

Towards a Grand Convergence for child survival and health:

A strategic review of options for the future building on lessons learnt from IMNCI

COUNTRY ASSESSMENT: MYANMAR

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Abbreviations

ANC	Antenatal care
AMW	Auxiliary Midwife
ARI	Acute respiratory infections
CBNC	Community Based Newborn Care
CCM	Community Case Management (pneumonia, diarrhoea)
CH/MOHS	Child Health Division, Ministry of Health and Sports
CNS	Central Nervous System
DFID	Department for International Development, UK
DHS / MICS	Demographic and Health Surveys / Multiple Indicator Cluster Survey
DHIS II	District Health Information System II, Electronic system
ENAP	Every Newborn Action Plan
ENC	Essential Newborn Care
EPI	Expanded Program on Immunization
ETAT	Emergency Triage Assessment and Treatment
F-IMCI	Facility-based IMCI – Hospital level
GAVI	Global Alliance for Vaccine and Immunization
GF	Global Fund
HBB	Helping babies Breathe (newborn Resuscitation)
HSDP	Health Sector Development Plan
HSS	Health Systems Strengthening
JHPIEGO	An alliance of Johns Hopkins University
iCCM	Integrated Community Case Management of Childhood Illnesses
IMNCI	Integrated Management of Newborn and Childhood Illnesses
INGO	International NGO
IYCF	Infant and young child feeding
KMC	Kangaroo Mother Care
KPI	Key Performance Indicators
MRH	Maternal and Reproductive Health division (MOHS)
MDGs	Millennium Development Goals
NGO	Non-Governmental Organization
ODA	Overseas Development Assistance
ORS	Oral Rehydration Salts
RDT	Rapid Diagnostic Test
RHC	Rural Health Centre (and sub-centres)
RMNCH	Reproductive Maternal Newborn and Child Health
SDGs	Sustainable Development Goals
T'ship	Township
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	Water, sanitation and hygiene
WCHD	Women and Child Health Development
WHO	World Health Organization
3MDG	3 MDG Fund, consortium of donors for MCH, HSS and HTM

I. Introduction (1 page)

Myanmar was under single party socialist regime and then under the military regime for five decades, and in 2011, the military handed over to a nominally civilian government following elections the previous year. In 2015 elections, opposition National League for Democracy - led by Aung San Suu Kyi won enough seats in parliament to form a government. A gradual liberalisation process has been under way since 2010, and the country is expected to see a major shift after the government changed hands early in 2016. Myanmar health care system evolves with changing political and administrative system and relative roles played by the key providers are also changing although the Ministry of Health remains the major provider of comprehensive health care. Health sector budget has significantly increased in the recent years.

Myanmar is divided into seven regions and seven states. The regions are the central area of Myanmar and are mainly Bamar people, the states comprise different ethnic groups with the state names after the ethnic group e.g Chin State. WHO Global Observatory Data Repository, the country's under five, infant and neonatal mortality rates are the second highest among 11 countries of WHO South East Asia Region, and even though Myanmar has significantly reduced mortality, in the past ARR was not significant enough to achieve MDG 4. The majority of these deaths are preventable. The latest UN estimates of 2015 show that the neonatal mortality rate is 26 per thousand live births, and neonatal deaths contribute to more than 40% of all under five deaths. The principal causes of neonatal mortality (within 28 days of age) are prematurity, birth asphyxia and sepsis, including pneumonia. Deaths are most common in home-delivered babies in rural areas. The Nation-wide cause specific under-five mortality survey conducted during 2013-2014, highlighted that the majority of neonatal deaths (74%) were due to preventable causes such as prematurity/ low birth weight, sepsis and birth asphyxia

In 2014 MoH with Unicef conducted a study on causes of under-five mortality. The pattern of the top three causes of death; Prematurity/LBW, Birth Asphyxia, ARI/Pneumonia, was similar across States and Regions. However, statistically significant differences were found in between State and Region for diarrhoea, CNS infection, beriberi and septicemia. Death due to diarrhoea was higher in the States while CNS infection, beriberi and septicaemia were higher in the Regions. In 11 States/Regions out of 14, prematurity and/or birth asphyxia are at the top of the list. However, beri beri and CNS infection are the leading causes in Ayeyarwady delta region. In Kayah and Chin States pneumonia and diarrhea are the leading causes of Under 5 deaths.

Indicator	Value (mean)	Source (Year)
Total population	51,486,853	Census (2014)
Total under-five population	4,472,130	Census (2014)
Annual births	944,000	Countdown (2015)
Neonatal mortality rate (per 1000 live births)	26/1000LB	Countdown (2015)
Annual neonatal deaths	24,380	Countdown (2015)
Average annual rate of NMR reduction, 2000-2015 (40 to 26)	0.93/1000LB	Countdown (2015)
Under-5 mortality rate (per 1000 live births)	48.7/1000LB	Countdown (2015)

Annual child deaths	46,000	Countdown (2015)
Average annual rate of U5MR reduction 1990 – 2015 (130 to 50)	3.2%	Countdown (2015)
2004 - 2015 (104 to 50)	2.2%	

In this report, we seek to understand the role of the Integrated Management of Childhood and Newborn Illness (IMNCI) strategy in the improvements in child health described above, as well as facilitating factors and barriers in the implementation of IMNCI and other child health strategies, and additional ways of improving access, quality, coverage and utilization of child health services. This country assessment takes place under the aegis of the Strategic Review, which aims to take stock of IMNCI implementation and the latest evidence on expanding coverage of high-quality case management and care for sick children, to identify options to increase access to and utilization of child health services at country and global levels. Two main methods were used for this country assessment:

1. An extensive desk review, drawing on published and unpublished reports, evaluations and articles in the programmatic and scholarly literature, as well as statistical data, completed in April – May 2016;
2. In-country data collection in the form of key informant interviews at national, district and facility levels in Yangon and Kyauktan Township, completed over 5 days in late May 2016.

Data analysis took place iteratively between national and international consultants using the following methods: systematic extraction of key themes from interviews, triangulation between written sources and interviews and amongst key informants, and debriefing of preliminary results with WHO Representative on the last day of data collection.

II. IMCI organization and management

In Myanmar IMNCI includes the newborn, is targeted mainly at The Midwife (MW) who serves at the RHC and sub-centre level and also conducts deliveries in the home. Community case management is still only implemented in selected districts (Townships) and targeted at the Community Health Volunteers. F-IMCI is based on the WHO Pocket Book (also includes ETAT) and targets the regional, district township and station level hospitals.

IMCI was introduced to Myanmar in 1998, initially it was adopted as IMMCI. Five days trainings courses for basic health staff (13,201) were conducted throughout the country. Approximately 1000 hospital based doctors and nurses were also trained in IMMCI. An evaluation in 2001 showed that although all the trainers were very enthusiastic, the step by step methodology for IMCI had been compromised and was inconsistent across maternal and child (3 ½ days child, 1 ½ days maternal). Quality had been compromised by coverage targets.

In 2001, IMMCI programme managed by Women's and Child Health Development, WCHD of the MOH. With the support of UNICEF, WCHD activities were implemented in 19 townships in 2002 and expanded to one third of the country by 2005. The materials were reformatted to more IMCI and over the next 10 years 11 day IMCI trainings for basic health staff were conducted in 32 townships with WHO funding,

and 7 days abridged course were provided in 200 townships with Unicef funding. From 2011 onward, community based case management of pneumonia and diarrhea (iCCM) was piloted in 5 townships and is currently being expanded to 37 townships of 3MDG MNCH project.

IMNCI currently includes:

Facility Level

- IMNCI – Basic Health Service level (includes RHC, sub RHC and MCH centres)
- F-IMCI/ETAT Regional/State, District, township and station hospital level
- Essential newborn care, ENC and HBB

Community Level

- Community Case Management, CCM, diarrhea and pneumonia treatment by community health volunteers.
- Integrated Community Case Management (pneumonia, diarrhoea, malaria, malnutrition) pilot areas.
- Community based newborn care (CBNC)

Pre-service

- IMNCI is included in pre-service training in all midwifery and nursing schools since 2012.
- In Medical schools not included as IMCI modules.

Other Child Health related Programmes

- EPI, All EPI vaccines.
- Nutrition (IYCF, IMAM, SUN and BFHI, GMP)

Under The Ministry of Health and Sports, MOHS, there are 6 Departments. Dept. of Public Health, Dept. of Medical Services, Dept. of Traditional Medicine, Dept. of Food and Drug Administration, Dept. of Medical Research, Dept. of Health Human Resource Development and management and Dept. of Sports.

The **Dept. of Public Health** is headed by a Director General and its 3 units, namely Public Health, Disease Control, and Admin/Finance are headed by Deputy Director Generals. The **Child Health and Development Division** is one of the seven divisions under the Public Health Unit, and headed by a Director Child Health and Development. IMCI/IMNCI is implemented under Child Health and Development Division in the Ministry of Health and Sports. The Director of Child Health Division is also the programme manager (director).

There is currently no separate child health budget line under government health budget but there are donor funded support to WCHD.

There is an overall **Health Development Plan** which includes a framing of the country's health problems, policy guidelines and framework for the national health plan. This includes health system issues and priority programmes. The 11 priority programme areas, which includes **MNCH** have been included in the National Health Plan 2011-16. There is a **National Strategic Plan for Newborn and Child Health and Development 2015-18**, the main thrust of this plan which has been costed, is a) newborn care, b)

management of common illnesses, c) engaging communities/communications for newborn and child survival and cross-sectoral coordination. **IMNCI** is thus embedded in the plan, as core to child survival, with 3 main strategies i) strengthening health systems for the provision of newborn and child health services, ii) improving access to quality newborn and child health services, iii) improving demand and utilization by engaging families and communities. Myanmar developed Every New Born Action Plan for the period of 2014- 2020 and it incorporated in to broader National Strategic Plan for Newborn and Child Health and Development 2015-18.

Planning until very recently has been a top down approach, although there are a number of projects in place (including 3MDG for maternal and child health), that aim to strengthen the planning process at Township level. The Township Medical Officer is responsible for planning in-service training, though does according to donor resources available. WHO supported to managing programme to improve child health was initiated since 2013 and continues do training at state and regional level.

Key stakeholders supporting government in implementing IMCI were until very recently the UN organizations, mainly WHO and UNICEF. They have given technical and financial support for IMNCI implementation almost exclusively until 2011. Bilateral partners joined together to form the 3MDG fund in 2011, in order to accelerate support for Maternal and Child Health, HIV/TB/Malaria and health Systems. Eight partners joined the 3MDG fund which started operations under UNOPS in 2012. IMNCI is a key strategy under the MCH component which supports 42 Townships. Since 2014 the World Bank has financed the health sector with numbers of health workers trained in IMNCI being a key indicator.

There are currently 57 INGOs & 14 national NGOs working in the health sector in the country. Stakeholders for newborn and child health have significantly increased in Myanmar over the last few years.

There is a very active private sector with general practitioners, and specialists including paediatrics and obstetrics/gynaecology. These are regulated b Myanmar Medical Council, there are however many nurses and health assistants who do private practice in their spare time, these are unregulated, in addition there are drug stores where a variety of medicines can be bought over the counter.

III. Implementation of IMCI and other child health strategies

Training has and still is mostly conducted with cascade modality, making the selection of ToT training participants, and quality and contents of ToT very crucial. At central level an excellent pool of trainers included paediatricians, neonatologists and senior nursing officers, whilst the Township Medical Officer, TMO, and Township Health Nurse, THN, were the key trainers for the Basic Health Staff, BHS, (mainly MW and RHC and sub centres). More than two thirds of the townships have received IMCI training but those were conducted over a long period (2004-2011). Training has also been focused on the MW and the Lady Health Visitor, LHV, as these are the main cadre who has contact with children in the community and primary health care level, other staff including Health Assistants (HA) and hospital Nurses, are not targeted and mainly do not receive in-service IMNCI training. Thus during the field visit only **one third** of all the health staff mentioned they received any of the child health related training within the past 12 months.

The first adaptation IMMCI (5 day) – included maternal – then following a review in 2001 changed back to IMCI (7 day). In 2012 Myanmar added newborn component. In 2016 following a further review decided to go back to 11 day training. Adaptation of the IMNCI latest 13 modules in Myanmar context is underway.

To date more than 2/3 of the Townships 231/330 have received IMCI training, either 11 day supported by WHO or mainly 7 day abridged course supported by UNICEF. In 2011 IMCI was updated to include the first week of life and became IMNCI, all in-service training since then has been IMNCI, much supported by UNICEF or the 3MDG fund. At the same time Community Based Newborn Care, CNBC was introduced. Most of the current WHO recommended interventions are included in the programme.

The WHO pocket book has been introduced to all regional hospitals and 20 trainees from four Townships have been trained in Facility-based IMNCI, F-IMCI, based on the India materials adapted for Myanmar. A further 6 hospitals in Sagaing and Ayeyarwady regions have been trained in F-IMCI/ETAT+ by RCPCH.

From 2011 onwards community case management, CCM, of pneumonia and diarrhea was piloted in 5 townships, and is now being expanded to 37 Townships of the 3MDG project. 5 pilot townships from the 3MDG project townships have expanded this training to iCCM, i.e. included malaria and malnutrition. There is a plan to further expand iCCM.

Community Case Management (CCM) initiative is an essential step to improve the health of under-five children. In Myanmar, a CCM approach has been introduced to implement in Dawei Township, Tanintharyi region since 2011. In 2012, the program was extended into another four townships in 2 States (Kayin and Shan State) including Dawei. To monitor and document the current implementation status of CCM through volunteers, monitoring visits were carried out to identify the needs, the bottlenecks/ challenges using a tool based on Monitoring Results for Equity System (MoRES).

The findings highlighted that the access to trained providers with adequate supplies (commodities), utilization of services provided by health volunteers, financial access, and social and cultural beliefs in the community they served.

To evaluate the quality of services provided to sick children in the community, observation and assessment of the technical performance of health volunteers, including the examination of continuity of care and quality of supportive supervision was conducted. According to the observation findings, there are some challenges in volunteers' skills in documentation as well as supervision skills to ensuring the documentation, and supportive supervision skills. Besides, it is a quite challenge to maintain the unpaid volunteer for sustainability. The number of recommendations was identified and proposed to secure the quality and sustainability of the programme.

Although there have been limited systematic **monitoring and evaluation** activities and evidence for IMNCI impact, regular monitoring and supervision programmes exist but the checklist is rarely used. There have been intermittent monitoring/evaluation of pilots as in the CCM or the programme. A **Health Facility Assessment** conducted by the MOH and UNICEF 2014 showed **very encouraging results**. Also WHO supported a SARA assessment in 2014.

The study included 134 facilities (27 hospitals and 108 RHC/sub Centres) from 3 states and 3 regions. 195 children were assessed.

- 35% HW had received in-service/preservice training on IMNCI in the past 12 months, this jumped to 83% in the past 3 years.

- More than 50% of the facilities visited received IMNCI training in the past 12 months
- 44% HW had received newborn training in past 12 months
- 34% HW had received supervision in the past 12 months
- HW performance ranged from 32% for danger signs to 89% appropriate treatment for pneumonia/diarrhoea/malnutrition
- Caretaker knowledge was 93%
- 58% medicines were available – average 4.3 items.
- Only 19% had all newborn supplies
- 66% had appropriate records.

These results show a positive impact of IMNCI training on health worker performance. However in the interviews on of the respondents said.

‘All hospital staff does not received the training. They should be provided with in-service training like BHS’.

For maternal health care (delivery and BEmOC) midwifery tutors received hands-on training from Ob-Gy Departments of Universities. But there is limited hands-on training on IMNCI for tutors. They may need more ToT and hands on training with updated modules and methodology. Trainees need attachment to facilities with high caseload, and more practicum like weighing children correctly, measuring MUAC, calculating the doses for children, etc. 2001 WHO IMCI report indicated that the introduction of IMCI into pre-service training should be piloted in one or two institutes, and should be linked to the IMCI implementation in a way that ensures the students will have their clinical practice/ field attachments in facilities already implementing IMCI and with adequate patient loads.

Other comments on the training and the CCM.

Task shifting should be done from MW to health volunteers. There is no pilot project of task shifting yet. (M0530b)

(M0602a) Recognise the need for MW skills to be strengthened to reduce newborn and maternal child mortality. IMNCI – need to look at policy for implementation. Competency skills need to be developed.

(M0603a) F-IMCI – needs to include a supplies management section. Paediatricians are not so good at looking which supplies and equipment needed. Modularisation of IMNCI will be helpful.

IV. Lessons learnt

- A. What are biggest bottlenecks getting care to children at national, district, facility and community levels?
- B. What lessons have been learnt about scale-up, monitoring and impact?
- C. What useful innovations have been identified, whether technological, programmatic, social, etc.?
- D. What are remaining gaps in coverage of high-impact child health interventions in terms of access, quality of care, and utilization at community, facility and health system levels?
- E. How to improve district implementation?
- F. How to improve training and supervision of health workers?

Lessons Learned

'IMNCI is very relevant for the country. It is complete (holistic) module with child health, development, Newborn, etc. Nothing needs to be taken out from the module. There are 13 modules which can be used as reference. Handbook can be used for case management'.

After almost 20 years of implementation in Myanmar, the IMNCI programme was found to be very dynamic, popular and the people involved were very dedicated. Coordination at central level is good at least for IMNCI module development, and coordination is regarded as an essential and critical task by directors of all programmes. Those who had received IMNCI training found that it is very useful for practice.

Comments such as *'I felt more confident in giving advice to mothers', 'I was happy to give the right treatment', 'I have made a difference'*, were frequent amongst HW trained in IMNCI.

IMNCI was appreciated for its simplicity and effectiveness in guiding mid- and lower-level health care workers to assess, classify and treat the most common cases of childhood illness, and the doctors interviewed who had been trained and used IMCI when they were in clinical practice, thought it useful for doctors as well as lower level HW. Furthermore, CBNC and CCM were seen as completing IMNCI because they filled in aspects that were less well covered in the initial strategy, namely delivery of newborn care and the extension of case management to the community level.

'IMCI is very useful for health personnel especially for BHS and junior doctors. But they rarely use handbook in front of patient care takers, because they think it may affect patient/care takers' impression on them. If the algorithm is in mobile phone, they may use it because they use their phone for different purposes.

Much of the training between 2001 and 2011 was rolled out through a shortened 7 day course, and often clinical practice was compromised, as there was low patient load at the township hospitals. Also all training had been centrally planned and reliant on external donor funding. The need for strengthening capacity for planning and management at Township level was recognized and supported through the 3 MDG fund since 2012, (42 townships). Also through the GAVI HSS project which is managed by WHO and strengthened the township level planning and management in 180 townships. In the World Bank funding – the % HW trained in IMNCI is a key disbursement indicator. It is recognized that there is still a gap between central level and the Township level, and plans are underway to strengthen the Regional/State level with appointment of MO MCH.

A key lesson learned is the need for **all three components** of IMNCI, as it was rolled out, the training component received most focus. It was felt that assuring **quality of care** i.e. through follow-up visits after training for skills reinforcement and routine supervision of IMMCI trained staff, had been compromised by training coverage targets. Also no attempts had been made to link the IMMCI classifications to HIS. The supply of medicines has improved greatly in the past 2 years, with the key medicines being available at all levels. Health workers cited shortage of staff being a constant problem, the new government has quickly stepped in and is recruiting 1000 additional doctors and nurses/midwives into the health system in the coming months.

The **community component** was the last to be adopted, with CCM and is still reaching relatively few townships. More coordination with malaria and nutrition departments and programmes at community level is being planned, and will move forward with roll-out of an integrated package (iCCM) in future. One interviewee commented *'For the family/community component to have an impact on morbidity and mortality, a bottom-up approach needs to be adopted, with assessment, participation and ownership by and of the families and communities concerned'*.

Although there have been a number of periodic reviews of IMCI (IMMCI, WCHP, HFA) over the years, there are different opinions among key stakeholders as to the model for scaling up. The results of the Health Facility Assessment conducted in 2014, were very encouraging (see above). There is currently no systematic, well organized, national training plan, nor any records keeping track of training. This makes it difficult to plan scale-up in a systematic way.

Scaling up in-service training is possible with concise version (M0530a). The 7 day and 11 day training methodology are different. Following a review in 2014 she feels 11 day is more comprehensive and a better training for the basic health worker – MW. IMNCI is invaluable for the country, however, need a change in the training methodology. *Needs to be more skills based, but there is not enough cases at township level.* (M0601a). Alternative models of training would be welcomed, however the ICAAT and distance learning modules have not been reviewed and made available for use by the programme yet.

Regarding the **private sector**, for a programme like IMCI to be effective in Myanmar, where the majority of sick children under five years of age in urban and peri-urban areas especially, are treated by private practitioners, it seems essential to involve the private sector in the programme/training along with social marketing of the strategy, and development of the family/community component.

The 11 day IMNCI module has been integrated into midwifery and nursing **pre-service** curriculum since 2012, so that newly trained nurses and MW will all have received IMNCI training. Some tutors would prefer to do intermittent IMCI training rather than the current block style training. Interactive training methods (effective use of skill lab, video, exercise, discussion, case scenario and training aids) may help the session more lively and useful for trainees. During the field visit the HAs commented – *'We have learned the different components of IMNCI in our training, but would love to have proper IMNCI training'*.

'Costed plans need prioritization to realize budget allocation. INGOs should work under the government health plan'. (M0530b)

Lesson Learned JIMNCH Project (post Nargis)

- Volunteers (including AMWs), had effective roles in preventive care, childbirth and childhood illness, and need close attention to their support and supervision;
- Optimizing health workforce placement and tasks, especially that of the MW, is potentially powerful, and needs continued work;

V. Perspectives for the future

Myanmar is at the cross roads, transitioning to democracy with lot of opportunities on investment. Recognising the shortage of Health Workers at all levels, and with many newly qualified doctors and nurses waiting months or years to get a position, the government has embarked on a rapid recruitment programme and will recruit an additional 1000 Doctors, nurses/midwives before the end of the year. This is a good start to improving the staffing situation at township level.

Maternal and child mortality are still high in Myanmar, with newborn mortality contributing over 50% of U5 mortality. Addressing this is a key priority of the new government and the Minister of Health has expressed the need for rapid progress. IMNCI remains the key strategy for management of childhood illness and is complemented by specific newborn care packages, as well as the community actions needed, all of which are included in the National Strategic Plan for Newborn and Child Health. In addition EPI and nutrition programme provide vital interventions for child health.

Regarding the first component of IMNCI on health worker performance, an important lesson expressed by all partners was that **training alone was not enough to bring change in quality of services**. Particularly as the quality of training it'self varied. The training must include practice, and follow-up supervision. The MOHS has decided to revert to the 11 day training for BHS, and encourage **continuous medical education**, CME, at Township level. **Pre-service training** in IMNCI has been included since 2012 in nursing and midwifery schools. However, in Medical Schools since 2009 is integrated rather than as a block IMNCI, and is not included as a block in HA pre-service training. Thus, fully integrating IMNCI into all the HW the curricula will be important to maximize the positive impact of IMNCI on health workers skills, mitigate issues of turnover and rotation, and also ensure sustainability of IMNCI in country. This will also effectively increase the pool of mid-level tutors/facilitators. The need for clinical practice is recognised, and JHPIGO is currently supporting the MOHS and Nursing and Midwifery Schools with development of skills labs particularly for midwifery and newborn care skills, they will also extend this to the sick child. In addition the new Nursing/MW council, has just been revised with new legislation being passed in 2015, and ratified in 2016. This includes new laws on PPP and strengthening of the training schools.

Regarding the Regional, State and District and Township hospitals, improving quality of care with F-IMCI or ETAT+ has started, with the F-IMCI module being adapted for Myanmar from the Indian training module. Experience with both F-IMCI and ETAT+ are both limited and a working group of paediatricians are looking at this to decide which option to adopt.

To date there has been only a small field test of mobile technology and no use of computer based learning. **Mobile and information technologies** could be useful in sustainably developing health workers skills. Virtually all HW have a mobile phone, with many having smart phones, many are using for referral or consultation with the T'ship MO and gave examples. *'I had a patient with PPH and used my phone to call the T'ship MO and get advice on how to treat and refer'*. They would welcome a mobile app and said they would prefer to use rather than the handbook *'as we always look at phones for other things'*. ICATT or computer-based learning, has not been used as internet connection is not good, however if distributed via USB key, would be a valuable addition to the current training methods. (COMCARE is going to introduce with 3 MDG support and will include IMCI algorithms).

Concerning the second component of IMNCI, there was strong agreement that **health systems strengthening must remain a key component** and be better elaborated in any future version of IMNCI or future child health strategy. A number of health systems strengthening activities are included under the 3MDG fund, the GAVI HSS component and the World Bank funding. These have facilitated more supervision and strengthening of **planning and management capacity at the Township level**, as previously all planning had been top down, with little or no financial management at Township level. These workers are at the frontline of implementation – and there is currently a big gap in the capacity of health managers to effectively plan, implement and monitor-evaluate health programmes. As a result implementation of IMNCI at lower levels has depended heavily on partners' technical and financial support; for this reason, many respondents said ownership at Township level was far from satisfactory, evidenced by the constant referral to GAVI, WB, 3MDG Townships and/or funds. The DHIS II electronic data system is in its infancy, it is currently being used in 28 townships – funded by 3MDG, (below Tship level paper base still used) – it is good as data is seen immediately. The plan is to roll out to 198 Tships in 9 Regions with Global Fund Money, and to roll out to all Tships in 2017 (pending funds availability). This will facilitate rapid analysis and use of data 'real time', which should enhance capacity for data-based planning and management.

As previously mentioned there is a growing private sector provision of services, and many children are seen by private general practitioners. It will be important to **strengthen linkages to private sector and consider this a part of the health system**, for example by introducing IMNCI in private facilities, and training the GPs in IMNCI.

The **third component of IMNCI**, family and community practices, is being taken forward in Myanmar, though currently there are a number of different community volunteers, and projects, which sometimes overlap. CBNC, CCM, as well as health promotion are the main IMNCI community programmes, but need better linkages to the community based nutrition, malaria and other related community based programmes. Auxiliary Midwives, AMWs are a well-established voluntary cadre, other voluntary cadres are seen as more short-term (often with different incentive/remuneration packages) and project based. A policy of community workers will be needed to clarify their roles and responsibilities. However community participation in the health system is seen as important, not least because health system improvement will not occur unless communities demand it.

Myanmar is an early adopter of the ENAP, and developed their newborn action plan, as well as a **newborn and child health strategy** in 2014/15. Newborn mortality is about 50% of U5 mortality and already a number of initiatives have been started beyond the inclusion of newborn in IMNCI and EmOC, these include HBB, CNBC and shortly HBS. Focus to date has been on the T'ship and basic level of service with provision of bag and mask and training. Newborn corners and shortly KMC corners are being set up, in addition to these there will be need to look at the referral care for newborns particularly for the pre-term who need care beyond KMC.

One important perspective for the future of IMNCI and child health more broadly in Myanmar will depend on obtaining **sufficient and sustainable sources of financing**, without which, the well written costed newborn and child health plan will not be implemented. Domestic funding for health has rapidly increased over the past 2-3 years, and the new government is committed to increasing domestic financing in health, however this will take time to reach adequate levels. There is need for a **budget line**

for child health (as well as for maternal health, although there is a budget line for family planning for the past 3 years, mainly used for purchasing commodities) to facilitate planning.

'A costed child health plan exists, but government did not allocate money for capacity building so relies on partners. States and districts are encouraged to use their own funds – i.e. WB money'.

However there is still need for significant partner resources, the current World Bank project focused at strengthening the Township level is an excellent example of good **partnership between partners and countries**, as is the GAVI HSS funds which give flexibility to the Townships in strengthening HS component. The 3 MDG fund comes to a close in 2017 and partners are in discussion with government on the future funding. Long term commitment and avoidance of fragmentation of funding to the health sector overall and RMNCH in particular will be important in building sustainability. Myanmar is potentially a GFF supported country, the development of an investment plan that all partners can buy into, may be a good opportunity towards sustainability.

VI. Actions needed at country level

As the new SDG era begins, Myanmar is starting a new chapter with a new government. There is great optimism and MNCH is high on the agenda and IMNCI clearly fits into the newborn and child health strategy. However it is clear that for health and financing there are a number of competing priorities and within newborn and child health there is a clear need to prioritise. A number of key actions were suggested by respondents to achieve national child survival goals and promote newborn and child health and development.

First continue and enhance coordination between programmes, especially between child health and Reproductive/maternal health, this would be facilitated by a **budget line** for both, so that effective annual planning can be done in line with the strategic plan. There is also need for **child health policies**, particularly in relation to CCM and pre-referral treatment.

Continue to strengthen **leadership and capacity at the Township level**, particularly in terms of enhancing planning and management skills and building toward ownership of IMNCI and other child survival programming. The appointment of MO MCH at the Regional/State level creates an opportunity for this level to be the key coordinator between the central level and township level, specific technical and managerial capacity building to realise this opportunity will be needed.

Regards delivery of basic health services, there may be need to revisit the **current model of service provision** where the MW visits the villages and only spends 1-2 days per week sub at the RHC/sub-centre, a model of FT MW at RHC bringing the deliveries to the RHC level and enhancing the referral system maybe more effective, though would need to be considered in relation to the overall HR plan. Also in relation to decisions on the model of community services and demand creation. There is also need **for integration and coordination** of the different service packages at community level, to avoid further proliferation of the current multiple and sometimes overlapping packages.

Regards scaling-up of IMNCI, currently in-service training is mainly targeted at MW, there is need to extend to the other cadres. Also for central level to develop a **training roll-out plan**, based on needs assessment. Partners funding Township level could then support this plan. Additionally, government and

other stakeholders should **consider how technology can contribute to scaling up** (e.g. Smart-phone apps for assessment & monitoring; ICATT, smartphones or computer-based training for clinical mentorship, on-the-job training). Now that many providers possess phones and even smartphones, it is worth considering whether one could utilize these platforms to facilitate both diagnosis and reporting or provide supportive supervision or clinical updates. Improving quality of training, particularly skills building, continued professional development, supportive supervision were all highlighted by respondents. Thus a system for **monitoring the quality** of training and services will be important going forward. The results of DHS due out later this year will give a good baseline for start to SDGs, regular monitoring with the DHIS II and periodic review through Health Facility assessment will be important to monitor progress. Furthermore engagement of the private sector and utilising this growing sector to provide quality IMNCI will be a good opportunity to extend reach.

VII. Actions needed at global level

Until recently Myanmar has been relatively cut-off from the multiplicity of global-level stakeholders, the UN agencies being their main point of reference. Over the past 2-3 years there have been an increasing number of different projects, which while contributing to overall child survival can be confusing. Key messages for global level were suggested.

1. The need to clarify the 'Gold Standard' for IMNCI 'is it still the 11 day training'? More clarity on shortened courses, and possibility of a modular approach to training. Also priorities in updates and new packages to avoid confusion as to which recommended (e.g. ENCC/ HBB, HBS. F-IMCI/ETAT etc). In addition to explore less costly and more user-friendly ways to disseminate updates and training materials to technical experts at the national level and end users, including 'off-line' e.g. USB sticks or CDs, also develop mobile Apps.
2. The content of IMNCI is generally appropriate, in looking at child health overall how IMNCI links with the additional newborn packages for the small and sick baby, KMC, and further integration and the inclusion of content for the well child, and the suggestion was made to consider including early child development in a future strategy. (Myanmar is planning to include in the next adaptation).
3. Add health system management into IMCI. The programme management modules are not well known and a more holistic approach to IMNCI needed.
4. Regarding **the question of re-branding IMNCI**, comments included:
 - a. *'IMNCI well known, even the community level know this name, they don't want to change the name'.*
 - b. *'Name of IMNCI is familiar to all health staff as integrated approach.'*
 - c. *'Global – Should not confuse with names by rebranding'.*

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Annex 1. Timeline of IMCI

Year	Policy event	Implementation milestone
1998	IMCI introduced in Myanmar IMMCI	IMMCI training cover the whole country. 13200 health staff and over 1000 doctors and nurses trained in IMMCI
2001	Review of IMMCI and changed to IMCI	WCHD program 200 townships trained between 2001 and 2011 in 7 day training
2011	3MDG fund started. 8 donors, includes IMCI in MCH component implementation plan.	Implementing in 42 remote townships
2011	iCCM pilot started	5 townships To date xx townships adopted iCCM
2012	Newborn included and name changed to IMNCI	32 townships received 11 day training from WHO. Total of 231/330 townships trained
2012	CBNBC training supported by Unicef in 30 townships	CBNBC integrated into initial training of Auxiliary MW covered the whole country
2012	F-IMCI started, using adapted India Version of pocket book ETAT training by paediatric society and RCPCH	4 townships 6 townships
2014	WB included IMNCI in district health funding	Number of HW trained in IMNCI is indicator for funds disbursement
2015	National Strategic Plan for Newborn and Child Health and Development 2015-2018	National ENAP adopted

Annex 2. List of persons consulted [for internal use only]

Name	Position / title	Organization	Contact	Areas of expertise
Dr Myint Myint Than	Director/Program Manager (Child health)	MOH, DoPH, Child Health Development Division	MoH, Office 47, NayPyiTaw	Public Health, Child Health programming
Dr Anoma Jayathilaka		WHO Myanmar		
Dr Kyu Kyu Khin	National Technical Officer (RH/CHD/ENC)	WHO Myanmar		
Dr Maung Maung Lin		WHO Myanmar		
Dr Shwe Zin Yu	National Professional Officer	WHO Myanmar		
Dr Nwe Nwe Khin	Director (Nursing)	MoH, Dept of Health Human Resource Development and Management	MoH, Office 4, NayPyiTaw	
Dr Thet Thet Mu	Director (M&E/HMIS)	MoH, DoPH	MoH, Office 47, NayPyiTaw	
Dr May Khin Than	Director (Nutrition)	MoH, DoPH	MoH, Office 47, NayPyiTaw	
Dr Htar Htar Lin	Director (EPI)	MoH, DoPH	Disease Control Complex, NayPyiTaw	
Dr Aung Thi	Director (Malaria)	MoH, DoPH	Disease Control Complex, NayPyiTaw	
Dr Tun Nyunt Oo	Director (HIV)	MoH, DoPH	Disease Control Complex, NayPyiTaw	

Dr Kyaw Kan Kaung	Director (Procurement and Supply Chain)	MoH, DoPH	MoH, Office 47, NayPyiTaw	
Dr Chaw Sanda Khaing	Township Medical Officer	MoH	Kyauktan Township	
Dr Penelope Campbell		Unicef Myanmar		
Dr Sarabibi Thuzar Win	Health Specialist	Unicef Myanmar		
Dr Panna Erasmus	MNCH Specialist – 3MDG Fund	UNOPS Myanmar		
Dr Hnin Hnin Pyne		World Bank		
Mr Billy Stewart		DFID		
Dr Mya Su Thet Maw	Health Specialist	DFID		
Dr Vin Thu Dinh	Health Specialist	USAID		
Dr Hnin Wai Haing	Deputy Country Director	JIPIEGO		
Dr Phone Zaw Phyo	MNCH Coordinator	Save the Children		
Dr Myo Thike	Sr Consultant Paediatrician	Bago General Hospital, MoH		

ANNEX 3. DESK REVIEW REPORT

Towards a Grand Convergence for child survival and health: A strategic review of options for the future building on lessons learnt from IMNCI

COUNTRY ASSESMENT: Myanmar

Desk Review, completed 6/5/2016 by [Thwe Thwe Win]

CHILD HEALTH DEMOGRAPHICS

Overview of child health statistics in country. (For data, check country Countdown profiles and WHO data.)

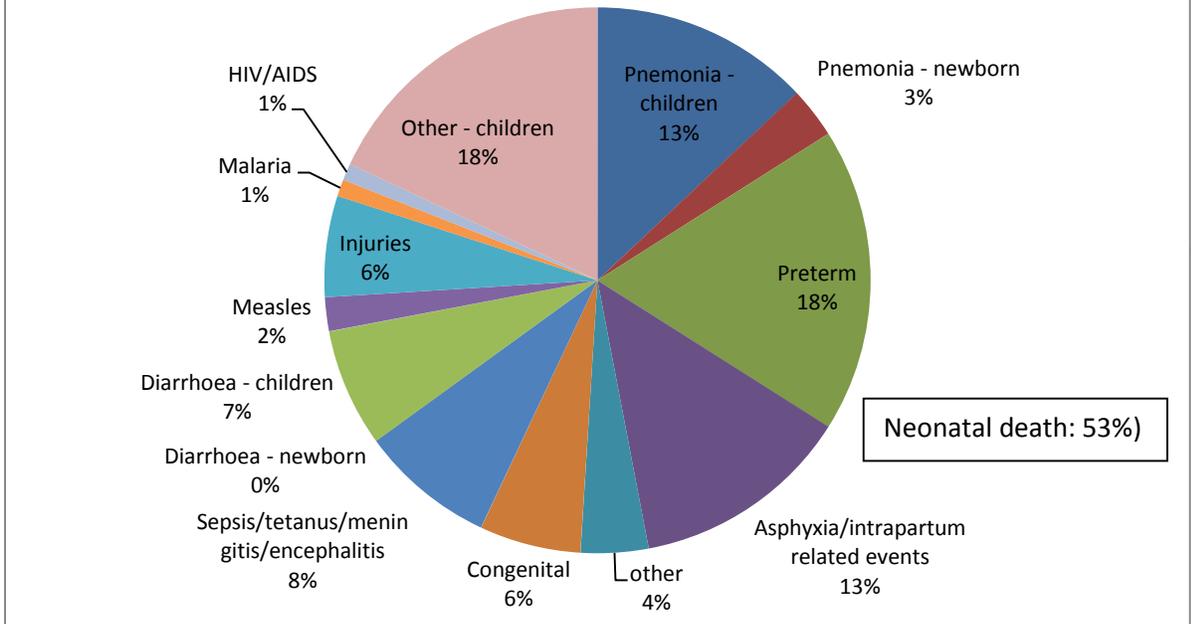
Indicator	Value (mean)	Min, median, max by district (where avail.)	Source (Year)
Total population	51,486,853 53,897,000	By State/Region (14) Min – Kayah State 286,627 Max – Yangon Region 7,360,703 By District (73) Min – Bawlakhe (Kayah) – 42,909 Max – North Yangon - 2,606,670 By Township (330)– Min – Ingyanyan (Kachin) 1,732 Max – Hlinetharyar (Yangon) 687,867	Census (2014) Countdown (2015)
Total under-five population	4,656,000 (0-4) 4,472,130		Countdown (2015) (2014 census)
Annual births	944,000		Countdown (2015)
Neonatal mortality rate (per 1000 live births)	26/1000LB		Countdown (2015)
Annual neonatal deaths	24,380		Countdown (2015)
Average annual rate of U5MR reduction 1990 – 2015 (130 to 50) 2004 - 2015 (104 to 50) Target 43/35	3.2/1000LB 2.24/1000LB		Countdown (2015)

Under-5 mortality rate (per 1000 live births)	48.7/1000LB	IMR Highest Magwe Region – 89 IMR Lowest Mon State – 43 (2014 Census)	Countdown (2015)
Annual child deaths	46,000		Countdown (2015)
Average annual rate of NMR reduction, 2000-2015 (40 to 26)	.93/1000LB		Countdown (2015)
<p><i>How do mortality rates vary regionally?</i></p> <p>[Answer using GIS maps provided in Annex and add any additional information you know about variations in causes of death.]</p>	<p>(Study on Causes of Under-five Mortality 2014 (MoH/Unicef) The pattern of the top three causes of death; Prematurity/LBW, Birth Asphyxia, ARI/Pneumonia, was not much different between States and Regions.</p> <p>However, statistically significant differences were found in between State and Region for diarrhoea, CNS infection, beriberi and septicemia. Death due to diarrhoea was higher in the States while CNS infection, beriberi and septicaemia were higher in the Regions.</p> <p>In 11 States/regions out of 14, prematurity and/or birth asphyxia are at the top of the list. However, beri beri and CNS infection are the leading causes in Ayeeyarwady delta region. In Kayah and Chin States pneumonia and diarrhea are the leading causes of Under5 deaths.</p>		
<p><i>In what ways is the epidemiology of child health in your country projected to change between 2016 and 2030?</i></p> <p>[Answer to the extent possible by talking to experts or using other sources.]</p>	<p>Causes of death (2014)</p> <ul style="list-style-type: none"> - Prematurity/LBW 17.4% - Birth Asphyxia 12.4% - ARI/Pneumonia 13% - Diarrhoea 7.7% - Neonatal Jaundice 7.1% - Neonatal Sepsis 5.8% - Congenital Anomaly 6.3% - CNS Infections 6.2% - Beri Beri 5.9% <p>Share of neonatal deaths – 49%</p> <p>Sources: Study on Cause of Under-five Mortality 2014 (MoH/Unicef)</p> <p>(2006 39%, 2008 40%, 2010 47%, 2011 47%, 2012 51%, 2015 53%) source – WHO countdown</p> <p>Share of neonatal deaths is in increasing trend</p> <ul style="list-style-type: none"> - Changes in equity outcomes (Not available) - Other 		

DASHBOARD

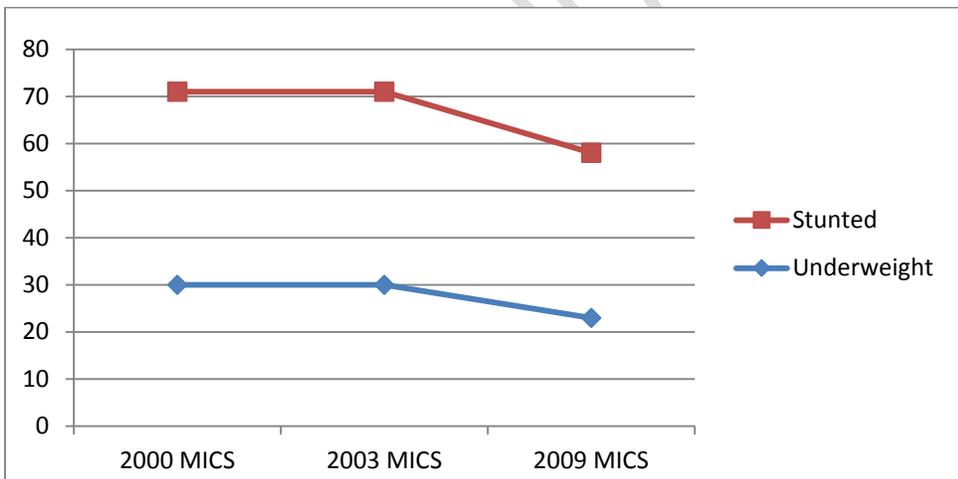
Causes of death, nutritional outcomes coverage of selected interventions (For data, use country Countdown profiles, IGME and DHS.)

Causes of under-five deaths, 2015

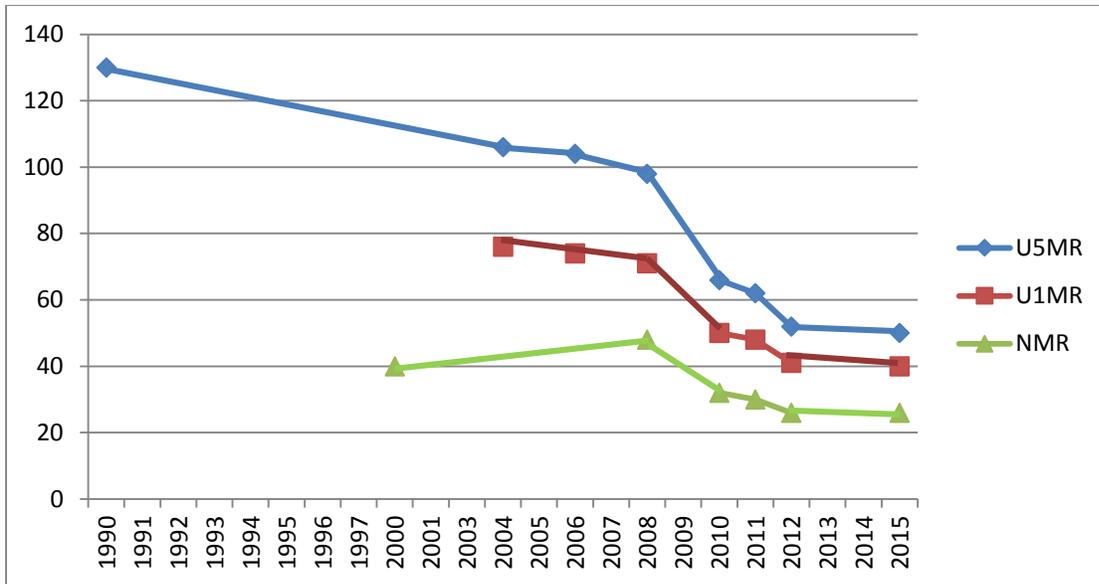


Source: WHO/MCEE 2015 (Provisional)

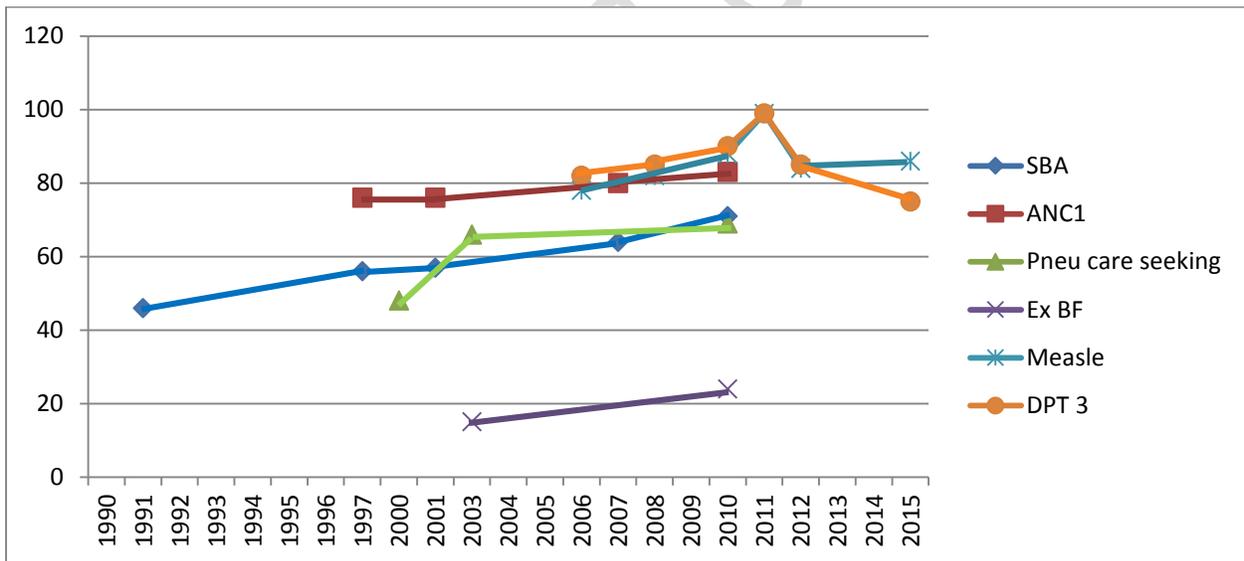
Nutrition - % of Children U5 with



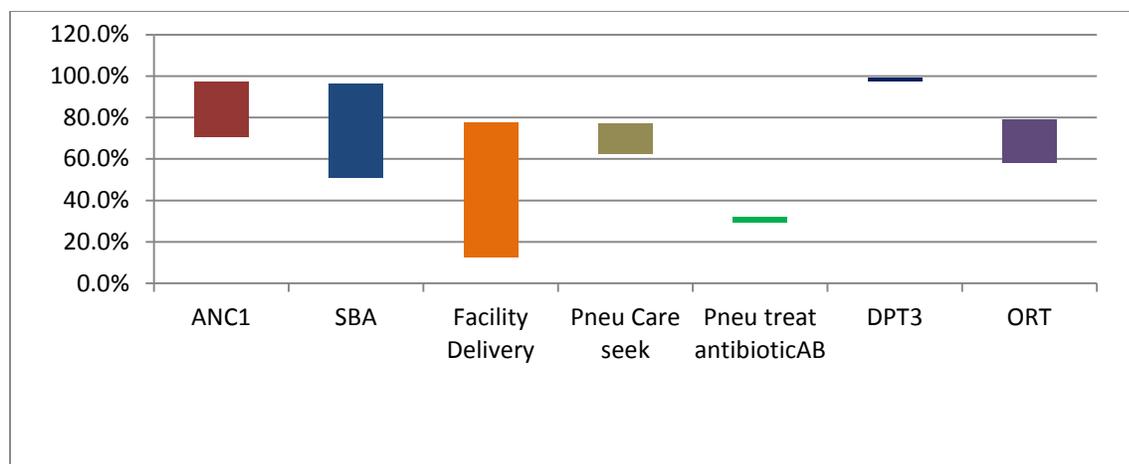
Child, Infant and Neonatal Mortality Rate over time



Trend in Coverage Over Time



Range in Coverage between Richest and Poorest



Has the pneumococcal conjugative vaccine (PCV) been introduced? No

Year of introduction:

Planned introduction mid 2016

Data sources:

MICS 2009-2010

WHO Countdown Reports

STAKEHOLDER MAPPING

What actors support the provision of treatment and care for sick children in your country? (Check the child health strategic plan, MOH policy documents, annual reports, etc.)

	Specific actors	Role(s) in child health	Comments / other
Government	MoH - DoPH Child Health Div. Primary health care Dept. of Medical Services Dept. of Health HR	- Policy, health system - Strategy, programming, coordination - Capacity building, monitoring - Service provision at facility level - Procurement, Service provision at referral level - Pre-service training	
Civil society / NGOs	<ul style="list-style-type: none"> Myanmar Maternal and Child Welfare Association Save the Children (BI) Burnet Institute (RI) Relief International IOM DRC IRC Cesvi 	- Demand site interventions at community level (7 things this year) - SC, MSI, IOM, Cesvi, BI, PSI, RI, IRC, DRC are implementing 3MDG MNCH project - work with private sector	There are 57 INGOs & 14 national NGOs working in the health sector in the country. Stakeholders for newborn and child health have significantly increased in Myanmar over the last few years.

	<ul style="list-style-type: none"> • Marie Stopes International • Population Services International • CDA • PATH • MMA • MNMA • MHAA • JSI 	<ul style="list-style-type: none"> - work with private sector - ORS, Zinc social marketing - NB resuscitation training - ENC training - NBC trainings - work with private sector -mhealth 	
Bi- and multi-lateral agencies	<ul style="list-style-type: none"> - Unicef - WHO - UNOPS - USAIDS - 3MDG Fund (Australia, Denmark, EC, Netherlands, Norway, Sweden and the UK) - - GAVI - UNFPA - DFID - Australian Aid 	<ul style="list-style-type: none"> - Oversee WCHD project, coordination, funding, supply, training - Technical guidelines, training - Fund management for 3MDG Fund - Newborn Care - MNCH projects <p>HSS</p>	
Private sector	<ul style="list-style-type: none"> - Private hospitals - General practitioners - Other private health care providers 	<ul style="list-style-type: none"> - Service provision 	

Describe ways in which these actors collaborate and work together.

- Coordinating mechanisms
- Financing
- Ways they could work together better

Newborn and Child Survival Forum has been held regularly with the purpose of

- (1) sharing information on newborn and child survival related issues including prioritization of interventions, establishment of database for all child survival research studies, and reports, identification of gaps, etc.
- (2) Involvement of all stakeholders and encouragement of collaboration through coordination and
- (3) linkage between Myanmar Newborn and Child Survival efforts and the international community and
- (4) resource mobilization.

Closer collaboration is also being sought from many related Ministries within the government, e.g., Education and Social Welfare.

A partnership with relevant professional organizations like those of pediatrics, obstetrics and gynecology, nurses and health assistants associations etc., provide critical technical and operational support to the Newborn and Child Health Programme (NCHP).

The NCHP collaborates closely with UN agencies, especially WHO and UNICEF. There are several international and national NGOs who are implementing newborn and child health related activities in the country.

Strengthening partnerships between governments and the private sector could help to mobilize additional resources and expertise and thus expand the range of health care providers. However, the need for adequate regulatory frameworks to ensure that private providers (both for profit and non-profit) meet the essential capacity, quality and accountability, is critical. Where there are public sector gaps at a given level of service delivery, based on the mapping, available NGOs/partners need to be considered.
(Source - NSP for Newborn and Child Health Development 2015-2018)

HEALTH POLICY AND SYSTEMS

What are the main supports and blockages in terms of health policy & systems for improving child health? (For answers, check the country's global implementation survey, national policies & strategies,

Indicator	Value	Source (Year)	Comments
What is the main child health strategy for treatment & care for sick children at the national level?	Name of strategy (dates) National Strategic Plan for Newborn and Child Health Development (2015-2018)	Global survey	
<i>Please describe the strategy.</i>	<p>The main thrust areas of the strategic plan were identified based on epidemiological profile, high impact interventions and current status. These are -</p> <ul style="list-style-type: none"> (a) newborn care, (b) management of common illnesses, (c) engaging communities/communications for newborn and child survival and cross-sectoral coordination. <p>The specific objectives of the plan are to:</p> <ul style="list-style-type: none"> (1) Scale up evidence-based, cost effective interventions through effective strategies within a HSS approach and provide equitable coverage with quality. (2) Reduce neonatal mortality by improved home-based newborn care, early identification of sick newborns and improved access to institutional newborn care of adequate quality. (3) Reduce common childhood illness related mortality (due to pneumonia and diarrhoea in all areas and malaria in endemic areas) by improving key family and community practices, community-based early diagnosis and management and referral care for complicated cases. <p>Three broad strategies for achieving the above stated objectives are:</p> <ul style="list-style-type: none"> (1) Strengthening health systems for the provision of newborn and child health services. 		

	<p>The sub-strategies include (i) creating an enabling environment, (ii) increasing the availability of skilled providers and supplies, and (iii) increasing the availability and utilization of health management information.</p> <p>(2) Improving access to quality newborn and child health services. Sub-strategies include (i) prioritizing underserved areas, (ii) task shifting, (iii) increasing access, (iv) improving performance, and (v) strengthening referral.</p> <p>(3) Improving demand and utilization by engaging families and communities. Sub-strategies include (i) implementation of a newborn and child survival Communication for Development (C4D) plan, (ii) community mobilization, and (iii) support for community volunteers.</p>			
Is the strategy costed?	<table border="1"> <tr> <td data-bbox="760 741 997 800">Yes</td> <td data-bbox="997 741 1205 800">Global survey</td> <td data-bbox="1205 741 1430 800"></td> </tr> </table>	Yes	Global survey	
Yes	Global survey			
Are medicines free for sick children under 5?	<table border="1"> <tr> <td data-bbox="760 800 997 858">Yes</td> <td data-bbox="997 800 1205 858">Global survey</td> <td data-bbox="1205 800 1430 858"></td> </tr> </table>	Yes	Global survey	
Yes	Global survey			
Are consultations free for sick children under 5?	<table border="1"> <tr> <td data-bbox="760 858 997 917">Yes</td> <td data-bbox="997 858 1205 917">Global survey</td> <td data-bbox="1205 858 1430 917"></td> </tr> </table>	Yes	Global survey	
Yes	Global survey			
Are there any health systems strengthening strategies to support implementation of newborn and child health interventions?	<ol style="list-style-type: none"> 1. For Maternal Health and Immediate Newborn Care - Five-Year Strategic Plan for reproductive Health (2014-2018) 2. For Maternal and Child Nutrition - National Food and Nutrition Plan - National IYCF Strategy 3. For Expanded Programme on Immunization - Comprehensive Multi-Year Plan (cMYP) 4. For Prevention and Treatment of Malaria - Strategic Plan for Malaria Prevention and Control (extended up to 2016) 5. For Prevention and Care for HIV - Myanmar National Strategic Plan on HIV and AIDS (2011-2015) 6. For Adolescent Health - Adolescent Health Strategic Plan 7. For ECCD Policy and Programme - ECCD Strategic Plan/Plan of Action 8. Every Newborn Action Plan (ENAP) is integrated in NSP for newborn and child. 9. CCM, CBNBC, C4D, CDSR 			
Describe system readiness to provide high-quality treatment & care for the sick child.	<ul style="list-style-type: none"> - Availabilities of MNCH services were found uneven among different types of health facilities. - There were mismatch between basic resource allocation and actual needs on the ground. - Facilities were often caught in the vicious cycle of under-utilization and insufficient upkeep for MNCH services both in material and skills. - Health centres were often found want of material inputs (hardware). RHCs/S-RHCs lacked about a half of the infrastructural requirements including patient beds, electricity, and clean latrine. 			

	<p>- Hospitals were generally found requiring management-related improvements (software). Regular instructive communications, practical supportive supervisions, technical support, and systematic performance reviews from higher facilities for MNCH services were largely missing in township and station hospitals.</p> <p>- The performances of health staff were generally good, except the lack of practical experiences in MNCH-related emergency cases.</p> <p>- While women were reluctant to use health services in facilities currently available to them, it did not mean that they did not want to use health facilities at all. Mothers expressed their wish for “modern” facilities for their delivery and newborn and child care needs if their practical and emotional needs were met in these facilities.</p> <p><i>Sources:</i> Health Facility Assessment – Quality of Maternal, Newborn and Child Health Care (Dec 2014) (MoH, Unicef)</p> <p><i>Sources:</i> SARA/SPA where available, other quality of care data, other survey or HMIS data</p>		
<p>Where does child health sit in the organogram of the MOH?</p> <p>Is newborn health combined with child health in the organogram?</p>	<p>Under MoH, there are 6 Departments.</p> <ol style="list-style-type: none"> 1. Dept. of Public Health 2. Dept. of Medical Services 3. Dept. of Traditional Medicine 4. Dept. of Food and Drug Administration 5. Dept. of Medical Research 6. Dept. of Health Human Resource Development <p>Dept. of Public Health is headed by a Director General and its 3 units, namely Public Health, Disease Control, and Admin/Finance are headed by Deputy Director Generals.</p> <p>Child Health Division one of the seven divisions under the Public Health Unit, and headed by a Director.</p>		
<p>Is there a focal point of IMNCI in the MoH? Who funds this position?</p>	<p>Yes: Government</p>		
<p>What written policies exist for community-based care?</p> <p>[Attach policies to the Desk Review.]</p>	<p>Malaria, diarrhea, pneumonia, newborn, other?</p>	<p>Global survey</p>	<p>There is a guideline for CCM, but no written policy.</p>
<p>In a few sentences, describe national programming (if any) for community case management of <u>childhood</u> illness.</p>	<p>Community Case Management (CCM): The Dept of Public Health has implemented CCM of pneumonia and diarrhoea by trained, supplied and supervised health volunteers in five townships, and developed a national implementation guide.</p> <p>Achievements: Health volunteers working in hard-to-reach (HTR) villages managed up to 2 % of expected ARI cases and 11 per cent of diarrhoea, as per the monitoring report.</p>		

	<p>Nearly 90% of health volunteers used standard handbills/protocols for case management and up to 90% volunteers had diagnostic classification and treatment consistency. Thus, CCM volunteers and their advice/treatment is well accepted and community referral compliance has been very high in all townships (86 – 100 per cent).</p> <p>Challenges: No incentive and significant drop-out (from 0 to 20 per cent); variable performance, probably reflecting the effectiveness of training, and supportive supervision has been observed; social mobilization, active community participation is essential at different stages of implementation.</p> <p><i>Source:</i> NSP</p>
<p>In a few sentences, describe national programming (if any) for community case management of <u>newborns</u>.</p>	<p>Slow decline in neonatal mortality. Neonatal mortality shows a slower rate of decline than overall under-five child mortality. Therefore, scaling up of Newborn Care (NBC) and quality perinatal care is the single biggest thrust area proposed under NSP.</p> <p>Community Based Newborn Care (CBNBC) The pilot of a CBNBC package began in Myanmar in 2011. Standards on CBNBC have been developed and implemented in 11 townships across 4 states and 3 regions. Health volunteers are trained for 5 days in the provision of NBC, in the areas which are identified by physical access. The health volunteers provide breastfeeding advice, assessment and identification of danger signs, thermal care, prevention of infections, weighing of newborns, management of LBW babies, and referral of sick newborns. In addition, they provide health education and counselling on clean delivery, newborn feeding and recognition of illness. According to monitoring reports, more than 80% of newborns received three Post-Natal Care (PNC) visits by volunteers. Eighty four per cent of villagers interviewed were aware of the services but the attrition rates for health volunteers were high. Supportive supervision increased the motivation. Recommendations include financial or nonfinancial incentives for retention, supervision and refresher training for skill deficits, and referral support. A provision for referral transport is an important area for strengthening.</p> <p><i>Source:</i> NSP</p>
<p>What are the main child health policy issues in the country – gaps, contradictions or inappropriate policies?</p>	<p>The readiness for scaling up of NBC in Myanmar has been assessed according to the 32 point Benchmark, which includes agenda setting, policy formulation and policy implementation components.</p> <p>The majority of these benchmarks are fully or partially met. However, some benchmarks need policy level action for the successful scaling up of neonatal health in Myanmar. The policy decision on treatment of neonatal sepsis with injectable antibiotics at SRHC and RHC level is difficult,</p>

	<p>especially in view of the absence of local evidence. It is therefore recommended that a well-planned pilot be considered to assess the technical and financial feasibility. Use of injectable corticosteroids in preterm deliveries has been identified for inclusion during SPR.</p> <p>Some of the policy/guidelines related to important actions required for newborn care need to be addressed. (NSP)</p> <p>There is a need to consider allowing a permissive policy environment for volunteers (auxiliary midwives) in rural and hard to reach areas to dispense oral antibiotics and for midwives to provide injectable antibiotics would be good interim measures to consider while Myanmar produces enough Skilled Birth Attendants.</p> <p>There is also a need to implement the policy on use of tube/bag and mask for asphyxia management by volunteers (auxiliary midwives). (Newborn Health Assessment)</p>
<p>What are some positive aspects of the policy environment?</p>	<p>The National Health Policy was developed with the initiation and guidance of the National Health Committee (NHC) in 1993 and placed the “Health for All” goal as the prime objective, using a primary health care approach.</p> <p>National Health Plan (2011-2016)</p> <p>The MoH has formulated a National Health Plan (2011-2016), which was prepared within the framework of the National Development Plans for the corresponding period. The current National Health Plan prioritizes MNCH, communicable diseases and HSS, as well as sector-wide coordination.</p> <p>The government has increased health spending on both their current and capital accounts. According to published data, total government health expenditure increased from 7,688 million Myanmar Kyat (MMK) in 2000-2001, to 100,825 million MMK in 2011-2012.</p>

FUNDING

Expanding on findings from the Strategic Review IMNCI implementation survey, please describe the amounts and main sources of funding for child health.

Indicator	Value	Source (Year)	Comments
<p>What are the main findings on funding from the Global survey?</p>			<p>Government funding for newborn and child health cannot be calculated because there is no separate budget line for procurement, activity or salary for newborn and child health.</p> <p>Government funding is mainly used for staff salary, medicine and infrastructure. Training, medicine & equipment, transport and monitoring cost are mostly from Multi-lateral and bi-lateral support, especially for Programme-related activities</p>

	There is no salary, remuneration or incentive for CHW.		
Describe funding to newborn and child health.	There is no health insurance scheme in Myanmar but consultancy fees and cost of medicines are free for under-5 children. ODA to child health per child is US\$15 and ODA for MNH per LB is US\$36. (2012 Countdown report)		
How much funding comes from the national treasury and how much from external sources? Who are the major funders of child health?	Data not available for national treasury. Major funder for child health is Unicef. Other funders include GAVI, WHO, 3MDG, USAID, etc. Unicef procurement Services during 2015 totaled US\$22,672,397, including supplies through GAVI valued at US\$18,973,178. (2015). 3MDG MNCH funding is around US\$200M for 5 years.		
Is funding ear marked for certain activities or certain regions?	No		
How do partners divide themselves up across regions? Are there any regions/ districts without MNCH partners?	Partners and Child Health Division work together to divide across the regions/townships and activities. Yes, there are districts/townships without MNCH partners, especially the remote and conflict affected areas, and some downtown areas of capital Yangon.		
<i>Country health expenditures</i>	Source: WHS , World Bank data		
Per capita total expenditure on health	37\$	2013 Countdown (2015)	
General government expenditure on health as % of total government expenditure (%)	2%		
Out of pocket spending on health as % of total government expenditure (%)	68%		
External resources for health (% total expenditure on health)	\$M (%)		Not available
Have any political commitments been publicly made to support child health, including financially?	Yes, but not include financial commitment		
<i>Overseas development aid (ODA)</i>		OECD database	Net ODA 2014 = 1380M USD
ODA for child health (% of ODA to RMNCH)	\$M (%)		
ODA for child health per child	15\$	2012	

		Countdown (2015)	
General budget support for MNCH	\$M		Not available
Sector budget support for MNCH	\$M		Not available
Basket funding for MNCH	\$M		Not available
<i>Project funding for</i>			
HIV (related to MNCH)	\$M		
Malaria	\$M		
Immunization	\$M		
Other child health activities	\$M		
Nutrition	\$M		

IMCI / IMNCI IMPLEMENTATION

Summarize and expand upon implementation of IMCI / IMNCI as described in the global implementation survey.

Indicator	Value	Source (year)	Comments
IMCI / IMNCI introduced in [year]	1998	Global survey Source - Assignment Report on "Child Health (IMCI/ IMMCI) in Myanmar" by Dr Lone Christiansen, WHO STC (2002)	
Does the country implement IMCI or IMNCI? Please provide any details.			<p>Started with IMMCI (Integrated Management of Maternal and Childhood Illnesses) in 1998.</p> <p>First IMCI training was in 2004.</p> <p>Newborn care component was integrated in 2012.</p> <p>IMNCI is being implemented in 231 townships out of 330. IMNCI is part of National Strategic Plan for Newborn and Child Health Development (2015-18).</p> <p>F-IMCI uses 2013 edition WHO pocket book. ETAT has been introduced in about 10 hospitals.</p> <p>Key family practices are also promoted using counseling cards. iCCM programme is implemented in 43 townships, and community-based newborn care is undertaken in majority of the townships. AMW</p>

	<p>received 6 months pre-service training and CHW received one month training.</p> <p>Technological innovation (eHealth, mHealth) is initiated in HMIS (DHISII), and is explored for BCC and electronic decision support.</p>		
<p>How many districts currently implement IMCI/IMNCI</p>	<p>231/ 330 of total districts (township)</p> <p>WHO 32 townships</p> <p>Unicef 200 tsps (one tsp overlapped)</p>	<p>Global survey</p>	
<p>What does IMCI/IMNCI implementation encompass in your country?</p> <p>(Include interventions, scale)</p>	<p>Community-based IMNCI</p> <p>Facility-based IMNCI</p> <p>Essential Newborn Care (ENC), HBB</p> <p>Community based Newborn Care (CBNC)</p> <p>Community based case management of Pneumonia and diarrhea (iCCM)</p> <p>EPI – nationwide (BCG, Polio, Penta, measles)</p> <p>Nutrition (IYCF, IMAM, SUN)</p>		
<p>Describe the position of IMCI/IMNCI vis a vis national health sector plan.</p>	<p>Health Development Plan</p> <p>Content</p> <p>Framing country health problems</p> <ul style="list-style-type: none"> • Policy guidelines and framework for the National Health Plan • Problems related to service provision, human resources for health, • the practice and provision of traditional medicine, health research • National Health Information System • Health system factors and determinants • Key outputs from evaluating the National Health Plan 2006-2011 • Prioritization based on National Health Policy objectives and country • health problems • Priority given to CDs, NCDs, MNCH, injury, nutrition and geriatric • health, also system factors, health determinants & env. factors • (11) Programme Areas have been addressed in the NHP (2011-2016) <p>Considering the rapid changes in demographic, epidemiological and economic trends both nationally and globally, a long-term (30) years health</p>		

	<p>development plan had been drawn up to meet the future health challenges. Myanmar Health Vision 2030 was formulated. The expected benefits for the long-term visionary plan are as follows:</p> <p>Indicator</p> <table border="1" data-bbox="813 352 1417 682"> <thead> <tr> <th></th> <th>2001</th> <th>2011</th> <th>2021</th> <th>2031</th> </tr> </thead> <tbody> <tr> <td>Life expectancy at birth</td> <td>60 - 64</td> <td>64 - 71</td> <td>-</td> <td>75 - 80</td> </tr> <tr> <td>IMR/1000 LB</td> <td>59.7</td> <td>40</td> <td>30</td> <td>22</td> </tr> <tr> <td>U5MR/1000 LB</td> <td>77.77</td> <td>52</td> <td>39</td> <td>29</td> </tr> <tr> <td>MMR/1000 LB</td> <td>2.55</td> <td>1.7</td> <td>1.3</td> <td>0.9</td> </tr> </tbody> </table>		2001	2011	2021	2031	Life expectancy at birth	60 - 64	64 - 71	-	75 - 80	IMR/1000 LB	59.7	40	30	22	U5MR/1000 LB	77.77	52	39	29	MMR/1000 LB	2.55	1.7	1.3	0.9
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<p>Where does IMCI/IMNCI sit in the MOH organogram? Does it have a programme manager? A focal person? Its own budget?</p>	<p>IMCI/IMNCI is implemented under WCHD programme of Child Health Division.</p> <p>Director of Child Health Division is also the programme manager (director) of WCHD programme.</p> <p>No separate child health budget under government health budget but there is donor funded WCHD own budget.</p>																									
<p>Implementation:</p> <ul style="list-style-type: none"> - Describe evolution from adoption to scaling up - Describe scale of implementation 	<p>From 1998 to 2001, 5 days- IMMCI trainings of basic health staff (13,201) were conducted throughout the country. Approximately 1000 hospital based doctors and nurses were also trained in IMMCI.</p> <p>In 2001, IMMCI programme progressed into WCHD. With the support of UNICEF, WCHD activities were implemented in 19 townships in 2002 and expanded to one third of the country by 2005.</p> <p>11 day IMCI trainings for basic health staff were conducted in 32 townships with WHO funding, and 5 days abridged course were provided in 200 townships with Unicef funding.</p> <p>From 2011 onward, community based case management of Pneumonia and diarrhea (iCCM) was piloted in 5 townships and being expanded to 37 townships of 3MDG MNCH project)</p> <p>Intensive F-IMCI training was implemented in 10 hospitals by RCPCH in Sagaing and Ayeyarwady regions.</p>																									
<p>Who funds IMCI/IMNCI implementation?</p>	<p>In-service: Staff salary – Government</p> <p>Training – Unicef, WHO, 3MDG Fund, INGOs</p> <p>Medicine and supplies – Unicef, government</p>																									

	<p>- Pre-service: Government</p> <p>- Other components: Unicef, WHO, 3MDG Fund, INGOs</p>
<p>Describe if any health system strengthening activities that have been undertaken to support implementation of IMCI/IMNCI.</p>	<p>GAVI/HSS project was implemented in 180 townships in phase manner with a main focus on MNCH.</p> <p>Multi-donor funded 3MDG MNCH project is being implemented in 37 remote townships with HSS component at township level, complemented by 3MDG HSS component at central level.</p>
<p>What have been the lessons learned from implementation of IMCI/IMNCI? Any challenges? How were the challenges overcome?</p>	<p>IMMCI (1998-2001)</p> <ul style="list-style-type: none"> • IMMCI training materials were bases on IMCI. However the incremental step by step methodology of IMCI seemed to have been compromised in an attempt to cover a broad range of issues. The methodology used for the maternal part and child part seemed inconsistent, and the technical content of the maternal part may not address the needs for women’s reproductive health. • The duration of five days training (3 ½ for the child, 1 ½ for maternal) to cover the content of IMMCI manual seemed brief if individual needs and understanding and sufficient clinical practice should be assured. • Assuring quality of care i.e. through follow-up visits after training for skills reinforcement and routine supervision of IMMCI trained staff, had been compromised by training coverage targets. • The implementation of IMMCI programme had not been done in a phase manner, with periodic review and evaluation. Particularly, analysis of experience from pilot townships, before further expansion, did not seem sufficiently explored. • Despite 4 years of IMMCI implementation, no attempts had been made to link the IMMCI classifications to HIS. • For a programme like IMMCI or IMCI to be effective in Myanmar, where the majority of sick children under five years of age are treated by private practitioners, it seemed essential to involve the private sector in the programme/training along with social marketing of the strategy, and development of the family/community component. • For the family/community component to have an impact on morbidity and mortality. A bottom-up approach needs to be adopted, with assessment, participation and ownership by and of the families and communities concerned. • The IMMCI programme was found to be very dynamic, popular and the people involved were very dedicated. It seemed however, to rely on dedicated clinicians, lacking a visible management structure in the DoH, MoH.

	<p>IMCI Pre-service training (2001)</p> <ul style="list-style-type: none"> • Despite a national workshop on the integration of IMMCI into pre-service curricula held in June 2000, there was no clear consensus on content, method and pace of the introduction. • The next step should be a structured IMCI pre-service planning workshop with review of the curriculum, student evaluation, and consensus building. The introduction of IMCI into pre-service training should be piloted in one or two institutes, and should be linked to the IMCI implementation in a way that ensures the students will have their clinical practice/field attachments in facilities already implementing IMCI and with adequate patient loads. <p>Lesson Learned Exercise – JIMNCH Project (post Nargis)</p> <ul style="list-style-type: none"> • Volunteers (including AMWs), had effective roles in preventive care, childbirth and childhood illness, and need close attention to their support and supervision; • Optimizing health workforce placement and tasks, especially that of the MW, is potentially powerful, and needs continued work; • Increasingly standardized procedures for emergency referral based on JIMNCH lessons may be useful for other townships and regions;
<p>Describe adaptation and adaptation process.</p> <p>How many times have the national IMCI/IMNCI guidelines been adapted?</p>	<p>IMCI guideline was adapted as IMMCI guideline in 1998. IMMCI strategy was based on WHO-IMCI with addition of maternal component.</p> <p>In 1999, IMCI demonstration course was conducted by WHO. The Myanmar adaptation of the IMCI training materials was reviewed in 2000. Major adaptations included malaria risk, dengue hemorrhagic fever, and assessment of vitamin A.</p> <p>In 2001, facilitators’ training and IMCI 11day case management course was conducted by WHO.</p> <p>IMMCI programme is planned to progress into the “Woman and Child Health Development (WCHD)” Program in 2001.</p> <p>In 2012-2013, newborn component was integrated and became IMNCI.</p> <p>In 2011, iCCM was piloted.</p>
<p>Is IMCI/IMNCI responding to today’s epidemiology of the country?</p>	<p>Yes: Increased in proportion of newborn deaths in U5MR led to initiation of newborn care interventions.</p>

<p>Provide more detail on any innovations on how IMCI/IMNCI has been implemented</p>	<p>An innovation project, “Seven Things This Year” for key family practices social mobilization was implemented by a local NGO, MMCWA.</p>
<p>When was the most recent evaluation of IMCI/IMNCI? What were its main findings? <i>[Attach the latest evaluation to the Desk Review.]</i></p>	<p>No specific IMCI/IMNCI evaluation was done in recent years. The last one was done in 2001 by WHO.</p> <p>Child Health programme review was done in 2014 before NSP development (not document available).</p> <p>Newborn health assessment was done in 2013.</p> <p>Facility Assessment for MNH was done in 2014.</p> <p>Unicef CCM monitoring report - 2014.</p>
<p>What evidence exists for the impact of IMCI/IMNCI in country? <i>Examples: evaluation reports, scientific articles or studies</i></p>	<p>Assignment Report on “Child Health (IMCI/ IMMCI) in Myanmar” by Dr Lone Christiansen, WHO STC (2002)</p> <p>Monitoring Report (Unicef) - Community Case Management on Pneumonia and Diarrhea</p> <p>Assessment of Newborn Health in Myanmar (Aug-Sept 2013) (MoH, Unicef)</p>
<p>Describe facilitating factors to IMCI/IMNCI implementation.</p>	<p>Strong political commitment for the health of people, including mothers and children.</p> <p>Strategic guidance and coordination. (NSP, MHSCC, NCH TSG, TWG)</p> <p>Increased in health budget.</p> <p>Support from UN agencies, partners and donors.</p>
<p>Describe barriers to IMCI/IMNCI implementation.</p>	<p>(Newborn Health Assessment) Health sector capacity is quite low especially for monitoring & supervision and most importantly the country needs to develop a well-functioning centralized procurement, logistics and supply chain system that is responsive to the needs on the ground.</p> <p>Quality of care for newborn health services at both facilities and communities needs to be improved considerably. For newborn care services at health facilities: this means developing appropriate standards for care, upgrading of existing health facilities, training, deploying and retaining trained health care providers at these facilities and creating an enabling environment for implementing evidence based standards into routine clinical practice.</p> <p>A nationally standardized community based package for newborn health interventions to be implemented jointly by all partners does not exist at present, as a result of which there are many fragmented, diverse,</p>

	<p>small scale, project- driven initiatives that are operating across the country.</p> <p>Some Determinants Retarding the Mortality Decline (NSP)</p> <p>a) Inequalities. There are several inequalities in the high-impact indicators coverage across States and Regions, as per the MICS data and Short Programme Review (SPR), leading to higher mortality rates in low coverage areas. This underlines the need to focus on underserved areas, especially for major killers like pneumonia and diarrhoea.</p> <p>b) Slow decline in neonatal mortality. Neonatal mortality shows a slower rate of decline than overall under-five child mortality.</p> <p>c) Mortality-related risk factors beyond the NCHP. The continued presence of several risk factors, which are significantly associated with neonatal and post neonatal mortality, retard the progress. Some of these are maternal education, inadequate spacing, and inadequate WASH facilities. Thus not only intra-sectoral but also cross-sectoral collaboration is emphasized as a strategic direction.</p>
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IMPORTANT DOCUMENTS

What documents do you think are most important when it comes to understanding the future of treatment for the sick child in your country? Examples of documents might include:

- Academic or scholarly articles;
- Dissertations or theses;
- IMCI/IMNCI reviews or evaluations;
- National child health situation analysis or national child health strategy;
- Health system analyses on health workforce, supply chain management, supervision and monitoring.

	Document title, date, author(s)	Main findings	PDF in Dropbox?
1.	National Strategic Plan for Newborn and Child Health Development (2015-2018)	<p>The newborn and child health plan will be implemented through a continuum of care from the community to facility level and include the provision of home-based newborn and child care through community volunteers, midwives, Non-government Organizations (NGOs) e.g. Myanmar Maternal and Child Welfare Association (MMCWA).</p> <p>Community level care for acute respiratory infections/ pneumonia, diarrhoea, and fevers would be scaled up as a medium term measure with a strong community empowerment component.</p> <p>Facility based Integrated Management of Childhood Illnesses (F-IMCI) would be expanded for the treatment of common newborn and childhood illnesses (IMNCI).</p> <p>Facility level readiness for newborn and young children referred for care is critical for their survival and is therefore emphasized in the plan. Early essential newborn care at all facilities through skilled personnel with standard supplies will be ensured, in a</p>	

		<p>phased manner. Facility based care for small and sick newborns will be strengthened through newborn/ childcare units at hospitals. The recently developed Myanmar-specific Every Newborn Action Plan (ENAP) is integrated in this strategic plan. The national Overarching Communication Strategy and Action Plan on Child Survival has prioritized key family practices and will guide the nationwide efforts for the community engagement and empowerment needed for the improvement of newborn and child health.</p> <p>A broad cross-sectoral approach is recommended for the plan, with collaboration within the MoH and across other sectors. The expanding partnership consists of professional associations, United Nations (UN) agencies, donors and civil society organizations including international and local NGOs. The bilateral organization is coordinated by the Myanmar Health Sector Coordinating Committee (MHSCC) and its thematic/technical working group. Operational plan(s) will be developed based on this strategic plan to translate the broad activities identified to actionable and costed activities at sub-national level, for newborn and child health, with a focus on equity.</p> <p>The implementation of the plan will be monitored through a series of outcome- and output-level indicators. A mid-term review and course correction will be necessary in a rapidly evolving programming context.</p>	
2.	Assessment of Newborn Health in Myanmar (Aug-Sept 2013) (MoH, Unicef)	<p>There were many challenges identified for improving newborn health in Myanmar. Information on the determinants of newborn health is currently limited. The coverage of effective newborn health intervention across the country is low given the existing resource constraints.</p> <p>Health sector capacity is quite low especially for monitoring & supervision and most importantly the country needs to develop a well-functioning centralized procurement, logistics and supply chain system that is responsive to the needs on the ground.</p> <p>Quality of care for newborn health services at both facilities and communities needs to be improved considerably. For newborn care services at health facilities: this means developing appropriate standards for care, upgrading of existing health facilities, training, deploying and retaining trained health care providers at these facilities and creating an enabling environment for implementing evidence based standards into routine clinical practice.</p> <p>A nationally standardized community based package for newborn health interventions to be implemented jointly by all partners does not exist at present, as a result of which there are many fragmented, diverse, small scale, project- driven initiatives that are operating across the country.</p>	

		<p>A standardized community based newborn care programme with standard operational guidelines endorsed for nation-wide expansion by all implementing agencies with robust monitoring oversight would be very helpful in initiating a better coordinated national response.</p> <p>There is a need to consider allowing a permissive policy environment for volunteers (auxiliary midwives) in rural and hard to reach areas to dispense oral antibiotics and for midwives to provide injectable antibiotics would be good interim measures to consider while Myanmar produces enough Skilled Birth Attendants.</p> <p>There is also a need to implement the policy on use of tube/bag and mask for asphyxia management by volunteers (auxiliary midwives).</p> <p>Coordination, information sharing and planning amongst various line ministries, implementing partners and stakeholders is also another important challenge for leveraging a better collective response for newborn health in Myanmar.</p> <p>Training of skilled birth attendants on newborn care needs to be urgently scaled up in order to effectively implement evidence based standards during routine clinical practice across the country.</p>	
3.	Study on Cause of Under-five Mortality - 2014 (MoH, Unicef)	<p>Some of the key recommendations based on the study findings were that -</p> <p>The health system should have a greater focus on reducing deaths due to non-infectious preventable causes like prematurity/LBW and birth asphyxia, while simultaneously accelerating the progress made in infectious diseases.</p> <p>Myanmar needs to focus on the quick scaling-up of evidence-based interventions that reduce neonatal mortality.</p> <p>As most of the high impact interventions to reduce neonatal mortality are effectively provided at health facilities rather than at community level, it is essential for Myanmar to strengthen health facilities and to reverse the current proportion of home- to facility-based deliveries.</p> <p>There is a demand for a greater level of consideration in sub-national planning, financing and geographically-targeted scaling up of health interventions, to address causes of deaths and the disparity in receiving health care, specifically among children residing in the states and regions as well as amongst the rural and urban population.</p> <p>Multi-faceted interventions are needed, that focus on strengthening the health system in order to provide an increase in</p>	

		services, a better enabling environment, adequate knowledge among caregivers and a strong demand for those services.	
4.	Health Facility Assessment – Quality of Maternal, Newborn and Child Health Care (Dec 2014) (MoH, Unicef)	<p>Major findings included the following:</p> <ul style="list-style-type: none"> - Availabilities of MNCH services were found uneven among different types of health facilities. - There were mismatch between basic resource allocation and actual needs on the ground. - Facilities were often caught in the vicious cycle of under-utilization and insufficient upkeep for MNCH services both in material and skills. - Health centres were often found want of material inputs (hardware). RHCs/S-RHCs lacked about a half of the infrastructural requirements including patient beds, electricity, and clean latrine. - Hospitals were generally found requiring management-related improvements (software). Regular instructive communications, practical supportive supervisions, technical support, and systematic performance reviews from higher facilities for MNCH services were largely missing in township and station hospitals. - The performances of health staff were generally good, except the lack of practical experiences in MNCH-related emergency cases. - While women were reluctant to use health services in facilities currently available to them, it did not mean that they did not want to use health facilities at all. Mothers expressed their wish for “modern” facilities for their delivery and newborn and child care needs if their practical and emotional needs were met in these facilities. 	
5.	Assignment Report on “Child Health (IMCI/IMMCI) in Myanmar” by Dr Lone Christiansen, WHO STC (2002)	<p>Recommendations</p> <ol style="list-style-type: none"> 1. Planning and implementation of the WCHD Programme 2. Monitoring and evaluation of WCHD Programme implementation 3. Adaptation of IMCI materials 4. Build capacity in IMCI facilitation skills 5. Capacity building in IMCI facilitation skills 6. Capacity building in IMCI Follow-up after training 7. Strengthening traditional practices 8. Strengthening the IMMCI activities 9. Alternative training methods 10. Introduction of IMCI training into pre-service curriculum of medical students 11. Involvement of private practitioners in IMCI 	
6.	Description of Action Multi Donor 3MDG Fund 2012-2016	<p>2.3. Rationale for the 3 MDG Fund</p> <p><i>Evidence on impact and cost-effectiveness.</i> The package of interventions to be supported by the 3MDG Fund is consistent with the evidence base on high-impact, cost-effective MNCH interventions and with current global guidance.</p> <p>Providing services in the community through community health workers can impact on neonatal mortality and, coupled with</p>	

		<p>community-based case management of diarrhoea, pneumonia and malaria, reduce under-five mortality.</p> <p>Evidence from community-based trials and complementary modeling activities have overwhelmingly demonstrated that, to maximize impact, interventions should be delivered as a coordinated package or a 'continuum of care' and coverage of the interventions must be at scale.</p> <p>For children, community-based provision of health services will result in the greatest number of lives saved. Home-based identification and management of sepsis would contribute to a reduction of almost one-third in under-five mortality. Breastfeeding promotion and community case management of pneumonia, malaria and diarrhoea are also critical.</p> <p>Provision of a package of essential health services through the public sector, together with complementary private sector delivery of targeted interventions with the potential to increase health impact for the poor will generate direct health benefits to the people of Myanmar.</p> <p>Key lessons learned, based on experience of the 3DF, JIMNCH, Global Fund and GAVI-HSS, are:</p> <ul style="list-style-type: none"> • Aid can be delivered effectively, results can be achieved and vulnerable populations can be reached through increased and focused investment despite a challenging political and operating environment. More timely, cost-effective and accountable funds flow mechanisms to township level are needed. • Effective and functional governance arrangements can be established for joint donor support. • The MOH is open to coordination with partners and entering into policy dialogue. Support to strengthen MOH leadership and ownership is critical. MOH engagement in planning and development of the JIMNCH can provide the basis for a similar approach to the 3MDG Fund. • Effective and functional national coordination structures, led by the MOH, that involve consultation with a wider group of stakeholders and are consistent with the principles of accountability and transparency can be established, as the CCM and TSGs have demonstrated. • Some current funding and programming approaches contribute to fragmentation of the essential health package and service delivery and to gaps in services, uneven geographical coverage and weak coordination at township level. More effective coordination between all implementing partners at township level is critical to avoid parallel systems and vertical interventions. Joint assessment and planning of health needs and interventions is feasible at township level, as are complementary working relationships between the public sector and the non-public sector including international and national NGOs, CBOs and the private sector. 	
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		<ul style="list-style-type: none"> • The focus on international NGOs had led to the establishment of parallel systems and a concentration of NGOs in some areas, with potential duplication of activity. Some international NGOs have also been unwilling to be seen working too closely with township health authorities. • For sustainability, there is a need for capacity building of public sector institutions, systems and staff to ensure the building blocks are in place to support delivery of essential health services. • Approaches are needed that strengthen the pivotal role of township health authorities in taking full responsibility for planning, management and coordination of services of all providers. • Implementing partners need predictable, multi-year funding to facilitate planning and sustainable support for interventions. • Approaches are needed that can both increase the stewardship and management capacity of public health authorities at all levels, and to build the capacity of civil society organisations and users of health services to hold service providers to account. • Programme monitoring needs to be better linked to existing data collection and reporting systems and needs to be used more effectively for operational planning and reflective learning. • Support for national surveys can improve the availability and quality of health data, which can, in turn, support more targeted health interventions. • Involvement of the private sector in improving access to essential health care for the poor is feasible. • Community participation in the planning, implementation and monitoring of programmes and services is possible. The JIMNCH experience highlights the need for mechanisms to ensure inclusiveness of all relevant actors at township level to be clear and explicit. • Emerging evidence from the JIMNCH suggests that support for demand- and/or supply-side costs can significantly increase utilisation and referral rates. 	
7.	Myanmar Multiple Indicator Cluster Survey 2009-2010 (MNPED, MoH)	<p>Child Mortality</p> <p>The Myanmar infant mortality rate has been estimated at 37.5 per 1,000 live births. Under-five mortality rate is estimated to 46.1 per 1,000 live births. Infant and under five mortality rates are higher in rural than in urban areas. The two lowest wealth quintiles show similar outcomes on child mortality, whereas there is a steady decline in the trend from the middle quintile to the richest. Comparisons across time indicate a decline in levels of infant and under 5 mortality rates.</p> <p>Nutrition</p>	

		<p>Overall, 22.6 % of Myanmar children aged under-5 are moderately underweight, and 5.6 % are severely underweight. 35.1 % are moderately stunted or too short for their age, while 12.7 % are severely stunted. 7.9 % of children are moderately wasted or too thin for their height, and 2.1 % are severely wasted. Whereas there is little difference between urban and rural children in terms of wasting, more children in rural areas are underweight and stunted than children in urban areas. Undernourishment in children is more common in Rakhine and Chin than in other states and divisions. When the mother has secondary or higher education, a lower % of children are underweight or stunted than if the mother has primary education only, but this difference is not strong for wasting. Undernourishment is more common among children in the poorest households.</p> <p>Breastfeeding</p> <p>75.8 % of mothers initiate breastfeeding within one hour of birth, and 89.3 % of women begin breastfeeding within one day of birth. Mothers in urban areas are more likely to begin breastfeeding within one hour of birth than mothers in rural areas. The proportion of mothers initiating breastfeeding within one hour of birth increases with their level of education, as well as their wealth level.</p> <p>23.6 % of children are exclusively breastfed up to age six months. The prevalence of exclusive breastfeeding is slightly higher in rural areas than in urban areas. Exclusive breastfeeding rate varies between 1.3 % in Rakhine and 40.6 % in Kachin. There is no association between the mother’s education level and exclusive breastfeeding.</p> <p>80.9 % of children aged 6-9 months receive breast milk and solid or semi-solid foods. By age 12-15 months 91 % of children are still breastfed, and 65.4 % of children are still breastfed at age 20-23 months. Continued breastfeeding of children aged 20-23 months is more common in rural areas than in urban areas, and is least common among mothers with secondary or higher education and among the richest mothers.</p> <p>41 % of children aged 0-11 months are adequately fed. Infant feeding patterns are similar across urban and rural locations. Low levels of adequate feeding of infants is mainly due to the low prevalence of exclusive breastfeeding up to six months.</p> <p>Vitamin A supplements</p> <p>56 % of children received a high dose vitamin A supplement in the last six months. 11.9 % received the supplement more than six months ago, and 21.3 % of children received it but the mother or caretaker was unable to specify when. 66 % of mothers with a</p>	
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		<p>birth in the previous two years received a vitamin A supplement within 8 weeks of the births. More mothers in urban areas than in rural areas received the supplement.</p> <p>Low Birth Weight</p> <p>Overall 56.3 % of infants were weighed at birth, and 8.6 % of infants are estimated to weigh less than 2,500 grams at birth. The proportion of infants being weighed at birth varies across location of residence, mother’s level of education and the economic status of the household. Whereas 81.6 % of infants in urban areas are weighed at birth, only 46.1 % of infants in rural areas are weighed at birth.</p> <p>Immunization</p> <p>88.6 % of children are fully immunized by age 1. Tuberculosis immunization coverage is reported as 97.2 %, and both polio and DPT immunization coverage were reported as 95.9 %. Measles immunization coverage is 90.7 %.</p> <p>Tetanus Toxoid</p> <p>91.8 % of mothers with a birth in the last 24 months are protected against neonatal tetanus. The proportion of mothers who are protected against tetanus is slightly higher in urban areas (94.6 %) than in rural areas (90.7 %). There is also a difference according to wealth levels. Whereas 87.2 % of the poorest women are protected against tetanus, the prevalence reaches 96.2 % among the richest women.</p> <p>Oral Rehydration Treatment</p> <p>Overall, 6.7 % of under-five children had diarrhoea in the two weeks preceding the survey. Prevalence is highest in Chin State with 13 %. 66.3 % of children with diarrhoea in the last 2 weeks received either oral rehydration salts (ORS) or a recommended home-made fluid. Prevalence of oral rehydration treatment is highest among children in urban areas, children whose mother has secondary or higher education and children in the richest households.</p> <p>50.3 % of children with diarrhoea received either ORT or increased fluid intake and at the same time continued feeding. Under-five children in urban areas are more likely than children in rural areas to receive ORT or increased fluids and continue feeding when sick with diarrhoea. 43.8 % of diarrhoea cases among the poorest children are properly managed, compared to 65.3 % among the richest children. Adequate home management of diarrhoea is lowest among children aged 0-11 months, with 36.5 %.</p> <p>Care seeking and Antibiotic treatment of Pneumonia</p>	
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		<p>2.6 % of children under-five had symptoms of pneumonia during the two weeks preceding interview, and 69.3 % of these were taken to an appropriate provider. A higher % of children with symptoms of pneumonia were taken to an appropriate provider in urban areas (74.4 %) than in rural areas (67.3 %). Whereas there is no considerable correlation between children being taken to an appropriate provider and the educational level of the mother, children from the richest households (77.3 %) are more likely to be taken to an appropriate provider than children from the poorest households (62.5 %).</p> <p>34.2 % of under-five children with suspected pneumonia in the two weeks preceding interview received antibiotics. Children whose mother has secondary or higher education (41.1 %) are more commonly treated with antibiotics when demonstrating symptoms of pneumonia than children whose mother has primary education (30.8 %).</p> <p>6.5 % of mothers or caretakers of children under 5 know of the two danger signs of pneumonia – fast and difficult breathing. The most commonly identified symptoms for seeking immediate healthcare are when the child develops a fever or becomes sicker. Awareness of the danger signs of pneumonia or recognition of other symptoms that would cause mothers or caretakers to take the child immediately to a health provider does not vary considerably between urban and rural areas or across other background characteristics.</p>	
8.	Lesson Learn Exercise JIMNCH (2012) (UNOPS, Burnet Institute)	<p>- JIMNCH lessons provide detailed models for critical aspects of services aiming to reach poor and vulnerable populations. These include:</p> <ul style="list-style-type: none"> • Volunteers (including AMWs), had effective roles in preventive care, childbirth and childhood illness, and need close attention to their support and supervision; • Optimizing health workforce placement and tasks, especially that of the MW, is potentially powerful, and needs continued work; • Increasingly standardized procedures for emergency referral based on JIMNCH lessons may be useful for other townships and regions; • Effective emergency referral requires maintaining well-managed local funds, with procedures that minimize up-front costs to the poor; and • Special efforts needed to overcome seasonal constraint and reach migratory populations. 	
9.	Unicef Annual Report Myanmar 2014	In health, a priority area for Government as part of its broader reforms is to improve efficiency by integrating service delivery components that are currently implemented by different vertical programmes.	

		<p>Contributing to this reform, UNICEF, along with the World Health Organisation (WHO) and the United Nations Population Fund (UNFPA), is advocating for developing an integrated national strategic plan for reproductive, maternal, newborn, child and adolescent health.</p> <p>This plan will provide guidance on integrated service delivery and avoid overlapping strategies such as that for newborn care and reproductive health for adolescents being implemented differently under separate strategic plans.</p> <p>UNICEF’s technical assistance resulted in a programme review of the newborn and child health programme. This review will inform key strategies for the child health component of the national strategic plan and is rooted in consultations with non-government organisations (NGOs) and CBOs.</p> <p>Procurement Services during the year totaled US\$22,672,397, including supplies through GAVI valued at US\$18,973,178, along with US\$3.4 million nutritional supplies requested and funded by MOH.</p> <p>The GAVI funded Measles-Rubella campaign with a target population of 17.4 million children is a major UNICEF commitment with responsibility for distribution directly to state/regions and townships. UNICEF procured cold chain equipment to facilitate storage and distribution of vaccines, and leased a warehouse to receive, repack and distribute injection devices, standard Information, Education and Communication (IEC) materials and cold chain equipment.</p> <p>The UNICEF logistics unit has been involved in ongoing supply chain strengthening process at the MOH.</p> <p>Analytical Statement of Progress: Limited routine data on nutrition continues to be a major bottleneck towards assessing progress on the nutritional status of women and children in Myanmar. Although some nutrition indicators have been integrated into the national Health Management Information System since 2013, data quality and availability is still limited. Effective integration of a comprehensive set of nutrition indicators into routine information management and surveillance systems in health and relevant sectors is required to improve national and subnational capacities to effectively plan, budget and monitor nutrition.</p> <p>Key national policies, plans and legislation for nutrition exist in Myanmar. However, implementation at a national scale has been slow, due to insufficient strategic planning and budgeting for adequate resources, limited human resources capacity to deliver nutrition services, and inadequate mainstreaming of nutrition into health sector supply chain, training and monitoring systems.</p>	
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10.	Performance Assessment of GAVI HSS in 20 Townships - 2014 (MoH, WHO, IHPP Thailand)	<p>Outreach service to hard-to-reach villages is the vital program that should be sustained and improved. Outreach is seen as an important transitional mechanism. The government should scale up supply-side capacities; especially at sub-centres. For instance; 117 out of 617 sub-centres (19%) do not have space for service provision.</p> <p>In view of change in government policy in providing free medicine, the supplies of five items of medicines (Paracetamol, Cotrimoxazol, misoprostol, ORS and ZnSO4) from GAVI HSS program should be reviewed.</p>	

11.	<p>Monitoring Report - Community Case Management on Pneumonia and Diarrhea</p> <p>Unicef</p>	<p>Community Case Management (CCM) initiative is an essential step to improve the health of under-five children. In Myanmar, a CCM approach has been introduced to implement in Dawei Township, Tanintharyi region since 2011. In 2012, the program was extended into another four townships in 2 States (Kayin and Shan State) including Dawei. To monitor and document the current implementation status of CCM through volunteers, monitoring visits were carried out to identify the needs, the bottlenecks/ challenges using a tool based on Monitoring Results for Equity System (MoRES).</p> <p>The findings highlighted that the access to trained providers with adequate supplies (commodities), utilization of services provided by health volunteers, financial access, and social and cultural beliefs in the community they served.</p> <p>To evaluate the quality of services provided to sick children in the community, observation and assessment of the technical performance of health volunteers, including the examination of continuity of care and quality of supportive supervision was conducted. According to the observation findings, there are some challenges in volunteers' skills in documentation as well as supervision skills to ensuring the documentation, and supportive supervision skills. Besides, it is a quite challenge to maintain the unpaid volunteer for sustainability. The number of recommendations was identified and proposed to secure the quality and sustainability of the program.</p>	
12.	<p>CDSR Technical Guidelines – 2015 (MoH, Unicef)</p>	<p>There are three components: 1) Death Review, 2) Surveillance and 3) Response.</p> <ul style="list-style-type: none"> • The Death Review component involves the analysis of information of causes and contributing factors of child deaths and monitoring the trend at various levels of the health system • The Surveillance component requires strengthening of existing surveillance systems in child health, and these only need to be strengthened to meet the purpose of CDSR. Surveillance in general exist in three main forms, and each will be applied to child health and survival – (i) routine surveillance through the HMIS, which can cover the whole country or from selected sites as sentinel surveillance (ii) periodic surveys such as DHS, MICS and verbal autopsy for causes of child deaths (for which a tool is available)2 (iii) ad-hoc surveys and studies based on an identified need. CDSR itself can contribute to surveillance of child death • The Response component follows all reviews with recommendations for actions. The response must be robust, documented and monitored. 	
13.	<p>Health in Myanmar 2015</p>	<p>Under-five clinics have been opened up to sub rural health centers all over the country in which services for provision of health care for sick children, regular medical checkup for under-five children, preventive activities such as promotion of personal hygiene, environmental sanitation, safe water supply, sanitary latrines, immunization, health education and communication for development, birth spacing counseling and provision of birth</p>	

		spacing services, regular growth monitoring for under five children have included.	
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