

**SURVIVE AND THRIVE GLOBAL DEVELOPMENT
ALLIANCE**

BURMA TRIP REPORT

AMERICAN COLLEGE OF NURSE-MIDWIVES

3-15 NOVEMBER, 2013



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Trip Report

Travelers: Suzanne Stalls MA, CNM, FACNM
Jody Lori PhD, CNM, FACNM, FAAN
Helen Welch MSN, CNM

Country Visited: Burma

Dates of Trip: October 31 – November 15, 2013

Purpose of Trip: Finalize the organizational capacity review of the Myanmar Nurse and Midwife Association (MNMA). Analyze results of the capacity review and develop gap analysis with the MNMA. Conduct a midwifery workforce assessment in the Magway Region. Analyze results of the review and develop recommendations for strengthening the midwifery workforce. Conduct an in-depth review of the midwifery education system. Analyze results of the review and develop recommendations for strengthening the midwifery education system. Plan, prepare, and conduct a debriefing on the findings of the review with key stakeholders.

I. Executive Summary

From November 4-15, 2013, Survive and Thrive Global Development Alliance (S&T GDA) representatives from the American College of Nurse-Midwives participated in a trip designed to carry out Objectives 1.2 and 1.3 of the Burma work plan, submitted by MCHIP and the Survive and Thrive GDA to the Burma Mission of USAID. During that time period, the delegation undertook three primary activities:

- Completion of the MACAT, a tool designed to analyze and identify gaps in professional associations, with ACNM and Myanmar Nurses and Midwifery Association (MNMA). Upon completion and analysis, the work group identified priorities for continued collaboration with the Survive and Thrive GDA and MNMA.
- A targeted review of the midwifery workforce and health care environment which was conducted in the Magway region through semi-structured interviews occurring at a township hospital, a station hospital, a rural health center and a sub-rural health center.
- A targeted review of midwifery pre-service education which took place at the Central Midwifery Training School in Rangoon, the Thanlyin Midwifery Training School in the Rangoon Township and University of Nursing in Rangoon.

Completion of MACAT: Upon request from MNMA, ACNM initially provided a technical update on pre-term birth and current global guidelines for treatment and management of pre-term birth to 40 members of MNMA (Appendix A). The group then divided into three smaller working groups who completed the MACAT, begun with the S&T GDA delegation in September 2013. Upon completion within the working groups, each group reported out the findings. After discussion and analysis of the findings, the executive membership of the MNMA collectively decided upon priorities for strengthening of their professional association. Please see Appendix B for this analysis and prioritization. These priorities were chosen, in collaboration with ACNM, as priorities that were feasible and doable within their current context and the resources that the GDA can offer.

Review of midwifery workforce: This review was conducted in the Magway region after permission to conduct the review was granted by the Deputy Minister, Ministry of Health, Dr. Thein Thein Htay. Suzanne Stalls and Helen Welch from the S&T GDA were accompanied by Dr. Hnin Wai Hlaing of Jhpiego, Dr. Kyi Kyi Ohn of Save the Children and Daw Yee Htay of MNMA. We visited the Township Hospital in Ngaphe, the Pa Dan Station Hospital, the Sub-Rural Health Center in Min Lwin village, and the Rural Health Center in Zin Pyun. (please see Appendix C for schedule). In those visits, we were able to meet with the medical officers, the Lady Health Visitors, the midwives, the senior nurses, the health assistants and auxiliary midwives. At the facilities, the workforce site review tool (Appendix D) was utilized, although each domain was not pertinent to each site. Please see Appendix E for a compilation of findings.

In the past few years, multiple healthcare workforce reviews have been conducted by both Government of Burma (GoB) and by external parties. Before representatives of the S&T GDA undertook this specific review, all available documents were thoroughly reviewed in order to gain a larger understanding of the comprehensiveness of what has been done to date. Given the time and geographical limitations of the S&T GDA review, representatives determined that the type of review which would be most valuable would be one which qualitatively examined findings to determine the extent to which these findings corroborated the other more exhaustive assessments. In general, the workforce site review supported the findings of the more comprehensive assessments. In addition, the qualitative nature of the review revealed the multiple adaptations and compensatory approaches that have been developed by a workforce that has been significantly constrained by an underfunded central government health budget and limited scope of practice for midwives, despite the realities of the clinical conditions that they encounter in the field. The findings illustrated midwives' and other staff members' willingness and desire to provide the most optimum health care that is possible, given the circumstances. What the reviewers could not determine (and this is a question which should be posed) is if this region was an exemplary region of innovation and ingenuity and/or if this region is provided more support than other regions. Of note, this is a fairly centrally located region and not one which is a peripheral state where services are purportedly much poorer

Review of pre-service midwifery education: This review was conducted at the Central Midwifery School in Rangoon, the Thanlyin Midwifery Training School in Rangoon Township and the University of Nursing in Rangoon by S&T GDA representative, Dr. Jody Lori from the University of Michigan. The tool used to conduct the review (please see Appendix F) was one which has been utilized in a number of settings throughout the developing world to determine and evaluate physical infrastructure, tutor staffing and capacity, pedagogical approaches, student composition, curriculum, access to resources (web-based and print), access to simulation centers, and structure of preceptorship system. Midwifery schools in Burma are post-secondary institutions. Admittance to all post-secondary institutions is determined by matriculation exams administered during secondary schooling. Those students with the highest scores are admitted to the medical schools; the next cadre are admitted to nursing schools and those students with lower scores are "tracked" to midwifery school. This inevitably gives both less educational preparation

and less favourable public perception to this cadre of health care workers who are entrusted to safely attend women and children at a vulnerable point in the reproductive health cycle. The midwifery curriculum was recently expanded to 24, rather than the previous 18, months but much could still be done to support and professionalize this cadre.

The findings reflected a system which has had little exposure or access to both updated clinical, evidence based information and updated educational approaches for clinicians. The physical structure of the two particular midwifery schools and the nursing schools is adequate for classroom instruction and for student accommodations, which is a distinct advantage over many other settings in the developing world. Relations between tutors and students are very congenial; commitment and morale on the part of the tutors is evident and students spoke freely of their respect for the tutors and their understanding of the tutors' desire to adequately educate the students. However, curriculum, while having been recently revised in 2011, uses references which are outdated and likely incongruent with the newest global guidelines. The simulation centers are inadequately supplied and little understanding of the use of these centers beyond demonstration is evident. Pedagogical approaches are conventional lectures and little use is made of competency based preparation and/or examination of the students. The tutors do accompany the students to their clinical practice sites but students have little opportunity to gain and become competent in clinical skills because of competition from students in other health cadres (e.g., doctors and nurses). There is virtually no access to web-based information and libraries are poorly resourced with hard copies of clinical textbooks and recent journals. In summary, with the exception of infrastructure and student-tutor relations, virtually all areas of clinical education of midwives could benefit from access to updated, integrated approaches.

II. Background

Burma is in the midst of a social and political transformation affecting all aspects of life and health and health systems in particular. After decades of isolation, Burma is now engaging more substantially with the world and building partnerships that will foster improved health and wellness. USAID has demonstrated a readiness to assist the government and people of Burma to improve their health service delivery system and health workforce educational programs. Under the umbrella of Survive and Thrive (S&T) Global Development Alliance (GDA), USAID's flagship program in maternal, newborn, and child health program, MCHIP, is ready to assist USAID/Burma and the Government of Burma (GoB) to achieve its stated goals.

Rates of maternal and newborn mortality have declined over the last twenty years in Burma. According to the World Health Organization (WHO), the country is "making progress"; however, it is not on target to meet either UN Millennium Development Goal 4 or 5, which are related to child and maternal mortality. As of 2008, the maternal mortality ratio (MMR) in Burma was estimated at 280/100,000 live births, and the current newborn mortality rate is 33/1,000 live births. These indicators are well above regional averages and are attributable, in part, to educational systems that have not been able to keep pace with technical advances realized in other parts of the world; public sector health service delivery systems that were stretched under the weight of a growing population of suboptimal infrastructure; and community health systems that were unable to flourish in recent years. Together, these factors have resulted in alternate formal and informal health care systems that are unable to meet the enormous needs of the people and under-resourced with the efficiencies and interventions proven to increase access, enhance quality, and expand capacity.

The USAID Survive and Thrive GDA will initiate partnerships between the GoB, the National Maternal and Child Health Program, and technical assistance partners including the 3MDG fund, as well as between the main professional associations in Burma related to maternal and newborn health and the US professional associations of pediatricians, obstetricians, and midwives: the American Academy of Pediatrics, the American College of Obstetrics

and Gynecology, and the American College of Nurse-Midwives. These strategic partnerships will allow Burma to benefit from outstanding technical knowledge, programmatic experience, and institutional capacity to enhance the role of Burma's professional associations in moving the health agenda forward.

III. Scope of Work

Objective 1.2

Review the fundamentals of the midwifery workforce in collaboration with the MOH.

Objective 1.3

Strengthen midwifery in partnership with the MNMA, based on immediate opportunities and greatest needs identified in analysis of midwifery.

Activities:

Activity 1.2.1 Conduct an assessment of the midwifery workforce.

MCHIP/S&T will work with the MOH and the Myanmar Nurses and Midwives Association (MNMA) to review the fundamentals of the midwifery workforce, including policy and scope of practice for midwives, the education of midwives, the regulatory environment for midwifery and the function of the Myanmar Nurse Midwifery Association.

Activity 1.2.2 Provide recommendations for updates to policy including strategic actions for strengthening the midwifery workforce.

Based on the assessment conducted in activity 1.2.1 and together with the MNMA, MCHIP/S&T will identify policy barriers that impede the delivery of high impact and quality services by midwives and identify recommendations for policy updates to strengthen the midwifery workforce.

Activity 1.2.3 Conduct technical consultation with stakeholders to review findings, elicit feedback and endorse action plan.

MCHIP/S&T will hold a technical consultation with stakeholders including USAID, the MOH, professional associations/societies and in-country partners, including the 3MDG Fund and others, to review findings, elicit feedback and endorse action plan identified through analyses conducted in activities 1.2.1 and 1.2.2.

Activity 1.3.1 Conduct an organizational capacity assessment of the MNMA and to identify opportunities for growth. Informed by activities 1.2.1 and 1.2.2, MCHIP/S&T will take a closer look at midwifery in Burma through an organizational capacity assessment of the MNMA including but not limited to a review of governance and leadership; mission, vision and strategy; and strategic relationships and identify opportunities for enhancing the abilities of the association that will allow them to achieve measurable and sustainable results.

Activity 1.3.2 Conduct an in-depth review of the midwifery education system to identify opportunities for growth. MCHIP/S&T will assess the midwifery education system and curricula to identify gaps and opportunities for improvement by providing recommendations based on globally accepted essential midwifery competencies and standards of midwifery education that enable midwives to function as skilled birth attendants with the skills to perform key high impact interventions (essential newborn care, newborn resuscitation, PPH prevention and management, etc.).

Activity 1.3.3 Link with existing projects to identify their plans for midwifery engagement and provide technical assistance (TA) for empowerment and enhancement of the role of midwives within project plans.

MCHIP/S&T will identify and coordinate with partner projects to advocate for enhancing the role of midwives within their plans as part of an overall strategy to strengthen the role of midwives as skilled birth attendants and decrease maternal and newborn mortality.

IV. Accomplishments

- Met and provided information regarding objectives of S&T GDA's work to officials at the Ministry of Health in Nay Pyi Taw: Dr. Thein Thein Htay, Deputy Minister, Ministry of Health; Dr. Min Than Nyunt, Director General, Department of Health, Ministry of Health; Dr. Than Zaw Myint, Director General, Department of Medical Sciences, Ministry of Health
- Met with Dr. Mya Thida, Professor and Head, Department of Obstetrics and Gynecology at University of Medicine (1), at Central Women's Hospital who has instituted a clinical skills update program (four months duration) for midwifery tutors
- Conducted an assessment of the midwifery workforce in the Magway Region
- Provided technical consultation with stakeholders to review findings, elicit feedback and endorse action plan
- Provided recommendations for updates to policy including strategic actions for strengthening the midwifery workforce
- Conducted an organizational capacity assessment of the MNMA and to identify opportunities for growth
- Conducted an in-depth review of the midwifery education system to identify opportunities for growth.
- Linked with existing projects to identify their plans for midwifery engagement and provide technical assistance (TA) for empowerment and enhancement of the role of midwives within project plans.

V. Main Findings/Conclusions

A. (Activity 1.2.1) Conducted an assessment of the midwifery workforce in the Magway Region.

Conducted site visits and interviews within the Nga Phe township. Visited township hospital, station hospital, rural health center and sub-rural health center. Staff present were: township medical officer, station medical officer, health assistants, midwives, lady health visitors, senior nurse and auxiliary midwives. Strategy was to qualitatively evaluate prior workforce assessments. This was NOT a representative sampling; we may have seen higher functioning systems and institutions. Reviewed practice patterns, referral paths, commodities, infrastructure, education for and use of essential life-saving interventions, staffing, deployment and retention.

Findings/Conclusions:

Referral pathways clearly delineated though there are no actual guidelines.

Many communities have mechanisms for emergency transport (community funds)

Stock-outs much less common with influx of medications which began April 2013

Staffing widely variable for health centers and hospitals—many midwives are not deployed for months/years. At this point, there are more graduates than can be posted

Updates primarily knowledge based with little opportunity for clinical practice

Wide discrepancy between education, policy and actual practice patterns in the field

B. (Activity 1.2.2) Provided recommendations for updates to policy including strategic actions for strengthening the midwifery workforce.

Findings/Conclusions:

Recommendations for strengthening the midwifery workforce will focus on three components: strengthening the professional association of MNMA; providing support to identified pre-service midwifery programs; providing support to midwives deployed to states/regions/townships that are contiguous with the identified pre-service midwifery programs in order to leverage efforts jointly in the continuum of clinical training and education. We would suggest that ACNM provide support in 1-2 regions.

MNMA

Provide support based on organization-identified priorities. Once the MACAT is fully assembled, ACNM will continue to work with Dr. Hla, president of MNMA, to identify activities and time line.

- Priorities are as follows:
- Funding diversification
- Development of financial SOPs
- Involvement in policy and decision making
- Professional standards and guidelines
- Membership services

PRE-SERVICE EDUCATION

With review and analysis of pre-service midwifery education tool, identify gaps in clinical education. While physical infrastructure and tutor/student relations are generally sound, significant gaps exist in:

- Updated pedagogical techniques
- Updated curriculum whose foundation rests on recent evidence-based information
- Tutors whose clinical knowledge and skills are updated
- Adequate simulation center capacity with administrative and tutor understanding of theory/practice integration
- Access to computer-based, web-based resource materials
- Formative and summative assessments of students based on demonstration of clinical competencies
- Clinical practice systems which could be strengthened

IN-SERVICE TRAINING

Based on findings of workforce site review, significant constraints are present for midwives who primarily attend births at homes and are posted at health centers or rural health centers; or midwives in station and township hospitals which are typically staffed by medical officers.

Identified gaps are:

- Access to updated clinical approaches which utilize both theory and competency-based trainings
- Policy constraints which limit scope of practice

C. (Activity 1.2.3) Provided technical consultation with stakeholders to review findings, elicit feedback and endorse action plan.

Please see Heading VI. “Future Activities and Next Steps”

D. (Activity 1.3.1) Conducted an organizational capacity assessment of the MNMA to identify opportunities for growth.

ACNM and MNMA jointly conducted an assessment of organizational strengths and challenges, using MACAT, a tool devised by ICM. With this analysis, the MNMA was able to pinpoint gaps and identify priorities for support.

Findings/Conclusions:

Relatively stable infrastructure

Lack organizational capacity in financial management and management of membership and membership services

Virtually no interaction with central or regional government level officials to provide input for policy and advocacy.

E. (Activity 1.3.2) Conducted an in-depth review of the midwifery education system to identify opportunities for growth.

Conducted reviews at two midwifery schools, Central Midwifery Training School, Thanlyin Midwifery Training School, and the University of Nursing at Rangoon. Interviewed principal, tutors, students of each school. Discussed curriculum and curriculum development, student clinical placement, library and resources, infrastructure; tutors' background and experience; continuing education requirements; formative and summative assessment for students; teaching methodologies; ratio of student:tutor and student:preceptor. Observed students in clinical practice areas in three locations: Central Women's Hospital; Central Domiciliary Training Midwifery School affiliated with Central Midwifery Training School; Thanlyin District Hospital.

Findings/Conclusions:

Physical plant/infrastructure in relatively good condition

Adequate numbers of faculty with basic pedagogical skills

Inadequate resources for updated clinical practice:

No access to internet

Inadequate computer labs

Inadequate simulation equipment and knowledge of its use

Professional development plans do not exist

Preceptor system lacking in structure

No mechanism for student-tutor feedback

With new curriculum, there are particular topics which have no learning materials

F. (1.3.3) Linked with existing projects to identify their plans for midwifery engagement and provide technical assistance (TA) for empowerment and enhancement of the role of midwives within project plans.

Findings/Conclusions:

With MNMA, establish priorities, schedule and timeline for interventions and activities. Assessment tool will enable benchmarking in the future for evaluation. One focus is to provide support in the upcoming strategic plan and create goals, objectives and pathways for engaging more directly with policy makers.

In strengthening in-service training approaches, consider collaborating with Dr. Mya Thida at Central Women's Hospital whose program has developed to enhance clinical skills of midwifery tutors

Continue collaborating and seeking avenues for joint programs with Jhpiego, Save the Children and the 3MDG Fund.

VI. Future Activities and Next Steps

- Develop strategic plan with GDA partner professional associations and our country counterparts to establish mechanism/pathway for maternal newborn health advocacy, policies and procedures
Some examples might include:
 - Post-dates guidelines
 - Midwives scope of practice: injections, intravenous fluids (IVF), intravenous antibiotics
 - Increase uptake of LARC with liberalized guide

- To support and strengthen pre-service midwifery education:
 - Work within 1-2 regions within 1-2 townships where the midwifery schools are located
 - Support school in areas of:
 - Curriculum
 - Teaching skills

- Clinical skills and updates
 - Equipping simulation centers and integrate simulation with theory
 - Enhance preceptor system
- With strengthening of pre-service education within designated schools, create “Centers of Excellence)
- Provide support to the township hospital/station hospital and rural health center/sub-rural health centers through:
 - Development of clinical updates (involving knowledge and skill acquisition) during meetings which are held regularly with midwives in surrounding areas
 - Provide simulation-based clinical updates at “Centers of Excellence” within midwifery school
 - Establish mentoring and support and supervision system to promote uptake
- With continued support to the MNMA, address the priorities identified through the MACAT. By the end of 2014, review MACAT as a baseline to establish which priorities have been addressed adequately and to evaluate if new priorities have arisen.

APPENDIX A: Technical update given to MNMA (powerpoint)

Pre Term Birth

Helen Welch CNM
Global Development Alliance
Myanmar 2013



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Objectives

- Outline the causative factors for pre term birth
- Discuss the interventions that can reduce complications resulting from pre term birth
- Able to appropriately and safely administer antenatal corticosteroids
- Able to counsel mother on importance of Kangaroo care
- Identify key elements of a sound transportation system



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Definitions

- Extremely preterm (<28 weeks)
- Very preterm (28 to <32 weeks)
- Preterm (32 to <37 weeks)
- Any baby born before 37 completed weeks is potentially at risk



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Pre Term Birth (birth before 37 completed weeks gestation)

- An estimated 15 million births worldwide per year
- An estimated 1 million babies die annually from preterm birth complications
- Preterm birth is the leading cause of newborn deaths



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How can we help?

- Over 80% of pre term babies are born after 32 weeks of pregnancy
- Three-quarters of them could be saved with current, cost-effective interventions, even without intensive care facilities.



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Pre Term Birth Management

- Pre term birth protocol development for management of pre term birth
- Keep mother and baby together
- Strong referral system
- Regular trainings/drills for newborn resuscitation
- Perinatal audit system



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Causes of PTB

- Multiple pregnancies
- Maternal infections
- Chronic conditions: diabetes, high blood pressure
- Pre eclampsia
- Premature rupture of membranes
- Placenta abruption



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Does mother have any of these conditions?



Give Mother first dose of antenatal corticosteroids immediately



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Primary Interventions

- Antenatal steroid injections (given to pregnant women at risk of preterm labour to prepare the babies' lungs)
- Appropriate and efficient referral and transport
- Effective resuscitation of the newborn when indicated (Helping Babies Breathe: HBB)



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Antenatal Corticosteroid Injection (ACS)

- Dexamethasone 6mg intramuscularly x 4 doses
- A single course of four separate injections over 48 hours should be given to any woman between 24 and 37 weeks gestation who is at risk of giving birth in the next 7 days
- Maximum benefit occurs after last dose (48 hours) but even partial course has some benefit



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Benefits for Baby

- 34% reduction respiratory distress syndrome (RDS)
- 46% reduction intraventricular hemorrhage (IVH)
- 54% reduction necrotizing enterocolitis (NEC)
- 31% reduction death



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Risks for Mother?

- No known risks to mother.
- No absolute contraindications
- If mother has diabetes will need to monitor glucose carefully as she will need more insulin
- If mother on chronic steroids may receive same dose but may need stress dose of steroids at time of delivery



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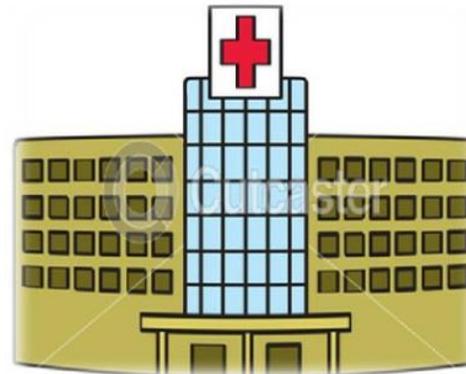
Mother <37 wks with these conditions? Give first dose steroids immediately



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*After administration of first dose of antenatal corticosteroids,
Referral and transport*



..... mother and baby together.



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Referral: Keep Mother and Baby together

- Do you have a referral and transport system in place?
- Does the system include contact names, numbers and location of facilities?
- What barriers to efficient transfer have you encountered?



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Resuscitation



- Training for resuscitation skills followed by regular drills to practice
- Audit following resuscitation to improve care



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Kangaroo Care: Skin to Skin

The baby is carried by the mother (or another adult) with skin-to-skin contact and frequent breastfeeding (WHO kangaroo care)



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Kangaroo Care

- Early and continuous skin-to-skin contact between the mother and the baby
- Exclusive breastfeeding (ideally)
- Initiated in hospital and continued at home
- Small babies can be discharged early
- Mothers at home require adequate support and follow-up
- Gentle, effective with preterm infants.



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***When less than 2000 grams and stable
Encourage 24 hour skin-to-skin
care (Kangaroo Mother Care)***



**To help maintain normal
temperature
Improve breast milk
production
Protect against apnea and
irregular breathing
Reduce infection**



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24 hour skin-to-skin can be used for a stable small baby who has:

- No severe illness.
- No problems with breathing.
- No need for special treatment .
- Been stable in intermittent or brief skin-to-skin.

(If baby not stable use incubator or warmer)



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Continuous or 24 hour skin-to-skin

- Can be attempted once a baby tolerates intermittent skin-to-skin.
- Can be provided during semi-upright sleep .
- Should include visual monitoring by mother for normal respirations, color and activity.
- Should include daily monitoring of temperature.



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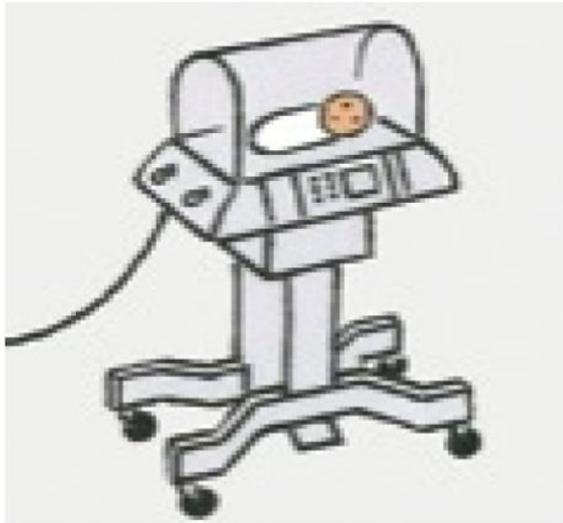
Skin-to-skin should usually be continued until a baby

- Is 2500 grams
OR
- 40 weeks gestation
OR
- Begins to wiggle or push away.



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Incubator



- Clean incubator / warmer
- Although baby at risk of hypothermia can also overheat in incubator
- Monitor temperature closely:
 - <1000 grams 35 +/- 0.5 C
 - 1500 grams 34 +/- 0.5 C
 - 2000+ grams 33 +/- 1.0 C



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Interventions

- Consider alternate feeding methods until breastfeeding well established:
 - Hand expressing and cup feeding
 - Gastric gavage



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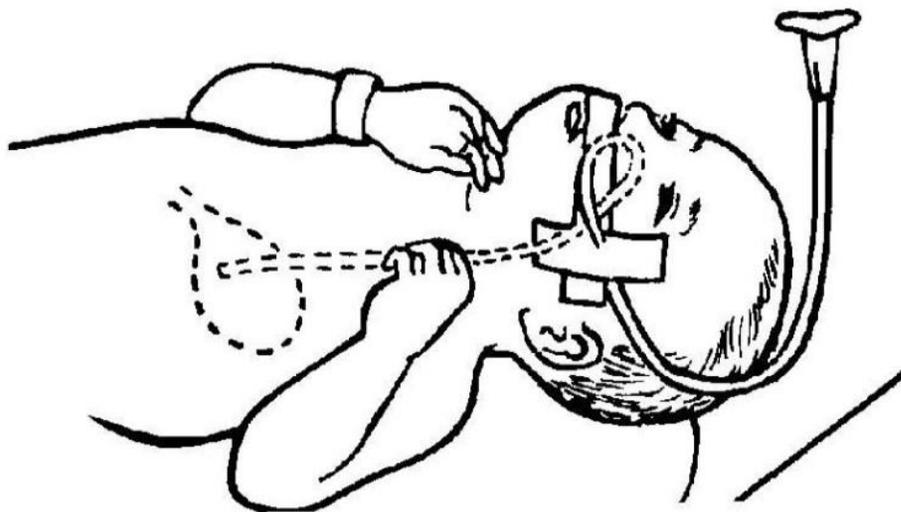
Hand Expression and Cup feeds



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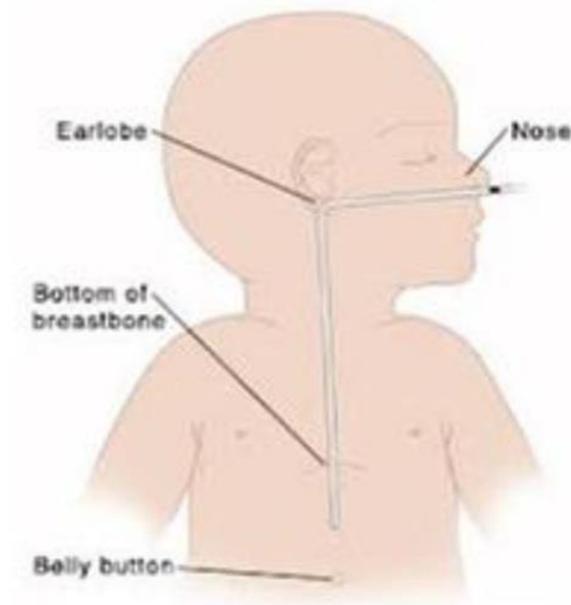
Gastric Gavage



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When a baby cannot feed from the breast or a cup
Measure and Insert a Gavage Tube



To provide



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When gavage feeding is used
Consider fresh breast milk (and alternatives)



NO



OK



BEST



To give fl...



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Gastric Lavage Amounts

Babies Without Major Illness (ml per feed)								
Birth Weight	Feeding Frequency	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
1.75-2.5 kg	q3h	15	20	25	30	35	38	40+
1.5-1.75 kg	q3h	12	18	22	26	30	33	35
1.25-1.5 kg*	q3h	10	15	18	22	26	28	30
<1.25 kg*	q2h	4	4	6	8	10	13	15

* These babies (and sick babies who are larger) most often require IV therapy in a referral unit.



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Supplements

- 400 IU vitamin D orally each day until 6 months after the expected date of delivery.
- Babies less than 1500g who are fed breast milk should be given 4 mg/kg/d of oral iron starting at 2 weeks until 6 months of age.
- They can also be given calcium (140 mg/kg/d) and phosphorus (90 mg/kg/d). All medications should be mixed with at least 5 mL milk.



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Discharge Home

- Breathing is normal
- Temperature is stable
- Skin to skin most of day
- Weight at least 1500 grams
- Feeding well
- Weight gain 12-15 grams/kg /day x 2-3 days



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References

- http://www.who.int/pmnch/media/news/2012/p_reterm_birth_report/en/
- <http://www.mchip.net/sites/default/files/ACS%20Technical%20Briefing%200.pdf>
- http://www.who.int/maternal_child_adolescent/documents/9241590351/en/



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APPENDIX B: MACAT (COMPLETED)

International Confederation of Midwives Member Association Capacity Assessment Tool (MACAT)

Myanmar Nurse and Midwifery Association
November 8th 2013

A. Governance	Yes	No	N/A
A1. Board			
<p>1.The Association has a Board (B) and/or an Executive Committee (EC) governed by a constitution and by-laws</p> <p><i>MNMA does not have bylaws but has rules and regulations. It is in Myanmar language and is printed.</i></p> <p><i>President and the Vice President are elected every four year. Seven members of the EC are selected by the government and the rest are elected. President is government appointment</i></p>	X		
<p>2.The association has clearly defined roles and responsibilities for the Board/Executive and members</p> <p><i>Clear roles for the 15 member executive committee (EC).</i></p> <p><i>6 sub-committees function under the EC and each sub-committee is headed by a EC member who functions as the chair of that sub-committee.</i></p>	X		
<p>3. The Board/Executive meets at least twice a year</p> <p><i>once a month</i></p>	X		
<p>4. The Board / Executive committee carries out the roles of strategy and development</p>	X		
<p>5.The B/EC carries out the roles of policy formulation</p> <p><i>MNMA is not involved with the government for any policy work. Previously MNMA were members of</i></p>		X	

<i>country coordination mechanism for the health sector, but now replaced by another NGO. MNMA expressed interest to go and listen, but sensed participation was not equal!</i>			
6. The B/EC carries out the roles of fund raising <i>Fund raising committee leads fund raising and public relation is carried by the public relation sub-committee - communications with branches across the country is carried out by this group</i>	X		
7. The B/EC carries out the roles of public relations <i>Yes in a minimal way. Believes MNMA seen in positive light by public. Could do more outreach PR work</i>	minimally		
8. . The B/EC carries out the roles of financial oversight <i>EC provides oversight for finances of the MNMA</i>	X		
9. . The B/EC carries out the roles of lobbying			X
A2. Vision and Mission			
10. The association has clearly stated vision and mission statements <i>The Myanmar Nurse and Midwife Association will contribute the most enthusiastic effort to bring up the best nurses who take compassion and empathy into their services and lives and the way they deal with people; helping people carefully and honestly in all their commitments regardless of any discrimination</i>	X		
11. The mission is developed in collaboration with members in some way (email or meetings) <i>Members provided input to the development of the mission and vision statements. Input was sought from the ground level and finalized at central level</i>	X		
12. New members have access and are orientated to the association's vision mission and goals	X		

<p><i>New member orientation to the mission and vision is the responsibility of the township, state or district committees where the new members apply for registration. President believes could be more effective</i></p>			
<p>13. The activities of the association are consistent with the vision and mission</p> <p><i>Project activities being conducted by MNMA were expressed to be consistent with the mission and vision of MNMA</i></p>	X		
<p>14. The vision and mission statements are shared with the member, giving sense of purpose and direction to the association</p> <p><i>yes but needs to be strengthened</i></p>	X		
<p>15. The vision and mission statements are reviewed and updated regularly with input from members at least every 3-5 years</p> <p><i>M&V statement was reviewed in 2009. Plans are to review it again in 2013 – funds not available</i></p>			
A3. Goals and Strategies			
<p>16. The association has a clear strategic planning process</p>	X		
<p>17. The association has a clearly written strategic plan with achievable long term and short-term goals</p> <p><i>Strategic plan was developed for 3 and 5 years – was facilitated by a consultant who was hired by an INGO. Current plan goes from 2009 to 2013 President of MNMA was open to receive support from S&T to support strategy development</i></p>	X		
<p>18. The association's goals and strategies, developed with input from the members are in line with the vision and mission</p> <p><i>The Central Committee would be engaged for strategy development – depending on funds the # participating will be decided, definitely not all of the</i></p>		x	

100 members			
19. Mechanisms exist for reviewing and updating the association's goals with input from the members	X		
<i>Yes at AGM but needs more focus and strengthening</i>			
20. The association has realistic budgeted operating work plans, aligned with the strategic planning process		X	
<i>The existing plan did not include budget for implementing of the plan.</i>			
21. The association monitors and evaluates the quality of it's work	X		
22. The association uses evaluation results to influence service delivery planning	x		
<i>Monitoring: EC members go out frequently and supervise. Project monitoring funds are within existing project. Check-lists used during monitoring and reports are generated. During monthly meeting project monitoring reports are discussed, successes shared, challenges discussed and plans made to overcome them.</i>			
A4. Legal Status			
23. The association is registered as an autonomous organization according to the country's legislation	x		
<i>Non-governmental mainly, but some positions government appointed – 7 out of 15 people appointed by the minister of health</i>			
24.The association is part of another health care professional association: a. Obstetric association b. Nursing association c. other	X		
25. IF YES TO 24 ABOVE; The association has its own structure and decision making processes and tools that are documented and transparent			
26.The association has a constitution developed and shared with members		X	

<p><i>Organization is run by rules and regulations: last one 2007; MNMA had proposed to revise their rules and regulations last year in 2012. EC members had endorsed this revision, but the minister did not approve. Hence still working on the 2007 version. This work was not led by the consultant, and was a separate process which was initiated after situation in country was changed - existing plan is in Myanmar language.</i></p>			
<p>27. The constitution is reviewed with input from the members every 5 to 10 years</p> <p><i>Rules and regulations only</i></p>			
<p>28. All new members are given or have access to a copy of the constitution</p>		x	
<p>Additional Comments:</p> <p><i>Central committee: 102 members Central EC – 15 members State and Division NMW Association – State +& Division EC (9-15 members) District NMA – District EC (7-11 members) – 6 sub-committee Township NMA (5-9 members) MNMA members – they have to go through Townships to become members</i></p>			
<u>B. Management Practices and Leadership</u>			
B1.Administrative Policies and Procedures			
<p>29. The association has policies and procedures for electing leaders and office bearers</p> <p><i>Process for election: members submit interest to be nominated for EC – election conducted during the conference that happens every 4 year. Election committee formed – doctor, nurses with good reputation – 5 members. This committee starts process from township level. The next election is in 2015. Annual meetings focused on sharing and updates.</i></p>	x		
<p>30. The association has operational policies and procedures in place</p>			Trying to

			develop them
<p>31. The association has defined roles and responsibilities for leaders, for staff if any, and for members</p> <p><i>Constitution has roles and regulations for members – basic rules and regulations.</i></p>			
B2. Infrastructure and Information Systems			
<p>32. The association has office/space to support and facilitate its daily work</p> <p><i>MNMA has south downtown office space at Yadanapon 2nd Street, Aye Yeik Mon (3), 10/North Ward, Thaketa Township, Yangon, Myanmar. Building is very old; need telephone for communication for the present line does not work. Has 3 computers New office being built in NyaPiydaw. Decision to build NPT 2007 made by MOH and endorsed by EC (likely no choice)</i></p>	X		
<p>33. The office / space is well equipped and maintained with relevant communication systems (telephone, email, fax, internet)</p> <p><i>Main office Yangon Sub office no telephone or computer. No access to membership/ financial data</i></p>		X	
<p>34. The association has systems in place to process/ manage information including an updated list of its members</p> <p><i>Dr Hla has implemented use of business software adapted to keep track of membership. 20,000 members and no idea who has paid up membership. By laws state membership lapses after non payment x 3 years. Issue is lack of time and resources for data entry Notification of new members received from state division who send the applications to center</i></p>		X	
B3. Authority and Accountability			
<p>35. Guidelines for the working relationship between B / EC staff and members are clearly outlined in the policy documents</p>		x	
<p>36. The B / EC regularly informs members on</p>	X		

the association's activities and at the AGM			
B4.Human Resources			
37. The association staff, if any, are recruited in a transparent, competitive manner to fulfill its needs			
38. The association, if it has staff, has clear human resources and employment policies in place (contracts, salary structures and benefits,job descriptions) <i>EC are volunteers - some EC members are engaged in projects and get paid MNMA have some paid staff - usually are not professional staff - clerks, cleaners; but have also hired midwives who run the maternity centers at the shelter</i>		X	
39. The association incorporates capacity building / development of staff as part of its annual plan		X	
40. The association has information kits, policy manuals etc for its staff and members available on request <i>Yes limited. Available at township level and on application for membership</i>	X		
C. Financial Resource Management			
C1. Accounting			
41. The association has an accounting system <i>Yes. Managed by treasurer with help from accountant</i>	X		
42. The association has regular audits conducted yearly	X		
43. The associations accounting system enables it to produce a financial report when required <i>Yes but not yet computerized. No computer in Souh dagon so data entry is a problem. Only computer is in downtown office yet most of activities take place in South Dagon.</i>	X		
C2.Budgeting			
44. The association has an annual budget which is approved by the B / EC	X		

<p><i>Yes. Has financial policy but not yet well developed. No SOP or Policies and Procedures. Dr Hla believes this necessary for strategic planning. Currently large portion of budget goes to building office in NPT. No funds easily available or able to be approved for building maintenance at sub office.</i></p> <p><i>Primary budget items:</i> <i>NPT office</i> <i>Professional continuing education for members</i> <i>Midwifery service at maternity shelter</i> <i>Social support for retired midwives</i> <i>Building maintenance office and sub office</i></p>			
<p>45. The association has a person specifically responsible for budget management</p> <p><i>EC decision making. Treasurer management.</i></p>	X		
C3. Financial Information			
<p>46. Donors, members or others can access financial information on request</p> <p><i>20,000 members. Do not distribute info but available on request. Financial information goes only to Executive Committee. Need better tracking mechanism for member contributions and donor projects. Currently unable to track where members are from or if they have paid.</i></p>	X		
<p>47. The association produces annual financial reports which are reviewed and approved by the B/ EC</p> <p><i>SOP needs development for improved strategic planning</i></p>	X		
<p>48. The association presents a full financial statement in its annual report</p>	X		
D. Functions			
D1. Membership Services			
<p>49. The association has mechanisms to identify the needs of its members</p> <p><i>not strong enough. Failure is at the district and township level where involvement and activity within MNMA is varied and often disorganized or</i></p>	X		

<i>absent. Members can always call MNMA with concerns. Attendance at the annual meeting is by representation so at the AM, members can voice concerns. However, there is no mechanism which gathers input from the members at large in order to fully represent those concerns at the AM. It is then unclear at the annual meeting if the representative are voicing personal concerns or larger concerns.</i>			
50. The association organizes general meetings with its members annually <i>Yes but attendance mainly by volunteer recommended by state or division. Attendance is self funded and therefore difficult for members. Transportation is an issue. Meetings always in Yangon</i>	X		
51. The association has a mechanism for recruiting new members <i>Yes but weak At township level when posted Membership available for those with license only. No student membership for last 2 years because when they submitted their new "rules and regulations" to the Ministry a student membership was not approved. No database for membership therefore unable to track current members or reasons for failing to renew membership.</i>	X		
52. The has mechanisms for membership retention <i>No way to remind members that dues are due. Do not have value messages.</i>		X	
53. The association has a membership structure	X		
54. The association has a membership fee structure <i>Yes only one fee for all. No pro rated fee for retirement. No student involvement</i>	X		
55. The association has mechanisms for updating its membership list		X	
56. New members are oriented to the information available and how to request it <i>Have pamphlet, magazine and facebook. Dr Hla</i>	X		

<i>believes could to a better job at District and Township level for member retention and recruitment</i>			
57. The association has mechanisms in place to make recommendations on salaries and working conditions of its members <i>Can send recommendation to ministry but no power currently to initiate change. Recent initiative was to improve safety for midwives in areas of conflict. Memorandum sent to ministry but no response</i>	X		
58. The association has mechanisms in place to provide continuing professional education for members <i>MNMA attends 2-4 States annually with CEEd program chosen by state. Attendance is good at sessions. May be up to 500! Have included ethics/ emergency care/ feeding/ disaster planning. Because funded by MNMA and funding is limited each state may only receive an update every 3 years</i>	x		
D2.Advancing Professional Practice			
59. The association develops or contributes to the development of professional standards for education and regulation. <i>MNMA advises MOH on MW curriculum All regulation set by MNMC. Standards have been submitted to ministry by MNMC but no response as yet</i>			limited
60. The association has the capacity to support and publicly recognize positive quality practice by members (eg practice, education, research policy leadership etc) <i>At the annual meeting, the EC recognizes excellence in research; no other recognition of quality practice</i>			limited
61. The association has mechanisms in place to share best practices and engage in mutual learning opportunities with other organizations.		x	
D3.Quality Control for Care			
62. The association has mechanisms in place to provide guidance, advice and information to its members on quality of care		x	

<i>Anticipate future meeting to provide guidelines</i>			
63. The association contributes to and advocates for the development and implementation of midwifery regulation			x
64. The association has mechanisms to assist its members in meeting any continuing competency requirements needed for licensure or renewal of license	x		
65. The association has a regularly reviewed code of Ethics for members or works within the ICM code <i>Use ICN code of ethics-member of ICN, not ICM</i>		x	
66. All new members have access to or are given the code of ethics in conjunction with other documents		x	
67. The association is in attendance in situations where member midwives professional practice is being questioned <i>Collaborate with Nursing and Midwifery Council in matters of disciplinary actions</i>	x		
68. The association s involved in human resource planning as it related to MNCH practitioners and quality of health care provision <i>The vice president of MNMA is the director of Nursing Services at the Department of Medical Services within the Ministry of Health</i>		x	
D4.Communication			
69. The association has a clearly defined communication strategy for internal and external relationships	x		
with members 70. The association has mechanisms for regular (at least quarterly) two way communication with its members <i>Communicates on an annual basis</i>			See notes
with MOH 71. The association has a mechanism to regularly inform the MOH and other relevant bodies of activities and issues impacting on its members and the midwifery profession	x		
72. MoH regularly informs the association of issues impacting on midwives, women , maternal newborn and child health	x		
with women, donors, civic society	x		

73. The association has communication systems in place such as newsletter and or website to communicate with all stakeholders (members, women, donors, civic society and grass roots such as NGOs such as WRA)			
D5.Advocacy			
74. The association has systems in place to facilitate advocacy for women, midwives and newborns	X		
74. The association has systems in place to facilitate advocacy for women, midwives and newborns	X		
75. There is a mechanism to provide advocacy training to association leadership and members (negotiation, public speaking information kit etc)	X		
76. The association has representatives in key government committees and policy making bodies on maternal, newborn and child health and midwifery <i>Very much desires increased dialogue and participation with policy makers</i>		X	
77. The association has guidelines for how to involve NGO partners in advocacy networks serving the interests of its beneficiary groups		X	
D6.Service Delivery			
78. The association has the relevant resources (human, capacity, financial material) to achieve its mission		X	
79. The association has the tools to monitor and evaluate the quality and impact of its work <i>The government has an evaluation checklist which is used to evaluate the midwives on a quarterly basis. Evaluation performed by senior health nurse or Lady Health Visitor from the Township Hospital.</i>	X (Only in project areas)		
80. The association uses evaluation results to influence service delivery planning		X	
E.Collaboration, Partnerships and Networks			
E1.With Women, Government and other NGOs			
81. The association involves women and families as true partners in service provision including planning, decision making and civic activities	X		

<p><i>Yes – rare. MNMA involved both women and men in preparation of strategic plan (2009 – 2012) and the association’s activities but not much in decision making. The association has no proper mechanism to involve them.</i></p>			
<p>82. The association has established a collaborative relationship with the government</p> <p><i>Yes – but the collaboration with the government – mainly for permission to implement the project activities. Apart from that, no other support is provided by the government.</i></p>	X		
<p>83. The association has established a collaborative relationship with national and international NGOs including womens organizations</p> <p><i>Yes – collaborative relationships with UN agencies, INGOs and NGOs such as USAID, UNFPA, MSI, Save the Children, Care Myanmar and Yadana Myitta. The EC’s members believe that there is an infrastructure to scale up the collaborative activities with the existing as well as with the potential new ones.</i></p>	X		
<p>84The association collaborates and networks with other health care professions associations in the country</p> <p><i>Yes - with MMA, MHAA, Dental etc but no technical support from the association like MMA which has many societies</i></p>	X		
<p>E2.Relationships with Donors and the Private sector</p>			
<p>85. The association has mechanisms for maintaining relationships with current donors and establishing contact with potential ones</p> <p><i>Yes – but very rare in establishing contact with potential ones and need capacity to initiate it</i></p>	X		
<p>86. The association engages donors in a free and open dialogue</p>	X		

<i>Yes – but not directly with the donors, just through the leading agencies and the EC's members concern about the communication gaps</i>			
87. The association engages the private sector in open dialogue relating to health issues <i>Yes – but not enough and need to be strengthened</i>	X		
Additional Comments			
<u>F. Visibility Including Media Relations</u>			
88. The association is approached by women and their families for information and advice on womens health issues <i>Yes – the association is approached by women especially for delivery and also RH services</i>	X		
89. The B/EC and staff are recognized by their stakeholders as being highly skilled and credible in their field <i>Yes – especially by the community but need to improve all members' capacity. The association has to make sure all members are providing quality services to maintain the positive recognition by their stakeholders.</i>	X		
90. The association is invited by government to provide midwifery expertise and contribute to policy and decision making in midwifery issues <i>No – the association has no voice in policy and decision making and also it is no longer a member of CCM since TWG has been transformed into CCM. The members perceive that even if the association has a chance to attend TWG/CCM meeting, they cannot influence/contribute much in policy making. It is a better way to involve in subcommittees cluster meetings such as SRH, HIV/AIDS and they can express their opinion and suggestions freely and then make a stronger voice and presented to central level by the focal/representative of cluster meetings such as UNFPA, NAP etc</i>		X	

<p>91. The association promotes its image and uses the media for public education</p> <p><i>Yes – the association used both printed and broadcasted media to promote its image and uses for example: pamphlet, magazine, face book and interview with MRTV 4</i> <i>Web page http://lrcmyanmar.org/en/ngo-donor-profiles/myanmar-nurse-and-midwife-association</i></p>	X		
<p>92. The association develops positive relationships with the media</p> <p><i>Yes – negative views may occur but it's on individual and not association</i></p>	X		
<p>93. The association is invited to take part in civic matters organized by other organizations and by government</p> <p><i>Yes – usually involve in donation activities for disasters and collaborate with INGOs and NGOs to provide comprehensive services to the community</i></p>	X		
<u>G.Sustainability</u>			
<p>94. The association has a diversified funding base capable of sustaining its programs over the long term</p> <p><i>No – the association receives some external donation and generates the income by collecting very few amounts of charges for delivery and stay at maternity center and also by collecting membership fees, they are not even enough to restock and pay for ICM membership fees.</i></p>		X	
<p>95. The association actively engages in fund raising and other resource mobilization activities as a means of limiting its dependence on donors</p> <p><i>No – the association depends merely on donors and no mechanisms for fund raising</i> http://lrcmyanmar.org/en/ngo-donor-profiles/myanmar-nurse-and-midwife-association#sthash.AphNw5Li.dpuf</p>		X	

<p>96. The association regularly seeks expertise (among leaders and members where possible) to write fund raising proposals and to help generate ideas for resource mobilization</p> <p><i>Yes – the association has monthly EC meeting and also urgent meeting if an issue comes up</i></p>			

PRIORITIES AS IDENTIFIED BY MNMA WORK GROUP

1. Increased diversification of funding
2. Involvement in policy and decision making
3. Development of financial standard operating procedures (SOP)
4. Development of professional standards and guidelines
5. Implementation of tracking system for dues and members

APPENDIX C: TRAVEL SCHEDULE TO MAGWAY FOR MIDWIFERY WORKFORCE REVIEW

Itinerary of Survive and Thrive Team Trip to Ngaphe

Date	Time		Total driving hour	Activities	Itinerary		Mode of Travel	Overnight Location
	Departure	Arrival			From	To		
10-Nov-2013	8 AM	5 PM	8 hours	Travelling	Yangon	Magway	By Car	Magway hotel at Magway
11-Nov-2013	6:30AM	9:00 AM	2:30 hours	Travelling	Magway	Ngaphe SC Office	By Car	
11-Nov-2013	9:00 AM	9:30AM	30 minutes	Meeting with SC staffs	Save the Children Office Ngaphe			
11-Nov-2013	9:30AM	12:30 PM	3 hours	Conduct interview with Township Medical Officer Township health nurse Township health assistant	Township Hospital, Ngaphe			
11-Nov-2013	12:30 PM	1:30 PM	1Hour	Lunch	Ngaphe			
11-Nov-2013	1:30 PM	2:00PM	30 minutes	Travelling	Ngaphe	Pa Dan	By Car	
11-Nov-2013	2:00 PM	5:00 PM	3 hours	Conduct interview with Station Health Officer	Pa Dan Station Hospital		By car	

				Station Health Nurse Health Assistant Lady Health Visitor				
11-Nov-2013	5:PM	7:00 PM	2 hours	Travelling	Pa Dan	Magway	By Car	Magway hotel at Magway
12-Nov-2013	7:00 AM	9:00 PM	2 hours	Travelling	Magway	Sub-RHC Min Lwin village, Ngaphe	By Car	
12-Nov-2013	9:00 AM	12:00PM	3 hours	Conduct interview with Assigned midwife Auxiliary midwife	Sub Rural Health Center Min Lwin village		By Car	
12-Nov-2013	12:00 PM	1:00PM	1 Hour	Travelling and lunch break	Pa Dan		By Car	
12-Nov-2013	1:00 PM	1:30 PM	30 minute	Travelling	Pa Dan	Zin Pyun RHC	By Car	
12-Nov-2013	1:30 PM	4:30 PM	3 hours	Conduct interview with Health assistant Lady health visitor RHC midwife Auxiliary Midwife	Rural Health Center Zin Pyun			
12-Nov-2013	4:30 PM	7:00 PM	2:30 hour	Travelling	Zin Pyun	Magway	By Car	Magway hotel at Magway
13-Nov-2013	8:00 AM	5:00 PM	8 hour	Travelling	Magway	Yangon		Yangon

APPENDIX D: SITE REVIEW TOOL

SITE WORKFORCE REVIEW

Date	
Facility Name	
Facility Location	
Facility Administrator	
Name of Person Conducting Review	

DOMAINS	
1. DEMAND	Essential interventions for MNH and Utilization: equitable and effective coverage
2. SUPPLY	People: appropriate midwifery workforce in quality, distribution and scale
3. FACILITATING ENVIRONMENT	Work environment: the MNH system facilitating quality and safe deliver of the essential MNH interventions
4. FACILITATING ENVIRONMENT	Management and policy: providing the overarching system for an appropriate and sustainable midwifery workforce
5. SUSTAINABILITY	Financing: enabling environment for financing and developing costed plans for a sustainable midwifery workforce

Domain #1: Essential Interventions	
Family planning:	Hormonal methods
	Barrier Methods
	Surgical Methods
Pregnancy care:	Risk screening
	Immunizations
	STI Prevention and Management
	PTB management

	Malaria prevention and management
Birth	Uterotonics/AMTSL
	Seizure prophylaxis
	Parenteral Abx
	ACS
	AVB
	C/sections
Do you feel that your education prepared you to provide essential interventions?	
If you are not able to provide these interventions, have you received education to recognize complications and need for the interventions?	
Tell us about your referral sytem. To whom do you refer? Do you have guidelines for referral? Who creates those guidelines? Do you contact them before referring the woman and/or newborn? How is the relationship between lower level facilities and referral hospitals? Are the women and families able/willing to be referred?	
Domain #2: Supply (people—appropriate midwifery workforce in quality, distribution and scale)	
Facility Staff: Give total number in each category Please describe training and years of experience How long at post	
Administrator: title, training	
Midwife	
Auxiliary Midwife	

Lady Health Visitor	
Nurse	
Nurse/midwife	
Community Health Worker	
What is the population that the facility serves?	
Do you feel that you have the adequate number of providers? If not, what other providers/how many providers do you feel would give an adequate amount of coverage?	
Who decides how many providers are posted to each station? Are posts filled regularly? Do you feel that you have a mix of providers whose educational backgrounds allow them to care for the population they serve? If not, do you feel that they are able to refer in a timely manner?	
Assuming you provide care for the pregnancy/birth/postpartum/neonate: how much of your work time is spent in this responsibility? Could you spend more time fulfilling this responsibility? Are there other duties which support or hinder your fulfilling this responsibility?	
Do you feel that you have the training and education that is required to serve the population that you see? If not, what areas of further training and education would allow you to fulfill your responsibilities?	
Tell me about your referral system which is in place for complications of pregnancy, birth, postpartum and the newborn. Do you have guidelines? How are they developed? Are you able to follow the guidelines? If not, tell me about the difficulties you experience.	
Do you have training for complications? Do you receive updates? Please tell me about the system for receiving technical updates and additional training?	

<p>Do you have the equipment and supplies needed to address the health needs? Where do the equipment and supplies come from?</p>
<p>Do you feel that families and the community are satisfied with the care they receive? Do providers at the facilities engage in community level activities and/or health education activities?</p>

Domain 3 and 4: Facilitating environment	
Facility structure and Environment	Please describe physical infrastructure and work environment.
	Is it accessible by road? If not, how do clients reach the facility?
	Hours of operation?
	Who staffs on the off hours? If there is no staffing during the off hours, what provisions are made for emergencies?
	Are all clients served at any time? Any specific days for specific clinical issues? If a patient arrives with a problem during a day which is a designated specific clinical issue, is the patient able to be provided services?
	Is there electricity? Running water? Reliable sources for water and electricity?
	Equipment and supplies: Please describe. Provision for sterilization, cold chain.

	Does facility have health information and/or job aids for providers and/or clients?
	Does the facility have the physical layout to provide privacy and confidentiality? Please describe.
	Are there provisions for transport during emergencies or does the community rely on POV?
	When a client arrives at the facility, please describe the process for intake.
	Are operational decisions made by facility manager or by centralized decision making body?
	Please describe the communication and interaction between first level facilities and referral facilities and/or the regional health office. How are workforce issues reported and/or assessed? How are supply and equipment issues reported and/or assessed? How are physical infrastructure needs reported and/or assessed?
Management and Policy	Who determines the distribution of BEmONC and CEmONC facilities? Please describe, in a township, the number of CEmONC facilities and the number of BEmONC facilities?
	Who determines the number of midwives per township? Are those postings generally filled? If not, what percentage is filled most of the time?
	How are midwives recruited and deployed to the township? How effective is the system?
	Once the midwives have arrived to the township level, who determines the specific posting? Are they provided housing? What happens if the midwife has a family? Are provisions made for the family?
	How is supportive supervision provided to the midwife? How does she communicate issues and needs? How often does that communication take place and to whom? Once she reports the issue and/or information, how is it followed up? And how is the information moved up the chain of command?

	How is the midwife evaluated for job performance? How often? By whom? Who provides follow-up if remediation is required? How is a midwife who is performing excellently rewarded?
	What are the policies for in-service training? How are they put into effect?
	If a midwife desires additional education and/or pursuit of another degree, how does that happen?
	In summary, do you feel that a midwife is trained and educated (and/or is subsequently provided opportunity) to perform the tasks which she is required to fulfill? If so, please describe. If not, please describe.

PLEASE USE THIS SHEET FOR ADDITIONAL COMMENTS:

APPENDIX E: SITE REVIEW FINDINGS

SITE WORKFORCE REVIEW

Date	11.11.13
Facility Name	Nga Phe Township Hospital (TH) PaDan Station Hospital (SH) Zin Pyune Rural Health Center (RHC) Min Lwin village, Sub Rural Health Center (SRHC)
Facility Location	Nga Phe, Magway Region PaDan, Magway Region Nga Phe, Magway Region Nga Phe Magway Region
Facility Administrator	Township Medical Officer Station Medical Officer Health Assistant RHC Lady Health Visitor SRHC
Name of Person Conducting Review	Suzanne Stalls Helen Welch

DOMAINS	
1. DEMAND	Essential interventions for MNH and Utilization: equitable and effective coverage
2. SUPPLY	People: appropriate midwifery workforce in quality, distribution and scale
3. FACILITATING ENVIRONMENT	Work environment: the MNH system facilitating quality and safe deliver of the essential MNH interventions
4. FACILITATING ENVIRONMENT	Management and policy: providing the overarching system for an appropriate and sustainable midwifery workforce
5. SUSTAINABILITY	Financing: enabling environment for financing and developing costed plans for a sustainable midwifery workforce

Domain #1: Essential Interventions	
Family planning: information derived from station hospital, RHC and SRHC	Hormonal methods <i>OCs, Depo (most popular and compliance not an issue); SMO reports that high utilization of Depo has decreased self-induced abortions. Women rarely come in for PAC unless seriously compromised. They have stock-out issues with Depo OC offered again after 1 yr PP will select if concerns about weight gain</i>
	Barrier Methods <i>IUD (low utilization), condoms</i>
	Surgical Methods <i>TL-available but woman must submit request to RHD first; if permission granted, station medical officer can perform procedure Vasectomy illegal in Myanmar</i>
Pregnancy care: *PaDan 90-100% coverage of 4 FANC visits ANC/postnatal care provided by LHV and midwife; 100 visits/month with 20 new cases/month Closest ob-gyn is in MinBu 5 deliveries/month at hospital; 10-18 births/month at home 30/month if you include SRHC Each SRHC currently has a midwife; all posts are currently filled	Risk screening: <i>very recently developed a risk screening checklist. Collaboration between SMO and midwives to determine management</i>
	Immunizations: <i>Maternal:TD, Infant: Hep B, BCG, OPV, pentavalent, measles</i>
	STI Prevention and Management: <i>midwives and SMO trained through national AIDS program in syndromic management; report that STIs "rare" RHC and SRHC utilize syndromic program for diagnosis and refer to SH or TH for treatment</i>
	PTB management: <i>reports PTB is "rare"; tube and mask at station hospital; midwives at RHC have tube and mask. SRHC does not receive tube and mask nor do newly posted midwives because newly posted midwives do not have their midwifery kit yet. Upon question, it is unclear why newly posted midwives do not have tube and mask though it appears to be a supply issue.</i>
	Malaria prevention and management: <i>ITN distributed throughout community, going to every household since 2007 with decrease in mortality rate. If a household has a pregnant woman or a child u<5, that household receives an additional ITN. Have mechanism for re-dipping nets. Are able to do rapid diagnosis and provide treatment. State that communities are compliant with using nets. Auxilliary midwives educate re net use and organize re dipping program at village level</i>
Birth	Uterotonics/AMTSL <i>Have miso at all levels of health system and it is used as soon as the baby is born (two 200 mcg miso given orally). Midwives carry IV</i>

	<i>solution which can be used in emergencies but do not have oxytocin. Midwife at sub rural HC reports carrying oxytocin and gives IV in emergency</i>
	<i>Seizure prophylaxis Midwives use MgSO4 IM for seizure prophylaxis Give first dose and refer to hospital</i>
	<i>Parenteral Abx: Abx only used orally Sub rural HC midwives give first dose Ampicillin IV for severe puerperal sepsis and transfer</i>
	<i>ACS: not used for PTB</i>
	<i>AVB: SMO and TMO both able to use vacuum extractor</i>
	<i>C/sections: Performed at both station hospital and township hospital CS rate quoted approx. 10% at all sites. Primary indicator: TH: post dates CS at 41 weeks SH: obstructed labor RHC: non engaged PP and post dates SRHC: unstable lie</i>
<p>Do you feel that your education prepared you to provide essential interventions? Questions not asked at hospitals <i>All midwives given 2 months at hospital with supervision from lady health visitor prior to deployment to HC Midwives at RHC both trained before 2007 and conducted 20 births prior to deployment. Acknowledgement that midwives trained after 2007 have decreased clinical skills exposure due to lowered birth rate and competition for births between student midwives, student nurses and student doctors. Feel less confident on deployment. All have support from LHV as needed</i></p>	
<p>If you are not able to provide these interventions, have you received education to recognize complications and need for the interventions? Questions not asked at hospital <i>Midwives trained before 2007 believe training adequate and skills improved with experience.</i></p>	
<p>Tell us about your referral system. To whom do you refer? Do you have guidelines for referral? Who creates those guidelines? Do you contact them before referring the woman and/or newborn? How is the relationship between lower level facilities and referral hospitals? Are the women and families able/willing to be referred?</p>	

RHC and SRHC refer to MO at hospital.
 RHC has mobile phones distributed by government to contact MO prior to referral or for consultation.
 SRHC midwives have no method to contact hospital prior to referral but transport with woman.
 RHC has checklist of guidelines for referral written by WCHD. Also has posters of warning signs and all families educated on warning signs by MW and auxiliary MW
 Women from RHC willing to transport if referred. Woman usually makes decision
 Women from SRHC sometimes reluctant due to cost. Husband makes final decision

Domain #2: Supply (people—appropriate midwifery workforce in quality, distribution and scale)

Facility Staff: Give total number in each category Please describe training and years of experience How long at post	Pa Dan: 16 bedded hospital Nga Phe: 25 bedded hospital Zin Pyune covers 4 SRHC Min Lwin has 2 midwives who cover 7 and 5 villages each			
Administrator: title, training	Township Medical Officer MBBS	Station Medical Officer; MBBS There x 3 years	RHC Health Assistant	SRHC Midwife
Midwife	5		3 (1 vacancy new posting)	2
Auxiliary Midwife			1/village	1/ village
Lady Health Visitor	1		1	
Nurse	4 (2 posts vacant)			
Nurse/midwife				
Community Health Worker				
<p><u>Auxiliary Midwife(AM):</u> One for each village to support midwife Demonstrates interest in role and selected by village leaders to serve Undertakes 6 month training at Nga Phe Township Hospital. 3 months theory. 3 months practical under LHV and THN Family go to AM at onset of labor and she contacts midwife. Both attend birth Occasionally AM attends birth if precipitous. Cannot give any medication.</p>				

PP care and education: home visit, nutrition, support exclusive breastfeeding, teach breastmilk expression, review warning sx for mother and baby, check for jaundice, assure baby feeding well

Other roles:

Submits report to MW of newly pregnant women, new delivery cases, maternal death, neonatal / child death, childhood illness.

Cares for child with minor illness (common cold)

Provides/ keeps population data

Ensures quality sanitation

Monitors malaria prevention/ net use and re dipping

Aids in collection of children for immunization clinic and documentation

Health ed for families:

What is the population that the facility serves?

TownshipHospital: 45,468

Station Hospital: 17,000 20 NOB per month, 30 births per year by MW

RHC: 7852. MW does 35 births/MW /yr. Refers 2-3 per year for high risk

SRHC: 5-7 villages . MW does 40 births / yr. Refers 3-4 women for high risk / yr

Do you feel that you have the adequate number of providers? If not, what other providers/how many providers do you feel would give an adequate amount of coverage?

Station medical officer unwilling to answer this question. 2 nursing posts vacant.

Assistant surgeon post vacant for "long time"

RHC: 1 new posting for MW vacant. Health Assistant believes adequate staffing.

SRHC one midwife had "scattered" villages farthest is 5 miles away. Reaching is challenge at times. Both midwives agree AM support essential for coverage

Who decides how many providers are posted to each station? Are posts filled regularly? Do you feel that you have a mix of providers whose educational backgrounds allow them to care for the population they serve? If not, do you feel that they are able to refer in a timely manner?

Assuming you provide care for the pregnancy/birth/postpartum/neonate: how much of your work time is spent in this responsibility? Could you spend more time fulfilling this responsibility? Are there other duties which support or hinder your fulfilling this responsibility?

MW also provides basic primary health care: TB, malaria, PMCT, pneumonia, diarrhea, HTN, minor injuries, health education, immunizations.

Supported by auxillary MW (AMW) at each village. AMW first contact for labor pains, illness and seeks help from midwife. AMW assists in all aspects of health education including nutrition, warning signs for mother and baby, keeps track of immunizations (mothers hold record) and collects children to attend immunization clinics held in village for SRHC and at RHC

Do you feel that you have the training and education that is required to serve the population that you see? If not, what areas of further training and education would allow you to fulfill your responsibilities?

Tell me about your referral system which is in place for complications of pregnancy, birth, postpartum and the newborn. Do you have guidelines? How are they developed? Are you able to follow the guidelines? If not, tell me about the difficulties you experience.

Do you have training for complications? Do you receive updates? Please tell me about the system for receiving technical updates and additional training?

Prior to 2005 continuing education was at regional level

*Since 2005 clinical updates at township level at monthly meeting. Meeting 9-5pm
Informal case review takes place at meetings.*

Updates include didactic and demonstration with hands on. Checklist to assure competency

Save provided funding for inservice on NB care 2/2013

Would like clinical updates on:

PPH

PTB

Pre eclampsia and eclampsia

Do you have the equipment and supplies needed to address the health needs? Where do the equipment and supplies come from?

Medicine and supplies from TH collected at monthly meeting.

Medicines available for use by MW:

Misoprostol

IV line LR/ NaCl/ Dextrose

MGSO4 IM

PNV

Vitamin A

Amoxicillin po

Trimoxacillin po

Metronidazole po

Pen V po

Albendazole

Depo

OC's

Birth Kit:

Artery forceps

Scissors

Kidney basin

Stethoscope

Apron

10 prs disposable surgical gloves

chlorhex

gauze

baby scale

Midwives instructed on use of partogram and required to use for each birth and send to TH who will send to Region. However MW not given copies of partogram and has to pay

for copies out of own pocket

RHC needs equipment for newly constructed delivery room. Staff believe women will come to RHC for delivery as is cleaner and safer than home

Do you feel that families and the community are satisfied with the care they receive?
Do providers at the facilities engage in community level activities and/or health education activities?

Villages have community based initiative "Village Health Committee" comprised of 5-6 members

No regular meetings but gather in emergency

Mixed gender: village administrator is chairman(male)

Midwife is secretary(female)

MNMA rep attends (female)

Leader of womens affairs (female)

Other heads of household

No feedback to MW or AMW on care

Committee arranges non-repayable funding for transportation if needed by family by requesting money from families in village (500 Kyat). Vehicle and driver is arranged at time of emergency.

Committee also helps with assembling village for immunization clinics and health education topics

(VHC attended RHC and SRHC site eval. All male attendees. 7 at RHC and 9 at SRHC)

Domain 3 and 4: Facilitating environment

Facility structure and Environment	Please describe physical infrastructure and work environment. <i>PaDan: SMO states the building is crumbling</i> <i>RHC clean well constructed. New delivery room under construction but</i>
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	<p><i>no money for equipment and supplies at this time</i> <i>SRHC clean well constructed</i></p>
	<p>Is it accessible by road? If not, how do clients reach the facility? <i>PaDan: SH is on main road and therefore heavily utilized</i> <i>Transportation challenging in rainy season. MW uses motorbike, oxcart to visit villages when able. If necessary must walk. Farthest village 5 miles for SRHC</i></p>
	<p>Hours of operation? <i>Responsible for maintain hospital open 24/7</i> <i>OPD hours are 9-12 and 1-4</i> <i>RHC open 8a -4p</i></p>
	<p>Who staffs on the off hours? If there is no staffing during the off hours, what provisions are made for emergencies? <i>SMO on call 24/7; nurses work in 3 shifts</i> <i>RHC open 9a-5p. Clinics daily. If after hours emergency LHV or Health Assistant attends patient at home</i> <i>All midwives and auxiliary midwives on call 24/7</i></p>
	<p>Are all clients served at any time? Any specific days for specific clinical issues? If a patient arrives with a problem during a day which is a designated specific clinical issue, is the patient able to be provided services? <i>No designated days for specific services. Patients seen regardless of issue.</i> <i>RHC had specific days for ANC but women attend anytime for care. All have at least 4 visits. Many have 12-15.</i> <i>SRHC ANC was Friday but for last year women can attend any day.</i> <i>All women have at least 4 visits. Most have 5-6 visits.</i> <i>In both settings if woman fails to attend ANC MW will visit at home.</i></p>
	<p>Is there electricity? Running water? Reliable sources for water and electricity?</p>

	<p>SMO states that electricity is reliable and continuous; there is running water.</p> <p>RHC has electricity 6p-10p. Has 5 wells to pump water but dry up in summer.</p> <p>SRHC no electricity or running water</p>
	<p>Equipment and supplies: Please describe. Provision for sterilization, cold chain.</p> <p>Able to maintain cold chain</p> <p>Use steam sterilization</p> <p>RHC and SRHC use boiling for sterilization</p> <p>RHC and SRHC organize immunization clinics and vaccine collected from TH and administered same day. Ice pack supplied by TH.</p>
	<p>Does facility have health information and/or job aids for providers and/or clients?</p> <p>Have some pamphlet and posters</p> <p>Have flip chart for HIV</p> <p>RHC has educational video clips shown at town meeting hall</p>
	<p>Does the facility have the physical layout to provide privacy and confidentiality? Please describe.</p> <p>Physical layout precludes privacy; they do their best to maintain confidentiality</p>
	<p>Are there provisions for transport during emergencies or does the community rely on POV?</p> <p><i>In an emergency, the Community Support Group (a local CBO) has two ambulances, both of which are functional, which can be utilized. The patient's family or the hospital contact the CSG to arrange for transport</i></p> <p><i>RHC utilizes motorbike or motor truck for transport. Paid for by family. Village Health Committee assists in funding if family cannot pay. SRHC same system</i></p>
	<p>When a client arrives at the facility, please describe the process for intake.</p> <p><i>The client carries her own health card.</i></p> <p><i>When she arrives, a history is taken and then she is admitted.</i></p> <p><i>For a patient who has not been seen before, they will start the</i></p>

	<p><i>registration process</i> <i>US not generally available. Private hospital in MinBu will provide for fee but most families cannot afford</i> <i>Primary dating by FH not LMP</i></p>
	<p>Are operational decisions made by facility manager or by centralized decision making body?</p>
	<p>Please describe the communication and interaction between first level facilities and referral facilities and/or the regional health office. How are workforce issues reported and/or assessed? How are supply and equipment issues reported and/or assessed? How are physical infrastructure needs reported and/or assessed? <i>With stock-outs, a report is made to the township health department</i> <i>For infrastructure needs, a report is sent to the regional health directorate. A detailed budget must accompany the request.</i> <i>There is a hospital committee composed of community officials, leaders and hospital staff. This hospital committee is able to raise money for the hospital from the community. The hospital committee does not provide for future planning but rather as the need arises.</i></p>
Management and Policy	<p>Who determines the distribution of BEmONC and CEmONC facilities? Please describe, in a township, the number of CEmONC facilities and the number of BEmONC facilities? <i>Both station hospital and township hospital provide CEmONC.</i> <i>However, the group states that not all station hospitals provide CEmONC because it depends on the level of skill and knowledge of the station medical officer though most do provide the service.</i></p>
*the following information was derived from the township	<p>Who determines the number of midwives per township? Are those postings generally filled? If not, what percentage is filled most of the time? <i>Currently in NgaPhe township, there are 24 posts, two of which are vacant though new posts. After some discussion, group decided that</i></p>

<p>hospital</p>	<p><i>generally there is a 35% vacancy rate (not consistent with original statement).</i> <i>Difficult to retain midwives in remote posts. After one year, they are able to request a transfer from the regional health directorate. No incentives offered for remote postings.</i></p>
	<p>How are midwives recruited and deployed to the township? How effective is the system?</p> <p><i>The central level asks for quarterly reports and through that determines vacancy rate. The central level then assigns the given number of midwives to the region which then assigns and deploys them to the townships.</i></p>
	<p>Once the midwives have arrived to the township level, who determines the specific posting? Are they provided housing? What happens if the midwife has a family? Are provisions made for the family?</p> <p><i>The regional health directorate assigns the midwife to the township. No housing is provided—they must find their own though sometimes the community will support the midwife in obtaining housing. The majority of midwives come without family—if they do have family, they tend to leave them. They have 1 month of leave per year. However when the midwife takes leave, the midwife in the adjoining area must cover all of her tasks so it is difficult.</i> <i>There is no clinic building—the midwife must create a room in her home where the pregnant women can be seen.</i> <i>RHC Village Health Committee provides home for midwives and ongoing repair / upkeep. MW does not have ability / support to take leave</i> <i>SRHC midwives trained in Yangon but returned to hometown Nga Phe so no leave needed</i></p>
	<p>How is supportive supervision provided to the midwife? How does she communicate issues and needs? How often does that communication take place and to whom? Once she reports the issue</p>

	<p>and/or information, how is it followed up? And how is the information moved up the chain of command?</p> <p><i>Many of the midwives have mobile phones though connectivity and electricity to recharge is a problem. She can talk to the TMO/THN or OPD if she has concerns about a patient. The group states that communication is frequent between the midwife and the township health center for both clinical and administrative aspects. LHV and THN evaluate midwives. Available to address midwife concerns at anytime</i></p>
	<p>How is the midwife evaluated for job performance? How often? By whom? Who provides follow-up if remediation is required? How is a midwife who is performing excellently rewarded?</p> <p><i>The midwife is evaluated with a 64 question checklist on a quarterly basis by the THN. Deficiencies are addressed though it depends on the level of deficiency. It can be OJT or if the issue is severe, it is reported to the TMO and he will arrange for further education. No community perspective is elicited.</i></p>
	<p>What are the policies for in-service training? How are they put into effect?</p> <p><i>There are monthly mandatory meetings. The Township hospital develops an annual CME plan such as seasonal illness; immunization issues; IMR, MMR. Last month they changed their style of training. Now a RHC chooses the topic and presents it to the group for discussion. Also, STC has given a midwifery refresher training. During this 10 day, the regional training team (RMO, RNO and the nursing assistant director) conducted the training. Support and supervision minimal—the midwife can bring up what she has learned with the THN when she is conducting the quarterly evaluation and review it with the THN. If the RHC is close to the township hospital, the THN can come to help the midwife.</i></p>
	<p>If a midwife desires additional education and/or pursuit of another degree, how does that happen?</p> <p><i>Central level of DOH announces that a certain number of positions are available in nursing/LHV institutions (only 1 LHV program in the country—9 months duration). The RHD asks for applicant who must</i></p>

	<p><i>then sit for the entrance exam. The top scorers are admitted. If they should go away to school, they are still considered to be posted but the post remains vacant. The LHV then has to cover the duties of the midwife from that post.</i></p>
	<p>In summary, do you feel that a midwife is trained and educated (and/or is subsequently provided opportunity) to perform the tasks which she is required to fulfill? If so, please describe. If not, please describe.</p> <p><i>It can take up to 4 years for a midwife to be posted. There are not enough sanctioned posts for the number of graduates. There are gaps between the DMS, the DOH and the planning department (DMS educates, DOH deploys and planning department creates the sanctioned posts). There is often a budget issue of salary and supplies. In this township hospital, even though the midwife comes to the hospital and has what essentially is an “internship” of 2 months, they still ask a LHV or nurse to provide support and supervise closely for a while.</i></p> <p><i>MW from TH can ask for help from THN for difficult birth</i></p> <p><i>RHC midwives one posted in 2 months. One waited 2 years for posting but worked in private hospital to maintain skills</i></p> <p><i>SRHC midwives posted within 6 months of training</i></p>

PLEASE USE THIS SHEET FOR ADDITIONAL COMMENTS:

APPENDIX F: Pre-service education review tools

Tool A:

PSE Assessment tools

Guidelines to Person Conducting the Assessment:

Notify senior academic administrators at least 30 days prior to the assessment. Ask her or him to prearrange visits with what they believe is a representative group of:

Faculty/Tutors

Clinicians/Preceptors

Students

Note – Ideally administrators will allow interviews of faculty and preceptors without their presence in order to decrease bias. Students ideally should be interviewed without administrator or faculty present.

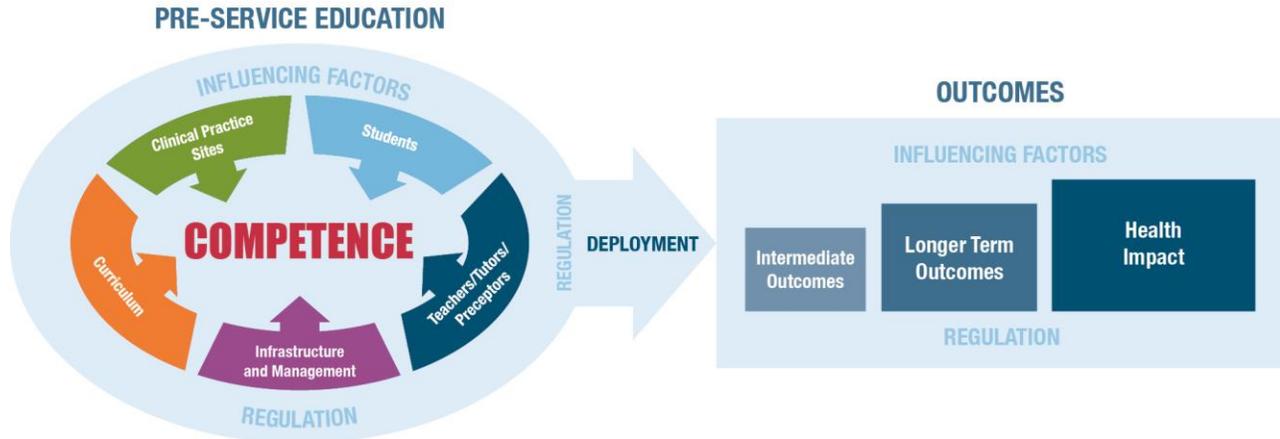
Propose a full day for the assessment – It may not take that long but a full day ensures your ability to conduct a complete and comprehensive assessment.

The assessment is BEST conducted by two individuals, at least one of whom has academic experience. Ideally both individuals will be proficient in the target clinical competencies.

Determine ahead of time, which member of the assessment team will be responsible for leading the interview of focus group. Both should listen actively and take individualized detailed notes.

Collect as much of the General/Demographic Information as possible from the academic administrator and then cross check during other interviews.

CONCEPTUAL MODEL: THE HEALTH IMPACTS OF PRE-SERVICE EDUCATION



Jhpiego developed an evidence-based conceptual model to guide its investments in pre-service education. The interview, focus group and observational tools contained in this package are intended to collect information needed to provide a balanced assessment of the essential inputs presented on the left side of the model and the context for which students are being prepared presented on the right.

Where possible, the elements in each tool have been coded to match the component of the model to which they relate. This is intended to facilitate the analysis of findings and presentation of the report. Please consider each input presented on the left side of the model in relationship to the other inputs and the intermediate and longer term outcomes desired on the right. For example, if the team is assessing a midwifery education program, they would want to consider whether the curriculum contains objectives and learning activities that are consistent with expected practice of the midwife upon deployment. If the curriculum contains learning activities that direct a student to practice in a skills lab, the team must look at the skills lab infrastructure, equipment and supplies to ensure congruency with the clinical infrastructure that the midwife will be working in after she is deployed. Likewise when looking at clinical practice sites, the team would want to look at whether the clinical practice sites used to educate midwives are similar to those that the majority of students will be deployed to following graduations. For example, if student are most needed in rural facilities, the team may recommend that a proportion of their clinical learning take place in those facilities.

Influencing Factors – such as community involvement, the engagement of professional associations, health care financing challenges and professional regulatory processes will all have an impact on pre-service education. The team is encouraged to look for these factors and their potential impact while conducting the assessment.

Assessment Key

S = Student

T/T/P = Teachers/Tutors/Preceptors

I&M = Infrastructure and management

C = Curriculum

CPS = Clinical Practice Site

General/Demographic Information

Name of school of nursing/Midwifery	
Location:	
Institutional Affiliation:	<input type="checkbox"/> Government <input type="checkbox"/> Private <input type="checkbox"/> Mixed
Cadres (put X to all that apply)	<input type="checkbox"/> Nursing <input type="checkbox"/> Midwifery
Names of team members conducting the assessment:	
Clinical practice sites visited (CPS)	
Dates of assessment:	
Administrator Interviewed (I&M)	Name _____ Position _____
Students (S)	Number _____ Oldest _____ Percent Male _____ Youngest _____
Faculty (T/T/P)	Number teaching Nursing _____ Number teaching Midwifery _____ Number teaching LHV _____ Percent Male _____ Total # with: Basic Degree Only _____ Master's Degree _____ Doctorate _____
Clinicians/Preceptors (T/T/P)	Number teaching Nursing _____ Number teaching Midwifery _____ Percent Male _____

Interview – National Level Stakeholder

Please describe the mission and history of your nation's nursing education program. Is it uniform throughout the country or specific to each region? (I&M)

What are the strengths of and major challenges faced by the program?

What are the major challenges programs face?

Describe your faculty in terms of their own nursing and midwifery competencies and their readiness to teach them. (T/T/P)

Describe your students in terms of their recruitment, standards for acceptance, support and deployment. (S)

Describe the curriculum used (both in the classroom and clinical practice site) and it's development (C)

Describe the clinical experience students receive in terms of location, supervision, and assessment. (CPS)

Interview – Academic Administrator (Director)

Describe the mission, vision and philosophy of your school/program of study.

How long have they been in place?

How frequently are they reviewed?

Are you satisfied with each? Why or why not?

Who do you report to within your government structure?

Describe the process for updating your curriculum (frequency, process, last update)

How long has the curriculum been in place?

How frequently is it reviewed?
Are you satisfied with it? Why or why not?

How is it ensured that country health priorities are addressed in the curriculum

How are nursing and midwifery educational institutions informed of priorities and policy changes?

How to you disseminate this information to the staff/faculty?

Describe your experience with the education accreditation process in terms of:

When your school was last accredited?

When will you be reaccredited?

Describe the Process

How could it be made more constructive?

Is it based on a set of national educational standards?

Are you satisfied with these standards? Are they currently relevant?

Describe your experience with the clinical sites accreditation process
Are clinical sites accredited?

If not, why not?

If yes, describe the process

Is it based on a set of national standards?

What is the process of initial and ongoing professional registration for each nurse/midwife cadre?

What regional/national body registers nurses/midwives

How often are they required to renew licensure?

Is continuing professional development required for relicensure?

If so, how is this monitored.

Describe your students in terms of:

Recruitment, selection criteria and admission strategies (Capacity/year)

Student support by educator/teacher and staff (relationship to educator/teacher, advisement process)

Workload (coursework and outside employment)

Attitude toward learning

Attitudes toward change

Technology literacy

Deployment after graduation

Background (urban, rural, socioeconomic status)

Describe educator/teachers in terms of:

Recruitment and retention strategy (educator/teacher development)

Student/teacher ratio

Educator/teacher support by administrator (e.g. job counseling, resource management)

Teaching experience/development of competency based instructional methods

Development and application of knowledge and skills assessment tools

Workload

Attitudes toward change/Can you identify early adopters?

Technology literacy

Work and living conditions

Career opportunities/Access to CPD

Describe your formal/informal relationship to the health care facilities where clinical education is provided.

Describe how clinical staff/preceptors are involved in educational planning

Explain the format of the clinical instruction

Who supervises the students in the clinical setting?(use of bedside nurses, use of part time clinical instructors, trained preceptors).

Describe clinical educators in terms of:

Recruitment and retention strategy of clinical educators

Are they proficient providers?

Continued professional development and/or specific training of clinical instructors/preceptors.

Student/Clinical instructor ratio

Discuss any gaps that you have in educational resources?

Skills lab, Library, Clinical learning environment, Computer lab, Classroom, student and educator/teacher housing/lifestyle support.

What is the school's policy for reviewing resources in response to changes in the curriculum?

Describe the budgeting processes used in your school/system?

Describe any possible benefits to using learning technologies. (e.g., a combination of mobile devices, computers, Internet, CD/DVD, video, audio, etc.)?

Describe your experience using and level of access to personal electronic devices (job and personal use):

Mobile phones

No experience

Some experience, but not proficient

Experienced, proficient

Very experienced, very proficient

Smart Phones

No experience

Some experience, but not proficient

Experienced, proficient

Very experienced, very proficient

MP3 players

No experience

Some experience, but not proficient

Experienced, proficient

Very experienced, very proficient

Television

No experience

Some experience, but not proficient

Experienced, proficient

Very experienced, very proficient

DVD players

No experience

Some experience, but not proficient

Experienced, proficient

Very experienced, very proficient

Radio

No experience

Some experience, but not proficient

Experienced, proficient

Very experienced, very proficient

CD players

No experience

Some experience, but not proficient

Experienced, proficient

Very experienced, very proficient

Describe the major challenges that you see with using learning technologies (e.g., a combination of mobile devices, computers, Internet, CD/DVD, video, audio, etc.)?

Describe a typical day in the life of an educator/teacher.

Describe a typical day in the life of a student.

Describe your program evaluation strategy in terms of:

Student input into educator/teacher and course evaluation

Assessment of students upon graduation

Tracking student challenges/employment patterns following graduation

Describe your students in terms of their ability to:

Meet licensing/registration requirements

Provide safely and effectively in their expected role upon graduation

Grow into leadership and management positions

Become lifelong learners

Interview -Faculty (Educator/Teacher)

What is typical level of education for a teacher in your country?

How long have you been a teacher?

How long have you been teaching at this school?

Describe your students in terms of:

Recruitment, selection criteria, admission process

Student/Teacher Ratio (Classroom)

Student/Teacher Ratio (Clinical)

Student anxiety/support strategies

Age

Gender

Background (e.g., recruited from rural/urban, socio-economic status)

Living and work conditions

Technology literacy/Access to technology

Motivation/Attitudes toward learning

Learning preferences

Describe your role in developing those competencies.

To what degree are learning objectives and assessment tools linked to those competencies?

Describe your role in supporting clinical education

How is the communication between clinical sites and faculty structured?

Are there regular meetings with between school and clinical facilities?

Are clinical instructors/preceptors proficient?

Do clinical staff have input on the students 'grade' in the clinical area?

Are the clinical sites sufficient in providing student the necessary cases/number of cases to achieve competency (census of clinical site, varied cases)?

Do you provide clinical objectives for your students to clinical staff?

Relationship with clinical staff working with students

Frequency of visits/follow up of students in clinical

How are students evaluated for competency in the clinical area?

Is there documentation (logbooks etc) of clinical hours/performance of students?

How is information shared with clinical preceptors

Involvement of clinical staff in school activities (invited to graduation etc)

How do you evaluate student performance in terms of:

Perception of the quality of learning

Knowledge

Skills (procedural & clinical decision-making)

Attitudes

Describe a typical day in the life of a teacher.

Describe any possible benefits to using learning technologies (e.g., a combination of mobile devices, computers, Internet, CD/DVD, video, audio, etc.)?

Describe your experience using and level of access to personal electronic devices (job and personal use):

Mobile phones

No experience

Some experience, but not proficient

Experienced, proficient

Very experienced, very proficient

Smart phones

No experience

Some experience, but not proficient

Experienced, proficient

Very experienced, very proficient

MP3 players

No experience

Some experience, but not proficient

Experienced, proficient

Very experienced, very proficient

Television

No experience

Some experience, but not proficient

Experienced, proficient

Very experienced, very proficient

DVD players

No experience

Some experience, but not proficient

Experienced, proficient

Very experienced, very proficient

Radio

No experience

Some experience, but not proficient

Experienced, proficient

Very experienced, very proficient

CD players

No experience

Some experience, but not proficient

Experienced, proficient

Very experienced, very proficient

Describe the major challenges that you see with using learning technologies (e.g., a combination of mobile devices, computers, Internet, CD/DVD, video, audio, etc.).

Describe the quality of your Internet connection in terms of speed and reliability.

No internet

Some internet access (very slow, often unreliable)

Good internet access (good speed, reliable >90% of the time)

Very good internet access (fast, reliable 100% of the time)

Describe challenges and opportunities that you have in terms of:

Professional career development

Living Conditions

Are there specific gaps in your skills that you would like to develop?

Interview –Student

Describe your experience as a student in your current program of study:
Classroom education (Teacher support, availability of learning materials)

Library (availability of current evidence based learning materials)

Clinical Skills labs

Clinical education (e.g. attention from tutor, preceptors, clinical and teaching resources available to you)

Informal learning (e.g., self-directed exploration, discussion with peers, etc.)

Workload (coursework & outside employment)

Describe your learning preferences (e.g., seeing, hearing, reading/writing, doing).

Describe a typical day in the life of a student.

Describe your living conditions

Describe the relationship between classroom and clinical education
Consistency (content, expectations, methods)

How do you feel about your opportunities following graduation (e.g. where do you see yourself in five years?)

Interview - Librarian

Describe your students in terms of:

Reading and writing English literacy

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____
Not competent Very competent

Using the library as a resource

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____
Not competent Very competent

Describe faculty (classroom and clinical) in terms of:

Reading and writing English literacy

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____
Not competent Very competent

Using the library as a resource

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____
Not competent Very competent

How is the skills lab financed and who manages the financing?

What resources does the Library possess and how are they used (library catalogue, volunteer librarians etc)?

Does the library have or do you have access to national and local language books and resources?

Describe any major challenges that you see in the library

Describe a typical day in the life of a Librarian

Describe the education, training and experience that have prepared you and/or your library staff for their role.

Describe any training your department provides for administrators, faculty and students.

What specific suggestions do you have for:

Physical location of the library

Specific Library needs (including staffing, resources, training etc)

Interview – Skills Lab Coordinator

Describe your students in terms of:

Student/Teacher Ratio (Skills Lab)

Student anxiety/support strategies

Learning preferences

How is the skills lab financed and who manages the financing?

What resources does the skills lab possess and how are they used?

Does the skills lab have or do you have access to national and local language books and resources?

Describe any major challenges that you see in the skills lab?

Describe a typical day in the life of a skills lab coordinator

Describe the education, training and experience that have prepared you and/or your skills lab staff for their role.

Describe any training your department provides for administrators, faculty and students.

Describe your role in supporting clinical education

How is the communication between clinical skills lab and faculty structured?

Are there regular meetings with between skills lab coordinator and faculty?

Are the skills lab facilities sufficient in providing student the necessary experience to achieve competency?

Do you provide clinical objectives for your students when they are in the skills lab?

How are students evaluated for competency in the skills lab?

Is there documentation (logbooks etc) of skills lab hours/performance of students?

How is information shared with faculty?

How do you evaluate student performance in terms of:

Perception of the quality of learning

Knowledge

Skills (procedural & clinical decision-making)

Attitudes What specific suggestions do you have for:

Physical location of the Skills Lab

Specific Skills Lab needs (including staffing, resources, training etc.)

Interview – Technology Administrator

Describe your students in terms of:

Technology literacy

Access to technology

Attitudes toward change

Describe faculty (classroom and clinical) in terms of:

Technology literacy

Access to technology

Attitudes toward change

Describe the major challenges that you see with using learning technologies (e.g., a combination of mobile devices, computers, Internet, CD/DVD, video, audio, etc.)

Describe any possible benefits/un-realized opportunities to using learning technologies.

Describe a typical day in the life of an IT professional.

Describe some of the typical recurring problems (network, server, desktop, user) with technology in your facility.

What processes and procedures are in place to address problems?

Network

Server

Desktop

User

Describe the education, training and experience that have prepared your ICT staff for their role.

Describe any technology training your department provides for administrators, faculty and students.

Discuss your relationship to any existing program(s) of study within and/or outside of your university that prepares ICT professionals.

In your judgment, how reliable is your computer network (internal, local area network)?

Describe the quality of your Internet connection in terms of speed and reliability.

Please describe your computer/network capacity (number of computers, network speed, network technology).

What specific suggestions do you have for:

Physical location of learning technology devices (e.g., computer lab, library, student hostel/dorm, classroom, clinical facility, etc.).

Learning technology user support

Facility Observation Tool (I &M)

Classroom

Physical Size/dimensions

Student Capacity

Furniture

Audiovisual equipment (flip chart, writing board, projector, DVD player)

Electrical supply

Internet/Intranet Access (wired or wireless)

Library

Physical Size/dimensions

Student Capacity

Furniture

Audiovisual equipment (flip chart, writing board, projector, DVD player)

Electrical supply

Internet/Intranet Access (wired or wireless)

Books (Sufficiency, relevancy and currency)

Maternal Child Health

Reproductive Health

HIV/Infectious Diseases

Public Health

Peer Reviewed Journals (Sufficiency, relevancy and currency)

Maternal Child Health

Reproductive Health

HIV/Infectious Diseases

Public Health

Audio Visual –Tapes DVDs, Computer Programs- (Sufficiency, relevancy and currency)

Maternal Child Health

Reproductive Health

HIV/Infectious Diseases

Public Health

Copier

Scanner

Access (evenings, weekends)

Lending Policies

Available Librarian Assistance

Skills Lab

Physical Size/dimensions

Student Capacity

Furniture

Audiovisual Equipment (flip chart, writing board, projector, DVD player)

Electrical Supply

Water Supply

Internet/Intranet Access (wired or wireless)

Access (evenings, weekends, supervision policy)

Anatomic Models (sufficiency, relevancy and condition)

Maternal Child Health

Reproductive Health

HIV/Infectious Diseases

Job Aids (Wall Charts, etc)

Maternal Child Health

Reproductive Health

HIV/Infectious Diseases

Infection Prevention

Clinical Equipment and Supplies (sufficiency, relevancy and condition)

Maternal Child Health

Reproductive Health

HIV/Infectious Diseases

Computer Lab

Physical Size/dimensions

Number of Computers

Software Installed

Student Capacity

Furniture

Audiovisual Equipment (flip chart, writing board, projector, DVD player)

Electrical Supply/Power Back-Up

Local Area Network

Internet Access

Access (evenings, weekends, supervision policy)

Policies (Software installation, student restrictions on use)

Faculty Offices

Physical Size/dimensions

Furniture

Electrical supply

Computer Work Station/Laptop

Printer

Copier

Scanner

Internet/Intranet Access (wired or wireless)

Books (Sufficiency, relevancy and currency)

Maternal Child Health

Reproductive Health

HIV/Infectious Diseases

Public Health

Student Living Space

Physical Size/dimensions

Furniture

Capacity (e.g. number of students per room, ability to accommodate all students)

Electrical supply

Water

Safety/Security

Transportation to Clinical

Student Lounge/ Recreational Opportunities

Computer Work Station/Laptop

Clinical Learning Facilities

Inpatient or Ambulatory

Structure (Clinical Services Delivered)

Number of Beds/ Outpatient Exam Rooms

Electricity/Back-Up Power

Lighting

Water Supply

Disposal of Infectious Waste

Sufficient Equipment for Teaching + Basic Service Delivery (e.g. health assessment, GYN exam, antenatal care, pediatric care, medical surgical, autoclave, laboratory testing etc)

Sufficient Supplies for Teaching + Basic Service Delivery (personal protective equipment, dressings, needles & syringes, needle disposal, disinfectants, drugs)

Availability of Post Exposure Prophylaxis

Tool B

**Pre-Clinical Infrastructure & Personnel Capacity Review Tool
Myanmar**

I. General Information

Name and Address of Institution:

Director/Officer in-Charge (name and contact details):

Name of person(s) conducting audit and date:

Year Nursing School Opened:_____

Types of pre-service existing programs currently offered:

1.) _____

2.) _____

3.) _____

4.) _____

5.) _____

Year	2013	2012	2011	2010	2009
Number of midwifery or nursing student applications per intake					
Number of midwifery or nursing students accepted/admitted per intake					
Number of graduates per year					

Total hours of theory: _____

Total hours of clinical practice: _____

II. Human Resources (the school has the human resources to function effectively)

School Staff/Personnel (give numbers)	Post filled	Vacant	Remarks
Principal/Director			
Tutors qualified to teach BeONC)			
Tutors qualified to teach EmONC			
Clinical Instructors qualified in BeONC			
Clinical Instructors qualified in EmONC			
Office staff/clerks			
Librarian/Library staff			
Home Sister (dorms)			
Housekeeper/Cleaner			
Clinical Preceptors in Community			
Other staff			

Tutor Identifier	Qualifications including degrees, experience, preparation in teaching	Years in clinical practice?	Total years as a tutor/years at this institution	Full time/part time	Currently in clinical practice? Where?

methodologies			
Tutors are required to undertake ongoing, periodic continuous education studies to update and keep abreast of advances in nursing science/practice/education			

Research Capacity/Training:

Please describe how research training is addressed and supported for faculty members at your institution

Is there opportunity for multi-disciplinary research activities? Describe:

Is research expected for promotion? (Describe)

What are some of the strengths of your institution with respect to research capacity?

What are some of the barriers to further development of research capacity?

Rooms for Tutors	Available number	Number usable	Number unusable	Number required	Number of tables and chairs or desks available per room
Offices for tutors					
Desks/chairs for tutors					
Bookcases for tutors					
Desktop computer for tutors					
Laptop computer for tutors					

III. Teaching Environment/Space(the school has the basic infrastructure to function effectively)

Classroom Space	Available number	Number usable	Number unusable	Number required	Number of tables and chairs or desks

					available per room
Large (more than 50 seats)					
Medium (20-49 seats)					
Small (less than 20 seats)					
Auditorium (is PA and projection for visual presentations available)					
Each classroom is well ventilated with a means of controlling temperature (fans in working order)					
Each classroom has working electricity and lighting available					
Chalkboards					
Whiteboards					
Overhead projector or LCD					
TV. Video, or DVD are available/used					
Projection Screen					
Bathrooms/Latrines available with running water and soap for: a.) male students b.) female students					
Clinical Lab Space	Available number	Number usable	Number unusable	Number required	Number of tables and chairs

					or desks available per room
Stations for practicing hospital based care					
Stations for practicing home based care					
Cupboards for storage of equipment					
Sinks available for hand washing					
Beds					
Manikins & Models (fetal skull, placenta, bony pelvis, zoe, arms)					
Please list on a separate sheet an inventory of all charts, equipment, instruments, etc available for use in the simulation lab					
Please list any other essential equipment that is missing or not working/available					
Library Space & Resources	Available number	Number usable	Number unusable	Number required	Number of tables and chairs or desks available per room
Individual study carrels					

Tables/Desks					
Office for Library staff					
PC for Library staff: a.) electronic data bases (name) b.) software (name) c.) electronic journals d.) DVD clinical reference guides (i.e. WHO)					
Please list on a separate sheet all major nursing textbooks (number of each title available and publication year) and journals available and dates of latest issues					
	Yes	No	Remarks		
There is a schedule showing library hours posted					
The library is accessible to students for at least 2 hours per day outside of class hours					
Students are able to borrow books and other materials from the library outside class times					
Photocopy facilities are available for students use – give cost per sheet students pay					
Internet services/HINARI are available for students to search for publications and course materials					

The library is managed or under supervision of a trained librarian				
Computer Lab Space/Resources	Number usable		Number not usable	Number required
Desktop computers				
Desks/Tables				
Chairs				
The computer lab is open to students after official class times (state times open and ease of access)				
Simulation lab Space & Resources	Available number	Number usable	Number unusable	Number required
Beds				
Manikins				
Please list on a separate sheet an inventory of all charts, equipment, instruments, etc available for use in the simulation lab				
Please list any other essential equipment that is missing or not working/available				

IV. Student Support and Accommodations (there is adequate hostel/dormitory space to accommodate students)

Hostel Accommodations (Dormitories)

Are hostel accommodations available for students? (Y/N)_____

If yes, total number of bedrooms available for:

a.) Female_____

b.) Male_____

Number of beds per room?_____

Total number of beds available for students?_____

Total number of students in hostel at current time?_____

Number of bathrooms in hostel for students?_____

Running water available in all bathrooms and toilet facilities? (Y/N) if no describe situation:_____

Lighting available for study if electric power is out? (Y/N) if no describe:_____

	Yes	No	Remarks (use probes such as “tell me about...”)
Recreational facilities are available for students (list)			
Living room/dining room space is available for student use			

There is a responsible person available at all times (hostel manage/resident advisor)			
Security is available (please comment on security of female students)			

Support to Students

	Yes	No	Remarks(use probes such as “tell me about...”)
The institution gives all students, at the commencement of the semester or course, a manual outlining the curriculum, expected competencies at end of training, schedule of classes, schedule of clinical, times of assessments, expected professional behavior?			
The institution has a mechanism by which students can make a formal complaint about the program or about teacher performance or behavior, or other grievances, such as unfair assessments that is fair and transparent.			
The institution has a			

<p>formal mechanism to support and counsel students who have personal problems that interfere with their learning.</p>			
<p>The institution has a formal mechanism for consultation with students – for students to give feedback on program and teacher performance.</p>			
<p>There is an academic advisor assigned to each student</p>			

1.) The school has a memorandum of understanding with clinical sites off campus for clinical placements of students? (Y/N)_____

2.) Where students are required to undertake placements off site (off campus) there is adequate transportation between the institution and the clinical practice site and residential accommodations close to the practice site if required (give details):_____

3.) The institution has a mechanism for assessing (auditing) all clinical practice sites, including community placements, to ensure they are quality-learning environments? (give details)

	Yes	No	Remarks (use probing questions)
Clinical sites used to develop competencies include opportunities for students to have <i>hands-on practice</i>?			
There are sufficient clinical supervisors in all areas where students go for clinical practices			

(give faculty:student ratio for in-patient facilities and community rotations)			
All clinical supervisors undergo a preparation program (in-service course) provided by the institution? (give details of preparation of clinical supervisors/preceptors)			
	Yes	No	Remarks (use probing questions)
Tutors from the institution spend time working with and supporting students in the clinical areas (on average how much time in clinical area per month?)			
Tutors from the institution spend time working with and supporting mentors and clinical teachers? (on average how much time per month?)			
A written report or record is used to document all clinical experience undertaken during clinical placement for use in the institution?			
Each student maintains a logbook of their clinical experiences?			
The institution has a mechanism for assessing/auditing all clinical practice sites,			

including community placements, to ensure they are quality learning environments (see copy of assessment tool).			
--	--	--	--

VI. Management & CQI (there are adequate mechanisms in place for quality improvement)

	Yes	No	Remarks (use probing questions)
Has the school analyzed the training needs of nurses in your area?			
Is there a written weekly/monthly/semester teaching plan that identifies who teaches what and when?			
Do all teachers teach all subjects in the curriculum? (if no, how are assignments made)			
Do you use written lesson plans?			
Is there any publicity for your school?			
Do you use assessment tools for evaluation student performance? (list tools)			
How often do you assess students' progress?			
	Yes	No	Remarks (use probing questions)
Does your school comply with the written education and training standards of Myanmar?			
Are there goals and			

objectives for the school written down?			
Is there a teacher mentorship scheme for new teachers/clinical instructors/preceptors?			
Is there a staff development plan for each tutor to maintain and improve their clinical skills?			
Is there a staff development plan for each tutor to maintain and improve their teaching skills?			
Are all staff personnel files kept in a locked place?			
Are all student files kept in a locked place?			
Does the school invite clinical specialists to provide theoretical lectures?			
	Yes	No	Remarks (use probing questions)
Is there regular written & verbal feedback to students?			
Is there regular written & verbal feedback to preceptors?			
There are standardized formative & summative evaluations of students?			
There is a policy in place			

for remediation of students when needed?			
What is your pass/fail rate on the national nursing examination after graduation?			
The school has a policy that directs student recruitment from urban and rural areas according to local needs			
The school has an admission policy for students			
Staff and tutor performance is measured on a regular basis using a standardized format?			
	Yes	No	Remarks (use probing questions)
Do students have an opportunity to evaluate and give feedback on courses?			
Do students have an opportunity to evaluate and give feedback on faculty?			

APPENDIX G: PRE-SERVICE REVIEW FINDINGS

PRE-SERVICE ASSESSMENT NOTES MYANMAR NOVEMBER 2013

Background

- DMS regulates the education side
- MOH regulates the practice side
- The Nursing and Midwifery Council is made up of retired nurses and midwives. It is comprised of 15 members. The role of the NMC is to issue license based on a list of those who pass the final exam which is graded by the DMS and sent forward from the DMS. Members of the NMC are not elected but rather appointed from DMS and MOH. There is one member from MNMA (the president) on the NMC.
- MOH dictates scope of practice and develops the guidelines for clinical practice. Scope of practice cuts across all areas but can be changed by hospital policy.
- MNMA has 14 members: half are elected and have are selected
- One time per year DMS brings together all the principals and director of nursing and midwifery schools.
- MOH holds quarterly meetings with the regional medical officers

Central Midwifery Training School, Yangon Daw Nyunt Nyunt Hein – Principal

- School opened in 1901
- Oldest midwifery school in Myanmar
- From 1998-2012 there have been 2,100 graduates
- The mission, vision, and philosophy is standard across all schools and was developed by the DMS
- Principal reports to the Director of Nursing at the DMS
- 162 current students: 62 finishing up with the 18 month curriculum and 100 students in the new 2 year diploma program. They have 45 students from Chen State (in the north). These students are bonded to return and work in Chen State for 3 years following graduation.
- The government pays for student's education and accommodations. The student has to pay for meals. Additionally, students get a stipend from the government for 10,000 kwat per year.

- The new curriculum was initiated by DMS with the assistance of UNFPA. All directors and principals from the nursing and midwifery schools were involved in the process of developing the curriculum
- There is no accreditation process for schools. DMS is thinking about doing this right now.
- Have only 1-2 students drop out per year
- Six tutors – 5 have attended the 4 month training course developed at the Central Women’s Hospital
- Tutors rotate classes and teaching topics
- Typical day: lectures from 8am-12noon. Lunch 12noon-1:00pm. Lectures from 1:00-4:00pm. Sunday through Thursday there is an additional “night study” from 7:00-9:00pm where one tutor is assigned to a study hall like atmosphere. Students work on their homework and can ask questions or use the lab/library, etc. During days they are in the hospital it is a full 8 hour shift (rotating).
- Faculty:Student ratio is 1:30 in the classroom; 1:20 on the wards when in the tertiary care facilities; and 1:2 in the domicillary
- Two office staff/clerks
- No librarian – very few reference books/textbooks. Most outdated.
- Tutors develop course packs for each course that the students are then required to purchase
- Simulation lab: 5 beds, 1 neo-natalie, 4 baby natalies, school was provided with a mechanized birth simulator (Noelle® by Gaumard) Students use the lab in groups of 10-15 students with one tutor. Typically use demonstration and return demonstration. Faculty is familiar with and uses OSCE’s. The work in the simulation lab is not part of the overall grade for a course. Lab work focuses on neonatal resuscitation, breastfeeding, catheterization, vaginal exams, normal delivery, abdominal exam for ANC, post-natal care, pelvimetry, and anatomy.
- One housekeeper
- Students live on campus in dormitories – usually 5 students to one room with a shared bathroom. Running water and electricity available. There is also an activities room where movies are shown on Friday and Saturday nights. Roll call at 8:00pm.
- Two computers in the school – no internet
- Two classrooms
- Have a PA system but don’t use
- 120 hours of English language is required in the first year/first term for all students
- Electricity available, fans available, LCD, DVD/TV and white board available
- Ten domiciliary preceptors attached to the Domiciliary Training School. These tutors are responsible for the oversight of a two-month portion of the curriculum devoted to seeing patients for antenatal care in the home, home deliveries, and postpartum care

follow up in the home setting. Twenty students at a time rotate through the DTS for 2 months during their training.

- The standard for graduation is 10 births for each student. Not all students reach this number.
- To become a tutor: must have a BNSc. You can join the faculty as a clinical instructor. You have to work at least 5 years as a clinical instructor before you can become a tutor. You must work at least 7 years as a tutor before you can become a principal.
- There is no CEU requirement for licensure renewal.
- When students graduate, the Nursing and Midwifery Council issues a temporary license and students wait for a posting. When posted, the NMC issues a 2 year permanent license.
- For the final licensure examination – each school submits a set of questions to the DMS and an exam is compiled. This exam is used by all the schools for the summative evaluation and for licensure. Formative evaluations (other tests/exams) are produced by each of the individual schools.
- There is a 98-99% pass rate reported at the Central Midwifery Training School
- If a student does not pass, they continue on in course work for an additional 6 months and then have one more chance to re-take the exam
- You must work at least 3 years as a BNSc before you can sit for the entrance exam into a MSc program. There are two MSc programs in the country.
- Year 1, Term 1 ALWAYS starts on November 15th. Students get one month of vacation in APRIL.
- Teaching pedagogy used is usually 45 minutes of lecture followed by 5-10 minutes of discussion. With the new curriculum there are no learning materials available for some of the topics. Tutors are trying to get information off the web using their phones.
- For the clinical area, tutors bring the students into the clinical area, introduce them to staff, and then return to check on the students 1-2 times per week. She then discusses their progress with the staff and with the students and tests their knowledge on various topics. Clinical occurs in May, August, and September. During those months there are no classes, only clinical. Half the students work the day shift and half the students work the night shift. Clinical practice has written objectives associated with the experience but no grade is assigned for the clinical area.
- Students prepare a casebook on at least one patient and present it back to the school to the tutor and their peers. No role play used.
- Exams consist of oral, written and practical with real patients after each semester
- Faculty develop lesson plans for their courses
- The faculty do not have self-development plans
- The tutors have an annual evaluation by the Principal

- Students do not have an “academic advisor”
- If they wish to file a formal complaint, they first go to a senior student who take it to the dorm leader, who then takes it to the tutors.
- Most of the tutors had 2-3 years of clinical experience before joining the faculty. Most are not currently in clinical practice.
- Regarding the four month training course at Central Women’s Hospital: the good points are that the tutors were able to update their knowledge and learn new teaching methodologies. The negative points are that there were no teachers on the ward, they felt like they wandered around without any direction. They were not able to perform deliveries – were only able to watch. They were told this was because there were so many complicated cases.
- Faculty would like update on family planning and modern methods

Central Women’s Hospital, Yangon

- Antenatal care area sees 150-175 patients/day Tuesday-Friday and 270 on Mondays.
- There are approximately 7 exam spaces. An obstetrician/gynecologist is assigned to each exam space along with a resident doctor and 3-4 students
- Family planning clinic sees approximately 30-40 patients/day. They allow 3 students in to watch but they do not provide counseling or have direct patient care experience. All methods are available.
- The hospital does 600 deliveries/month
- First stage room holds approximately 30 patients
- During second stage the patient is moved from the first stage room to L&D
- Women stay 5 days postpartum
- No maternal deaths in 2013
- The hospital is using antenatal corticosteroids for preterm birth
- There is a tubal ligation review board. They review 100-150 requests for TL twice a month (200-300 cases per month).
- Students spend 2 weeks in the ANC clinic
- Students spend 2 weeks on L&D
- Students spend 2 weeks in the OPD

Central Domiciliary Training Midwifery School

Dashi Hkawnu – Principal

- Opened in 1954 with a focus entirely on home deliveries
- A new building opened November 1, 2013
- Faculty includes 3 tutors and 10 clinical instructors
- One housekeeper

- Pilot project supported by the DMS. School takes only students from the CMTS for their domiciliary rotation. New building supported by UNFPA. This is fashioned similarly to what we would know as an “out of hospital birth center”. It is a large two story building with self-contained sterilization equipment, labor room, delivery room, and postpartum room. No deliveries had occurred yet at the time of our visit.
- Home births are quite low in the area so this project is seen as a response to that situation.
- When students cannot get the numbers of deliveries they need, they are sent to the small township hospital or to the center at MNMA for additional deliveries.
- Twenty students at a time for two months each. Students can stay longer than two months if they are having learning difficulties
- Student:Tutor ratio is 2:1
- Students visit pregnant women in their homes for ANC, PP follow up and deliveries 5 days/week with a faculty member
- The entire faculty currently does approximately 60 home visits/week with 10-12 new patients seen per week
- Five of the tutors have attended a four-month course similar to the one at Central Women’s Hospital although this one was at Nor Okkalapa Hospital – they believe it is the same curriculum
- The faculty and students carry the following drugs to home deliveries and have them available at the new “birth center”
 - Oxytocin – injectable
 - Antibiotics – oral
 - IV drip
 - Misoprostol – using mainly in home delivery, not much in facility delivery
 - MgSO4 – No. Those patients are transferred to the hospital
- Faculty report they know and practice AMTSL
- Faculty refer breech, women with underlying medical conditions, women less than 30 years of age, and women with poor obstetrical history
- A typical day at the Central Domiciliary Training School starts with home visits from 8:00-12:00, then theoretical discussions in the afternoon with the students and also in some evenings
- The faculty would like additional teaching aids (none available right now), clinical updates and equipment to teach neonatal resuscitation. Stated HBB is “critical” for the tutors
- No staff development plans
- Four computers – no internet
- Midwifery license is renewed every two years – you need to submit a letter from your supervisor that you are still “in practice”. You go back to a temporary license every year you are not working (i.e. had a baby)

- Tutors choose to be tutors but are posted by the DMS
- Lady Health Visitors supervise midwives – they have additional skills in planning, organization, and epidemiology. The LHV program is 9 months following midwifery school and three years of service before you can apply
- There is also a “Health Assistant” program which is an additional two years. The school is in Magway. For entry into that program you must have completed midwifery school, taken the LHV program worked for two years.
- Following the HA program, after you work an additional 7 years you can apply to be a “Township Health Nurse” – which sounds like it carries more administrative responsibilities

University of Nursing – Yangon

Prof. Dr. Nwe Nwe Oo - Rector, Director WHO CC for Nursing and Midwifery

Prof. Kaw Nau - Pro Rector, Co-Director, WHO CC for Nursing and Midwifery

- There are two universities conferring the BSc in Myanmar: one in Yangon and one in Mandalay
- There are 23 nurse training schools
- There are 20 midwifery training schools
- There is one domiciliary training school
- There is one Nursing Related Field Practice Training School – which focuses on research
- There is one Lady Health Visitor school
- Every region and every state has at least one school
- University of Yangon is a WHO Collaborating Center. It received its original designation in 2004, renewed in 2008 and again in 2012. There are 6 WHO CC in Asia.
- From 1986-1991 the school was a Nurse Training Center and conferred a certificate to its graduates
- In 1991 it was changed to an Institute for Nursing and began awarding a BSc
- In 2005 it became the University of Nursing
- They offer the following programs:
 - 4-year BNSc (generic students)
 - 2-year BNSc bridge program which accepts diploma nurses who pass an entrance exam and have 3 years of government service
 - 2-year MNSc program which accepts BNSc graduates who pass an entrance exam with 3 years of government service

- There are also 9-month certificate courses available for nurse with a diploma or BNSc who passes and entrance exam and has 2 years of government service in the following specialities:
 - Orthopaedics
 - Child
 - Critical care
 - Mental health
 - EENT
 - Dental
- Currently enrolled in the 2013 academic year:
 - 612 generic students
 - 211 bridge students
 - 15 masters students
 - 43 specialty students
- The school uses 11 hospitals for clinical practice sites
- The school has a program for capacity building of faculty which included CEU talks once a month, workshops on educational science, focus on building capacity with technology and research.
- The university networks with the nursing and midwifery training schools
- There is a program of on-going research among the faculty. Current research focuses on strengthening newborn care (Okkalapa Hospital); patient satisfaction (Magway Hospital); and Choice of ANC practice in public clinics (Pyay Township). There have been 216 studies conducted between 2000-2013.
- The university is interested in collaboration with other universities for short term visits, short training courses for their faculty, scholars for MS/PhD programs, and seminars/scientific meetings. Also interested in an undergraduate student exchange program, research in nursing and midwifery, evidence based practice
- Their students are poor in clinical skills
- There are approximately 100 faculty members – most have BNSc or MS. Faculty are rotated between Yangon and Mandalay
- There is one PhD prepared nurse in the country that is working – currently in Mandalay
- Student:Faculty ratio in the clinical area is 30:1
- Have a skills lab
- Have a computer lab

Midwifery Training School Thanlyin

Principal: Daw Mya Thida Hlaing

- 47 students – 35 in the new two year program, 12 finishing up the 18 month program
- Three tutors; a fourth is in a MS program; school has one additional open position
- One tutor has taken the 4 month training course at CWH
- Two positions for clerks at the school – both currently empty
- Housekeeper (1) – this position is also empty
- Cook
- Dormitory for students
- Faculty has housing on campus
- Students do clinical placements at rural health centers – most have one labor room. They also receive “bedside teaching” at the district hospital – which we were able to tour. Hospital has 150 beds with an additional 50 beds currently being added. Here they are mainly able to witness deliveries not conduct. For domiciliary, they go to the sub-centers. There is a “MCH Center” in this area where student conduct deliveries. It is run by a Lady Health Visitor and 3 midwives. We did not see this facility.
- Every urban district has a MCH Center where deliveries and ANC occurs. It was described as the same as a rural health center (only in urban areas).
- Students get at least 10 deliveries – usually more
- The faculty function the same as at the CMTS – they accompany the student into the clinical area and then check on them once or twice a week
- Students at this school have 3 months when they conduct deliveries at a sub-center and one month in a rural health center or MCH center for a total of 4 months.
- 3 computers – no internet
- Have LCD, white boards
- Skills lab has a Noelle as well – faculty do not know how to use it
- School is getting a new building – to open the end of November. The current classrooms will be converted to dormitory space for students to accommodate the increase in numbers with the new 2-year program
- With the increase in the numbers of students they plan to expand the number of villages they cover
- Typical day starts at 8:00am 8-10 lecture or 9-12 bedside teaching on two wards and in the OPD
- Students

APPENDIX H: USAID OUTBRIEF BY ACNM

USAID OUTBRIEF: SURVIVE AND THRIVE GLOBAL DEVELOPMENT ALLIANCE

American College of Nurse-Midwives:
Suzanne Stalls, MA, CNM, FACNM
Jody Lori, PhD, CNM, FACNM, FAAN
Helen Welch, CNM, MSN
American Academy of Pediatrics:
Francis Rushton, MD
November 15, 2013



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SCOPE OF WORK AND OBJECTIVES

- **ACNM**
 - Review the fundamentals of the midwifery workforce
 - Provide recommendations for updates to policies
 - Strengthen midwifery in partnership with MNMA
- **AAP**
 - Conduct capacity assessment of the Pediatric Society of Myanmar
 - Discuss opportunities for AAP involvement with newborn and child health programs



ACTIVITIES

- MNMA
 - Conducted assessment of organizational strengths and challenges, using MACAT, a tool devised by ICM
 - With analysis, able to pinpoint gaps



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ACTIVITIES

- MNMA
 - With MNMA, established priorities for interventions and activities
 - Assessment tool will enable benchmarking in the future for evaluation



ACTIVITIES

- Pre-service review:
 - Conducted reviews at two midwifery schools, Central Midwifery Training School, Thanlyin Midwifery Training School, and the University of Nursing at Yangon
 - Interviewed principal, tutors, students of each school.
 - Discussed curriculum and curriculum development, student clinical placement, library and resources, infrastructure; tutors' background and experience; continuing education requirements; formative and summative assessment for students; teaching methodologies; ratio of student:tutor and student:preceptor



ACTIVITIES

- Pre-service review:
 - Observed students in clinical practice areas in three locations:
 - Central Women's Hospital
 - Central Domiciliary Training Midwifery School affiliated with Central Midwifery Training School
 - Thanlyin District Hospital.



ACTIVITIES

- Review of midwifery workforce in Magway Region
 - Conducted site visits and interviews within the Nga Phe township
 - Visited township hospital, station hospital, rural health center and sub-rural health center
 - Staff present were: township medical officer, station medical officer, health assistants, midwives, lady health visitors, senior nurse and auxiliary midwives



ACTIVITIES

- Midwifery workforce review:
 - Strategy was to qualitatively evaluate prior workforce assessments
 - NOT a representative sampling; we may have seen higher functioning systems and institutions
 - Reviewed practice patterns, referral paths, commodities, infrastructure, education for and use of essential life-saving interventions, staffing, deployment and retention



FINDINGS

- MNMA:
 - Relatively stable infrastructure
 - Lack organizational capacity in financial management and management of membership and membership services
 - Virtually no interaction with central or regional government level officials to provide input for policy and advocacy.



FINDINGS

- Pre-service review:
 - Physical plant/infrastructure in relatively good condition
 - Adequate numbers of faculty with basic pedagogical skills
 - Inadequate resources for updated clinical practice:
 - No access to internet
 - Inadequate computer labs
 - Inadequate simulation equipment and knowledge of its use



FINDINGS

- Pre-service review:
 - Professional development plans do not exist
 - Preceptor system lacking in structure
 - No mechanism for student-tutor feedback
 - With new curriculum, there are particular topics which have no learning materials



FINDINGS

- Workforce review:
 - Referral pathways clearly delineated though there are no actual guidelines
 - Many communities have mechanisms for emergency transport (community funds)
 - Stock-outs much less common with influx of medications which began April 2013



FINDINGS

- Pre-service review:
 - Staffing widely variable for health centers and hospitals—many midwives are not deployed for months/years. At this point, there are more graduates than can be posted
 - Updates primarily knowledge based
 - Wide discrepancy between education, policy and actual practice patterns in the field



RECOMMENDATIONS

- MNMA
 - Provide support based on organization-identified priorities. Once the MACAT is fully assembled, will continue to work with Dr. Hla to identify activities and time line
 - Priorities are as follows:
 - Funding diversification
 - Development of financial SOPs
 - Involvement in policy and decision making
 - Professional standards and guidelines
 - Membership services



RECOMMENDATIONS

- Pre-service and in-service:
 - Time to begin programming?
 - If so, the outlines of an ACNM programming effort for midwives, with supportive efforts from AAP and ACOG might be as follows:



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RECOMMENDATIONS

- Work with STC/Jhpiego to determine if programming feasible/desirable and if it helps support their implementation
- Work within 1-2 regions within 1-2 townships where the midwifery schools are located
- Support school in areas of:
 - Curriculum
 - Teaching skills
 - Clinical skills and updates
 - Equipping simulation centers and integrate simulation with theory
 - Enhance preceptor system



RECOMMENDATIONS

- Provide support to the township hospital/station hospital and rural health center/sub-rural health centers through:
 - Working alongside the township hospital during meetings held regularly with midwives in surrounding areas
 - Provide simulation-based clinical updates at “Centers of Excellence” within midwifery school
 - Establish mentoring and support and supervision system to promote uptake



RECOMMENDATIONS

- Develop strategic plan with GDA partner professional associations and our country counterparts to establish mechanism/pathway for maternal newborn health advocacy, policies and procedures
- Some examples:
 - Post-dates guidelines
 - Midwives scope of practice: injections, IVF, IV abx
 - Increase uptake of LARC with liberalized guidelines



Many thanks to our partners and our gracious country hosts!



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professional associations, private sector and global health scholars
saving mothers, newborns and children

wives

APPENDIX J: CONTACT LIST

Name	Title	Organization/Location	Email/Skype Address	Contact Number
INTERNATIONAL NGOS				
Dr. Kyi Kyi Ohn		Save the Children	KyiKyi.ohn@savethechildren.org	
Dr. Hnin wai hlaing [Cherry]	Technical Advisor	Jhpiego	cherryhninwai@gmail.com	
Dr. Pansy Tin oo	Consultant	Jhpiego	pansytinoo@gmail.com	95-9-500-9435
Dr. Kyaw Kyaw Cho	Program Manager	Jhpiego		
US & FOREIGN GOVERNMENT INTERNATIONAL DEVELOPMENT AGENCIES				
William (Bill) Slater	Director, Office of Public Health	USAID/Burma	wslater@usaid.gov	
ThuVan Dinh	Health Advisor, Office of Public Health	USAID/Burma	tdinh@usaid.gov	95-1-536-509 ext4852
MYANMAR UNIVERSITIES AND PROFESSIONAL ASSOCIATIONS				
Dr. Mya Thida	Professor and Head of Department	Univ Medicine 1 Central Women's Hospital O&G Society	profmyathida@gmail.com	Phone: Office +95 1 211769 Home: +95-1-223375 Mobile: +95-9-534 1969 Fax: 95-1-221013
Prof. Nang Htawn Hla	President MNMA	MNMA	Email: nanghtanhla@gmail.com	Phone: 01 388361 HomePhone 09 509 3765

Name	Title	Organization/Location	Email/Skype Address	Contact Number
Prof. Dr. Nwe Nwe Oo	Rector, Director WHOOC for Nursing and Midwifery development	University of Nursing, Yangon	Email: drnwenweoo@gmail.com	Phone: +95-9-2012590 Fax: 95-1-227449
Prof. Kaw Nau	Pro Rector Co-Director, WHO Collaborating Center for Nursing and Midwifery Development	University Nursing Yangon	Email: profkawnau@gmail.com	Phone: 01-227448
GOVERNMENT OF MYANMAR				
Dr. Thein Thein Htay	Deputy Director General (Public Health)	Ministry of Health, Department of Health	Email: thtay@mptmail.net.mm	Phone: 95 0 67 411157
Dr. Min Than Nyunt	Director General	Ministry of Health Department of Health Nay Pyi Taw, Myanmar	Email: mintn2008@gmail.com	Phone: +95 (0) 67 411001 Fax: +95 (0) 67 411022
Dr Tin Tin Lay	Deputy Director General	Ministry of Health Dept Medical Science	Email: drdawtintinlay@gmail.com	Phone: +95 67 401317 Fax: 95-67-411150
Dr. Than Zaw Myint	Director General	Ministry of Health Department of Medical Science Nay Pyi Taw, Myanmar	Email: dr.tzmyint@gmail.com	Phone: +95 (0) 67 411023 Fax: +95 (0) 67 411150
Dr Tin Tun	Director Post Graduate Training Planning (Assistant to Dr Than Zaw Myint)	Ministry of Health, Dept Medical Science	Email: tintundms@gmail.com	Phone: +95 95 67 411145 Fax: 95 67 411150
Nwe Nwe Khin	Director (Nursing) Vice President	Ministry of Health Dept Medical Science	Email: dnnknpt@gmail.com	Phone: 95 67 401318 Fax: 95 67

Name	Title	Organization/Location	Email/Skype Address	Contact Number
BA (Psy) MA(Q) BNSc, MPH (Mahid)	MNMA			411150

APPENDIX K: NARRATIVE OF DAILY ACTIVITIES

Trip Narrative

31 October 2013

Suzanne Stalls, Jody Lori, Helen Welch leave USA for Yangon, Myanmar

1st November 2013

Travel day

2nd November 2013

Suzanne Stalls, Helen Welch arrive Yangon, Myanmar. Rest day.

Jody Lori flight delay Hong Kong

3rd November 2013

Suzanne Stalls, Helen Welch meet at Chatrium Hotel with Jhpiego in country team Dr Hnin Wai Hlaing (Cherry) technical advisor, Dr Pansy Khin May Oo consultant, Kyaw Kyaw Cho program manager. Review of scope of work (SOW) and proposed schedule for visit.

Field visit to Nga Phe, Magway by Suzanne Stalls and Helen Welch arranged by Save the Children in country representative Kyi Kyi Ohn. Intended dates of travel November 10th 2013 returning November 13th 2013. Transportation and accommodation arranged. Permission from ministry applied for and expected but still pending. Permission for Jody Lori to visit to review PSE in midwifery and nursing schools in Yangon November 11th 2013 thru November 14th 2013 applied for and pending. Entire ACNM team will need to travel to capital Nay Pyi Taw for meetings with ministers once date/time finalized. This week's schedule will need to revolve around trip to NPT as movement/ work impossible without permission. Dr Cherry and Dr Pansy will reconnect with ministry tomorrow to try and finalize dates/ time for meetings.

Plan to meet MNMA leadership on Tuesday 5th November for clinical update on PTB requested by MNMA and review of ICM MACAT tool to lay foundation for completion on Friday 8th November.

4th November 2013

Jody Lori arrives in Yangon, Myanmar. ACNM team work meeting at Chatrium hotel. Review of all documents pertaining to SOW. Workforce reviews already completed by SDC/ Merlin / DOH will utilize as foundation for completion of gap analysis and proposal development. Workforce assessment tool created from High Burden Country Initiative (HBCI) Midwifery workforce assessment tool.

Review of current midwifery and nursing curriculum. Review and discussion of pre service education tool

5th November 2013

Visit to MNMA Sub Office/ maternity clinic, South Dagon Township. Clinical update on pre term birth as requested by MNMA by Helen Welch. Focus on ACS administration and Kangaroo care. Attended by group student midwives and nurses, midwifery tutors, MNMA president and EC. Gaps around ACS administration in rural and sub rural setting identified in post discussion. Review of ICM MACAT tool in preparation for intended completion November 8th 2013. Lunch provided by MNMA.

6th November 2013

ACNM S&T team and Jhpiego in country team travel by car to NPT for meetings with following ministers:

Dr Min Than Nyunt, Director General, Dept of Health, MoH Overview of Global Development Alliance Survive and Thrive organizational structure, SOW and objectives for this trip. Expressed support for SOW of GDA S&T. Support for workforce assessment trip to Magway. Described unique initiative in Magway where midwife oversees care in 7 villages. Due to volume of work each village assigned auxiliary midwife (6 months training) who cares for MNH and reports back to midwife. Dr Nyunt requests report back with evaluation of how program is functioning.

Also present at meeting Dr Tin Tin Lay MBBS M.Med.Sc(P&TM) Dip.Med.Ed Deputy Director General, Dept Medical Science

Dr Than Zaw Myint MBBS MMedSc MPH DipMedEd Director General, Dept Medical Science, MoH. Overview of Global Development Alliance Survive and Thrive organizational structure, SOW and objectives for this trip. Dr Myint described his recent visit to Johns Hopkins in US. Impressed with and hope for initiation and development of simulation training in all schools in Myanmar. Expressed support for SOW of ACNM as representatives of GDA for this trip. Advised to contact him if group needed permissions or support in field.

Also present at meeting Nwe Nwe Khin BA (Psy) MA(Q) BNSc, MPH (Mahidal) Director (Nursing) Dept Medical Science MoH

Dr. Thein Thein Htay, Deputy Minister, Ministry of Health: Overview of Global Development Alliance Survive and Thrive organizational structure, SOW and objectives for this trip. Expressed support of concepts and SOW. Stressed high expectation for reports from all findings in order for Ministry to fully coordinate in-country projects and leverage capacity avoiding duplication and overlap. Also stressed need for compliance with SOW allowed by permission.

7th November 2013 ACNM team meet with Kyi Kyi Ohn Save the Children at Save office. In depth discussion of plans for field trip and workforce analysis in NgaPhe. Logistics: travel, accommodation, translation, support, MNMA representative from Yangon. MoH minder to be collected in Magway. Planned visits to Township hospital, Station hospital, Rural HC and Sub Rural HC. Permissions requested by KKO from MOH pending and expected by 8th November 2013.

ACNM meet Dr Mya Thida MBBS MRCOG, FRCOG, FSRH at WCH. Overview of Global Development Alliance Survive and Thrive organizational structure, SOW and objectives for this trip. Dr Thida expresses support of midwives in Myanmar. Instrumental in redesign of midwifery curriculum to extend from 18 to 24 months. She conceived and developed a 4 month clinical training program for tutors for practical skill building. She has concerns around lack of clinical skills building in training. Possible to graduate from midwifery school and not deliver a baby. Interested in development of low risk maternity clinics for midwifery teaching/training. Interested in development of simulation sites.

8th November 2013

ACNM team, Dr Hnin Wai Hlaing (Cherry), Kyaw Kyaw Cho visit Central Midwifery Training school, Yangon. Met Daw Nyunt Nyunt Han, Principal. PSE tool completed as related to clinical site assessment.

Jody Lori, Kyaw Kyaw Cho remain and complete PSE tool. (JL lead, KKC translation)

Suzanne Stalls, Helen Welch, Dr Hnin Wai Hlaing (Cherry), return to MNMA South Dagon. Group meeting with MNMA EC to review and complete MACAT domains C through G. Overview, small group breakout sessions followed by plenary. Identification of areas for strengthening and priorities completed.

9th November 2013

ACNM team meet with ThuVan Dinh, Health Advisor, Office of Public Health USAID at Chatrium hotel. Review SOW. Review planned trips/ meetings. USAID strong support of midwifery. Discussion re midwifery development and strengthening in Myanmar. Want to empower midwives to carry out all 7 essential functions as endorsed by govnt. Need to develop national strategy for formulary development. Requests for in-service development for short term impact. Professional association strengthening for improved engagement and inclusion of MNMA in public policy development for MCH at highest levels for long-term impact. Also potential focus on development of Centers of Excellence with simulation labs at midwifery schools in strategic areas associated with 3MDG.

10th November 2013

Suzanne Stalls, Helen Welch, Kyi Kyi Ohn, Dr Hnin Wai Hlaing (Cherry), MNMA EC representative travel by car to Magway

Jody Lori completion of report on findings from visit to Yangon school of midwifery

11th November 2013 MoH representative met in Magway to accompany trip members to all sites. Suzanne Stalls, Helen Welch, Kyi Kyi Ohn, Dr Hnin Wai Hlaing (Cherry), MNMA EC

representative travel to NgaPhe. Visit Save project team. Brief on S&T SOW. Receive input on active Save projects in Nga Phe.

AM: Meet with Township Medical Officer and Township nurse and Township Health Assistant at Township Hospital. Workforce tool completed

Lunch courtesy Save

PM: Meet with Station Hospital Medical Officer and Station Health Nurse and LHV. Also present nursing/midwifery team. Workforce assessment tool completed.

Return to Magway.

Jody Lori and Dr Pansy Khin May Oo (translation support) visit clinical practice site AM:Central Womens Hospital. Met Director

PM:Central Domiciliary Training School: Met Daw Dashi Hkawnu, Principal

12th November 2013

Suzanne Stalls, Helen Welch, Kyi Kyi Ohn, Dr Hnin Wai Hlaing (Cherry), MNMA EC representative travel to NgaPhe.

AM: Visit sub rural HC. Interview 2 midwives, 2 auxilliary midwives 1 LHV. Workforce tool completed

Lunch courtesy Save

PM: Visit Rural HC. Interview 2 midwives, 2 AMW, 1LHV, Health Assistant. Workforce tool completed

Return to Magway

Jody Lori and Dr Pansy Khin May Oo (translation support) visit:

University of Nursing Yangon. Met Rector and Asst Rector

13th November 2013

Suzanne Stalls, Helen Welch, Kyi Kyi Ohn, Dr Hnin Wai Hlaing (Cherry), MNMA EC representative return to Yangon

Jody Lori visits Thanlyin. Met Daw Mya Thida Hlaing, Principal. Toured Thanlyin District Hospital.

14th November 2013

ACNM team debrief collective findings from work completed

Jody Lori, Helen Welch visit simulation lab at University of Nursing, Yangon

.Suzanne Stalls begins work on debrief report for USAID

ACNM team meet with Dr Francis Rushton to brief on work completed by ACNM and AAP during current trip

15th November 2013

AM: ACNM team work meeting to prepare for USAID debrief.

PM: ACNM team debrief meeting with USAID. Present Dr Rushton, Jhpiego in country team, Kyi Kyi Ohn STC.

Suzanne Stalls departs for Malawi

Helen Welch, Jody Lori depart for US