities, is desirable if health interventions are to be improved.

In working to achieve this goal, the programme has strengthened Village Health Committees, helped villages establish trust funds to finance emergency treatment, set up an emergency referral system, and trained Voluntary Health Workers. In future, the programme will focus also on mapping the variety of health initiatives underway and building consensus on how best to move ahead with key lessons.

12 Operational Guidelines

In consultation with the FMO, a draft of the JI-MNCH Operational Guidelines has been written. Before the guidelines are submitted to the Steering Committee for approval, consultation and review must be undertaken with stakeholders including IPs, WHO and UNICEF.

13 Reporting to MOH

The State Peace and Development Council handed over power to the new, democratically elected government at the end of March 2011. A result of this change was the appointment of a new minister and vice ministers to the Ministry of Health. The country director of the Myanmar Operations Centre under UNOPS, the Fund Management Executive and programme managers from 3DF and Global Fund met with the new government staff in June to brief them on their programmes, governance structures and objectives.

A month earlier, MOH was informed of the programme's name change from Health PONREPP to Joint Initiative on MNCH. This name change puts the programme in line with government policy, which, following the end of the Tripartite Core Group and post-Nargis recovery phase, is focused now on the health of mothers, newborns and children.

14 Documenting Lessons Learned from JI-MNCH

Establishing the JI-MNCH programme has been a learning process that partners have expressed a wish to document. Four questions will provide the basis for study:

- What is the impact of the programme?
- Has the programme reached the target H2R populations?
- What is the indirect impact of the programme?
- What would be the cost and value for money if the programme were scaled up?

To conduct this study, a consultant has been chosen to develop a lesson-learning plan, identify data needs, support partners in the collection of robust data, analyse findings and document lessons for discussion

A request for proposal was advertised on 1st April 2011 on the UNOPS and UNDP websites and among the NGO network in Myanmar. Bidders submitted their proposals to UNOPS Myanmar and four bids were received by the deadline on 30th April.

To evaluate the proposals, a committee was established that met for the first time on 20th May. Ms Julia Kemp, Health Advisor at DFID Myanmar and member of the JI-MNCH Steering Committee, briefed the committee on the TOR and purpose of the consultancy.

The committee met for the second time on 25th May and scoring sheets were submitted by the evaluators to the Chair. This was followed by discussion of the aggregate scores with the committee members. As a result of the technical evaluation, two of the four bids did not pass the 70% threshold and were rejected.

The evaluation committee recommended that HEFE Consultants be contracted to document the lessons learned from the JI-MNCH. This work will proceed once permission is received from MOH in the third quarter of 2011.

15 Budget and Disbursement

Funds received consisted of US$1,670,525 from AusAID, US$1,881,460 from DFID and US$1,669,273 from Norway. Bank interest was US$10,277. A total of US$5,231,535 was received.

Fund expenditures consisted of US$269,170 for the operation of the FMO, US$43,313 for facilities and administration, US$1,458,792 for grants to IOM Geneva, US$237,637 for grants to Save the Children and US$824,920 for grants to Merlin. Total expenditure was US$2,833,832.

The balance as of June 30 was US$2,397,703.

16 Risk Assessment

Coordination at the field level among health partners

Some JI-MNCH activities are being implemented by other partners. For example, risk reduction plans and first aid training are being undertaken by the Myanmar Red Cross Society. The programme aims to provide services to populations in H2R areas, which makes coordination with other health actors important, especially those organisations and projects targeting these unreached populations. Meetings and

information sharing among INGOs, NGOs and CBOs for detailed coordination and planning and the sharing of practices are critical.

Insufficient health staff

The public health system suffers from an inadequate number of health staff, which creates difficulties in project areas when conducting activities and data collection. The presence of sufficient health staff in H2R areas is a crucial factor in the achievement of project objectives. As there are no Township Health Officers to lead the projects at the township level, the quality of monitoring and supervision by township health teams is questionable. In addition, the high turnover of BHS in township health departments represents a risk to the timely implementation of project activities.

Access to essential services for H2R areas and populations

Barriers to the delivery of essential services for H2R areas and populations include seasonal population migration, unpredictable and unfavourable weather and transportation access that is inadequate and expensive. Currently, health workers prioritise EPI because few visits can be made to H2R areas due to transportation costs. Supporting such costs allows the frequency of visits to increase, which in turn allows health workers to expand the provision of health care services.

Limited field data

Although M&E frameworks have been finalised for all townships, there are limitations in the field on the availability and validity of some data. To improve the situation, population-based surveys are recommended at the end of each year.

Sensitisation of township hospital teams

Township hospital teams need training in how to handle patients who are referred to them for emergency services. Medical Superintendents should provide this training as necessary.

Standardisation of policies and strategies

The programme relies on partnerships and has introduced activities that have not been widely implemented before. Though some policies, SOPs and guidelines exist, they are not adequate or practical for implementation of the activities.

Change in government

The change in government structure as created a need for advocacy and orientation sessions to be conducted at the township and divisional level. IPs will conduct such meetings following discussion with the FMO and local administrative and health authorities.

Unfunded Activities in the Essential Services Package

In the programme's first phase, MNCH, EPI and nutrition were funded but activities under Health Emergency Preparedness and Response (HEPR), and Demand Side Interventions were not. Planning for these activities was not considered by IPs although some activities that were not part of the Coordinated Township Health Plans, such as the construction of RHCs and sub-RHCs, did take place. Phase 2 of the programme will fund HEPR at the township level and within H2R villages.

Monitoring and Evaluation issues

Although an M&E framework was developed for the townships, the availability of data from different sources and the utilisation of that data by IPs remains a problem. It is expected that issues arising from this will be discussed, and appropriate action taken through the Advisory Committee and at Township Coordination Committee meetings.

Joint Township Work Plan unit rates

The FMO has studied the unit cost and rates used by the IPs and started a process of harmonisation of training unit costs during the reporting period. Also, it began analysing programme and management costs

for the IPs in relation to the population and number of villages in their project areas. The aim of this analysis is to identify and refine benchmarks, harmonise costs where possible and improve future programming.

17 Conclusion

The start of implementation in Middle Island and the stronger pace of implementation in Bogale and Labutta townships marked the first half of 2011. Merlin and IOM were the first IPs to establish coordination mechanisms, emergency referral policies and VHC training guidelines in their respective townships in 2010. These townships are now delivering significantly higher results in the 2011 reporting period and, crucially, the experiences and lessons learned by those IPs have been shared with new partners. After a challenging start, we can now say confidently that the programme is achieving its goal of increasing access to maternal and child health services among poor and hard-to-reach populations.

There is still much to learn and improve upon, both in the scope and the quality of the work to be carried out. During the second half of 2011, the FMO will focus on the programme's expansion into Pyapon and Mawlamyinegyun townships, as well as improving programme implementation in existing project areas until December 2012. It will work to complete the harmonisation of training unit costs and development of cost indicators for programme management and Joint Township Health Plans. Also, a formal process to document the lessons learned from the programme will be conducted with the assistance of an international consultant.

Since the programme started in May 2010, it has gained the trust and collaboration of all stakeholders and delivered a substantial contribution to the national response in maternal, newborn and child health. As a successful health trust fund, the programme has paved the way for other donor initiatives in Myanmar and complements efforts underway already. This approach offers a potential new model for health funding in the country and will inform the next phase of the Three Diseases Fund from 2012 and the Global Alliance for Vaccine Initiative and Health Systems Strengthening.

The programme wishes to thank donor countries, the Ministry of Health and Implementing Partners for their continued support towards improving maternal, newborn and child health in the Ayeyarwady Delta.

18 Success Stories

A Community Health Worker gains the trust of her village

Mee Long Kwin is a poor village with about 70 households. When I arrived there by boat, I was welcomed by the smell of unsanitary latrines. An old man soon emerged from a small house and asked, "What do you want to distribute?"

"We are not a distributing organisation," I replied. We would like to provide health services for pregnant women and under-5 children. We would like to meet with the village leader." The old man pointed to the leader's house.

There, I explained that we would like to identify one volunteer from the village for training as a Community Health Worker. Mee Long Kwin is under the purview of Gwe Chaung Gyi sub-RHC, which was established after Cyclone Nargis. There is no midwife so health services in the area are not accessible easily, which is why CHWs can play such an important role in their communities.

"I don't think anybody will be interested in this training," said the leader. "There is a lot of poverty here and we face many challenges just to survive." Nonetheless, he agreed to take the CHW criteria and consult the villagers.

A Community Health Worker conducts a health education session.

On our return a month later, the village leader said that Thin Yu Aung, just 19-years-old, was interested in the training. She hadn't passed her high school matriculation exam. "I would like to attend [the training], but my mother is worried about me," she said. After some negotiation, her mother agreed that she could attend.

CHW training is provided by MOH and IOM. It covers many topics such as basic health information and preventive measures. But we emphasise that having a good attitude is one of the most important requirements when conducting activities. Although we were a little worried about Thin Yu Aung because of her young age, she completed the 28-day training and returned to her village.

Children are screened for malnutrition.

She began her work there with hygiene activities. Despite some initial reluctance, she convinced all the villagers to enjoy *kaung nyin paung* (steamed sticky rice) one evening beside the potable waterpond. But first, she taught them about good sanitation and the importance of hand-washing before eating.

When the village was visited by a health team, the health assistant asked her: "Did you collect the people that need immunizing?"

"Yes, but there's one mother I haven't been able to get," she replied. She went to the house were Ma Thida ran a small shop.

"I have nobody to look after my shop and to take care of the older children," she said. To solve the problem Thin Yu Aung took responsibility. It is this type of problem-solving that brought her the respect of the villagers.

Thin Yu Aung provided health education sessions on World AIDS Day and during Nutrition Week. Yet despite her enthusiasm, she was not present at RHC meetings for three months running. We heard that she was not allowed to go on these trips because her parents were not comfortable with her travelling.

We were worried that her motivation might have declined but four months later, I was reassured when I visited the village again. Thin Yu Aung gave a health education session with me and her presentation skills had improved markedly. She also wanted to hold a competition to refresh people's knowledge on the health topics they'd discussed. Things were definitely improving.

"Villagers are getting better at hand-washing," she said. "Also, I don't need to organise them one by one to arrange immunizations. The behaviour of the villagers has changed slightly. I'm really happy when I see their good behaviour."

Kwin Sa Khan establishes a functioning VHC

Kwin Sa Khan Village in Bogale Township did not have a Village Health Committee. But with support from IOM's Community Health Team and assistance from DOH staff, members of the village have come together to work for better health outcomes.

Nine committee members make up the VHC. These include village leaders, CHWs, AMWs and other interested persons. The committee holds regular meetings and assists BHS to coordinate health activities in the village. To establish a revolving fund they collected donations from VHC members. With this money they bought two bags of rice, which they later sold to villagers at a below average price. With the profit, they bought more rice. The fund started at 22,500 Kyat, but over time it has grown to 60,000 Kyat, which is enough to refer two pregnant women to the hospital in case of emergency.

Annex A – JI-MNCH Indicator Achievements

	Laputta (Merlin)				Middle Island (Save The Children)				Bogale (IOM)			
Goal: Improve maternal and child health in the townships most affected by Cyclone Nargis												
Impact Indicators	**Target 2011**	**Actual (Jan-June 2011)**			**Target 2011**	**Actual (Jan-June 2011)**			**Target 2011**	**Actual (Jan-June 2011)**		
Proportion of malnourished children between 6 month to 5 years of age (Global Acute Malnutrition)	2%	Survey not completed			2%	Survey not completed			2%	Survey not completed		
Number of unintended pregnancies averted	New indicator	NA			New indicator	NA			New indicator	NA		
Purpose: To increase access to essential maternal and child health services in the townships most affected by Cyclone Nargis												
Outcome Indicators	**Target 2011**	**Actual (Jan-June 2011)**	**Actual (Jan to Dec 2011)**	**Achiev-ed (%)**	**Target 2011**	**Actual (Jan-June 2011)**	**Actual (Jan to Dec 2011)**	**Achiev-ed (%)**	**Target 2011**	**Actual (Jan-June 2011)**	**Actual (Jan to Dec 2011)**	**Achieved (%)**
Percentage of births attended by skilled and/or trained personnel	65% MW 17% AMW	NA	Available end of 2011	Available end of 2011	65% MW 17% AMW	NA	Available end of 2011	Available end of 2011	65% MW 17% AMW	NA	Available end of 2011	Available end of 2011
Proportion of one year olds vaccinated against diphtheria, pertussis and tetanus (DPT3)	10791 (86%)	NA	Available end of 2011	Available end of 2011	10791 (86%)	NA	Available end of 2011	Available end of 2011	7584 (93%)	NA	Available end of 2011	Available end of 2011
Proportion of one year olds vaccinated against measles	10665 (85%)	NA	Available end of 2011	Available end of 2011	10665 (85%)	NA	Available end of 2011	Available end of 2011	7503 (92%)	NA	Available end of 2011	Available end of 2011
Proportion of pregnant women vaccinated against tetanus toxoid	13364 (87%)	NA	Available end of 2011	Available end of 2011	13364 (87%)	NA	Available end of 2011	Available end of 2011	8389 (91%)	NA	Available end of 2011	Available end of 2011
Outpatient visits per capita per year	0.3	NA	Available end of 2011	Available end of 2011	0.3	NA	Available end of 2011	Available end of 2011	0. 15	NA	Available end of 2011	Available end of 2011
Proportion of children under 5 year with diarrhoea receiving oral rehydration therapy	60%	NA	Available end of 2011	Available end of 2011	60%	NA	Available end of 2011	Available end of 2011	60%	NA	Available end of 2011	Available end of 2011
Output 1: Maternal and Child Health												
Output Indicators	**Year 1 Target**	**Actual (Jan-June 2011)**	**Actual (May 2010 to June 2011)**	**Achiev-ed (%)**	**Year 1 Target**	**Actual (Jan-June 2011)**	**Actual (Nov 2010 to June 2011)**	**Achiev-ed (%)**	**Year 1 Target**	**Actual (Jan-June 2011)**	**Actual (May 2010 to June 2011)**	**Achieved (%)**
Percentage of pregnant women who received AN care one or more times	82% (10582)	Available end of 2011	Available end of 2011	Available end of 2011	82% (2013)	Available end of 2011	Available end of 2011	Available end of 2011	87 % (8021)	Available end of 2011	Available end of 2011	Available end of 2011

Proportion of RHCs / s-RHCs with no stock out of antibiotics and ORS during last six months	100%	Available end of 2011	Available end of 2011	Available end of 2011	100%	Available end of 2011	Available end of 2011	Available end of 2011	100%	Available end of 2011	Availabl e end of 2011	Available end of 2011
New Auxiliary Midwives trained	50	25	50	100	42	42	42	100	60	22	40	67
New Community Health Workers trained	51	0	51	100	46	46	46	100	132	91	114	86
Coordinated Township Health Plan in place	Yes	Yes	Yes	100	Yes	Yes	Yes	100	Yes	Yes	Yes	100
NGO service providers attending quarterly township JI-MNCH coordination committee meetings	300	39	172	57	264	132	154	58	960	732	953	99
Monthly Township JI-MNCH meetings conducted with BHS	12	6	12	100	12	6	8	67	12	6	12	100
Monthly RHC meetings with BHS and VHWs	132	66	130	98	48	24	24	50	144	75	105	73
Township supervision of RHCs by the supervisory team	48	14	22	46	24	5	5	21	36	13	16	44
Routine outreach visits (EPI Plus)	5280	2614	3852	73	1200	309	309	26	3540	1620	3240	92
Hard to Reach outreach visits	1248	614	1023	82	240	30	30	13	708	324	648	92
Maternal death follow-up visits and reporting	25	0	0	0	10	0	0	0	24	5	8	33
Child death follow-up visits and reporting	25	0	0	0	50	18	18	36	24	5	20	83
Number of referrals for EmOC and ECC	660	327	377	42	198	21	21	11	720	605	760	106
Provision of RHC drug kits	22	10	21	95	8	0	0	0	18	18	18	100
Provision of Sub RHC drug kits	104	48	96	92	40	0	0	0	35	45	45	129
Provision of emergency health care drugs / Drug Kit (UNICEF Kit) for Station Hospital	12	5	11	92	NA	NA	NA	NA	12	5	5	41
Provision of clean delivery kits to RHCs and sub-RHCs	7020	747	5152	73	2700	675	675	25	1200	621	1121	93

NB. The projects in Laputta and Bogale started in May 2010 and in Middle Island from November 2010.