

## **A co-ordinated township approach to health service delivery – using opportunities to support the health system in Myanmar in the aftermath of Cyclone Nargis**

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### **1. Context**

Myanmar is ranked 149 out of 168 countries in the Human Development Index. It has been characterised as a fragile state due to its governance record and on-going conflict in many parts of the country (CIFP, 2012)<sup>1</sup>. Following more than 40 years of military rule, the 2010 election brought in a new civil government and constitution. Since then a number of political and economic reforms have been introduced which have gone some way to improving democracy and peace in the country. These include: electoral reforms; the release of political prisoners; increased labour and media freedom and peace talks with a range of ethnic groups. However large areas of the country continue to experience on-going conflict and marginalisation.

Access to basic health services remains very poor even in areas where peace and stability have been gained. Investment in the public health system has been pitifully low from internal and external sources alike, over many years. Despite recent commitments to increase government spending on the health sector, the low starting base means that projections for health spending remain below 1% of GDP for 2012/2013. External donor support is also low (1.23 US \$ per capita) when based on a regional comparison, though this is expected to improve in coming years (Grundy, 2012)<sup>2</sup>.

Support to the public health system has been restricted by donor policies as well as limitations to external actor engagement within the system placed by the Ministry of Health (MoH). As a result a major focus of investment over recent years, certainly for a number of International NGOs (including Merlin) has been through community based health programmes. While achieving good results, these programmes suffer from critical limitations including the inability to provide a comprehensive range of health services for the population and a vital continuum of care to address maternal and child health. Implementation outside the public health system has also meant that the long term scale up and sustainability of the programmes have been severely hampered. A changing context is now presenting increasing opportunities to re-dress this limited focus.

Informing the development of these opportunities are a few notable programmes where the focus to date has been on supporting the public health system. One is the GAVI-HSS programme, signed in 2007/8 to support coordinated township programmes through the MOH, in conjunction with UNICEF and WHO, in a total of 180 townships across the country. The second is the coordinated township approach to the delivery of maternal and child health care (JI-MNCH). This latter programme is currently being implemented by NGOs in collaboration with the Ministry of Health and supported by a number of key international donors, in the Delta area. This presentation focuses on this latter approach though it is recognised that the Delta programme has both been influenced by, and has in its turn contributed to, the development of the GAVI-HSS programme.

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<sup>1</sup> Assessing State Fragility: A Country Indicators for Foreign Policy Report. Carlton University for CIDA, June 2012

<sup>2</sup> Health Financing Review. Myanmar, March 2012

## **2. Brief description of the intervention**

Following the devastating Cyclone in 2008, opportunities for international NGOs and other partners to work with the Ministry of Health in a collaborative manner, and with higher levels of the health system (facility level and above) in the Delta area, have increased dramatically. This has been a progressive process. An initial emergency response was followed by a recovery programme (Post Nargis Recovery and Preparedness Plan –PONREPP) which included the health sector. The health PONREPP, (renamed the JI-MNCH in 2011), aims at supporting longer term improvements in health for the populations in the Delta through a coordinated township approach. The programme was inspired by the discussions for the GAVI-HSS proposal and is a joint initiative between donors and the Ministry of Health, implemented by a range of International NGO partners including Merlin. The JI-MNCH programme provides a model of engagement at Township level which supports the delivery of a package of essential maternal, neonatal and child health services, linking community based services with basic health staff and facilities under the township health authorities. The programme is overseen at township level by the Township Health Authority and the International NGO implementing partner under the guidance of a national Steering committee which includes the Department of Health, donors and implementing partners.

Plans are currently being developed to build on the Joint Initiative model to support the institutionalisation of programme activities and processes within the health system and other township structures at the end of the current funding cycle in December 2012. This further programme is expected to provide a model for longer term sustainability and system development for the township approach.

The JIMNCH has also acted as model for a large scale health programme (covering 40 townships) using the coordinated township plan approach which will be implemented over the next 5 years. In addition Merlin is also looking at how elements of the JI-MNCH model, including township planning and support to MoH staff within the public health system can be supported in townships still experiencing conflict, thus promoting a health system strengthening approach in these contexts at the earliest possible opportunity.

## **3. Brief description and reflection on the challenges encountered**

The programme in Laputta (as well as other townships in the Delta) has provided a model for supporting health in communities that uses opportunities presented within the external environment to progressively support the health system and build capacity within the system over time. A coordinated approach has been vital to ensure buy-in from the MoH and reduce fragmentation and as a basis for accountability and oversight. The aim is to deliver services more effectively through the township health authorities and health staff.

This approach has required a long term view, a constant analysis of the prevailing context and the identification of potential opportunities to increase involvement in the sector, and the ability to adapt progressively to allow opportunities to be used to best advantage. This has not been easy within a context where external as well as internal actors are often reluctant to move beyond the status quo and it has required delicacy of engagement and discourse.

The on-going challenge is to progressively move from a direct implementation approach to a more supportive role and ultimately for ownership of the programme to shift from external implementer to national decision making and implementation, over time. The programme has

and will continue to require intensive efforts in terms of coordination and partnership working with national partners, at times at the expense of greater short term efficiency.

#### **4. Reflection on the (possible) contribution to conflict transformation**

Conflict transformation is taken to mean addressing the divisions and tensions that lie behind violent conflict and war in a manner that supports the realisation of expectations within communities. These expectations include access to essential social services such as health. Myanmar has experienced internal conflict for more than 60 years which has had a major impact on the availability and access to even basic health services. In areas where conflict is still on-going this impact continues.

Addressing access to services, as well as promoting increased space to determine appropriate policies and programmes within the health system is a critical aspect of realising expectations for health services and contributing to conflict transformation within the country. For those communities still affected by conflict this remains particularly critical. The township approach piloted in Laputta and elsewhere in the Delta, provides a model that can be scaled up in townships when circumstances allow and which can potentially be adapted for use in those townships where conflict is still ongoing.

#### **5. Evidence of impact of intervention on health, health system, and/or conflict transformation**

The JI-MNCH programme has already achieved significant gains in terms of health outputs and outcomes across the townships. In Laputta these gains include achievements in training targets for community health workers and auxiliary midwives, which reached 100% for new trainings by the end of 2011 and targets in joint supervision visits between Merlin and Township health staff to Rural Health Centres which reached over 70%. Achievement rates for vaccinations in pregnant woman and under one children reached over 85% in 2011; antenatal care coverage reached over 90%, and an emergency referral system linking over 1000 cases in communities to life-saving emergency maternal and child care at township level with an 80% positive outcome.

These gains are building confidence in the public health system to deliver services, going beyond purely supporting the delivery of services in the Delta and with the potential for positive impact more widely through example and adaptation.

#### **6. Other relevant information**

The coordinated township approach (both through GAVI-HSS and the JI-MNCH) has been innovative in the Myanmar context. Both approaches have provided a platform for collaboration between the MOH and external partners within the health sector. The approach provides the basis for further support to the health sector from both internal and external sources as the country moves forward with reforms. At the same time a coordinated approach is also potentially adaptable to more fragile areas of the country and thus a model for early engagement in health system support.