JOINT MNCH PROGRAMME DOCUMENT
Country: **Myanmar**

Programme Title: **IMPROVING MATERNAL, NEWBORN AND CHILD HEALTH (MNCH) IN MYANMAR**

Joint Programme Outcome(s): Not applicable

Programme Duration: **One year**

Anticipated start/end dates: **Jan 2012 to Dec 2012**

Fund Management Option(s): **Pass-through**

Administrative Agent: **UNICEF**

Total estimated budget*:5 Million AUD
Out of which:

1. Funded Budget: 5 Million AUD

2. Unfunded budget: Nil

* Total estimated budget includes both programme costs and indirect support costs

Sources of funded budget:

- Government _____
- UN Org… _____
- UN Org… _____
- AusAID… 5 Million AUD
- Donor … _____
- NGO… _____

Names and signatures of (sub) national counterparts and participating UN organizations

By signing this joint programme document, all signatories – national coordinating authorities and UN organizations - assume full responsibility to achieve results identified with each of them as shown in Table 1 and detailed in annual workplans.

UN Organizations	**National Coordinating Authorities**
Dr H.S.B. Tennakoon *Representative* *Signature* *World Health Organization (WHO)* *Date & Seal*	***Ministry of Health (MOH)*** ***Government of the Republic of the Union of Myanmar*** *Approval letter from Ministry of Health, Letter No. Na Hsa Ya/YM-9(03)/ 505, Dated. 16th September, 2011 for two years proposal to AusAID amounting to AUD 15 million.*
Mr Ramesh Shrestha *Representative* *Signature* *United Nations Children's Fund (UNICEF)* *Date & Seal*	
Mr Mohamed Abdel-Ahad *Representative* *Signature* *United Nations Population Fund (UNFPA)* *Date& Seal*	

CONTENTS

- AMW Auxiliary Midwife
- ARI Acute Respiratory Infections
- AusAID Australian Agency for International Development
- AWP Annual Work Plan
- BCA Basic Cooperation Agreement
- BCC Behaviour Change Communication
- BEmONC Basic Emergency Obstetric and Newborn Care
- BHS Basic Health Staff
- BS Birth Spacing
- C-section Caesarean section
- CBNBC Community Based Newborn Care
- CCM Community Case Management
- CCS Country Cooperation Strategy
- CEmONC Comprehensive Emergency Obstetric and Newborn Care
- CH Child Health
- CHW Community Health Worker
- CoRH Community-Operated Reproductive Health
- CPR Contraceptive Prevalence Rate
- CSOs Civil Society Organizations
- DHP Department of Health Planning
- DHS Demographic and Health Survey
- DOH Department of Health
- DPT Diphtheria, Pertussis and Tetanus (Vaccine)
- DQA Data Quality Assessment
- EmONC Emergency Obstetric and Newborn Care
- ENC Essential Newborn Care
- EPI Expanded Programme for Immunization
- FRHS Fertility and Reproductive Health Survey
- GAVI Global Alliance for Vaccine Initiative
- HLCS Household Living Condition Survey
- HMIS Health Management Information System
- HTR Hard-to-reach
- IEC Information, Education and Communication
- IMCI Integrated Management of Childhood Illnesses
- IMNCI Integrated Management of Newborn and Childhood Illnesses
- JP Joint Programme
- JPMF Joint Programme Monitoring Framework
- LMIS Logistics Management Information System
- MBB Marginal Budgeting for Bottlenecks (Costing tool)
- MCH Maternal and Child Health
- MDG Millennium Development Goal
- M&E Monitoring and Evaluation
- MICS Multiple Indicator Cluster Survey
- MMCWA Myanmar Maternal and Child Welfare Association
- MMR Maternal Mortality Ratio
- MNCH Maternal Newborn and Child Health
- MOH Ministry of Health
- NGO Non Governmental Organization
- ORS Oral Rehydrating Solutions
- PCM Project Cycle Management
- PCPR Project Contraceptive Prevalence Rate
- PCPNC Pregnancy, Childbirth, Postpartum and Newborn Care
- PSI Public Services International
- QBSS Quality Birth Spacing Services
- RH Reproductive Health
- RHC Rural Health Centre
- RTI/STI Reproductive Tract Infection/ Sexually Transmitted Infection
- SBA Skilled Birth Attendants
- SDPs Service Delivery Points
- SOP Standard Operation Procedures
- TT Tetanus Toxoid
- UN United Nations
- UNDAF United Nations Development Assistance Framework
- UNDG United Nations Development Group
- UNDP United Nations Development Programme
- UNFPA United Nations Population Fund
- UNICEF United Nations Children's Fund
- WHO World Health Organization

1. Executive Summary

Myanmar is committed to achieving the Millennium Development Goals but maternal and child mortality projections for 2015 indicate that MDG 4 and 5 targets unlikely to be met. UN organisations are actively working with the Ministry of Health to address maternal, newborn and child health (MNCH) mortality and morbidity in Myanmar. This joint UN proposal submitted to AusAID by WHO, UNICEF and UNFPA (AUD 5 million for one year) provides the opportunity for scale up and/or maintenance of support for the on-going low cost high impact maternal and child health interventions that the three UN organisations are delivering in Myanmar. Included in the proposal is furtherance of UN support to the Ministry of Health for the development of national MNCH guidelines and strengthening coordination of MNCH activities.

This proposal describes the activities that will be supported by AusAID in the context of the overarching WHO, UNICEF and UNFPA Myanmar MNCH programme for 2012. Three broad strategies –enabling environment, service delivery, capacity development/health system strengthening– underpin the programme approach.

The UN joint MNCH programme has four main outputs: (1) evidence-based policies for improved maternal and child health are in place and health sector coordination improved among relevant partners; (2) an increased percentage of children receive preventive services and appropriate case management (for more prevalent diseases) in project townships; (3) skilled delivery and provision of newborn care increased in project townships; and (4) increased access to birth spacing services in project townships.

The UN MNCH programme prioritizes 132 townships (of the 330 townships in Myanmar); of these, 70 are defined as hard to reach. The programme will cover a projected population of 21.3 million; around 8 million live in hard-to-reach townships. The programme will provide key MNCH interventions as two distinct packages:

- mobile outreach based, low cost, high impact preventive health interventions focussing on around 3,000 remote/inaccessible villages in 70 hard to reach townships
- facility based curative and preventive package for common MNC killers (skilled health providers and supplies of drugs and commodities)

These interventions will be complemented by improved coordination, an enabling policy environment at national level and capacity building at regional/ state level.

The Ministry of Health is the lead partner for the implementation of the MNCH activities proposed under this joint programme. Township Health Departments, State/Regional Health Departments and local authorities will be the primary implementing partners, partnered with the three UN agencies, international and local NGOs and community leaders.

A Joint Programme Steering Committee comprising of the three Heads of UN agencies and representative from Ministry of Health and AusAID is responsible for overall management and coordination of the programme. WHO, UNICEF and UNFPA MNCH specialists and gender focal person will provide technical oversight of the programme through the Joint Programme Technical Working Group. The funding mechanism agreed by the joint programme steering committee is pass-through funding based on donor preference and with UNICEF as the Administrative Agent.

The monitoring framework for the proposal includes periodic informal progress review in steering committee and validation of reported data after 2012. One year workplan detailing activities, time lines and the financial proposal is presented. Programme and financial activity report will be submitted to AusAID by early 2013.

2. Situation Analysis

2.1 Trends for Under-five Mortality

The under-five mortality rate is high in Myanmar, estimated at 71 and 66 per 1,000 live births by UN interagency estimates and Ministry of Health respectively[1]. In 1990, the base year for monitoring progress on MDG targets, child mortality was estimated at 118 by UN interagency estimates.

Myanmar is committed to the Millennium Development Goals but the progress of MDG4 -- to reduce the 1990 under-five mortality rate by two-thirds by 2015 - is slow and is categorized as "insufficient progress"[2].

It is clear that the rates for infant and under-five mortality have been declining during the last two decades although the rates of decline may be slowing down during the decade 2001-2010 as compared to the period 1981-1990 and 1991-2000. The rate of decline may not be sufficient to meet the MDG target.

There is considerable geographic and socio-economic variation in the levels of infant and under-five mortality. Child mortality rates are substantially higher in the rural areas amongst the uneducated and in children who are from families in the lowest socio economic quintile.

2.2 Trends for Maternal Mortality

Women of reproductive age constitute about 30% of the total population in Myanmar, which is estimated at 58.38 million[3]. There is a significant disparity in the health situation between urban and rural area, where 70% of the population reside. About 76% of deliveries take place at home[4], with 90% of maternal deaths occurring in rural areas. Estimated crude birth rates of 18.4 live births per 1,000 population in urban areas and 21.2 per 1,000 in rural areas[5] translate into approximately 1,188,600 births per year.

New WHO/UNICEF/UNFPA/World Bank (H4) time trend estimates (2008) show a small reduction in MMR: from 250/100,000 live births in 2005 to 240/100,000 live births in 2008. The rate of decline in Myanmar lags behind other countries in the region. Meeting the MDG5A goal of reducing MMR by 75% presents a huge challenge for Myanmar.

2.3 Causes of mortality in mothers and children under five years of age

Two-thirds of under-five deaths occur in the first year of life; around 40% in the first month.

Neonatal Mortality: The three leading causes of neonatal deaths are low birth weight/prematurity (31%), neonatal sepsis (26%) and birth asphyxia (25%)[6]. Around 90% of the neonatal deaths occurred in home deliveries in rural areas compared to 76% in urban areas. Delivery by an auxiliary midwife or traditional birth attendant doubled the risk of neonatal death compared to delivery by a midwife or doctor.
Post neonatal mortality: The principal causes of post neonatal mortality (death after four weeks of birth) of children under five include acute respiratory infections (ARI) or pneumonia (28%), followed by diarrhoea (18%), brain infections including cerebral malaria (17%) and malaria (8%)[6]. More than 90% of the deaths during the post neonatal period were attributed

[1] UN Interagency Estimates 2010 and DOH 2002-2003
[2] Countdown to 2015 MNCH Report
[3] Planning Department, Ministry of Planning and Economic Development, 2008-2009
[4] Fertility and Reproductive Health Survey, Department of Population and UNFPA, 2007
[5] Statistical Year Book, Central Statistical Organization, 2007
[6] Myanmar Overall and Cause specific under-five mortality survey 2002-2003, MOH Myanmar 2003

to single causation. Most of the deaths investigated by verbal autopsy (85.5%) occurred at home. Malnutrition was considered to be a direct cause of death only in 1.0% of all deaths investigated but it was a contributing factor in a high proportion of deaths.

Maternal Mortality: The 2004-2005 cause specific maternal mortality survey by MOH and UNICEF showed that severe postpartum haemorrhage was the main direct obstetric cause of maternal deaths (31%), followed by hypertensive disorders of pregnancy including eclampsia (17%) and sepsis related to abortion (10%).

2.4 Causality Analysis and Corresponding Programming Response for Under-five Mortality

The following is a summary of causality analysis from which the newborn and child heath proposed activities in this joint MNCH programme are derived.

Direct causes of child mortality: The direct causes of death for under-five children are neonatal causes (see above) followed by pneumonia, diarrhoea and malaria. The proposal addresses these through improving the enabling environment and improving service delivery at the community level through the provision of low-cost, evidence-based, high-impact interventions. The interventions target immediate needs in child health with a focus on vulnerable populations in hard-to-reach townships[7] thus reducing inequity.

Underlying causes of maternal and child mortality: Important causes include: limited access to maternal, newborn and child health services especially in some hard-to-reach areas; inappropriate key caring practices at community level e.g. for newborn care; and low utilization of some services especially curative which may be due to non-availability of supplies, skills and/or quality of services. This proposal addresses these through capacity development especially at township level and below within an overall health systems strengthening initiative.

Root/Basic causes: The principal reasons are: inadequate government funding for health, especially MNCH services (MoH has not made an investment case for MNCH services which would demonstrate the positive impact of increased expenditure on MNCH outcomes); the lack of reliable and up-to-date health data necessary for decision-making; and gaps in national policy and guidelines e.g. community based newborn care; community case management of pneumonia and diarrhoea in children. These are addressed in this proposal by upstream policy related work by WHO and UNICEF relating to the National Five-Year Strategic Plan for Child Health Development (2010-2014) and by UNFPA and WHO relating to the National Five-year Strategic Plan for Reproductive Health (2009-2013).

2.5 Causality Analysis and Corresponding Programming Response of Maternal Mortality

Immediate causes of maternal mortality: The immediate causes of maternal death are bleeding, eclampsia and sepsis as outlined above. All three delays in receiving medical care, namely (1) delay in decision making at home to seek care (knowledge, economy, culture), (2) delay in reaching a health facility (remoteness, lack of transportation), and (3) delay in receiving adequate care at a health facility (quality services) are experienced in Myanmar due to a vicious cycle of poverty, transportation difficulties and the lack of high quality clinical care. It is estimated that 7-10% of deliveries require emergency obstetric and newborn care (EmONC)

[7] Lancet (2003) and see annexure-5

Antenatal care coverage (at least one visit) was only 70.6% in 2009 (MoH HMIS) and around 83% according to MICS 2010. Quality of antenatal care needs improvement. Skilled birth attendance is around 64.4% in Myanmar in 2009, showing an obvious gap between this reality and the Strategic Plan's target figures for skilled birth attendance (80% by 2015)[8]. Emergency obstetric care is neither adequate nor affordable for all in Myanmar. According to WHO estimates, 23 health care providers with midwifery skills are required for a population of 10,000 in order to achieve 80% coverage of skilled delivery. In Myanmar, the corresponding figure is 14 health care providers per 10,000. The doctor/population ratio is 1:3315, and for nurses or midwives the ratio is 1:1195.

Root/Basic Causes of Maternal Mortality: The three delays are all too common. It is estimated that the cost of ensuring appropriate antenatal, delivery and emergency obstetric care for 1.2 million pregnant mothers per year is $25 million annually. There has been a large funding gap for maternal health and birth spacing coverage for the 15 million women of reproductive aged who are dispersed across a large geographic area, often in hard-to-reach locations. Maternal and neonatal health services have received less priority and resources.

Programme Response to address the reduction in Maternal Mortality: The programme response comprises three key components that address both immediate and basic causes of maternal mortality. (i) provision of newborn and maternal health care commodities for facility based and outreach antenatal and postnatal care; provision of drugs, equipment and supplies for institutional and home-based delivery care; and provision of drugs, equipment and supplies for facility based EmONC; (ii) capacity development to increase the skills of health staff to provide quality reproductive health care; and (iii) provision of outreach based schedulable services.

3. Strategies including lessons learned and the proposed joint programme

3.1 Lesson Learned

Reaching the Unreached

While access to basic social services improved nationally, challenges remain in reaching the most vulnerable population in hard-to-reach areas. A more systematic approach will be required to reach those children and families in more inaccessible areas. The challenge for the programme will be to push for equity in services with greater emphasis on 'reaching the unreached'. An optimal mix of delivery of services through various channels such as facility-based, outreach-based and family/community-based as identified in the National Strategic Plan would maximize decrease of inequity of access.

Evidence-based Programming

An evidence-based, integrated and focused programme maximizes utilization of available resources: there is a need for more investments on assessments and research to inform programme design and management.

Health Financing

In Myanmar, the percentage of GDP spent on health is only 2.2%. Government expenditure is also very low as a proportion of total expenditure on health and there are very high out-of-pocket expenditure on health (86.9% in 2006), including for MNCH emergencies. The key challenge is to provide a comprehensive package of essential MNCH services, affordable and accessible at the primary health care level. There is significant funding gap for MNCH e.g of 75% for implementation of the Five Year National RH Strategic Plan (2004-2008).

[8] Five year strategic Plan for Reproductive Health (2009-2013); DOH

Relatively low levels of targets have been set at national level in the Child Health Implementation Plan largely due to resource constraint.

Partnership and Linkage with 3 MDG Fund

The 3DiseaseFund has provided essential assistance towards life-saving health interventions in Myanmar during the last couple of years. The implementation of 3DF was designed to end in 2011, and during the preparatory work has been on-going to provide a logical follow-up towards a focus of Maternal, Neonatal and Child Health interventions covering MDG 4, 5 and 6.
Different initiatives through the international community are now designed or in place to improve the health status of vulnerable groups in Myanmar. The Global Fund has re-established itself and although Round 11 was recently called off, on-going rounds are still active for several years. GAVI-HSS has started implementation in 2011 in 20 townships, expanding to 180 townships over the next 3 years.

Unfortunately, all these initiatives are still fragmenting services and geographic focus, leading to a detrimental patchwork of responsibilities, service quality spreads and high health service inefficiencies. It is not unlikely that in 2012/2013 more actors in the health sector may appear with the risk of even more confusing the landscape. It will therefore be an historic opportunity for the 3MDG Fund to bring this altogether and thus 3MDG Fund needs to have a national perspective in design and implementation mode. It is clear that the capacity of States/Regions as meso-level management focus should be strengthened considerably to support a manageable number of townships. The concerned donor consortium has indicated that implementation of 3MDGF should start halfway 2012, but many hurdles are still to be taken, including the preparation of the selected Fund Manager.
The proposed Joint Programme can start quickly as it supports on-going agency activities, bringing them more close together under a joint implementation and monitoring framework. Downstream it takes responsibility to provide low cost effective health interventions to those most ostracized and upstream the JP assists national and State/regional levels with increased capacity for coordination and health policy initiatives, providing a proper bridge framework.

Human Resource Development
Program management skills e.g related to child health program is a gap which needs to be addressed. Furthermore, to meet the international threshold and secure skilled midwife, production, deployment and retention of a well-trained work force with midwifery skills need to be reinforced. The quality of both pre- and in-service trainings need to be strengthened through training need assessment, review and inventory of training courses and standardization across the country with emphasis on competency-based training.

Sustaining Vaccine Preventable Disease Status
Targeted national campaigns against polio, measles and maternal-neonatal tetanus resulted in maintaining Myanmar free from polio, minimum cases of measles and Myanmar being declared MNT eliminated status. A sustained routine immunization programme is essential to maintain this status with increases human, financial and material resources and in Myanmar provides the backbone of preventive health services in Myanmar.

3.2 Proposed joint programme

Background/context: The joint programme will contribute to the achievement of MDGs 4 and 5 through support for the implementation of the National Child Health Development Strategic Plan 2010-2014 and the National Reproductive Health Plan 2009-2013. The inputs of this proposal will complement development and humanitarian obligations under MDG 4 and 5 provided by government and national and international NGOs.

3.2.1 Geographic Sites

The UN agencies together with the national government as per national strategic plan have agreed on the selection of a total of 132 priority townships for the UN joint proposal based on agreed pro-poor criteria:

70 Hard-to-reach townships: The criteria are (a) township classified by MOH as hard-to-reach due to remote/geographic/forest area/no access during long monsoon. The National Five-Year Strategic Plan for Child Health Development (2010-2014) specifically prioritized hard-to-reach townships. The hard to reach areas in these townships due to geographic situation itself represent vulnerable and poorer population. Also included in this category are (b) four townships affected by Cyclone Giri *in* 2010 in Rakhine State which require on-going support for public health services and lastly (c) several underserved peri-urban slums around large cities where urban poor are concentrated.

This list of 70 hard-to-reach townships is annexed as *Annexure 1a*.

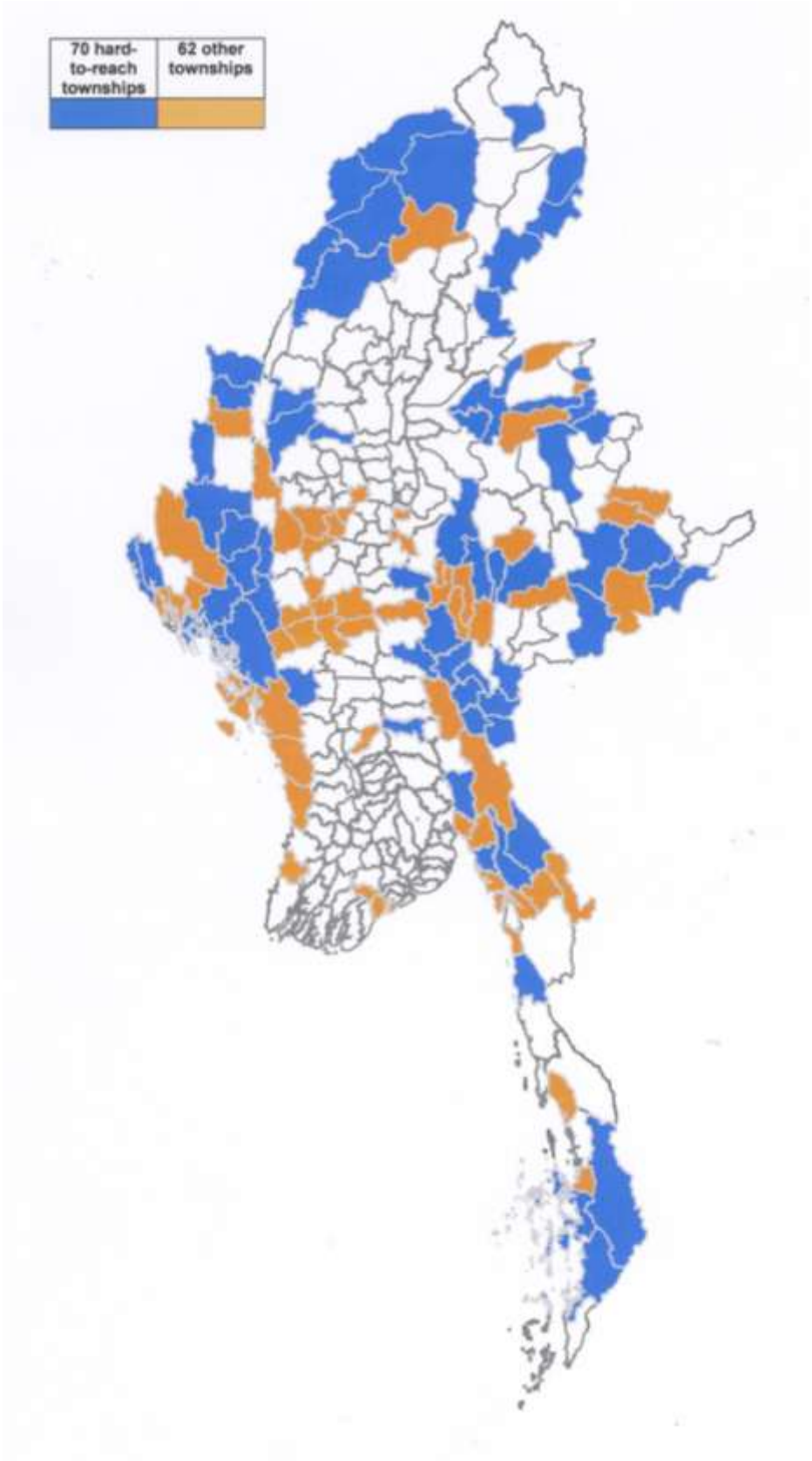
62 existing Maternal, Neonatal, Child Health (MNCH) project townships: Lack of supplies is the major contributory factor affecting the quality of services in the public health system. The programme will ensure the provision of essential lifesaving commodities for child survival and reproductive health supplies by UNICEF and UNFPA respectively. Sixty-two such townships have been selected in consultation with Ministry of Health where UNICEF can assure life-saving supplies up to Sub Rural Health Centre level for child survival and UNFPA with reproductive health (RH) commodities.

The list of the 62 townships is annexed as *Annexure 1b.*

Based on the overall programme performance and on any additional resources provided through the GAVI Health Systems Strengthening efforts as well as from the Ministry of Health the list of the 132 townships will be reviewed in mid-2012 to ensure that evidence-based cost effective interventions are reaching maximum number of eligible population.

Attached *annexure 1c* details the added value/ new or top-up activities to be funded by AusAID by each of the three UN agencies. For 2012, UNICEF expects an additional funding of USD 11 million, UNFPA USD 3.15 million and WHO USD 0.24million (2012-13).

Joint Program – Geographic Sites



3.2.2 Overall Goal and Outputs

The overall goal of the joint UN MNCH programme is to contribute to the attainment of objectives, outcomes and targets of National Strategic Plans for Reproductive Health and Child Health Development by reducing maternal, newborn and child deaths.The direct causes of maternal, neonatal and young child deaths are known and are largely preventable and treatable using proven and cost-effective interventions and practices (see annex 5). The series in *The Lancet* has estimated that around two thirds of both neonatal and young child deaths are preventable with existing low-cost, low-technology interventions many of which are included in AusAID supported joint program on MNCH as prioritized in the strategic plan. The value of money invested and impact of interventions is also detailed out in Annex 5.

There are four outputs out of these interventions;

1. Evidence-based policies for improved maternal and child health are in place and health sector coordination improved among relevant partners

2. An increased percentage of children receive preventive services and appropriate case management in project townships

3. Skilled delivery and provision of newborn care increased in project townships

4. Increased access to birth spacing services in project townships

3.2.3 Key Strategies

The maternal and child health inputs under this proposal focus on (a) a facility based curative package in around 132 townships including many of 70 hard-to-reach townships, and (b) outreach based preventive services in 70 hard-to-reach townships

UNFPA is supporting Myanmar in addressing MDG5 through a three-pronged strategy, (1) advocating and supporting family planning services, (2) promoting skilled birth attendance; and (3) provision of emergency obstetric care, and high quality antenatal care and mobilizing community support mechanisms.

Three overarching strategies that would be followed in this joint proposal are

1. Strengthening the enabling environment,
2. Improving service delivery and gender equality and equity for reduction of morbidity and mortality
3. Enhanced capacity development at various levels

Strategy 1: Strengthening the enabling environment

Strengthening coordination of services and related technical guidelines at the national level: With support from AusAID, WHO and UNICEF will continue to engage with the Ministry of Health in upstream work formulated by observations from the field, service delivery experiences and new technical developments in the field of child health. Recent examples of this work include the development of National Child Health Development Strategic Plan and National Child Health Implementation Plan. A pilot study for community case management of diarrhoea and pneumonia is already underway; it is anticipated that based on positive findings it may lead to policy change and phased roll out of community case management. Similarly, WHO is working on integrating newborn care in IMCI. In 2012, UNICEF, WHO and UNFPA plan to undertake the costing of the integrated MNCH as well as the Child Health Development Strategic Plan and National Strategic Plan for Reproductive Health using the Marginal Budgeting for Bottlenecks (MBB) tool linking per capita cost to impact for MDGs 1,

4, 5 and 6. During 2012 the MBB tool will be used at national level. WHO and UNFPA will continue to work with the Ministry of Health in upstream work related to maternal health care especially emergency obstetric care, and implementation of the National Strategic Plan for Reproductive Health.

WHO will take the lead in finalising the integration of newborn care into IMCI (Integrated Management of newborn and child illnesses IMNCI) followed by IMNCI training in 4 new townships where UNICEF has not provided the training for newborn and child health; strengthening the health management information system (HMIS) for integrating data on MNCH; Child Health Programme management training and Facility-based IMNCI for hospital staff. Community IMNCI- essentially the promotion of key family health practices- will also be implemented. The State/Regional and District program managers will be trained on MNCH program management. WHO and UNFPA will support to upgrading pre-service midwifery training in the 22 midwifery schools (competency-based, delivered by midwifery tutors trained in modern teaching method and using modern teaching aids). WHO will also provide capacity development of midwifery teachers/tutors for Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC).

The draft HMIS workplan is found in Annex 4. WHO will support the improvement of the mechanism for the collection, validation and analysis of high quality data.
The programme will strengthen technical guidelines and coordination mechanisms in reproductive health care. As a follow up activity of the National Reproductive Health Plan WHO, UNFPA and UNICEF will engage in upstream work in the field of maternal health care services based on field data and the realities in Myanmar. These inputs would include development of technical guidelines to include standard operating procedures for use of parenteral magnesium sulphate, misoprostol and/or oxytocin to prevent/treat postpartum haemorrhage and updating of PCPNC (Pregnancy, Childbirth, Postpartum and Newborn Care). The National Reproductive Health Working Committee is the coordination mechanism with all partners at national level. This is supported by the National Reproductive Health Technical Working Group and National Reproductive Health Commodity Security Sub-working Committee. An attempt will be made to review the policy and regulations related to midwifery by WHO and UNFPA using National Reproductive Health Committee as the forum.

Health Sector Coordination: There is universal stakeholder support for the need to strengthen overall health sector coordination. Due to the diversity of health related interventions it is equally important to maintain and strengthen coordination of the thematic health forums- National Reproductive Health Working Committee and the National Child Survival Forum. Government, NGOs and UN agencies are an integral part of these national level coordination mechanisms. GAVI Health System Strengthening is indirectly represented by WHO and UNICEF (both as recipients of GAVI funds). Greater efforts will be made to ensure current National Child Health and Reproductive coordination mechanisms and Country Coordinating Mechanism (CCM) are further strengthened for MNCH (and the upcoming 3 MDG fund with its focus on MNCH services).

For improved coordination, donors are invited to attend the national forums for reproductive and child health. NGO/INGOs are represented (e.g. SC, Merlin, PSI, CARE and MSI etc.) and involved in current national level coordination mechanisms, namely the National Child Survival Forum for Child Health Development Strategic Plan and the Reproductive Health Committee for the Reproductive Health Strategic Plan. NGOs and INGO inputs were taken into account while drafting the national strategic plans.

Dialogue around Health Financing**:** WHO and UNICEF have initiated a dialogue around health financing. An inter-agency group for social protection has Ministry of National Planning and Economic Development, Ministry of Health, Myanmar Insurance, Ministry of

Finance, Social Security Board, and Ministry of Labour as members and has initiated discussions. Various options for "Alternative Health Care Financing" has been considered and explored on a pilot basis by the Department of Health Planning. This would be carried forward using other resources.

Facility Based IMNCI: WHO will adapt the Facility-based IMNCI module and implement this in 4 selected townships. AusAID support would ensure that this process is implemented as early as possible.

Strategy 2: Improving service delivery and gender equality and equity to reduce morbidity and mortality

Gender Equality

Women play a significant role in the health sector, both in their role in reproduction and their role in household and community services. With the exception of sexually transmitted diseases, the health risks associated with re production impact solely on women and children. Infant and maternal mortality rates are a major concern in many countries. The reproductive role of women is important in determining their health standards. However the health needs of women lie beyond their reproductive role, and can include illnesses related to malnutrition, occupational health hazards, overwork, tiredness, family breakdown and violence. At the household and community level women are often the main providers of health care. They provide food to household members, are primary caretakers of children, are responsible for water collection, sanitation and the provision of health care services to other community members, in particular the elderly. As health care providers, women play an active role in addressing the health needs of the family and the community.
The Joint Programme prioritizes access to health care in hard to reach townships, focusing on key low cost highly effective interventions, which are mainly focused on children and women. The objectives of the JP include specific objectives for maternal care and birth spacing services, with child health outcomes gender 'neutral'.

Hard to reach areas in Myanmar are found in culturally diverse environments, with different gender dynamics. Health care delivery support will be organized and implemented with due respect to these differences. For example, gender will be incorporated in RH trainings of basic health staff, at the client engagement level, women's need will be supported, men will be reached for more support for maternal health and counseling will be undertaken with a gender perspective.

UNICEF has introduced gender marker system for all its results areas, thus facilitating monitoring and reporting on advancing gender equality. UNFPA also taken into account the different needs and different division of labor of women and men, and barriers for men's participation in maternal health in health service delivery strategies.

Due to the short project duration of one year it is not possible to introduce sex disaggregated data collection different from routine HMIS.

Equity

To reduce disparity in health care, the programme will focus on two delivery modes. They are outreach based and facility based while family oriented community based activities will be implemented with other funding resources.

Outreach based: Using DPT3 as proxy indicator the outreach based activities will offer preventive services based on National Strategic Plan for Child Health Development, which has identified more than 80 townships with low coverage/unreached areas. With equity focus and using the "Reaching Every Community" guidelines recently developed jointly with MOH to complement GAVI HSS, UNICEF and UNFPA aim to deliver a package of preventive and

schedulable maternal and child health interventions in 70 townships through enhanced outreach targeting hard-to-reach areas especially during the dry season of the year. The interventions proposed include (a) immunization for children under 18 months and women of child bearing age (b) micronutrient supplementation including Vitamin-A and deworming for children and iron supplementation for pregnant women (c) distribution of insecticide treated nets to households in malaria-endemic villages using other resources in 24 malaria-endemic townships and (d) case management of diarrhoea, pneumonia in many of hard-to-reach townships and malaria (endemic areas only, and in hard-to-reach townships where GFATM/ 3 Diseases Fund are not providing support) during the outreach visits, and establishing ORS depots with community health workers.

This package will be complemented by UNFPA through provision of (a) antenatal care kits including clean delivery kits, (b) midwifery kits, and (c) birth spacing commodities.

Facility based: the facility based services will focus on strengthening curative packages addressing the major killers of young children. UNICEF has developed a selected life-saving medicines child survival kit up for sub rural health centres. These include ORS and zinc for diarrhoea and antibiotics for pneumonia. The kit contents have also been adopted by GAVI Health System Strengthening project. Townships receiving support from GAVI HSS and child survival kits will be excluded from the Joint Program MNCH. AusAID support will extend to providing child survival kits to around 100 townships therefore, in 2012.

The child survival medicine and equipment for hospital level in selected townships would be procured by UNICEF using other resources.

Facility based or community level packages supplied by UNFPA will include
(i) drugs and supplies for facility based and outreach antenatal care and postnatal care (urine test strip, haemoglobin colour scale, TPHA test kits, bathroom scales, ferrous/folate, vitamins, methyl dopa, IEC materials, records and registers, etc.) and reproductive health care commodities (instruments and antibiotics for post abortion care and RTI/STI, etc.) to increase antenatal care coverage, especially for pregnant women living in hard-to-reach villages;

(ii) Drugs, equipment and supplies for institutional and home-based delivery care (labour beds, MCH A centre kits, midwifery kits, clean delivery kits, tube and mask neonatal resuscitation device, disposable De Lee type suction traps, Salter weighing scales for infants, misoprostol, magnesium sulphate, oxytocin, etc.) to rural and sub rural health centres as well as to NGO maternity homes to promote clean home delivery and institutional delivery by skilled health personnel;

(iii) Drugs, equipment and supplies for facility based EmONC (emergency obstetric and newborn care) including equipment for operating theatres, caesarean section kits, labour beds, spot lights, generator, bag and mask neonatal resuscitation kits, drugs, supplies and test kits for C-section, assisted delivery, abortion management, safe blood transfusion and, weighing scales, etc. for township and station hospitals to promote adequate and timely interventions for maternal and newborn emergencies; and

(iv) Drugs, equipment and supplies for birth spacing including, depot injection, disposable syringes, contraceptive pills, intrauterine contraceptive device and insertion kits, emergency contraceptive pills, condoms, etc.

The supplies provided through this programme focus on a limited number of evidence-based interventions considered low cost high impact based on the Lancet's child survival services. These provide the best value for money (see annex 5) and aim to fill the critical gap of ensuring life saving medicines are available in the community.

Refurbishment of Health Facilities (UNFPA): Criteria for selecting public health facilities for refurbishment (i) facilities where institutional delivery can be promoted and human resources available (where there is need and expecting high utilization); (ii) Township and Station hospitals requiring upgrading of operating theatres and maternity wards. Military facilities will not be eligible for refurbishment. Refurbishment will be limited to ensuring that the facility is structurally sound, and has the infrastructure to provide a clean delivery (including an operation theatre where appropriate) with access to clean water and sanitation. UNFPA will select and contract qualified construction companies to undertake the work. Township and village health committees will be involved in the selection process.

Strategy 3: Capacity Development

National Level: The three UN agencies will work with national level authorities in development and updating of relevant guidelines and strategic framework related to MNCH. With support from the UN, the Ministry of Health has recently put in place coordination mechanisms for both the National Strategic Plans for Reproductive Health and Child Health Development. These efforts will be further strengthened under this proposal for a continuous dialogue between Ministry of Health and partners including donors. Integrated HMIS for MNCH would also be strengthened after consensus on activities is reached with Department of Health Planning.

State/Region Level: The Child Health Management training at state and regional level will be undertaken by WHO together with UNICEF under this proposal to ensure enhanced managerial skills for the implementation of national child health strategy. Depending on the speed and level of decentralization of decision making and resources to State/ Regional level, technical and managerial capacities would be strengthened to respond to these changes.

Township Level: UNFPA and WHO will conduct training, human resource and facility needs assessment in intensive intervention township SDPs and nursing/midwifery schools and training aids will be procured and distributed for midwifery schools.

4. Results Framework

The National Strategic Plan for Child Health Development and the National Strategic Plan for Reproductive Health have been used as a basis for developing the results framework. The outputs are articulated in greater detail in the workplan (with activities, timeframe and budgets by each UN agency (See *Annexure 2*).

There are four outputs for this joint proposal and for each of these corresponding results are briefly described below:

1. Evidence-based Policies for improved maternal and child health are in place and health sector coordination improved

   a. Functional coordination mechanism for MNCH program with partners is in place through Child Survival Forum under National Child Health Committee and National RH working Committee
   b. HMIS strengthened for record management and ICD 10(see annex 4 for more details)
   c. National level guidelines on such as community case management of pneumonia, community-based newborn care, Standard Operation Procedure SOP for priority child health interventions, communication strategy/ standardized materials on key practice for child health, and modules on PCPNC and RH

(see work-plan for agency-wise detail)

d. State/Regional and district program managers have capacity for MNCH in programme management
e. Updated competency-based midwifery curriculum and trained midwifery teachers/tutors on Essential Newborn Care and PCPNC are available
f. Maternal, and newborn death audits and data collected in selected townships to strengthen MNCH
g. National RH Strategic Plan (2009-2013) implementation reviewed by short program review of reproductive, maternal and newborn care services
h. WHO appointed MNCH expert to coordinate AusAID assisted program
i. Development of an investment case for MNCH by using MBB costing tool at national level initiated

2. By end of 2012, increased percentage of children receiving preventive services and appropriate case management in project townships

a. 80% of Basic Health Staff are trained for community-based IMNCI in 4 selected townships
b. 90% of Hospital staff are trained for Facility based IMNCI in 8 selected townships
c. Quality of care for Neonatal and child health care in State/ Regional, District and Township (tertiary and first referral) Hospitals assessed 3 per State/region in 3 selected State/Region
d. 70% of 200,000 pregnant women receive two doses of TT vaccine in 70 hard-to-reach townships by end 2012
e. 70% of estimated 260,000 children aged 0-18 months are immunized with DPT3 in 70 hard-to-reach townships by end 2012
f. At least 90% of rural health sub-centres in 100 townships received child survival kit by end 2012
g. At least 60% of around 1,500 hard-to-reach villages 35 townships have ORS available at CHW or AMW
h. 60,000 cases in 24 hard-to-reach townships received anti-malaria treatment

3. By end of 2012, skilled delivery and provision of newborn care increased in project townships

a. 80% of district paediatricians have capacity for Newborn Care
b. 80% of Basic Health Staff trained for Essential Newborn Care
c. Delivery and EmONC service delivery points in 37 project townships provided with equipment and supplies
d. Nursing and midwifery schools equipped with necessary training aids and equipment
e. Nurses, midwives and doctors in selected townships trained in EmONC
f. 20 delivery rooms and 10 Comprehensive EmONC facilities in most needed areas refurbished
g. Outreach mobile services for community based MNCH care organized in 70 HTR and

4. By end of 2012, increased access to birth spacing services

a. Public sector SDPs and programme supported NGOs' Service Delivery Points (SDPs) in targeted townships received adequate and regular supply of birth spacing commodities
b. Targeted service providers received birth spacing training

5. Management and Coordination Arrangements

This joint programme document does not substitute for the organization-specific arrangements required by the respective internal policies of WHO, UNICEF and UNFPA.

A Joint Programme Steering Committee was established during the development of this proposal comprising the heads of the three participating UN agencies. Two additional members will join the Steering Committee: a representative from MoH (as a co-signatory to joint proposal document) and a representative from AusAID. The functions of the Steering Committee are: to set the overall direction of the joint programme: review and approve the workplan and budget; review progress; and address any constraints to the programme. The steering committee will also review programme reports (using a standardised format) and expenditures as well as direct the joint programme technical working group. A commodity availability survey can be conducted after 12 months of program implementation if required.

A Joint Programme Technical Working Group has been formed comprising the technical specialists for MNCH and gender focal person from the three participating UN agencies. This group has met frequently during the development of this proposal under the guidance of the Steering Committee. The Technical Working Groups will continue to meet at least monthly to discuss operational matters as well as technical issues and concerns, and keep the Heads of the three implementing UN agencies informed of the results of their discussions.

6. Fund Management Arrangements and Cash Transfer Modalities

There are three fund management options for joint programmes: a) parallel b) pooled and c) pass-through. Based on AusAID's requirements, the Joint Programme Steering Committee has approved the Pass Through mechanism.

In a joint programme with pass-through fund management, each participating UN organization prepares annual and final Financial Progress Reports, and a final Certified Statement of Income and Expenditure for its components of the programme. The participating UN organizations submit these reports to the Administrative Agent (AA). The AA consequently prepares consolidated/aggregated Financial and programme Progress Reports and a consolidated/aggregated Certified Statement of Income and Expenditure. The AA submits these consolidated reports to the Joint Programme Steering Committee and donor.

It has been agreed that UNICEF will act as the Administrative Agent. A Standard Administrative Arrangement would be signed by UNICEF with AusAID and a Memorandum of Understanding (MOU) with the UN agencies i.e. WHO and UNFPA in accordance with UNDG guidelines/ protocols and using standard formats approved by all UN agencies.

7a. Monitoring and Reporting

Monitoring**:** The "Joint Programme Monitoring Framework (JPMF)" Table 1 summarizes the monitoring arrangements for the programme. The detailed programme activities and indicative timelines are found in the workplan in annexure 2.

The monitoring framework for the joint programme is aligned with the M and E frameworks proposed in national reproductive health and child health implementation plans. Within the one-year timeframe of the programme, the impact on child and maternal mortality may not be readily demonstrable. Hence coverage levels of the high impact interventions introduced in this programme, and known to impact on maternal and child mortality, will be used as proxy indicators. It is anticipated that there may be difficulties in capturing some of the required datasets (for example, this may involve large-scale community-based surveys). To

counter this, data will be derived from a range of sources; including the 2010 multiple-indicator cluster survey

Table 1 : Joint Programme Log Frame including Monitoring Framework–

	Expected Results (Outcomes & outputs)	Indicators (with baselines & indicative timeframe)	Baseline	Target	Means of verification	Collection methods (with indicative time frame & frequency)	Responsibilities	Risks & assumptions
Goal	**JP Expected Outcome:** Contribute towards the achievement of Millennium Development Goals 4 and 5 in Myanmar	• U5MR	71	69 (by 2013)	• UN inter-agency group for child mortality estimates, UNICEF		All Stakeholders	Continued political commitment for strategic shift Security and free access to hard-to-reach villages is maintained Natural disaster/ outbreak would not divert resources Maintain or increase in # of health staff in programme tsps Favorable working environment for health staff in terms of area and population coverage, transportation , workload distribution, clear clinical guidelines and legal framework, capacity building and adequate supportive supervision Enabling environment for clients in terms of accessible and user-friendly services at affordable cost Availabilty of reliable data
		• IMR	48	45 (by 2013)	• MICS 2010 and 2013, National progress reports		All Stakeholders	
		• MMR	240	238 (by 2013)	• Trends in maternal mortality, WHO, UNICEF, UNFPA, WB 2010, 2013		All Stakeholders	
Purpose: Improving maternal, newborn and child health in program townships	**JP Output 1:** Evidence based policies in place & improved sector coordination	• # of guidelines/policy shifts for child health and newborn care prepared as planned	planned (3 guidelines, 1 costed plan for investment case for MNCH)	At least half the planned activity outputs achieved	• Guidelines • Coordination Meeting minutes with MOH and partners • Project activity reports	• Guidelines and meeting minutes prepared by lead UN agency	UNICEF, WHO, DOH	
		• Functional Coordination mechanism for child health and newborn in place	Bi-annual meetings at national level with partners	Quarterly meetings at national level with partners				
		• # of guidelines / policy shifts for maternal health care system approved and implemented	planned (3 clinical guidelines, 2 updated manuals,1 updated curriculum)	At least half the planned activity outputs achieved			UNFPA, WHO, DOH	
		• Functional Coordination mechanism for maternal care in place	Bi-annual meetings at national level with partners	Quarterly meetings at national level with partners				
	JP Output 2: Increase % of children receiving appropriate case management	• % of randomly visited RHC & Sub centres having ORS and antibiotics in project townships	Not available	90%	• Field monitoring reports • Routine report/ JRF • HMIS 2010, 2011, 2012, 2013 • Programme monitoring reports	• Disaggregation of routine HMIS data for programme areas (HMIS collected monthly and compiled by DHP annually) • Program monitoring data compiled and analysed on quarterly basis	UNICEF, WHO, DOH/ DHP	
		• % of estimated 260,000 children aged 0-18 months immunized with DPT3 in 70 townships	63% (validated against >90% reported)	70% (validated)				
		• # of cases receiving anti-malaria treatment in 24 townships	50,000	60,000				
	JP Output 3: Increase percentage of skilled delivery and provision of newborn care	• # / % of deliveries attended by skilled health personnel (midwives and above) in from programme townships	• 2009 HMIS data from programme townships	• increase in SBA in intensive townships to 70% by 2012	• HMIS 2010, 2011, 2012, 2013 • Programme M&E reports • Baseline & end-line assessment • FRHS 2007 & 2013 • Programme monitoring reports	• Disaggregation of routine HMIS data for programme areas (HMIS collected monthly and collated annually) • Program monitoring data compiled and analysed on quarterly basis • MICS data collection (3 years interval) • FRHS data collection (5 years interval)	UNFPA, WHO, DOH/ DHP	
		• # / % of institutional deliveries (RHC / NGO delivery rooms and hospitals) in programme townships	• 2009 HMIS data from programme townships	• 10% increase in institutional deliveries in intensive townships by 2012			UNFPA, WHO, DOH/ DHP	
		• # / % of deliveries by C-section in public hospitals in programme townships	• 2009 HMIS data from programme townships	• At least 4% of deliveries by C-section in programme townships by 2012			UNFPA, WHO, DOH/ DHP	
		• % of pregnant women receiving two doses of TT vaccine	• 65.6%	• 70%			UNICEF, DOH/ DHP	
	JP Output 4: Increased access to birth spacing services	• % of programme supported SDPs with at least two types of contraceptives available	• Not available	• 90%	• Field monitoring reports • M&E reports	• FRHS data collection Disaggregation of routine RHMIS data for programme areas (RHMIS collected monthly and compiled by DHP quarterly)	UNFPA DHP DOP	
		• # of birth spacing consultations and users / CPR/ PCPR in programme supported service delivery points in programme townships	• 2007 FRHS - CPR 38.4% (national) • 2010 CPR / PCPR in programme townships (RHMIS)	• CPR Increased by 2-3% annually in programme townships	• 2007 FRHS • RHMIS 2010, 2011, 2012 • HLCS			
		• # of programme supported service delivery points offering quality birth spacing services in programme townships (at least 3 methods offered without stock out, provider trained for birth spacing counseling and birth spacing IEC materials available)	• Total SDPs supported by programme & SDPs providing QBSS	• increase in # of SDPs providing QBSS- 70% of SDPs	• Baseline & end-line facility assessment survey • M&E reports • RHMIS • Project activity reports			

Activity Level	Activity Level Output	Indicators (with baselines & indicative timeframe)	Baseline	Target	Means of Verification
	Output 1				
	Functional coordination mechanism for MNCH in place	National Child Health committee, child survival forum and National RH working committee holding meetings attended by representatives from donors, INGOs and NGOs Maternal and Child Health Technical and Strategy Group of the Country Coordinating Mechanism regularly briefed on the work of the UN agencies in relation to policies/guidelines on maternal, newborn and child health	Six-monthly co-ordination meetings	Quarterly coordination meetings	• Minutes of coordination meetings
	HMIS strengthened for record management and ICD 10	Number of staff trained	None	30 staff	• Joint UN report • MoH MNCH documents
	National MNCH policies and guidelines	Number of MNCH EB policies and EB guidelines introduced	None	3 EB policies in place	
	State/Regional and district program managers have capacity for MNCH programme management,	Number of State/Regional and district program managers trained	None	40 managers	
	Updated competency-based midwifery curriculum and trained midwifery teachers/tutors	Number of midwifery teachers/tutors trained in updated curriculum	None	22 teachers/tutors	
	Maternal and neonatal death audit	Report on maternal and neonatal death audit	Not available	Report available	
	National RH Strategic Plan (2009-2013) implementation reviewed by short program review	Review documentation availability	Not available	Short program review report available	
	WHO appoint MNCH expert	P4 MNCH expert in post	WHO reports	In post 2nd/3rdquarter 2012	
	Investment case for MNCH using MBB costing tool	Investment case presented to MoH	None	Initiation of investment case	
	Output 2				
	Basic Health staff trained in IMNCI	% of basic health staff trained in 4 selected townships	None	80%	• Joint UN reports (monitoring data) • HMIS 2011 – 2013 disaggregated data
	Hospital Staff trained in facility IMNCI	% hospital staff trained in 4 selected townships	None	90%	
	Quality of care for Neonatal and child health care in Township and Station Hospitals assessed	# of hospital assessed in State/region in 3 selected State/Region	None	3 hospital per state/region	
	Children 0-18m immunised with DPT3 in 70 HTR townships	% (estimated 260,000) children immunised	63% (validated)	70%	
	1500 villages in 35 HTR townships have ORS available	No (%) villages with ORS available	Baseline data	60%	
	Children in 24 HTR townships treated for malaria	Number of children treated for malaria	50,000	60,000	
	Output 3				
	District paediatricians have capacity for essential and advanced Newborn Care	% of District paediatricians trained for NBC	None	80%	• Joint UN reports (monitoring data) • HMIS 2011 – 2013 disaggregated data
	Basic Health Staff have capacity for Essential Newborn Care	% of Basic Health Staff trained for ENC in 4 selected townships	None	80%	
	Training and facility need assessment	Findings of the needs assessment	None	Findings of the needs assessment used for programming	
	Health staff trained on PCPNC, BEmONC or CEmONC	# / % of health staff trained	Baseline data	Selected townships	
	Delivery and EmONC services selected townships provided with equipment and supplies	# / % of townships/ SDP supported	Baseline data	37 townships	
	Nursing and midwifery schools equipped with necessary training aids and equipment	# of midwifery schools supported	Baseline data	22 nursing and midwifery schools	
	Facilitators trained in essential newborn care	Number of townships where facilitator are trained on IMNCI	Baseline data	8 townships	
	Outreach services for community-based MNCH established in 70 HTR	Number/ % townships providing outreach services	Baseline data	70%	
	Refurbishment of delivery rooms and comprehensive EmONC facilities	Delivery rooms and hospital theatres refurbished	None	20 delivery rooms and 10 theatres	
	Output 4				
	Health staff trained on provision of quality RH services including BS	Number of health staff and townships	Baseline data	Selected townships	Joint UN programme reports FRHS 2007, 2013 UNFPA monitoring reports
	Adequate birth spacing commodities procured and distributed to programme townships	Number of items and quantity of contraceptives procured and distributed compared to forecasted requirement	Baseline data	37 townships	

Validation of reported data: This will be undertaken in randomly selected sites using the Data Quality Assessment (DQA) tool developed for GAVI Health System Strengthening for antenatal care, childhood illness and immunization. It will be implemented by Department of Health Planning with technical support from WHO and linked in with the existing Reproductive Health DQA being undertaken by Department of Health Planning

Logistics and Supplies monitoring: The basic Logistic Management Information System (LMIS) will be strengthened by UNFPA for RH commodities. UNFPA procurement associate, field coordinators and MoH staff of Central Medical Stores Depot and Sub-Depots will be responsible for the receipt, warehousing and distribution of supplies to the townships. State/regional level statisticians and township focal persons for reproductive health will work together for the proper functioning of LMIS for reproductive health commodities.

UNICEF Yangon Officers will be responsible for the receipt, warehousing and distribution of supplies from Central Medical Stores and Central Vaccine Stores to Regional and State levels. Monitoring of the distribution of various child survival commodities at township level would be undertaken by UNICEF Field Officers as well as MOH appointed Supply System Management Officers.

Programme review and reporting mechanism: UNFPA and UNICEF already have an annual review arrangement with Ministry of Health based on their respective annual work plans. This forum will be used to review the joint programme progress in and December 2012.

Reporting**:** Informal progress will be reported by each agency in the steering committee with AusAID representative. AusAID will receive the following formal reports;

- Consolidated First and Final Report (narrative part) from the Administrative Agent based on the inputs from the three agencies using the common reporting format used by all UNDG Ex-Com agencies and finalized by the Steering Committee.
- A final certified financial statement will also be submitted. Financial utilization is reported against agreed budget lines by headquarter.

7b. Risk Management

The table below summarises the risks identified, and the measures that can be taken to mitigate them

Table 2: programme risk matrix

Description of Risk	Likelihood	Impact	Mitigation Measure
Changed priorities in MNCH strategy (including inadequate funding)	Low	Medium	UN agencies have a close working relationship with government and MoH, who recognise the UN's key role in developing MNCH strategy. The Joint UN proposal has been developed with the approval of MoH. MBB will be utilised by UNICEF as a resource mobilisation tool to advocate for increased funding for MNCH If difficulties did arise, because programme funding will be through the UN, most planned service provision would be maintained
Restricted access to 'hard to reach' townships	Medium	High	UN and AusAID advocacy with government to use dry season to reach remote villages.
MOH may have reservations regarding the policy/ guideline changes required for expanding community and facility based services	Low	Medium	UN agencies are actively working with MoH in introducing MNCH policy changes (pilots on-going already), and have reported early successes. The appointment of an MNCH expert in WHO to further improve coordination with MoH should mitigate the risk further.
Lack of skilled health personnel. Frequent turnover of staff and vacancies.	Medium	High	UN agencies will continue to advocate for timely recruitment and deployment of skilled health personnel The joint programme will implement comprehensive training programmes for health personnel delivering MNCH services in programme townships
Limited capacity at sub-national level to implement the Joint programme	Low	High	The Joint programme will focus on capacity building at national/sub-national level
Limited demand for services at community level.	Low	Medium	Advocacy and capacity building for village level leaders and community volunteers is included in the Joint programme. Refresher training for community volunteers to track down and mobilise the eligible population should increase demand for services. This may be implemented in selected

			townships using non-AusAID resources.
Poor quality/ inadequate data limits evaluation of the impact of the programme	Medium	Medium	UN agencies working with MoH to improve M and E and the national HMIS through capacity building at facility, township and central level, and collaborate with partners
Leakage of commodities or not available free of charge	Low	Low	Procurement of all commodities by UN through international/ UN system. Despatch from Central Medical Stores monitored by UN logistics officers. All supplies will bear the UN logo (and if required, AusAID' logo) for clear identification. UN officers will monitor end-use of supplies together with MoH counterparts including random visits to health facilities.
Public health emergencies or major disease outbreaks interrupt service delivery	Medium	High	No mitigation measures: delay in programme implementation would be inevitable

End use monitoring of supplies is also undertaken by UNICEF Field Officers up to sub-centre/community level. One of the indicators that would be reported on is proportion of randomly visited rural health centres and sub-centres having ORS and antibiotics in project townships. Facility records would also be reviewed for usage of these commodities to the extent possible.

8. Legal Context or Basis of Relationship

WHO: The WHO Country Cooperation Strategy (CCS) documents for Myanmar (2008-2011) describe WHO's medium term strategies for working with the government and how the WHO Myanmar Country Office aligns its work with the National Health priorities and harmonizes activities with the UN and other partners.

WHO is in the process of developing the Country Cooperation Strategy for 2012-2015. A detailed biennial workplan 2010-2011 was prepared in consultation with the Ministry of Health, in line with the current CCS. Action has already been taken to prepare the 2012-2013 workplans.

UNICEF: The Government of Myanmar and UNICEF have agreed on a programme of cooperation for 2011-2015 to improve the lives of children and women in Myanmar (the "UNICEF Myanmar Programme") which was approved by the UNICEF Executive Board in 2010. The UNICEF Myanmar Programme forms part of the Government's overall development strategy. UNICEF is accountable to the Government and to the UNICEF Executive Board for the results achieved in implementing the UNICEF Myanmar Programme. The Basic Cooperation Agreement ("BCA") between UNICEF and the Government of Myanmar dated 22 April 1950 forms a platform for UNICEF's work in Myanmar.

UNFPA: The second Programme of Assistance to Myanmar 2007-2010 was approved by the UNFPA Executive Board in 2006, and a subsequent request for extension for one year (2011) was approved in 2010. The Government of Myanmar and UNFPA signed the Memorandum of Agreement of its 2nd Programme of Assistance to Myanmar in August 2008, with the main objectives of promoting the status of reproductive health of women and men including adolescents and youth in selected areas. UNFPA is currently preparing the 3rd Programme of Assistance, 2012-2015. The programme agreement signed by the Government and the Minister of National Planning and Economic Development in February 2010 serves as the legal basis for UNFPA's operations.

The Implementing Partners agree to undertake all reasonable efforts to ensure that none of the funds received pursuant to this Joint Programme are used to provide support to individuals or entities associated with terrorism and that the recipients of any amounts provided by Participating UN Organizations do not appear on the list maintained by the Security Council Committee established pursuant to resolution 1267 (1999). The list can be

accessed via *http://www.un.org/Docs/sc/committees/1267/1267ListEng.htm*. This provision will be included in all sub-contracts or sub-agreements entered into under this programme document.

9. Workplan and budgets

The workplan details all the activities to be carried out within the joint programme and the responsible implementing agency/partners, timeframe and planned inputs/ activities from the participating UN organizations. The basis for all resource transfer would be the joint/ individual workplans, agreed by the Ministry of Health and participating UN Organizations. When partnering with NGOs and Civil Society Organisation (CSOs), the participating UN Organizations would sign legal instruments in accordance with their procedures following discussions with MOH.

Implementing Partners**:** The Ministry of Health is the lead partner in implementation of the MNCH activities proposed under this joint programme. Township Health department, State/Regional Health Department and local authorities will be the primary implementing partner and UN Agencies, International and local NGOs and community leaders will be the partners. NGOs will be funded directly for the implementation of the activities prescribed in the project cooperation agreement. MMCWA volunteers in programme townships and village tracts will receive training and some essential supplies etc., through the Department of Health. A mutually agreed communication strategy for this support will be developed by steering committee based on AusAID's global partnership agreements with all three UN agencies.

Subject to the annual review, any revisions to the workplans or budget will require written approval from the Steering Committee. Substantive changes to the scope of the programme, or in financial allocation may require revision of the joint programme document, signed by all parties.

The detailed workplan with time lines and agency-wise budget by activity is attached as an Annex to this joint programme document. The indirect cost is a general cost that cannot be directly related to any particular programme or activity of the organization. These costs are recovered in accordance with each organization's own financial regulations and rules. They are 7% for UNICEF, UNFPA and WHO. The workplan details the costs for each of the three UN agencies.

All three agencies have staff costs related to implementation of this joint programme and these are detailed in separate annexures. These have been kept to a minimum. It may be noted that UN recruits personnel based on its institutional policy and mechanisms. The senior MNCH position in WHO will be funded separately by AusAID. A ToR is being drawn up, based on a generic job description and in consultation with the three UN agencies and AusAID.

The total planned budget including both programme cost and indirect support cost is as follows:

Total UN organization 1 (WHO):	**0.8 million AUD**
Total UN organization 2 (UNICEF):	**2.2 million AUD**
Total UN organization 3 (UNFPA):	**1.98 million AUD**
Total Administrative Agency (AA):	**50,000 AUD**
Total	**5 million AUD**

1AusD=0.097 USD on November 24, 2011

Signatures:

UN Organization(s)	Implementing Partner(s)
Dr H.S.B. Tennakoon *Signature* *World Health Organization (WHO)* *Date*	*Ministry of Health (MOH)* *Government of the Republic of the Union of Myanmar* *Approval letter from Ministry of Health, Letter No. Na Hsa Ya/YM-9(03)/ 505, Dated. 16th September, 2011 is attached*
Mr Ramesh Shrestha *Signature* *United Nations Children's Fund (UNICEF)* *Date*	
Mr Mohamed Abdel-Ahad *Signature* *United Nations Population Fund (UNFPA)* *Date*	

Annex 1 a

UN Support for Improving MNCH Services (70 Hard-to-Reach Townships for outreach services)

	State/ Region		Township	GAVI population	2 UN	UNICEF		UNFPA
					UNICEF - EPI Plus (outreach) UNFPA - ANC kit, CDK	Child Survival Medicine	Malaria	RH commodity, training for new staff
1	Yangon	1	Dagonmyothit (E)	74,234	1	1		1
2		2	Hlaing Tharyar	206,420	1	1		1
3		3	Shwepyithar	133,317	1	1		1
4	Mdy	1	Pyinmana	213,731	1			
5		2	Tharzi	259,638	1	1		1
6	Kachin	1	Chepwe	18,744	1			
7		2	Hsawlaw	17,035	1			
8		3	Machanbaw	142,983	1	1		
9		4	Moemauk	242,463	1	1	1	
10		5	Tanai	37,846	1			
11		6	Waingmaw	90,447	1	1		
12	Kayah	1	Bawlakhe	9,990	1	1	1	
13		2	Demawsoe	79,197	1		1	
14		3	Meisai	2,043	1			
15		4	Phasaung	39,420	1	1		
16		5	Prusoe	37,047	1	1	1	
17		6	Shadaw	21,238	1			
18	Kayin	1	Hlainbwe	366,695	1		1	
19		2	Hpa an	529,861	1	1		
20		3	Kamamaung	92,457	1			
21	Chin	1	Htantlang	72,809	1	1		
22		2	Kangpetlet	21,609	1	1		
23		3	Matupi	69,090	1	1		
24		4	Mindat	48,834	1	1		
25		5	Tiddim	100,654	1	1		
26		6	Tonzang	38,021	1	1		
27	Mon	1	Thaton	359,191	1		1	
28		2	Ye	290,312	1	1		

29	Rakhine	1	Ann	124,818	1	1		1
30		2	Buthedaung	304,392	1	1	1	1
31		3	Maungdaw	459,315	1		1	1
32		4	Minbya	207,683	1	1		
33		5	Myebon	129,998	1	1	1	1
34		6	Pauktaw	170,802	1	1	1	
35	Shan (E)	1	KeingTong	284,205	1		1	1
36		2	Mongphyat	42,771	1		1	
37		3	Mongpyin	94,515	1	1	1	
38		4	Mongtong	37,344	1	1	1	
39		5	Tachileik	108,134	1	1	1	1
40	Shan (N)	1	Hopan	95,387	1		1	
41		2	Loukaing	75,991	1			
42		3	Maingye	76,050	1			
43		4	Momeik	76,756	1	1		1
44		5	Namkham	131,399	1	1	1	
45		6	Namsan(n)	93,137	1	1		
46		7	Namtu	155,219	1	1		1
47		8	Tantyan	205,213	1			
48		9	Theinni	78,918	1	1	1	1
49	Shan (S)	1	Hopone	102,538	1	1		1
50		2	Lauksauk	134,178	1		1	
51		3	Loilem	152,271	1	1		1
52		4	Namsam(S)	92,915	1			1
53		5	Pekon	78,894	1	1		1
54		6	Pinlong	159,884	1			
55	Bago	1	Oke-twin	178,519	1	1		1
56		2	Shwekyin	92,857	1			
57	Magwe	1	Mindon	92,298	1	1	1	
58		2	Saw	95,453	1	1	1	
59		3	Setoktara	60,403	1	1	1	
60	Sagaing	1	Hommalin	191,513	1			
61		2	Kalewa	74,290	1	1		
62		3	Khanti	41,662	1	1		
63		4	Lahe	56,060	1			
64		5	Layshe	20,748	1			
65		6	Mingin	131,733	1	1		
66		7	Nanyunn	77,574	1			
67		8	YeOo	175,508	1			
68	Tanintharyi	1	Bokepyin	67,826	1	1	1	
69		2	Kyunsu	157,008	1			
70		3	Tanintharyi	107,474	1	1	1	

				8,908,979	**70**	**44**	**24**	**18**

Annex 1 b

UN Support for Improving MNCH Services (62 Other Existing Townships)

State/ Region			Township	GAVI population	WHO	UNICEF	UNFPA
					IMNCI training	Child Survival Medicine	RH commodity, Training for new staff
1	Yangon	1	Dagonmyothit (S)	264,899			1
2	Mandalay	1	Myittha	232,529		1	
3		2	Singaing	171,917		1	
4		53	Yamethin	313,690		1	1
5	Kachin	1	Phakant	60,981		1	
6	Kayin	1	Kawkareik	295,801		1	
7		2	Kyainseikkyi	185,636		1	
8		3	Myawady	83,689		1	
9		4	Papun	23,489		1	
10		5	Thandaung	90,626		1	
11	Chin	1	Falam	77,323		1	
12		2	Paletwa	98,586		1	
13	Mon	1	Bilin	256,918		1	
14		2	Chaungzone	220,966		1	
15		3	Kyaikmaraw	291,093		1	
16		4	Kyaithto	211,392		1	
17		5	Mawlamyaing	461,532		1	
18		6	Paung	348,274		1	
19		7	Thanbyuzayat	217,486		1	
20	Rakhine	1	Gwa	83,419		1	
21		2	Kyaukphyu	206,016		1	
22		3	Manaung	104,610		1	
23		4	Myauk Oo	237,778		1	1
24		5	Ponnagyun	139,830		1	
25		6	Rambye	155,273		1	
26		7	Rathedaung	176,638		1	1
27		8	Taunggoke	153,079		1	1
28		9	Thandwe	160,362		1	1
29	Shan (E)	1	Monghkat	52,046		1	
30		2	Monghsat	86,742		1	
31		3	Mongyoung	113,629		1	
32	Shan (N)	1	Kunlone	149,673		1	
33		2	Lashio	283,881			1
34		3	Muse	17,902		1	1
35		1	Hsiseng	105,850		1	1

36	Shan (S)	2	Kalaw	152,892	1	1	1
37		3	Linkhe	61,590		1	
38		4	Monai	53,388		1	
39		5	Nyaungshwe	181,018	1		
40		6	Pindaya	78,905		1	1
41		7	Taunggyi	345,516			1
42	Bago	1	Paungde	194,170		1	
43	Magwe	1	Chauk	316,012		1	
44		2	Gangaw	153,688		1	
45		3	Magway	386,754		1	1
46		4	Minbu	228,139		1	1
47		5	Myaing	351,643		1	1
48		6	Myothit	207,813		1	
49		7	Natmauk	313,072		1	
50		8	Ngape	55,553		1	
51		9	Pakokku	431,973		1	1
52		10	Pauk	214,600		1	
53		11	Pwintbyu	221,950		1	
54		12	Yenangyaung	251,808		1	
55		13	Yesagyo	354,658		1	
56	Sagaing	1	Myaung	183,492		1	
57		2	Myinmu	165,468		1	
58	Tanintharyi	1	Beik	303,228	1		
59		2	Thayetchaung	171,812	1	1	
60	Ayeyarwady	1	Dedaye	270,688		1	1
61		2	Pathein(E)	384,699			1
62		3	Kyaiklat	237,335		1	1
				12,405,419	**4**	**56**	**19**

Annex 1c

UN Joint Programme MNCH activities supported through AusAID funds 2012

	WHO	UNICEF	UNFPA
70 Hard-to-Reach townships	• None	In addition to 52 townships supported in 2010, 18 new townships would be included through AusAID support. Thus over 56,000 infants and nearly 60,000 pregnant women would benefit from EPI plus, which integrated at least 2 low cost high impact interventions using "Reach Every Community" strategy. Altogether over 200,000 infants in 70 townships will benefit from AusAID support.	• RH commodities will be provided to 18 UNFPA 3rd country programme townships with 3 million population. The beneficiaries include 60,000 pregnant mothers, newborn and 750,000 women of reproductive age. • Clean delivery kits and commodities for mobile outreach ante-natal care will be provided to other hard-to-reach townships.
62 Other townships	Scaling up of following health staff training in 4 new townships with around 0.8 million population; • IMNCI for Basic Health Staff • Facility based IMNCI for hospital staff (F-IMNCI) • Capacity strengthening of district Paediatricians on Essential and Advanced Newborn Care	Increased access and availability of medical supplies in 100 township by inclusion of 6 new townships with nearly 0.6 million population not receiving basic life-saving medicines for child survival till 2011	• 19 UNFPA programme townships with 4.6 million population including 92,000 pregnant mothers, newborn and 1.15 million women of reproductive age will receive regular RH commodities. • RH training for health staff will be provided in selected programme townships according to needs assessment. • Hospital staff will receive CEmONC training
financial contribution to MNCH by UN Agencies: **2012-13: WHO - 0.24 million USD** **2012: UNICEF – up to 11 million USD (regular and other resources)** **UNFPA - 6.3 million USD**			

Annex 2

Joint Programme Workplan (2012)

JP Outcome: Contribute to reduction in maternal and under-5 child mortality											
UN organization-specific Annual targets	**UN organization**	**Activities**	**TIME FRAME 2012**				**Implementing Partner**	**PLANNED BUDGET**		
			Q 1	**Q 2**	**Q 3**	**Q 4**		**UNFPA**	**UNICEF**	**WHO**
JP Output 1: Ensuring evidence-based policies for improved maternal and child health outcomes are in place and improved health sector coordination										
• HMIS strengthened for record management and ICD 10 • National level guidelines developed to improve MNCH, ensured • State/ Regional and district program managers have capacity on MNCH in programme management • Updated Midwifery curriculum and trained Midwifery teachers/tutors for Essential Newborn Care and PCPNC are available • National RH Strategic Plan (2009-13) implementation reviewed by Short Program Review for • Maternal, and newborn death audits and data collected in selected townships to strengthen MNCH • WHO appointed MNCH experts to coordinate AusAID assisted program	WHO	1.1 HMIS on integrated MNCH record management and ICD 10 and computer assisted record system	x	x	x	x	WHO/ DOH/ DHP			55,000
		1.2 Development of national level training materials on maternal, newborn and child health and printing	x	x			WHO/ DOH/ DMS			49,400
		1.3 Workshops on Program Management for MNCH Program Managers at State/ Regional and District level			x	x	WHO/DOH			20,000
		1.4 Review and update midwifery curriculum and conduct training of trainers for Essential Newborn Care and PCPNC	x	x			WHO/DOH			34,000
		1.5 Review of Short Program for National Reproductive Health Strategic Plan (2009-2013 implementation	x	x						20,000
		1.6 Conduct training, data collection, reporting and supportive supervision for maternal and newborn death audits	x	x	x	x	WHO/ DOH/ DMR			34,000
		1.7 APW works for programme reviews and management workshops MNCH (Personnel, APW based work)	x	x	x	x	WHO			22,000
		1.8 Provide technical assistance (Personnel and Admin Cost) for upstream work	x	x	x	x	WHO			239,840
• National guidelines on; Community case management of pneumonia, and Community-based newborn care developed by MOH by 2012 • Availability of communication	UNICEF	1.1 Finalize National manual/guideline on Community Case Management following a pilot	x				UNICEF/ DOH		1,000	
		1.2 Finalize and print National manual on Newborn Care by volunteers at community level (partly funded by AusAID)	x				UNICEF/ DOH			

strategy/standardized materials on key practice for child health • SOP for priority child health interventions initiated • Strengthened coordination of Child Health program interventions with partners in Myanmar • An Investment Case for MCHN by using MBB costing tool at national level		1.3 Undertake costing of RH and child health strategic plan at national level	x	x			UNICEF/ WHO, UNFPA/ DOH		20,000	
		1.4 Review communication strategy/ standardized materials on key practices for child health	x	x	x		UNICEF/ DOH		4,000	
		1.5 Support National level Technical Standard Operation Procedure (SOP) for child health interventions		x	x	x	UNICEF/ WHO/DOH/NGOs		2,000	
		1.6 Undertake Cause of Death study for under-five deaths in Myanmar using verbal autopsy (partly funded by AusAID)	x	x			UNICEF/ DOH/ DMR		3,000	
		1.7 National Child Health Committee and Child Survival Forum	x		x		UNICEF/ DOH/ NGOs		15,000	
		1.8 Provide technical assistance (personnel and related cost) for upstream work and implementation	x	x	x	x	UNICEF		170,250	
• Updated versions of PCPNC and "Provision of Quality Reproductive Health Services" and IEC materials available • Strengthened coordination of maternal health program interventions with partners in Myanmar	UNFPA	1.4 Updating the Myanmar version of PCPNC (Pregnancy, Childbirth, Postpartum and Newborn Care) modules according to WHO 2010 version	x	x	x		UNFPA/ DOH/ DMS/ WHO/ UNICEF	5,000		
		1.5 Updating IEC materials (pamphlets on birth spacing, maternal health and AN care vinyl)	x	x	x		UNFPA/ DOH/ WHO/ UNICEF	5,000		
		1.6 Provide technical assistance and supplies for upstream work (personnel cost, coordination, review and evaluation)	x	x	x	x	UNFPA/ DOH/ DHP/ WHO/ UNICEF	100,000		
JP Output 2: Increased percentage of children receiving preventive services and appropriate case management										
• 80% of Basic Health Staff are trained for community-based IMNCI in 4 selected townships • 90% of Hospital staff are trained for Facility based IMNCI in 8 selected townships • Quality of care for Neonatal and child health care in State/ Regional, District and Township (tertiary and first referral) Hospitals assessed 3 per State/region in 3 selected State/Region	WHO	2.1 Conduct training of facilitators, BHS, follow up training supervision for community IMNCI in 4 selected townships		x	x	x	WHO/ DOH			127,285
		2.2 Conduct Facility-IMNCI trainings for hospital staff in Township and Station Hospitals in 8 selected townships		x	x	x	WHO/ DOH			12,000
		2.3 Conduct assessment of quality of newborn and child care in State/Regional, District and Township Hospitals		x	x	x	WHO/ DOH			36,000
• 70% of 200,000 pregnant women receive two doses of TT vaccine in 70 hard-to-reach townships annually	UNICEF	2.1 Procure vaccines(BCG,DPT,OPV etc) AD syringes, vaccine carriers, cold boxes and micronutrients for pregnant women, infants and children for 70 hard-to-reach townships and cold-chain strengthening	x	x			UNICEF/ DOH		938,500	

• 70% of estimated 260,000 children aged 0-18 months are immunized with DPT3 in 70 hard-to-reach townships annually • At least 90% of rural health sub-centres in 100 townships received child survival kit annually • At least 60% of around 1,500 hard-to-reach villages 35 townships have ORS available at CHW or AMW • 60,000 cases in 24 hard-to-reach townships received anti-malaria treatment		2.2 Review Micro planning exercise and plans by UNICEF professional Officers and monitor implementation in selected hard-to-reach/underserved areas in 70 townships	x		x		UNICEF/ DOH		100,000	
		2.3 Provide operational support to 70 townships to conduct mobile outreach sessions three times one month apart in dry/open season for integrated preventive services	x		x		UNICEF/ DOH		195,000	
		2.4 Provide ORS, Zinc, antibiotics at midwife level for around 20% ARI and diarrhoea cases in 100 townships and ORS to available volunteers in remote villages of 35 hard-to-reach townships	x				UNICEF/ DOH		341,850	
		2.5 Provide supplies and CCM training for screening 140,000 suspected malaria cases by RDT and anti-malaria therapy for around 60,000 cases in 24 HTR townships	x				UNICEF/ DOH		245,000	

JP Output 3: Increase percentage of skilled delivery and provision of newborn care (*safe delivery including CEmONC & BEmONC)*										
• 80% of district paediatricians have capacity for Newborn Care • 80% of Basic Health Staff trained for Essential Newborn Care	WHO	3.1 Conduct skill based training of Essential and Advanced Newborn Care for district Paediatricians		x	x	x	WHO/DOH			12,000
		3.2 Conduct skill based training for trainers and multiplier training for Essential Newborn Care and supervision in 4 townships	x	x	x	x	WHO/DOH			78,660
• Training, human resource and facility need assessment survey conducted in selected townships • Targeted service providers received required training on PCPNC, BEmONC or CEmONC • SDPs in 132 JP townships equipped with maternal health care commodities • Delivery and EmONC services selected townships provided with equipment and supplies • Nursing and midwifery schools equipped with necessary training	UNFPA	3.1. Conduct training, human resource and facility need assessment survey in selected poor townships SDPs and nursing /midwifery schools	x				UNFPA/ DOH/ DHP/ DMS/ MMCWA	5,000		
		3.2. Conduct PCPNC, BEmONC and CEmONC training for new staff and refresher training according to training need assessment findings in targeted townships		x	x	x	UNFPA/ DOH/ MMCWA	100,000		
		3.3. Procure and distribute maternal health care commodities for service delivery points in 37 townships	x	x	x	x	UNFPA/ DOH/ MMCWA	580,467		
		3.4 Procure and distribute training aids and equipments to nursing and midwifery schools	x	x	x	x	UNFPA/ DOH/DMS	50,000		
		3.5. Refurbish selected number of delivery rooms and CEmONC facilities in selected poor townships		x	x	x	UNFPA/ DOH/ MMCWA	300,000		

aids and equipment • 20 delivery rooms and 10 CEmONC facilities in most needed areas in poor townships refurbished • Outreach mobile services for community based MNCH care supported in 70 HTR		3.6. Support outreach mobile services for community based MNCH care in 70 HTR		x	x	x	UNFPA/ DOH/ MMCWA	100,000		
JP Output 4: Increased access to birth spacing services										
• Public sector SDPs & programme supported NGOs' SDPs in targeted townships received adequate & regular supply of BS commodities • Targeted service providers received BS training •	UNFPA	4.1. Procure and distribute birth spacing commodities for public and NGO service delivery points in targeted townships	x	x	x	x	UNFPA/ DOH/ DHP/ PSI/ MMCWA	500,000		
		4.2. Conduct training for service providers on provision of quality birth spacing services in targeted townships		x	x	x	UNFPA/ DOH/ PSI/ MMCWA	100,000		

WHO	Programme Cost			***740,185***
	Indirect Support Cost (7%)			***51,815***
UNICEF	Programme Cost		***2,035,600***	
	Indirect Support Cost (7%)		***142,400***	
UNFPA	Programme Cost	***1,850,467***		
	Indirect Support Cost (7%)	***129,533***		
Agency-total	Programme Cost and Indirect Cost	***1,980,000***	***2,178,000***	***792,000***
	Programme Cost			***4,626,252***
	Indirect Support Cost for 3 UN organizations			***323,748***
	Indirect Support Cost for Administrative Agency (AA) (1%)			***50,000***
	Grand Total			***5,000,000***

Annex 3

UN Staffing requirements for AusAID supported programme

WHO

WHO will recruit the following personnel/staff to implement AusAID funded programme activities.

- A Temporary MNCH International professional P4 (TIP), short term for 6 months, will be recruited initially
- A Fixed-term MNCH Consultant P4 will be recruited later. This senior consultant will be contracted for 5 years (with funding sourced elsewhere after the AusAID programme ends in 2013)
- One National Technical Officer (for programme management and coordination of Reproductive Health Strategic Plan and Child Health Development Strategic Plan implementation) for AusAID supported activities (on a Special Service Agreement base) throughout the implementation period. This comes under activity and not as an entitled HR position.
- One General Secretarial staff G4 for office management.

The WHO Regional Advisor, Maternal and Reproductive Health Unit (MRH) and Child and Adolescent Health Unit, WHO-SEARO, will also provide technical support. APW based short term National Technical Officers (on the basis of Special Service Agreement base) and International experts may be recruited if required.

UNICEF

UNICEF will deploy the following staff to support AusAID programme.

- A UNICEF international staff member already in place - 40% of time
- A national professional at Yangon recruited to support the AusAID programme
- 10 UNICEF professional field officers currently working in 10 States/ Regions and 5 professional staff working in the UNICEF Yangon office -30% of their time
- A Logistics officer at Yangon -10% of time (salary from UNICEF funds)

UNFPA

UNFPA will recruit the following staff to implement AusAID funded project activities -

- One National Programme Officer (for programme management and coordination including National Reproductive Health Working Committee)
- Two Field Coordinators (One in Rakhine State, one in Shan State)
- One Programme Assistant

Two national programme officers, one programme associate, one programme assistant, and one procurement associate- all currently working for UNFPA in Myanmar will work together with the new staff.

Annex 4

HMIS strengthening package

Background information

Medical record system had been established in Myanmar since 1962. ICD 8 and 9 were used for morbidity and mortality coding in 1966 to 1995. From 1996 onwards a classification of diseases ICD 10 which morbid entities are assigned according to established criteria is used for the purpose to translate diagnoses of diseases and other health problems from words into an alphanumeric code, which permits easy storage, retrieval and analysis of the data. It is necessary for the technicians to acquire knowledge and dexterity development of ICD coding. ICD coding is one of the mechanisms for managing health information system that is to assemble, explore, hoard and allocate retrieval of data about inpatients.

In Myanmar, there is no medical record training school and human resources who tackle with medical record management including facility based information of maternal newborn and child health is weak in Myanmar. In other countries like Thailand, Australia there were medical record training school or proper courses for medical record technicians or health information managers. Although we try to establish like those types of training school like paramedical courses, we did not get success yet and we would like to train our medical record technicians who are working at public hospitals for three months course containing basic anatomy, physiology, pathology, medical terminology, ICD 10 and computer assisted medical record system. In addition this course will cover medical record management because we should still need to manage paper records.

Most of the health care professionals and administrators widely believed that electronic medical record system will lead to major health care savings, reduce medical errors, and improve health. But there is basic manual procedure are already in place and medical records cannot be used to coordinate care, routinely measure quality or reduce medical errors. The administrators face with a number of problems associated with maintaining manual medical records, especially storage space.

Medical record procedures computerized in some of public hospitals include the admission and discharge and disease index by using software donated by MIT Software Company. Although there is some limitation, it is still useful for health administrators.

Regarding data entry in this software, medical record technicians should know basic computer, ICD coding, database and maintenance of software. At the same time, they need the help of medical doctors for some complicated diagnosis and some abbreviations not common in use. If it is done, it will be very useful for many aspects including administrative purpose.

Objectives

- To raise the knowledge and practice of diagnosis coding (disease and health related conditions) by using ICD 10
- To strengthen and furnish hospital morbidity and mortality reporting
- To raise the awareness, knowledge and practice of medical record system by using computer
- To support the health administrators by producing hospital administrative indicators and hospital morbidity and mortality reporting

Expected Outcomes/outputs

Medical record technicians from public and private hospitals will be aware and capable of application of ICD coding and produce hospital morbidity and mortality reporting.

Computer assisted medical record system will be implemented in their hospitals and will produce hospital administrative and morbidity and mortality data by using this software.

Proposed duration of training is three full months using the following training materials and training methods:

Training Materials: International Classification of Disease version 10 hard and soft copy, Medical terminology, flip charts, Computers, CAMRS software, , medical record charts, hospital reporting forms.

Training Methods: Lectures, demonstration, exercises, discussion, examinations, Hands on practice

Annex 5

Value of Money: Low cost high impact priority interventions for Millennium Development Goal 4 and their potential impact on neonatal and under five mortality, grouped in illustrative service delivery modes (AusAID supported interventions are bolded)

	Service delivery modes	Pre-conceptual, Antenatal and Delivery Care	Neonatal and Postnatal Care	Potential NNMR impact*	Child (post neonatal) Care	Potential U5MR impact
Preventive	**Schedulable outreach services**	Antenatal Care: -**Tetanus immunization** -Intermittent presumptive malaria treatment -Screening & management of; ▪ HIV ▪ Syphillis ▪ Micronutrients ▪ Iodine ▪ **Iron** ▪ Calcium	Vitamin A supplements Post-partum	8% (6-9%)	**Childhood immunization,** especially measles and HIB, Vitamin A supplements, **Zinc supplements**	12%
Promotional	**Family/ Community care**	**Clean Delivery**	**Clean cord care** **Thermal care** **Early breastfeeding** **Extra care of low birth weight infants**	24% (15-32%)	Insecticide Treated Bednets Exclusive/continued breastfeeding Complementary feeding Hygiene and Water/Sanitation	35%
Curative	**Clinical Care Primary**		**Early diagnosis and management of pneumonia in newborns**		**Oral rehydration/ Zinc** **Case management of ;** **-Malaria** **-Diarrhoea** **-Pneumonia** **-HIV/AIDS**	28%
		Subtotal impact		28% (18-37%)	Subtotal impact	50%
	Clinical Care Referral	**Skilled maternal and immediate neonatal care** **Emergency Obstetrical Care**	**Emergency Neonatal Care**	37% (23-50%)		14%
		Total Impact		48% (31-61%)	Total Impact	60%

*Neonatal Mortality Rate

Source- UNICEF's Joint Health and Nutrition Strategy (2006-2015)h