

Strategic Assessment of Needs and Priorities to Improve Maternal and Child Health and
Family Planning

USAID Regional Development Mission Asia

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ACRONYMS

AED	Academy for Educational Development
ACCESS	Addressing Unmet Need for Family Planning in Maternal, Neonatal and Child Health Programs
ADB	Asian Development Bank
AI	Avian Influenza
ANE	Asia/Near East
CCSDP	Coordinating Committee for Displaced Persons in Thailand
CHW	Community Health Worker
CMR	Child Mortality Rate
CPR	Contraceptive Prevalence Rate
EOC	Emergency Obstetric Care
ESD	Extending Service Delivery for Reproductive Health and Family Planning
FP	Family Planning
GHI	President's Global Health Initiative
GHFSI	President's Global Hunger and Food Security Initiative
HR	Human resources
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
JICA	Japanese International Cooperation Agency
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics And Obstetrics
LAPM	Long acting, permanent methods
LSS	Life Saving Skills
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
NMR	Neonatal Mortality Rate
PEPFAR	President's Emergency Plan for AIDS Relief
RDMA	Regional Development Mission Asia
RESPOND	Responding to the Need for Family Planning through Expanded Contraceptive Choices and Program Services
RH	Reproductive Health
SBA	Skilled birth attendant
SHIELD	Support for Institution Building, Education and Leadership in Policy Dialogue
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WB	World Bank

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EXECUTIVE SUMMARY

The five countries that comprise the USAID Regional Development Mission Asia (RDMA)—China, Thailand, the Lao Peoples Democratic Republic (Lao PDR), Burma and Papua New Guinea—are a diverse selection, based on the fact that they do not have an established USAID Mission located in country. Although the five have different social and economic profiles, they share many common health challenges that cross borders and can be addressed with similar approaches adapted to each country.

In early 2010, RDMA initiated a strategic assessment of regional needs and potential activities to address an area new to the Mission portfolio: maternal and child health, and family planning (MCH/FP). The objective of the assessment is to analyze problems of mothers and children and priorities in the RDM/A region, review ongoing programs and current national /donor support, and to identify a strategic framework and opportunities for potential Mission inputs that could lead to program and policy strengthening across the region.

Findings and Conclusions of the Assessment

Countries with Priority health needs. On reviewing the available health data, it is clear that China and Thailand have made major advances in reducing their infant, child and maternal mortality, have achieved replacement level fertility and high contraceptive prevalence, and are capably addressing the MCH/FP needs of their populations. Their health profiles would make them a low priority for RDMA technical and other support.

Burma, the Lao Peoples Democratic Republic and Papua New Guinea, on the other hand, each with very differing socio-economic and health system structures, demonstrate severe maternal and child health profiles. In these countries, maternal mortality ratios range from above 300 to over 700 maternal deaths per 100,000 live births; seven to ten per cent of children do not survive to age five—a total number probably exceeding 120,000 die each year; and over a quarter of these children die in their first month of life; over 30% of children in these countries are malnourished or stunted, conditions that are underlying causes of high rates of child and maternal mortality. Some key mortality rates in these three countries exceed or are comparable to other priority Asian countries: the under age five child mortality rate in Burma is higher than those of India, Pakistan and Bangladesh, and maternal mortality in Papua New Guinea, the Lao PDR and Burma are comparable to the rates in those South Asian neighbors.

There are serious technical, health system and resource gaps in each of the three countries which impede their ability to fully and effectively address the MCH/FP needs of their populations. Knowledge of and access to effective, quality health services that could prevent much of the illness and mortality are limited for substantial segments of the population. Based on their health profiles, all three countries have a clear need for targeted MCH/FP support that RDMA could provide.

Since it is likely that the initial RDMA funding for MNCH/FP activities will be limited, further narrowing of the country priorities is a pragmatic first step. Although PNG's MCH/FP health profile defines a serious need, current RDMA experience there—difficulty of access, very high cost of technical and other support, and weakness of the health system, complicated by social and political challenges—would suggest that PNG be given a lesser priority initially. Once the RDMA MCH/FP platform is launched, and if further funding were available, PNG activities might be considered.

Based on the situation analysis, from the seriousness and impact of their health problems and the gaps in the countries' ability to respond adequately and effectively to those needs, Burma and the Lao PDR should be the first priorities for RDMA technical assistance and investment in MNCH/FP.

Strength of successful RDMA approaches in the region. RDMA has developed an effective strategic approach to address regional health needs by: testing model prevention programs to expand access; strengthening service delivery to improve access and quality; generating strategic information to monitor program progress, results and impact and use it to affect program and policy action; and building an enabling environment to facilitate civil society participation and promote development of supportive policies and regulations.

Using this strategic approach, RDMA has focused on addressing critical cross-regional problems, including the focused HIV/AIDS epidemics, malaria, tuberculosis and other infectious diseases, and more recently, the emerging avian influenza and H1N1 influenza pandemics. By providing technical leadership, incorporating evidence-based best practices in well-monitored pilot activities or directly to national efforts, the OPH team, in collaboration with governments, regional institutions and implementing partners, has helped to build technical and institutional capability and change policies and programs to effectively meet these disease challenges in presence and non-presence countries' across the region. RDMA can readily adapt this well-established platform to cost-effectively initiate MCH/FP activities in the region with limited resources, drawing on USAID's worldwide technical leadership, technologies, experience and lessons learned in MCH/FP to share in the region and help the countries respond to the gaps in their national efforts. Adding an MCH/FP component to the regional platform also responds to the guidance of the Global Health Initiative's call for a focus on women and children, which comprise a major burden of the region's health need—and which, to date, RDMA has not had the resources to address.

The presence of RDMA-supported partners currently working in each of the priority countries also provides a potential entrée for MCH/FP activities. Although the RDMA/OPH support in health is focused on HIV/AIDS and other infectious diseases, the current implementing partnerships are with UN groups, such as WHO and FAO, other INGOs and firms, such as Save the Children, PACT, PATH, Academy for Educational Development, Population Services International, all of whom are deeply involved in broader maternal, child health and reproductive health issues. In addition, with other non-health funding, RDMA is supporting substantial health activities inside Burma (post-

Nargis relief and reconstruction) and migrant health activities on the Thai-Burma border. These partners form a potential base for RDMA to build MNCH/FP technical support from the regional platform.

Other areas of Mission involvement in MCH/FP programs

Global Hunger and Food Security Initiative. One component of the Mission's new regional Global Hunger and Food Security Initiative (GHFSI) focuses on reducing malnutrition. Because of malnutrition's underlying impact on maternal and child health, the initiative offers the potential for region-wide synergies with the emerging MCH/FP strategy. The Mission's plan to work through ASEAN (and other international agencies) to strengthen food security and reduce malnutrition could stimulate enhanced interest and priority among the member states if malnutrition were linked to the impact on both the health of mothers and children, and on young child learning capabilities. For this reason, it would be fruitful and synergistic for RDMA to look at the potential to also build in a maternal and child health/family planning element into the GHFSI ASEAN agenda.

Thai/Burma border activities. Because of their unique organization and transitional nature, the border migrant health services program supported by RDMA does not appear, at first face, to have a clear link to a regional strategy for improving MCH/FP. However, given the continuing USG commitment to assisting the migrant populations and to addressing their health care needs—and the links to the health situation in Burma, there could be a useful element of technical support as part RDM/A's regional strategy for strengthening MCH/FP services and systems. There may also lessons to be learned from the migrant health care system that could be applicable to remote, underserved area of countries such as Laos and Burma. The Thai Ministry of Health is a key player in supporting the migrant health service system, and RDMA should look at opportunities to share with the MOH USAID's wide MCH/FP experience and lessons and to provide technical assistance to strengthen the MOH support to migrant health services.

An RDMA MCH/FP technical assistance presence could strengthen the Mission's capacity to review and provide technical support for the MCH/FP programs that are a core of the migrant health care systems inside and outside the camps on the Thai-Burma border. RDMA's implementing partner and other NGO collaborators have built self-reliant, effective health care programs that are improving the migrant's health in very difficult circumstances and with limited resources. They are eager to build their teams' technical capabilities and would welcome RDMA technical assistance and sharing MNCH/PF lessons learned and best practices to strengthen their programs.

Main Recommendations

1. Comprehensive MCH/FP assessment. With the Lao PDR and Burma as the first priorities, RDMA should complete a more comprehensive follow-on assessment to: better identify MCH/FP needs and the gaps in programs to address them in each country; systematically document the roles of government, donors and other partners; and target the concrete areas for RDMA technical support and collaboration. At the same time, the

in-depth assessment should also look broadly across the region to identify opportunities for strengthening technical capacity, sharing best practices and strategic information.

2. Establish an MCH/FP technical assistance capacity in RDMA. Another priority should be to identify a resident MCH/FP technical advisor for the RDMA health team. An experienced MCH/FP specialist based in the Bangkok Mission is critical to developing the new program component, to establish RDMA technical leadership and credibility, and foster collaborative linkages within the region—as it has been done so effectively in HIV/AIDS and other infectious disease programs.

3. Strategic Information. RDMA should use the planned Lao PDR Demographic and Health Survey (DHS) results dissemination to further assess information gaps, particularly in the routine health information systems, and identify opportunities for strengthening them. RDMA should discuss with the donors and Lao Ministry of Health the opportunities for complementary SI strengthening in conjunction with the recently-developed National Health Information System Strategic Plan, which comprehensively addresses all areas of health information needs and use.

4. Behavior change communications. As the Lao PDR National Integrated Strategy for MNCH Services gets underway, technical support for designing a supportive communications strategy is an important niche that does not appear to be currently built in. In Burma, RDMA similarly currently supports communications and social marketing activities into which MCH/FP communications for behavior change could be built. The consultant team believes that there is a substantial need and recommends that the Mission further review the opportunities for strengthening behavior change communications support with the governments and implementing partners.

5. Building capacity and sharing best practices and lessons learned. RDMA should participate in and stimulate organization of regional fora to build capacity for improving MCH/FP interventions and delivery approaches, and to share and adapt MCH/FP best practices and lessons learned, focusing on experiences from the RDMA countries, as well as global experiences. This could build on the 2007 (and planned 2010) Asia Near East Bureau-organized best practices conferences in Bangkok, which focused on newborn, infant and child health, maternal health and family planning, but included few participants from the RDMA countries.

6. Review the capable MCH/FP technical resources in Thailand—institutional and individual—which could be a source of South-South collaboration. Identify opportunities to utilize these resources in supporting in-country and regional technical assistance.

7. As RDMA establishes an MCH/FP technical assistance capacity, the RDMA regionally-based advisor could strengthen the Mission's capacity to review and provide technical support for the MCH/FP programs that are a core of the migrant health care systems inside and outside the camps on the Thai-Burma border.

8. Global Food Security and Hunger Initiative. Several steps are recommended:

First, as RDMA/GDO conducts further assessments in the coming months to facilitate its planning of the nutrition component, it should ensure that they include the broader impact of malnutrition as an underlying cause of maternal and child health problems, as well as the proven positive contribution of effective MCH/FP services on reducing malnutrition.

Second, as part the final plans for implementing the Mission's Food Security and Hunger Initiative, RDMA should introduce in ASEAN discussions the important linkages between malnutrition and maternal and child health, with a focus not only on increasing food availability, but also on the impact of MCH/FP services on improving nutritional status.

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1. INTRODUCTION

The five countries that comprise the USAID Regional Development Mission Asia (RDMA) are a diverse selection, based on the fact that they do not have an established USAID Mission located in country. Although the five—China, Thailand, the Lao Peoples Democratic Republic (Lao PDR), Burma and Papua New Guinea—have very diverse social and economic profiles, they share many common health challenges that cross borders and can be addressed with similar approaches adapted to each country. RDMA has built a strong health portfolio based on identifying important problems common to all or most of the five countries, relying on its team of expert technical specialists and managerial staff to help the countries test and share and scale up evidence-based solutions across the region. RDMA’s health team provides direct support, and also guides and monitors a number of partners who work with governments and local organizations to implement the Mission’s health strategy and provide technical support from both regional and in-country locations.

RDMA has used a regional strategic approach linked to individual countries with four components:

- support for testing model public health prevention programs and expanding access to for most at risk populations;
- strengthened health service delivery to improve access and quality of services for the groups most affected;
- generating strategic information to monitor program progress, results and impact and use it to affect program and policy action;
- building an enabling environment to facilitate civil society participation and promote development of supportive policies and regulations.

Under this general approach, the Office of Public Health (OPH) has, for almost a decade, focused on addressing critical cross-regional or cross-border problems, such as the focused HIV/AIDS epidemics, malaria, tuberculosis and other infectious diseases, and more recently, the emerging avian influenza and H1N1 influenza pandemics. By incorporating evidence-based best practices in well-monitored pilot activities or directly to national efforts, the OPH team, in collaboration with governments, regional institutions and implementing partners, has helped to build technical and institutional capability and

change policies and programs to effectively meet these disease challenges in presence and non-presence countries across the region.

In January, 2010, RDMA initiated a strategic assessment of regional needs and potential activities to address an area new to the Mission portfolio: maternal, neonatal and child health, and family planning and reproductive health (MNCH/FP/RH). The objective of the assessment is to analyze problems of mothers and children and priorities in the RDMA region, review ongoing programs and current national /donor support, and to identify a strategic framework and opportunities for potential Mission inputs that could lead to program and policy strengthening across the region

RDMA contracted two outside consultants experienced in maternal and child health and family planning/reproductive health to carry out the MCH/FP assessment over the period January 6 to February 4, 2010. The consultants began the assignment with briefing meetings with key Asia Bureau staff and Global Health Bureau maternal and child health and family planning specialists at USAID/Washington. The in-country part of the assessment began on January 11 with RDMA/OPH briefings for the consultant team, who then met with a variety of implementing partners, NGOs, international agencies, and donors. The consultant team also traveled to Laos and to Mae Sot District on the Thai-Burma border to review ongoing MCH/FP programs and meet program implementers and donors. Because of the preliminary nature of the assessment, the consultants had no official meetings with host country governments, except for a briefing from the Community Medicine Department in Mae Sot District Hospital, a Thai Ministry of Health facility supporting the Burmese migrant program on the border. A complete schedule and work plan and a list of persons/organizations contacted are attached in Annexes 1 and 2.

With limited opportunities to visit field program sites, the consultants reviewed documents provided by USAID/Washington and the Mission, other documents supplied by the organizations and informants interviewed, and complemented by reports and data culled from on-line sources. The data used in this analysis come from multiple sources: surveys, government statistics and reports, UN and other international agency sources, which are not uniform in quality and time frame. There are also substantial gaps in the information, but, overall, the consultants view the available data as sufficient to provide a reliable picture of the current maternal and child health, family planning situation for most of the region.

2. USAID PRIORITIES IN MATERNAL, NEONATAL AND CHILD HEALTH AND FAMILY PLANNING (MNCH/FP)

The recently-announced President's new Global Health Initiative (GHI) outlines basic principles for the six-year, \$63 billion plan to address major global health needs. The initiative reinforces USAID's effort to maintain leadership and advance an ambitious agenda to address the major global health challenges. The guiding principles and approaches of the GHI provide a useful framework for reviewing the health needs of women and children and approaches to addressing them in the region. The GHI health

recognizes the achievements and integrates the high-priority HIV/AIDS (PEPFAR), malaria, tuberculosis and other infectious disease programs; but by putting women and children in the forefront, the GHI gives prominent emphasis to addressing the heavy burden of mortality and disease on women and children, which has been overshadowed by other disease priorities in recent years. In the period 2009-2014, it sets concrete goals for: saving the lives of 3 million young children (half of them newborn); preventing 54 million unintended pregnancies through increased contraceptive use—reducing the risk of maternal death and improving child survival; and reducing child malnutrition—an important underlying cause of up to half of child deaths—by 30%. This latter GHI goal is also reinforced by the new President’s Hunger and Food Security Initiative (PHFSI).

One of the GHI implementation approaches is “Do more of what works”. This means identifying and integrating evidence-based, field-proven approaches, applying them on a large scale, and evaluating their impact. USAID global health teams—with MCH and FP at the forefront—have led the way in developing tools and sharing globally the evidence-based best practices with proven impact. USAID collaborates closely with other USG agencies, UN and other international organizations, private sector groups and host countries to foster application of the proven technologies on a large scale. Demographic and Health Surveys and other evaluative/research tools have been the foundation of USAID’s ability to test interventions, measure impact and report results to Congress, as well as to enable cooperating countries to measure the results of their programs and modify national policies. These tools have also become a key element in tracking progress on the Millennium Development Goals (MDG) on both national and global levels.

RDMA’s health team currently uses many of the approaches outlined in the GHI guidelines, incorporating proven technologies, emphasizing monitoring, evaluation and strategic information to document and share best practices and lessons learned to scale up for broad impact. These approaches have helped build an effective regional platform which has achieved success in addressing the problems of HIV/AIDS, malaria and tuberculosis, and more recently, in responding to the avian influenza (AI) and other pandemic influenza strains. Some of these current programs involve women and children, but not necessarily as a main focus. To date, RDMA has not had the resources to focus on and support addressing the broader health needs of women and children, which constitute a huge part of the region’s health burden. The following assessment of MCH/FP need outlines the potential for for integrating MCH/FP into the RDMA health portfolio.

3. SITUATION ANALYSIS, NEEDS AND PRIORITIES

In reviewing the situation in the region, several criteria have been used to analyze the maternal/child health and family planning situation in the RDMA countries and to determine needs and priorities for potential USAID support to strengthen MCNH/FP: first, the seriousness of the countries’ health needs and the national response to addressing those needs; second, the probable MNCH/FP budget limitations for MCH/FP

support; and third, the potential opportunities for USAID support and presence of collaborating partners.

Table 1 below provides a summary overview of key health indicators that demonstrate the wide diversity in maternal and child health, fertility, family planning and reproductive health need across the region. It shows a sharp divergence in the health status of mothers and young children, and service delivery to meet their needs, in the RDMA countries. China and Thailand, on one hand, represent, for most indicators, more advanced country profiles. The Lao PDR, Burma and Papua New Guinea, on the other hand, reflect strongly contrasting health status profiles of lower income countries. The latter three countries are among the most severely affected in the region.

Lao People's Democratic Republic (PDR)

The Lao PDR is a small, landlocked country with a population of 5.6 million, 49 ethnic groups, and sharing borders with China, Cambodia, Vietnam, Thailand and Burma. The majority of the population (75%) lives in rural areas primarily involved in subsistence farming. The total fertility rate (TFR) declined in recent years from 5.6 children per 1000 women in 1995 to 4.0 in 2005 (Lao PDR 2005 Reproductive Health Survey³; UNICEF data suggest 3.2 for 2007), with broad regional variations: the highest TFR is in Sekong Province (6.5) and the lowest in Vientiane Capital (2.3). Contraceptive prevalence is 38% nationally, but also varies widely from 57.2% in Sayaboury Province to less than 30% in the entire southern region. (Lao Reproductive Health Survey 2005³ and The Provincial Report of the Lao Reproductive Health Survey 2005⁴).

Infant mortality (IMR) is 70 infant deaths pr/1000 live births, under-five mortality is 98/1000, which means almost 20,000 children die each year before reaching their fifth birthday. More than 50% of the infant deaths are neonatal deaths, and most of those occur in the first week of life. Neonatal deaths constitute about 50% of all infant mortality. Malnutrition is an important underlying cause of mortality in children under age five: 14% of children born are of low birth weight, 37% of children under age five are underweight for age and 40% are stunted.¹

Only 27% of children receive the full course of eight immunizations by the end of their first year, and only 40% receive a measles immunization. According to the 2006 MICS (UNICEF-supported Multiple Indicators Cluster Survey⁶), about 52% of pregnant women were immunized against tetanus.

Safe motherhood is a serious concern in Lao PDR. The maternal mortality ratio (MMR) is estimated at 405 deaths /100,000 live births (MOH, Lao PDR), although UN-adjusted data suggest it is closer to 600¹ ("Strategy and Planning Framework for the Integrated Package of Maternal Neonatal and Child Health Services 2009-2015⁷"). The Lao maternal mortality ratio is higher than those of India, Pakistan, and Bangladesh¹.

Most maternal deaths occur at home where 85% of deliveries take place, and only 18.5% of all births are attended by a skilled birth attendant (SBA). There is a sharp urban/rural difference: 51% of urban women deliver in a health facility, while only 13% of women

living in a rural village with an access road, and 3.5% from a rural village without a road, deliver in a health facility, respectively ⁷. Even when women are able to reach a

Table 1 Comparison of Key National Demographic and Health Indicators in the RDMA Region

Indicators	China	Thailand	Lao PDR	Burma	PNG
Population	1.3 billion	65 mil	5.6 mil	55 mil	6.3 mil
% poor	4.6	10	33.5	37.5	37
IMR	19	16	56	74	50*
NMR	18	9	30	49	32
<5MR	22.0	7	70	103	65 (74*)
MMR	45	14	400-600**	316- 380**	470 (733*)
TFR	1.7	18	3.2	2.1	4.4*
% immunized for measles<24 months	94	96	40	81	58
% low birth weight	2.0	9	14.0	15	9*
% < age 5 mod-severe low weight for age	6.0	9	37	32	28*
% < age 5 stunted	11	12	40	32	NA
% ANC for >1 visit	90	98	27	76	77
% skilled attendant delivery	98	97	19	57	53*
Modern CPR	85	77	38	34	26

Data in the table have been drawn from UNICEF, State of the World's Children¹, Maternal and Child Health, 2009, and from WHO country reports and statistics on line

* 2006 PNG Demographic and Health Survey²

** There are differences between rates used in country and UNICEF adjusted rates

facility, access to emergency obstetric care (EOC) is often limited. Only 66% of provincial hospitals can provide comprehensive EOC, and only 5% of district hospitals offer these emergency services (Skilled Birth Attendance Development Plan, Lao PDR 2008-2012 ⁸).

In 2007, the MOH conducted a study of human resource needs (Human Resources for Health: Analysis of the Situation in the Lao People's Democratic Republic ⁹) which provides a clear picture of the current situation. There is a serious mal-distribution of doctors, with only eight assigned to district health centers; doctors also comprise only 6%

of all district health staff. There are four central teaching and referral hospitals, five regional hospitals, 13 provincial hospitals, 127 district hospitals, and 750 health centers. Approximately 55 medical doctors graduate each year. Auxiliary nurse training is being phased out and mid-level nurses and midwives will be increased. The conclusion of the HR situation analysis was that the total health workforce is inadequate to meet current health service needs, with continuing inequities in access to qualified providers in large areas of the country.

The data presented indicate that current human resource gaps will continue to challenge the Lao PDR in achieving the ambitious goals it has set for its integrated MNCH strategic plan. The completion of the National Strategy and Planning Framework for the Integrated Package of Maternal Neonatal and Child Health Services 2009-2015 ⁷ is a positive response to the current maternal and child health situation and lays a foundation for concrete actions with coordinated financial and technical support from the donors and international agencies, as outlined below.

Current Response from Lao PDR Government, Donors and Implementing Partners.

Lao government financing in the health sector is quite limited: 70% of health expenditures are out-of-pocket, 20% are from donors, and 10% come from the Lao government. Most government funds are distributed directly to and managed by the provinces, and are used primarily for personnel and some operational costs. Donor funds, managed by the MOH, support the various health programs.

The MOH programs receive support from many sources including the World Bank, Asian Development Bank, Lux Development, UNFPA, UNICEF, JICA, and WHO. Support from NGOs includes CARE, Save the Children (Australia), and Health Frontiers (private organization engaged in training pediatricians). RDMA-supported partners are working in the Lao PDR to help address and monitor the HIV/AIDS concentrated epidemic and other infectious diseases (malaria, tuberculosis and avian influenza).

The MOH, donors, international agencies and NGO partners have collaborated to develop a Sector-wide Coordinating (SWC) Mechanism for Health, with the Policy Level Working Group, co-chaired by the Minister of Health, the Japanese ambassador and WHO representative, providing overall policy leadership and coordination. Other Sector Working Groups—Operational Level, include Health Planning and Finance, Human Resources, and Maternal and Child Health/EPI. Each donor or implementing partner that the team met confirmed its commitment to the sector-wide coordination mechanism and to the integrated MNCH plan.

All of the major donors and implementing partners have agreed to support the National Integrated Maternal Neonatal and Child Health Strategy which was collaboratively prepared with the MOH in 2009. The Japanese International Cooperation Agency (JICA) has pledged Y500 million (\$5.4 million) to support primarily equipment and technical assistance for five years, focused on four southern provinces, and will assist public health schools, and nurse and midwifery training programs. The development banks (with strictly grant funding) have agreed to support the plan in different regions: the Asian

Development Bank will provide an initial \$20 million for five years to support infrastructure and training (with technical support from the UN agencies) in eight northern provinces. Luxembourg-Development will support integrated MCH services in three central provinces, and the World Bank (WB) will support five southern provinces (the consultants did not meet with Lux-Development or the WB, so did not get estimated funding levels). UNFPA has been a key player in the MNCH Strategy development, supporting the 2005 Reproductive Health Survey and the comprehensive assessment and implementation plan for training skilled birth attendants, and will be in a lead role in the roll-out of new midwifery training programs. UNICEF is engaged in EPI, working on both routine EPI delivery and campaigns.

Many NGOs and private organizations also contribute to improving the health situation. CARE International, Save the Children (Australia) and Health Frontiers are examples. Health Frontiers is a private group that is engaged in training pediatricians and has pioneered the first post-graduate education and certification for pediatricians throughout the country. One important example the team reviewed was the Save the Children (Australia) program, which has supported integrated primary health care (PHC) development in Sayaboury Province for 18 years. In collaboration with the Provincial Health Office, Save has supported development of a comprehensive PHC program which leads with MCH and FP as top priorities. Save has used a province-wide, phased approach, completing planning and implementation in one district before moving on to another. All districts of Sayaboury Province have now been covered, and Save has moved to the adjacent Luang Prabang Province to assist the provincial health authorities to implement a similar program there. Sayaboury's success stems from the close collaboration with the provincial health staff on an integrated approach, with sustained technical and operational support led by a skilled expatriate nurse midwife consultant resident in the province the entire time. The results achieved by the province-wide integrated approach are impressive: CPR is 67.6%, ANC coverage is 72.6%; 43.7% of deliveries are done by skilled birth attendants; and immunization coverage is 83%--all much higher than national averages (Save presentation 1/14/10). The impact achieved is also pronounced: infant, child and maternal mortality, and fertility have all declined sharply—all in contrast to national level indicators.

With very preliminary observations during a brief visit, there appear to be a number of options for potential MCH/FP support from RDMA.

The evolving cordial Lao-US political relations and current receptive government environment has facilitated ongoing collaborative HIV/AIDS and ID activities supported by RDMA under its regional framework. As noted earlier in this report, the Lao government has built a strong, integrated framework for the health sector, and particularly in their "National Strategy and Planning Framework of the Integrated Package of Maternal and Neonatal and Child Health Services", under which all donors, international agencies and NGOs are integrated and have committed funding and technical support. This is a positive environment to which complementary USAID inputs would be welcome.

A core area of the Integrated MNCH Strategy is building the capacity to effectively deliver quality maternal and child health services, with an emphasis on rapid expansion of skilled birth attendants. There has been a well-crafted assessment of need and training plan and materials are in development, with capable support from UNFPA, JICA and others. However, the tasks are huge and complex, and there appear to be many areas where USAID's long experience and technical strengths in improving interventions, capacity building, and community-based approaches for improving maternal, neonatal and child health, and family planning and reproductive health could make valuable contributions. Follow-up, in-depth technical reviews by RDMA are needed to pinpoint the best use of RDMA technical support.

As the Lao PDR National Integrated Strategy for MNCH Services gets underway, technical support for designing a supportive communications strategy would be an important niche that does not appear to be currently built in, would be welcomed by other donors, and which RDMA could readily address with modest resources. RDMA's current support for both behavior communications and social marketing partners in the Lao PDR provides a platform for collaboration and technical support. PSI has an established program and social marketing and service network in Laos, which RDMA currently supports for HIV/AIDS activities. PSI is also involved in their core reproductive health services and products, with strong social marketing and behavior change communications capabilities, and their established presence could permit potential technical cooperation to introduce complementary MCH/FP activities.

As the Lao PDR National Strategy for Integrated MNCH Services goes into implementation and roll-out, monitoring and assessment of progress and results will be an area for potential RDMA technical support. In recent meetings with Lao-based UN and other agencies, OPH team members (and the consultant team) have received expressions of interest for USAID technical support to conduct a Lao Demographic and Health Survey. This proposal was agreed on in principle by the Ministry of Health, but there is still ongoing discussion on details among the participating agencies. When consensus is reached, this could be an excellent opportunity to demonstrate USAID's technical capabilities and also serve as an entrée into broader SI discussions in the circle of partners supporting the national strategy.

RDMA technical support for the DHS should be viewed as a first step. The value of the DHS is not only the quality data and analysis it produces, but also the policy and program discussions that it generates at all levels of government and the health community through the survey results dissemination process. Well-programmed, targeted dissemination is a proven DHS approach for bringing the data into mainstream policy decision-making. Given the apparent government and donor support for the DHS, the team also recommends that RDMA use the DHS dissemination to further assess information gaps, particularly in the routine health information systems, and identify opportunities for strengthening. With WHO and other donor support, the Lao government has recently developed a National Health Information System Strategic Plan (2009-2015)¹⁶, which comprehensively addresses all areas of health information needs and use. The team sees an option for RDMA should discuss with the donors and Lao

Ministry of Health the opportunities for complementary SI strengthening in conjunction with the National HIS plan.

Finally, the successful results of the Save Australia-supported primary health care approach in Sayaboury Province is a model with proven impact for effectively achieving significant impact on MCH/FP indicators for that province. These results and the lessons gained from implementing the province-focused approach would be usefully shared both within Laos as well as in the region. Current RDMA SI team members could assist in identifying mechanisms for further disseminating this and other important approaches.

Burma

Burma's profile for maternal and child health indicators make it one of the most seriously affected countries in the region (see Table 1). The consultant team was not able to visit Burma, but from various UN and Burmese government documents, and from discussions with groups working inside Burma, the key health status indicators demonstrate a high level of need.

With a population of 55million, Burma is the third largest of the RDMA countries, after China and Thailand. The population is predominantly rural (76%), over 35% is classified as poverty level, and there are great variations in health indicators among the regions, with the poorest, most remote areas carrying the heaviest health burden.

- The maternal mortality ratio is 316 (the UNICEF ¹ adjusted figure is 380), and an estimated 90% of the maternal deaths occur in rural areas with limited access to life-saving emergency obstetric care; 1.3 % of pregnant women test positive for HIV (WHO Myanmar Country Health Information Profile ¹⁰).
- Although a reported three-quarters of pregnant women have at least one ante-natal visit, and almost 60% of women giving birth are delivered by a skilled birth attendant (SBA), maternal mortality remains unusually high; 76% of births take place at home—85% in rural areas, and 49% in urban areas. One-third of births are still attended by a traditional birth attendant. (Myanmar 2007 Reproductive Health Survey ¹¹)
- Under-age-five child mortality is 103, with an estimated 92,000 child deaths annually—almost 10% of children born do not survive to age five. The infant mortality rate is 74 (UNICEF 2009 ¹), which accounts for almost 70% of all child deaths, and deaths of newborn children in the first 28 days (neonatal mortality) account for over half of all infant deaths. Variations are reported among the regions, and the IMR in eastern Burma is estimated at above 90 (IRC communication¹⁷). The level of under-age-five child mortality in Burma is higher than Cambodia, India, Pakistan and Bangladesh (UNICEF 2009 ¹).
- Malnutrition is a major underlying cause of child mortality and morbidity: 15% of newborns are of low birth weight, 32% of children under age five are malnourished (8% seriously), and 32% are stunted. The malnutrition prevalence in rural children is 30% higher than the rate for urban children (UNICEF, MICS 2003¹²); about half of all under-age-five child deaths are estimated to be linked to underlying malnutrition. High levels

of iron deficiency anemia are also reported in both women (55%) and children (45%) (IRD presentation ¹⁷).

- Total fertility is surprisingly low at 2.1 children per woman (1.7 in urban areas, 2.2 rural), given that only 38% of married women are currently using modern family planning methods (UNICEF 2009¹). Injectable contraceptives, oral pills and the IUD are the preferred methods; choice of sterilization has declined as access is limited by a tacit government pro-natalist policy. Several informants noted that abortion (which is illegal) is frequently sought from a variety of clandestine providers, raising the risk of maternal mortality or serious complications. In the Myanmar 2007 National Reproductive Health Survey ¹¹, 13% of women over age 35 admitted to at least one abortion. Abortion levels among younger women are thought to be substantially higher.

-Burma remains the center of malaria transmission in SE Asia, accounting for an estimated half of the total reported cases and malaria deaths in the region each year (and for over 5% of all deaths reported in Burma), seriously affecting pregnant women and children. (briefing from RDMA malaria specialist)

In summary, although there are some inconsistencies in the maternal and child health indicators and variability in the available data, it appears clear that the burden of mortality and morbidity for women and children is very high and remains a major challenge for Burma and the region.

Current Response from the Government, Donors and Implementing Partners.

Burma has a national network of hospitals, health centers, and midwifery centers that covers much of the country down to the community level. But the government budget for health is less than 3% of the national budget, the lowest in the region, so the health system is seriously lacking in resources and is considered a neglected government priority, undermining performance and quality of the health system. (WHO, Myanmar Country Health Information Profile, 2009 ¹⁰) Less than 10% of the Ministry of Health budget is allocated to prevention and promotion. The number of doctors, nurses, midwives and health workers has increased in the past two decades, but the number of hospitals and other health facilities has changed little (MOH data). The recent Nargis cyclone devastated large areas in the Irawaddy Delta region, destroying many health facilities, disrupting staff, and seriously undermining the availability of health services in an area containing almost a third of Burma's population, as well as in other areas.

Even before the Nargis cyclone, there were clearly problems in the Burmese health system's quality, performance and results, as evidenced by the high maternal and child mortality indicators and modest levels of coverage with key health services, which are clearly not effectively reaching the highest-risk mother and child populations. One informed observer noted that the continuing high mortality is linked to limited access to effective services in many areas, "low utilization of those health services, low use of or compliance with appropriate treatments, and low level of practice of key preventive health behaviors. Other indirect causes include "low level of knowledge about health services, appropriate treatments and key preventive health behaviors; lack of access to

health services and environmental health facilities; and the poor quality of health services. Both the direct and indirect causes are affected by four basic or contextual factors--health policies, a weak civil society, poverty and discrimination". (Save the Children, Draft Myanmar Program for Health, 2009-2013¹³)

Other observers note the serious limitations on the health system ¹⁷):

- Limited emergency referral services in rural areas, particularly for EOC
- Lack of outreach activities and inadequate coverage of basic health services
- Lack of supervision of basic health workers
- High drop out of community health workers due to lack of support/monitoring
- Unreliability of health information system data

Despite the limitations on interaction with Burma's government, working through respected, well-established partners, RDMA has been able to provide important technical assistance and support pilot activities in-country to help respond to HIV/AIDS and other infectious disease problems, especially malaria and avian influenza, in collaboration with international agencies and NGOs. The consultant team did not visit Burma, but was able to have discussions and communicate with non-government implementers, and with other partners based there who currently receive RDMA funding for HIV/AIDS and other infectious disease activities. PSI (the largest INGO), Save the Children and PACT have been in Burma for many years and have extensive program networks (offices, staff and service outlets) located in large segments of the country, working with townships and communities. Save activities expanded significantly during the post-Nargis relief effort. Many of the key INGOs are also deeply involved in strengthening maternal and child health and/or family planning/reproductive health services with other funding sources, and are also working with the private sector (PSI).

Although the analysis of the Burma situation is limited, it is clearly the country with the most challenging situation, both in terms of the MCH/FP need and population affected, and also due to the lack of government support and resulting low performance of the health care system in responding to the needs of women and children. It also appears that there are many potential areas where RDMA could provide useful MCH/FP technical inputs, but it is premature to suggest which options would be most appropriate without a further, in-country review and assessment. But from the analysis, several areas of need stand out:

- Analysis of the major causes of maternal and child mortality
- Strengthening of health information systems
- Capacity building for delivery care and emergency obstetric care
- Behavior change communications related to maternal and child health

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Papua New Guinea (PNG)

The PNG data summarized in Table 1 provide a profile of a country with serious maternal and child health problems. Under-age-five child mortality is 65, and infant mortality is 50 ¹. The maternal mortality ratio is listed at 470 per 100,000 live births by UNICEF, but the 2006 PNG Demographic and Health Survey (DHS) ² measured it at 733,

among the highest levels in South and Southeast Asia (UNICEF 2009¹). According to WHO (WHO PNG Country Health Profile¹⁴), the MMR has increased in recent years due to a decline in the quality and coverage of services. Only 41% of births are attended by a skilled birth attendant. Total fertility is 4.4 and modern contraceptive prevalence is 26%². Over 85% of PNG's population of 6.4 million is dispersed in scattered rural communities speaking dozens of languages; only 3% of roads are paved, and many areas can only be reached on foot, impeding access to and delivery of health communications and services.

Health expenditures account for about 3.2% of GNP, and 7.3% (about \$200 million) of the 2007 PNG government budget was allocated for health. Unlike almost all other countries in the region, 80% of health expenditures are government expenditures, and less than 20% are private¹⁴. An estimated \$200 million has been provided annually by donors in official development assistance, accounting for approximately 24% of total health expenditures, and 40% of the Department of Health budget. Australia has traditionally been the major source of donor funding, as well as technical assistance, but in 2004, a sector-wide approach was established, with Australian AID (AusAID), New Zealand AID (NZAID), UNICEF, UNFPA, WHO, and more recently, ADB, signing partnership arrangements with the National Department of Health for a Health Sector Improvement Programme¹⁴.

Under the Law on Provincial Governments and Local Level Governments, the National Department of Health takes responsibility for policies, standards, training, medical supplies, special services, public hospitals and monitoring, while provincial and local governments are responsible for implementing, managing and funding health programs. However, the provincial and local governments also implement other priorities and the reality is that health programs in rural areas are chronically under-funded. There are also serious shortages in key staff, such as nurses and community health workers, and there is a lack of supervisory capacity, lack of funds and sufficient support for training and supervision. As a result, many health facilities have been closed, health staff positions are unfilled and the health system is severely handicapped—a major challenge to service delivery and system strengthening¹⁴.

Implementing health programs in PNG is also challenging because of the high cost and time required for activities: travel in-country must be by air because of the lack of roads; distances to scattered population centers, and the weaknesses in the health care system are formidable impediments. RDMA currently supports only one implementing HIV/AIDS partner in PNG, and similarly finds that managing and monitoring the activities are high cost, with limited results—plus the added challenges of the complexity of government interactions, and the great distance from Bangkok headquarters.

There is little doubt that Papua New Guinea faces serious and compelling MCH/FP needs, as well as health system challenges to the country's ability to address those needs. It is possible that USAID technical resources could productively contribute to improving the health of women and children in PNG. However, given the current lack of a strong receptive framework, the high cost of operating there, and the expected initial limitations

on RDMA's MCH/FP funding, PNG should not be considered the first priority for potential activities. The option for involvement there should be left open, pending a much fuller assessment of the needs and possible areas for involvement.

China and Thailand

A brief review of health data from China and Thailand confirmed to the consultant team that these two countries are strikingly different from the other three RDMA countries, the Lao PDR, Burma and PNG. As can be seen in Table 1, China and Thailand's health profiles are those of middle-income countries. Both China and Thailand have achieved huge improvements in the health status of their populations and in their health service systems over the past thirty years. Both have poverty levels at 10% or below, whereas the Lao PDR, Burma and PNG all have levels above 30%. Chinese and Thai infant mortality and under-age-five mortality levels are one-third to one-quarter of the other three countries, and China's and Thailand's maternal mortality ratios are one-eighth to less than one-twentieth of the other three countries. Coverage of key health services such as antenatal care, skilled delivery care, immunization and contraceptive services are substantially higher than in the Lao PDR, Burma and PNG.

Aside from reviewing health data for China and Thailand, the consultant team had no contact with government officials or groups working in those countries, as such interactions were not planned in the scope of work. Nor was there any further review of health systems or ongoing MCH/FP programs in the two countries. It is quite clear that China and Thailand have achieved success in providing high coverage with effective maternal and child health services which has led to impressive impact on MCH/FP indicators. Neither, therefore, would be a priority for additional support from RDMA to further extend these MCH/FP outcomes. But each of these countries may have technical approaches and lessons critical to their success to share with their neighbors, and which RDMA could utilize in providing MNCH/FP technical support to other countries in the region. The consultant team did not have the opportunity to assess the potential of such cross-regional cooperation, but would recommend that this potential be looked at in more depth in a more comprehensive follow-on assessment.

Migrant Health Activities on the Burma/Thai Border

The consultant team traveled to Mae Sot District, which borders Burma, where they met with International Rescue Committee (IRC) staff for a briefing on the SHIELD Project (Support for Institution Building, Education and Leadership in Policy Dialogue), followed by visits to the Mae Tao migrant health clinic in Mae Sot town, the clinic in Mae La migrant camp on the Burma border and a Community Health Post in the nearby Mae La Klo village (all supported by IRC). The consultants were also briefed by the chief of the Community Medicine Department and his team in the Mae Sot District Hospital, which is the major referral destination and Ministry of Health collaborating facility in the district.

IRC staff estimate that there are 135,000 people in the nine refugee camps in six Thai provinces along the Burmese border, and many more in villages surrounding the camps.

IRC also estimates that there are 450,000 internally displaced persons located in conflict areas on or near the border in eastern Burma, which continually feed into the Burmese migrant population. The USAID-funded SHIELD Project is a collaborative partnership between IRC, the Program for Appropriate Technology in Health (PATH), World Education, the Thai Ministry of Public Health and Ministry of Education, and Burmese Community-Based Organizations (CBOs). SHIELD's health objectives are to increase knowledge about health and improved health behaviors in migrants; to increase their access to sustainable, quality preventive and curative health care, including how to appropriately access Thai health services. SHIELD's primary beneficiaries are 80,000 migrants in camps, or "clusters", 270,000 secondary beneficiaries in the communities adjacent to the camps who can access camp health services, and another 150,000 migrants who live in four provinces and receive educational messages and interpreter services.

The Mae Tao Clinic in Mae Sot town operates on 24-hour basis offering a comprehensive range of free MCH/FP and other services: antenatal care (with HIV screening and counseling, then ARV treatment and deliver at the district hospital), delivery and post-natal care, newborn care, and for complicated deliveries or post-abortion care, there are emergency obstetric services. For serious complications, or for laboratory or other specialized services, patients are referred to the District Hospital. The situation in the clinic in Mae La Camp, located an hour's drive from Mae Sot town, is similar to the Mae Tao clinic. One of the largest and oldest (20 years) camps, Mae La has almost 50,000 migrants living in primitive bamboo and thatched huts in a very confined area. The clinic provides comprehensive preventive and curative services, backed up by a small Medcins du Monde hospital and a Planned Parenthood center, also located in the camp.

What is notable about both the Mae Tao Clinic and the Mae La Camp clinic is that the great majority of services are provided by various types of non-professional staff called "medics" and health workers, the majority of whom are migrants with no previous health background. They are trained in stages by a few local and expatriate health professionals, first as a community health worker in primary health care (six months), then as health assistants (one year), and continually adding advanced training, such as MCH, emergency obstetric care (EOC) and life saving skills (LSS). Under the supervision of one or two physicians, the medics appear to capably respond to the heavy migrant patient demand, and have been progressively trained and encouraged to take the greatest responsibility possible in dealing with the in-patient and out-patient load, providing comprehensive preventive and curative services, and the full range of MNCH care. There is a strong motivation to operate as self-sufficiently as possible with minimal referrals to the district hospital.

In villages adjacent to the camps, SHIELD has established a network of simple Village Health Posts, staffed by Border Health Workers (trained for six months with a modest salary), to serve migrants in the areas outside the camp, provide first aid and family planning supplies, test for malaria, provide health information and refer or take patients to the camp clinic. In some cases, they might also accompany patients to the district

hospital. The network of Border Health Workers and a larger group of Community Health Volunteers work in close cooperation with the camps.

The Mae Sot District Hospital, with 317 beds, is an unusually large and modern structure for a district, and is heavily utilized as a referral center for the district's 22 health centers and other nearby districts. The hospital's Community Medicine Department team coordinates hospital support for the migrant population, providing a wide range of preventive and curative services. The Community Medicine Department also coordinates the hospital's technical and logistic support to the Mae Tao Clinic from various hospital departments and has established health posts in Mae Sot town. It also employs a team of community health workers and volunteers (equipped and funded by IRC); trains migrant health volunteers and traditional midwives; and provides MCH services in the hospital and through outreach teams.

In summary, from the migrant health clinics visited, it is clear that responsive, client-oriented comprehensive care—with a reasonable level of quality given the temporary structures and human and financial resource restrictions—has been established and is competently serving large portions of the migrant communities. Because of limited access to the Thai health network, the migrant health care system has emphasized self-sufficiency, based on training a variety of highly-motivated, non-professional migrant service providers who form the backbone of the system. There are many lessons to learn from this system: the migrant populations arrived with serious problems reflecting the dire conditions and lack of services in their home territory, and now have fair access to an indigenous service network which has had an impact on improving their health. It is also clear that the service providers in the migrant health facilities visited are eager for further training and any additional technical assistance to improve skills and service quality, and would likely be receptive to and make productive use of USAID technical support and best practices. (More detailed notes on the migrant health program are found in Annex 6)

4. STRATEGIC APPROACHES AND OPPORTUNITIES FOR SUPPORTING MCH/FP PROGRAMS IN RDMA COUNTRIES

The OPH team has used its technical leadership to evolve an effective regional approach for addressing HIV/AIDS, malaria, TB, avian and other pandemic influenza, based on applying proven technologies and implementation approaches to address these cross-regional problems. OPH has worked with many partners to adapt or test these approaches in the region—both in non-presence, and at times, presence countries, building capacity, testing models and generating strategic information to document and share lessons and impact that have influenced program and policy changes across the region.

RDMA's unique capabilities to support MNCH/FP in the region

RDMA-Based Technical Assistance and Leadership. A key ingredient in RDMA's health program effectiveness and success has been the presence of experienced technical

leaders on its team to initiate, support and manage the programs and policies in HIV/AIDS and key infectious diseases, along with as technical leaders in the critical areas of strategic information and behavior change communications. They have also been the channel for absorbing and adapting key global health technologies and best practices to pilot or improve programs across the region. Similarly, resident technical assistance in MCH/FP will be an important element in RDMA's response to the region's needs. As MCH/FP funding is allocated to RDMA, it is probable that the level may initially be less than the more substantial funding provided for HIV/AIDS and other infectious diseases. Under these circumstances, the best potential avenue for the Mission would be to build a MCH/FP technical assistance capacity at the region to fully assess program needs, to articulate and foster best practices, policy advocacy and information sharing, as well as to provide targeted technical assistance to specific countries.

Strategic information. Another priority area in which RDMA capability is recognized through the region is building strategic information systems to guide programs and policies. Strategic information gathering, analysis and dissemination are the tools the Mission has used to share effective lessons learned and document impact to build support for scaling up successful approaches. The assessment has shown the consultant team many gaps, as well as wide variations in data quality and reliability in Burma, the Lao PDR, and other neighboring countries. There is clearly a need for improved collection, analysis, evaluation and dissemination of MNCH/FP data.

Behavior change communications and social marketing. RDMA technical support for HIV/AIDS, AI, malaria & TB is built on technologies that USAID and its partners have tested and proven effective worldwide. The Mission has piloted HIV/AIDS models for addressing the specialized needs of the most at risk populations (MARPS) which have been adapted and applied across the region. Making effective services available and accessible has been a prime objective in all of the health programs. But emphasis on the supply side of services is only one aspect of addressing these problems. The other aspect is the behavioral, or demand side—addressing the population's lack of knowledge and understanding of the need for and how to prevent the problems, and how to access effective services. RDMA health programs have incorporated approaches to increasing knowledge and changing behavior through support for behavior change communications (BCC) and social marketing, which have been pioneered and fine-tuned by USAID over the past two decades, and which are a unique capability that RDMA brings to its regional programs. The OPH funds the Academy for Educational Development (C-Change) and the Kenan Institute Asia—recognized global leaders—to support behavior change communications for its regional infectious disease programs. Population Services International (PSI), as a global pioneer in its field, also receives OPH funding for communications and social marketing to market services, products and behavior change in HIV/AIDS and other infectious diseases. All of these groups have long, credible experience in the Asia Pacific region.

RDMA's strong capabilities and current partnerships in behavior change communications and social marketing are well-recognized and readily adaptable for MNCH/FP programs, and would be unique, complementary Mission contributions to the regional and country

support for MNCH/FP. There are serious gaps in MNCH knowledge and behavior in both the Lao PDR and Burma which are currently major obstacles to improving access to and use of services. In Burma, RDMA similarly currently supports communications and social marketing activities into which MCH/FM communications for behavior change could be built. The consultant team believes that there is a substantial need and recommends that the Mission further review the opportunities for strengthening behavior change communications support with the governments and implementing partners.

Mission Global Hunger and Food Security Initiative (GHFSI)

The consultant team met with the General Development Office (GDO) staff to discuss the new Presidential Global Hunger and Food Security Initiative, guidance for which is still evolving. RDM/A is expecting about \$5 million for a regional initiative, which is in the final planning stage following a 2009 food security and nutrition assessment. One component of the RDM/A strategy is to address the problem of serious child malnutrition in several presence and non-presence countries of the region, seen as an important consequence of food availability and food insecurity. Malnutrition—both weight for age and height for age (known as stunting)—is prominent in non-presence countries such as the Lao PDR and Burma, as well as in USAID presence countries, such as Cambodia and Vietnam. Although found across all income groups, malnutrition is most pronounced in the poorest, remote and ethnic minority populations. Iron-deficiency anemia is another common nutrition-related problem that affects substantial proportions of women and young children in these same countries of the region. These well-documented malnutrition and micro-nutrient deficiencies are underlying causes or complicating factors which have a serious impact on the key health indicators for women and children: neo-natal, infant and child mortality, maternal mortality and morbidity, and low-birth weight—all of which are priority areas identified for attention in the MNCH/FP/RH assessment. The nutritional deficiencies which leave young children more vulnerable to early mortality and common diseases are also seriously detrimental to their cognitive and physical development. For these reasons, the Mission's Food Security and Nutrition Initiative appears to present potential region-wide synergies for the emerging maternal and child health/family planning strategy.

Another important aspect of the initiative is the plan to work through the well-established Mission relationship with ASEAN, a forum to bring both high-level policy makers and technical leaders from both RDMA presence and non-presence countries. Reducing malnutrition is only one core aspect of the food security agenda, but its importance as a result of food insecurity could be enhanced in the view of member states if it were linked to its impact on both the health of mothers and children, and on young child learning capabilities. For this reason, the consultant team believes it would be fruitful and synergistic to look at the potential to also build in a maternal and child health/family planning element into the ASEAN agenda. In the past, RDM/A supported an HIV/AIDS secretariat in ASEAN for several years which played a useful role in informing ASEAN country policy leaders and program managers about the effective approaches for addressing the common problems of the concentrated HIV/AIDS epidemics in their countries. The ASEAN forum could similarly address the problems and effective

solutions for improving nutrition, and integrate the linkages to the health of mothers and children in the region, as part of the policy agenda.

Likewise, under the nutrition component of the proposed Hunger and Food Security and Nutrition Initiative, the Mission is considering partnerships with a number of donor and INGO groups (eg., UNICEF, UNFPA, PSI, CARE) which are also deeply involved in addressing the broad needs of maternal and child health in the region.

There are several concrete steps that could begin almost immediately to build in MCH/FP content and linkages as plans for the Mission's for the Food Security and Nutrition Initiative are finalized:

-First, the OPH team should provide materials and a detailed briefing for the GDO team on the relationships between malnutrition and infant, child and maternal mortality, the linkages between child spacing and malnutrition, and the impact of malnutrition on young child development. The GDO team members were quite interested in these areas during the consultant discussions, and further orientation and collaboration with the health team would enhance final plans for the malnutrition component of the Mission initiative. There are an abundance of materials developed by the Global Health Bureau which provide solid evidence on these linkages and lessons learned.

-Second, as RDMA/GDO conducts further assessments in the coming months to facilitate its planning of the nutrition component, it should ensure that they address the broader impact of malnutrition as an underlying cause of maternal and child health problems, as well as the proven positive contribution of effective MCH/FP services on reducing malnutrition.

-Third, as part the final plans for implementing the Mission's Food Security and Nutrition Initiative, RDMA should introduce in ASEAN discussions the important linkages between malnutrition and maternal and child health, with a focus not only on increasing food availability, but also on the impact of MCH/FP services on improving nutritional status. As collaboration with ASEAN is established, RDMA technical staff could provide technical presentations at appropriate ASEAN meetings to build awareness by outlining the nutrition/ MCH situation in the region, where the key problems lie, and lessons and impacts gained in other areas. This approach has been used effectively by RDMA's HIV/AIDS team in the ASEAN forum to build policy makers' awareness of and commitment to successful approaches brought forward during ASEAN presentations. The objective would be to get recognition of the malnutrition-maternal/child health linkages built into the strategic plan of action.

5. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Based on the criteria outlined for analyzing the country and regional priorities—seriousness of the health needs and country responses in addressing them, projected resource availability, and strengths of the RDMA health platform, the following

conclusions can be drawn. In addition to identifying the RDMA countries which have priority MCH/FP needs, other Mission-supported programs which could benefit from MCH/FP collaboration are also noted.

Countries with Priority health needs. On reviewing the available health data, it is clear that China and Thailand have made major advances in reducing their infant, child and maternal mortality, have achieved replacement level fertility and high contraceptive prevalence, and are capably addressing the MCH/FP needs of their populations. Their health profiles would make them a low priority for RDMA technical and other support.

Burma, the Lao Peoples Democratic Republic and Papua New Guinea, on the other hand, each with very differing socio-economic and health system structures, demonstrate severe maternal and child health profiles. In these countries, maternal mortality ratios range from above 300 to over 700 maternal deaths per 100,000 live births; seven to ten per cent of children do not survive to age five—a total number probably exceeding 120,000 die each year; and over a quarter of these children die in their first month of life; over 30% of children in these countries are malnourished or stunted, conditions that are underlying causes of high rates of child and maternal mortality. Some key mortality rates in these three countries exceed or are comparable to other priority Asian countries: the under age five child mortality rate in Burma is higher than those of India, Pakistan and Bangladesh, and maternal mortality in Papua New Guinea, the Lao PDR and Burma are comparable to the rates in those South Asian neighbors.

There are serious technical, health system and resource gaps in each of the three countries which impede their ability to fully and effectively address the MCH/FP needs of their populations. Knowledge of and access to effective, quality health services that could prevent much of the illness and mortality are limited for substantial segments of the population. Based on their health profiles, all three countries have a clear need for targeted MCH/FP support that RDMA could provide.

Since it is likely that the initial RDMA funding for MNCH/FP activities will be limited, further narrowing of the country priorities is a pragmatic first step. Although PNG's MCH/FP health profile defines a serious need, current RDMA experience there—difficulty of access, very high cost of technical and other support, and weakness of the health system, complicated by social and political challenges—would suggest that PNG be given a lesser priority initially. Once the RDMA MCH/FP platform is launched, and if further funding were available, PNG activities might be considered.

Based on the situation analysis, from the seriousness and impact of their health problems and the gaps in the countries' ability to respond adequately and effectively to those needs, Burma and the Lao PDR should be the first priorities for RDMA technical assistance and investment in MNCH/FP.

Strength of successful RDMA approaches in the region. RDMA has developed an effective strategic approach to address regional health needs by: testing model prevention programs to expand access; strengthening service delivery to improve access and quality;

generating strategic information to monitor program progress, results and impact and use it to affect program and policy action; and building an enabling environment to facilitate civil society participation and promote development of supportive policies and regulations.

Using this strategic approach, RDMA has focused on addressing critical cross-regional problems, including the focused HIV/AIDS epidemics, malaria, tuberculosis and other infectious diseases, and more recently, the emerging avian influenza and H1N1 influenza pandemics. By providing technical leadership, incorporating evidence-based best practices in well-monitored pilot activities or directly to national efforts, the OPH team, in collaboration with governments, regional institutions and implementing partners, has helped to build technical and institutional capability and change policies and programs to effectively meet these disease challenges in presence and non-presence countries' across the region. RDMA can readily adapt this well-established platform to cost-effectively initiate MCH/FP activities in the region with limited resources, drawing on USAID's worldwide technical leadership, technologies, experience and lessons learned in MCH/FP to share in the region and help the countries respond to the gaps in their national efforts. Adding an MCH/FP component to the regional platform also responds to the guidance of the Global Health Initiative's call for a focus on women and children, which comprise a major burden of the region's health need—which, to date, RDMA has not had the resources to address.

The presence of RDMA-supported partners currently working in each of the priority countries also provides a potential entrée for MCH/FP activities. Although the RDMA/OPH support in health is focused on HIV/AIDS and other infectious diseases, the current implementing partnerships are with UN groups, such as WHO and FAO, other INGOs and firms, such as Save the Children, PACT, PATH, Academy for Educational Development, Population Services International, all of whom are deeply involved in broader maternal, child health and reproductive health issues. In addition, with other non-health funding, RDMA is supporting substantial health activities inside Burma (post-Nargis relief and reconstruction) and migrant health activities on the Thai-Burma border. These partners form a potential base for RDMA to build MNCH/FP technical support from the regional platform.

Other areas of Mission involvement in MCH/FP programs:

Global Hunger and Food Security Initiative. One component of the Mission's new regional Global Hunger and Food Security Initiative (GHFSI) focuses on reducing malnutrition. Because of malnutrition's underlying impact on maternal and child health, the initiative offers the potential for region-wide synergies with the emerging MCH/FP strategy. The Mission's plan to work through ASEAN (and other international agencies) to strengthen food security and reduce malnutrition could stimulate enhanced interest and priority among the member states if malnutrition were linked to the impact on both the health of mothers and children, and on young child learning capabilities. For this reason, the consultant team believes it would be fruitful and synergistic for RDMA to look at the

potential to also build in a maternal and child health/family planning element into the GHFSI ASEAN agenda.

Thai/Burma border activities. Because of their unique organization and transitional nature, the border migrant health services program supported by RDMA do not appear, at first face, to have a clear link to a regional strategy for improving MCH/FP. However, given the continuing USG commitment to assisting the migrant populations and to addressing their health care needs—and the links to the health situation in Burma, there could be a useful element of technical support as part RDM/A’s regional strategy for strengthening MCH/FP services and systems. There may also lessons to be learned from the migrant health care system that could be applicable to remote, underserved area of countries such as Laos and Burma. The Thai Ministry of Health is a key player in supporting the migrant health service system, and RDMA should look at opportunities to share with the MOH USAID’s wide MCH/FP experience and lessons and to provide technical assistance to strengthen the MOH support to migrant health services.

An RDMA MCH/FP technical assistance presence could strengthen the Mission’s capacity to review and provide technical support for the MCH/FP programs that are a core of the migrant health care systems inside and outside the camps on the Thai-Burma border. The SHIELD Project and other NGO collaborators have built self-reliant, effective health care programs that are improving the migrant’s health in very difficult circumstances and with limited resources. They are eager to build their teams technical capabilities and would welcome RDMA technical assistance and sharing MNCH/PF lessons learned and best practices to strengthen their programs.

RECOMMENDATIONS

1. Comprehensive MCH/FP assessment. With the Lao PDR and Burma as the first priorities, RDMA should complete a more comprehensive follow-on assessment to: better identify MCH/FP needs and the gaps in programs to address them in each country; systematically document the roles of government, donors and other partners; and target the concrete areas for RDMA technical support and collaboration. At the same time, the in-depth assessment should also look broadly across the region to identify opportunities for strengthening technical capacity, sharing best practices and strategic information.
2. Establish an MCH/FP technical assistance capacity in RDMA. Another priority should be to identify a resident MCH/FP technical advisor for the RDMA health team. An experienced MCH/FP specialist based in Bangkok is critical to developing the new program component, to establish RDMA technical leadership and credibility, and foster collaborative linkages within the region—as it has been done so effectively in HIV/AIDS and other infectious disease programs.
3. Strategic Information. RDMA should use the Lao PDR DHS results dissemination to further assess information gaps, particularly in the routine health information systems, and identify the gaps and opportunities for strengthening them. RDMA should discuss with the donors and Lao Ministry of Health the opportunities for complementary SI

strengthening in conjunction with the recently-developed National Health Information System Strategic Plan, which comprehensively addresses all areas of health information needs and use.

4. Behavior change communications. As the Lao PDR National Integrated Strategy for MNCH Services gets underway, technical support for designing a supportive communications strategy is an important niche that does not appear to be currently built in. In Burma, RDMA similarly currently supports communications and social marketing activities into which MCH/FM communications for behavior change could be built. The consultant team believes that there is a substantial need and recommends that the Mission further review the opportunities for strengthening behavior change communications support with the governments and implementing partners.

5. Building capacity and sharing best practices and lessons learned. RDMA should participate in and stimulate organization of regional fora to build capacity for improving MCH/FP interventions and delivery approaches, and to share and adapt MCH/FP best practices and lessons learned, focusing on experiences from the RDMA countries, as well as global experiences. This could build on the 2007 (and planned 2010) Asia Near East Bureau-organized best practices conferences in Bangkok, which focused on newborn, infant and child health, maternal health and family planning, but included few participants from the RDMA countries.

6. Review the capable MCH/FP technical resources in Thailand—institutional and individual—which could be a source of South-South collaboration. Identify opportunities to utilize these resources in supporting in-country and regional technical assistance.

7. As RDMA establishes an MCH/FP technical assistance capacity, the RDMA regionally-based advisor could strengthen the Mission's capacity to review and provide technical support for the MCH/FP programs that are a core of the migrant health care systems inside and outside the camps on the Thai-Burma border.

8. Global Food Security and Hunger Initiative. Several steps are recommended:
First, the OPH team should provide materials and a detailed briefing for the GDO team on the relationships between malnutrition and infant, child and maternal mortality, the linkages between child spacing and malnutrition, and the impact of malnutrition on young child development.

Second, as RDMA/GDO conducts further assessments in the coming months to facilitate its planning of the nutrition component, it should ensure that they include the broader impact of malnutrition as an underlying cause of maternal and child health problems, as well as the proven positive contribution of effective MCH/FP services on reducing malnutrition.

Third, as part the final plans for implementing the Mission's Food Security and Hunger Initiative, RDMA should introduce in ASEAN discussions the important

linkages between malnutrition and maternal and child health, with a focus not only on increasing food availability, but also on the impact of MCH/FP services on improving nutritional status.

9. Child Survival Grants. As competition for the current year's round of Child Survival Grants opens, the Mission should encourage appropriate groups working in Burma and Laos to submit proposals, which could further help to demonstrate the critical needs in these countries and innovative approaches that are being designed to address them.

Annex 1

STATEMENT OF WORK Senior Maternal and Child Health Expert

**Office of Public Health, USAID/Regional Development Mission Asia
January - February 2010**

A. Background

The Asia-Pacific region is home to approximately 60% of the world's population and a number of countries still struggle with high mortality rates among women and children with poor access to basic health services. The region also bears a heavy disease burden of malaria, tuberculosis (TB), dengue fever, emerging animal-to-human diseases, and HIV/AIDS. Drug resistance is of growing concern in part due to the amount of low-quality and counterfeit drugs both produced and distributed in the region.

Since its inception, the US Agency for International Development (USAID) Regional Development Mission Asia (RDMA) mandate was to reduce infectious diseases incidence and to mitigate the impact of HIV/AIDS, tuberculosis, malaria, avian influenza and other infectious diseases in the region. Contributing to sustainable control of infectious diseases in the region, USAID/RDMA focuses on increasing access to prevention, care and treatment services for most-at-risk and other vulnerable populations; monitoring drug resistance, improving capacity for health service delivery to the poor and marginalized, and collection of quality regional monitoring and evaluation data and operations research to inform sound analysis and decision making. In FY 2010, RDMA's portfolio will expand into additional program areas of Family Planning, Maternal Health and Child Survival with additional contribution towards the forthcoming US Government initiative on food security and nutrition goals in the region.

RDMA's Office of Public Health (OPH) provides technical assistance both directly and through implementing partners to strengthen national and regional institutions and networks, building the capacity of member country governments, leaders, civil society organizations and other key community stakeholders and practitioners, fostering increased political will and participation at all levels. Resources support development of innovative interventions, policies and practices; state-of-the-art systems to monitor the disease spread and the efficacy and effectiveness of prevention, care and treatment programs including ensuring that countries have the capacity to effectively manage health

services and in-country drug supplies guaranteeing availability to meet the growing demand.

The first component of OPH's strategy is public health prevention programs to prevent disease and increase access to comprehensive interventions for most at risk and other vulnerable populations. The second component is strengthening health service delivery systems in order to improve access to screening, care, support and treatment for people living with infectious diseases and their affected families. A third component is the critical need for strategic information necessary for policy action and developing interventions. Activities include surveillance and data analysis at country and regional levels; operations research; outcome and impact evaluation studies; building and monitoring information systems in order to analyze and track key health indicators. The final component is to strengthen an "enabling environment" which encourages participation of civil society, and promotes supportive policies and regulations. Activities include community mobilization, programs to reduce stigma and discrimination; capacity building of non-governmental organizations (NGOs) and networks of vulnerable and affected people, community leaders and other civil society organizations; supporting host government-civil society partnerships to build trust and understanding; facilitating advocacy groups at the sub-national, national levels and regional levels; analyzing and strengthening policies and guidelines; developing resource allocation tools; and region-wide sharing of models for scale-up.

The RDMA Office of Public Health manages HIV/AIDS programs in countries where there is no bilateral USAID mission (Burma, China, Laos, Papua New Guinea and Thailand). RDMA also implements regional programs supported through funds for malaria, TB, Avian Influenza and other public health threats. RDMA has been notified of the first allocation of budget for Family Planning (FP) assistance in FY 2010, and for Maternal and Child Health (MCH) in FY2011. The current scope of work is to acquire the services of a consultant to help determine the need for technical support for maternal and child health improvement in the region. The consultant will work together with another expert on family planning services delivery and they will together interface with a review team that will conduct a parallel review of RDMA's overall program portfolio.

B. Objectives of the Services

The purpose of the assessment is to identify the needs for technical support to improve maternal and child health services which target poor and marginalized populations in the South East Asia region. Specifically the assessment will contribute towards the following:

1. Developing a strategy for RDMA/OPH that guides the three year support to improving access to maternal and child health and family planning services in the region, combining efforts on both elements into an integrated package of assistance;

2. Identifying practical approaches for implementation that ensure efficient management systems, enabling synergy and complementary skills across the many components of the portfolio;
3. Determine the kinds of support that would contribute and add to in-country efforts by US Government, host country government, NGOs and other donors.

Specifically, the assessment will address the following concerns:

1. Take stock of the trend in maternal and child mortality including neonatal mortality in lower-income countries especially USAID non-presence countries in the region;
2. Trends in maternal and child nutrition and strategies to reduce malnutrition and micronutrient deficiency among the poor and under-privileged communities;
3. Factors that continue to prevent women from access to safe deliveries including provider-client interaction, quality of counseling and provision of information that enables women to make appropriate choices;
4. Best practices and models that have improved access to maternal and neonatal health services among the poor, from both spectrums of demand and supply side with demonstrated attention and ownership among in-country government and/or non-government sectors;
5. Opportunities for strengthening health systems that would promote improved quality, efficiency and coverage for safe deliveries, child survival and nutrition including improvement in neonatal survival rates;
6. Major MCH/FP initiatives in the countries that are supported by domestic and/or donor efforts; and opportunities for leveraging collaboration among countries (e.g. within the Mekong region) or from private sector.

The assessment will review the output of recent assessments in food security and nutrition, and determine synergies and complementary activities. The vast material and documentation compiled through the “best practices” program initiative of USAID/Washington, Bureau for Global Health in the Asia region will provide valuable reference and perhaps inform interventions that can be further scaled up into policy and national program plans. The expert(s) will also explore strong regional or national institutions that can be facilitated to provide technical support to recipient country programs and sustain efforts beyond 2012.

Annex 2 MEETINGS AND TRAVEL SCHEDULE

DATE	LOCATION	INDIVIDUALS MET
January 6-8	USAID/W/Global Health	Dr. Al Bartlett, Mary Ellen Stanton, Gary Cook, Caroline Alba, Liz Shoenecker, Bob Emrey
January 11	RDM/A, Bangkok	A. A. Thwin, M. Satin, C. Cortez; attended OPH staff meeting and met all staff members; S.Pyne, Burma Program Manager
January 12 - 13	IOM, Bangkok	N. Jitthai, Migrant Health Program Manager
	PSI Burma	John Hetherington, PSI Country Director Burma
	FHI	Dr. Graham Neilsen, Tech. Advisor
	Save the Children, US	Tory Clawson, Dir.; John Stoeckel, Health advisor
	Travel to Laos	
January 14-17	US of America Embassy	Ambassador Huso, Dr. Andy Corwin, Franc Shelton
	WHO	Dr. D. Ahn, Country Rep.; A.Hammerich, Program Mgt. Officer; K. Feldon, Technical Officer - EPI
	JICA	K. Osone, Rep., Dr. S. Noda, Chief Advisor for Capacity Development, SWC
	Health Frontiers	Dr. Leila Srouf
	UNICEF	Dr. A.K. Andele, Health & Nutrition Section Chief; S. Danailov, Dep. Rep.
	Save the Children, Australia	M. Pickard, Country Dir.; L. Sampsom, Programme Dev. Advisor
	Asian Development Bank	G.H.Kim, Country Director; H.Win, Social Sector Specialist
	UNFPA, Laos	M. Yabuta, Country Rep.; M. Coren, Dep. Rep.; Dr. D. Xaymounvong, D. Sherratt,

		Sr. Midwifery Advisor & Trainer
1/18	Bangkok	P. Connell, B. Pick, A. Bloom – briefing on work of both teams
1/19	RDM/A	Dr. Thwin, M. Satin
	Bangkok	Dr. S. T. Mathai, Reg. Team Coordinator, Maternal Health, UNFPA
1/20-21	Mae Sot, Thailand	Dr. N.N. Thein, Sr. Health Coordinator, International Rescue Committee, and SHIELD project, Dr. Aung
	Mae Tao Clinic in Mae Sot town	SHIELD-funded clinic
	SMRU Clinic in Mae La camp	Dr. Gaby Hoogenboom and staff of clinic
	Mae Sot General Hospital, Dept of Community Medicine	Dr. Withaya, Dept Head, and staff
	Border Health Post, Mae La Klo Village, adjacent to camp	Mr. Charin, Border Health Worker
1/22, 23 & 25	Bangkok/RDM/A	Presentation & report drafting
1/26	RDM/A	Michael Satin, B. Butterfield, J. Mike, GDA team meet on Food Security Global Initiative
1/27	RDM/A	Met A.A. Thwin & M. Satin to discuss report/findings
1/28	RDM/A	Debrief P. Connell, B. Pick, A. Bloom
1/29	RDM/A – OPH	Attend debrief by PSI evaluation team; Debrief OPH team
1/30	Bangkok	Report drafting
2/1-2/3	Bangkok	Report drafting
2/4	RDMA	Debriefing with MD
2/5	RDM/A	Draft report submitted to OPH
2/18	RDMA	Review draft with OPH team
3/10	RDMA	Final draft submitted to OPH

Annex 3 List of Contacts

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Mae Tao Clinic in Mae Sot Town

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Dr. Siriya, clinic director

Mae Sod MOH District Hospital

Dr. Withaya, Director, Dept. of Community Medicine, 66-5-554-2337, and team

Mae La Klo Village

Border Health Worker, Mr. Charin, in Mae La Klo Village, Adjacent to Mae La
Camp

SMRU Clinic, Mae La Camp (SMRU is the Shoklo Malaria Research Unit)

Dr. Gabie Hoogenboom, physician with obstetrics training, [gabie@shoklo-
unit.com](mailto:gabie@shoklo-unit.com)

Midwives and nurses of the clinic, most called Medics

Annex 4 QUESTIONS ASKED DURING INTERVIEWS AND FIELD VISITS

Note: The questions listed below were adapted to the setting or contact, whether for a technical informant, a donor, an implementing organization, or a government representative.

For the country or areas where you are working, what are the most critical needs related to maternal, neonatal and child health, and for reproductive health and family planning?

What is the data and evidence that documents these needs, and do you feel the data are sufficient and reliable?

What are the priorities that have been chosen for attention and how is the service delivery system organized to address these priorities? What are the weaknesses in availability and coverage of services, and in quality of delivery?

What are the policies and programs of the host government that support addressing the needs you have outlined, and what are the results achieved?

What specific activities are you supporting under your program, or those which do you feel need to be strengthened, to address the MNCH/FP/RH problems and delivery system needs that you have outlined?

Are these activities planned with and linked to ongoing host country policies and programs?

What evidence is there of outcomes and impact resulting from the activities that you support?

What technical, delivery system or policy gaps do you wish to identify relating to addressing MNCH/FP/RH?

Annex 5: Footnotes/References

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Annex 6 Notes on Migrant Health Activities on the Burma/Thai Border

Prior to visiting the Thai Burma border area, the consultants met with the Migrant Health Program Manager at the International Organization for Migration (IOM) in Bangkok. IOM estimates that there are about 130,000+ migrants in camps along the Thai-Burma border, and a total of two million migrants in Thailand, mostly undocumented, who have disbursed throughout the country, many absorbed by the Thai economy. The migrants constitute a potentially large health burden for Thailand, and beginning with USAID support for the “Health Migrants, Healthy Thailand” project in 2003, IOM has collaborated with the Thai Ministry of Health and local health authorities, other donors and NGOs to foster development of a sustainable migrant health system. The goal is to ensure that migrants can take care of themselves to the greatest extent possible, but linked to and backed up by the MOH health system. Building health service capacity within the migrant community has been a major operational goal. The IOM program manager noted the important improvements in Thailand’s health care system in recent years, including Universal Health Care Coverage, and the importance of ensuring that Thai citizens do not perceive that migrants are getting preferential treatment.

The migrants coming to Thailand from across the Burmese and Lao borders represent several different ethnic groups: Burmans, Karen (largest group) and other Burmese ethnic minorities, who have come from many areas across Burma, and Lao ethnic minorities in the more northerly Thai provinces. The consultant team traveled to Mae Sot District, where they met with International Rescue Committee SHIELD (Support for Institution Building, Education and Leadership in Policy Dialogue) lead staff for a program briefing, and then visited the Mae Tao migrant health clinic in Mae Sot town, the SMRU (Shoklo Malaria Research Unit) Clinic in Mae La migrant camp and a Community Health Post in the nearby Mae La Klo village (all supported by IRC). The consultants were also briefed by the chief of the Community Medicine Department and his team in the Mae Sot District Hospital, which is the major referral destination and Ministry of Health collaborating facility in the district.

IRC’s Senior Health Coordinator, a Burmese-trained public health physician and citizen of New Zealand, and his colleague, also with medical training from Burma and now a doctoral candidate in public health at Mahidol University, briefed the consultant team. IRC estimates that there are 135,000 people in the nine refugee camps in six Thai provinces along the Burmese border, and many more in villages surrounding the camps. IRC also estimates that there are 450,000 internally displaced persons located in conflict areas on or near the border in eastern Burma, which continually feed into the Thai migrant population. The USAID-funded SHIELD Project is a collaborative partnership between IRC, PATH, World Education, the Thai Ministry of Public Health and Ministry of Education, and Burmese Community Based Organizations (CBOs). Many other international NGOs and agencies also collaborate in serving migrant health and other needs under the Coordinating Committee for Displaced Persons in Thailand (CCSDPT). SHIELD supports education and health services for the migrant population. Their health objectives are to increase knowledge about health and improved health behaviors in migrants; to increase their access to sustainable, quality preventive and curative health

care, including how to appropriately access Thai health services. SHIELD's primary beneficiaries are 80,000 migrants in camps, or "clusters", 270,000 secondary beneficiaries in the communities adjacent to the camps who can access camp health services, and another 150,000 migrants who live in four provinces and receive educational messages and interpreter services.

The Mae Tao Clinic, founded by a well-known Burmese physician, Dr. Cynthia Maung, and located in Mae Sot town, operates on a three-shift, 24-hour basis and offers a comprehensive range of free MCH/FP and other services: antenatal care (with HIV screening and counseling, then ARV treatment and deliver at the district hospital), delivery and post-natal care, newborn care, and for complicated deliveries or post-abortion care, there are emergency obstetric services, including D&C, a blood bank, oxytocin. Only with serious complications or when a Caesarean section is required, or if a female sterilization procedure is requested, or for laboratory or other specialized services, are patients referred to the District Hospital. Family planning services are offered in the clinic are funded by other donors (not SHIELD support), and include pills, condoms, injectables, IUDs, Norplant and non-scalpel vasectomy. The antenatal clinic was quite busy, and the staff claimed approximately 200 deliveries the previous month, a case load that would rival the district hospital, and 1000 family planning clients. The team was not able to examine clinic records during a quite brief visit.

What is most remarkable about the Mae Tao Clinic is that the great majority of services are provided by various types of staff called "medics" and health workers, the majority of whom are migrants with no previous health background. They are trained in stages, first as a community health worker in primary health care (six months), then as health assistants (one year), and continually adding advanced training, such as MCH, emergency obstetric care (EOC) and life saving skills (LSS). Several have also been trained to do no-scalpel vasectomies. Under the supervision of a single physician, and one or two trained midwives, the paramedics appear to capably respond to the heavy migrant patient demand. There is clearly a strong motivation to operate as self-sufficiently as possible, although referrals to the district hospital are easier with the clinic located in the district town. But the clinic staff mentioned the often difficult entry and communication for non-Thai speaking migrants, and the financial barriers they face in using the MOH facilities.

The situation in the SMRU clinic in Mae La Camp, located an hour's drive from Mae Sot town, is quite similar to the Mae Tao clinic. One of the largest and oldest (20 years) camps, Mae La has almost 50,000 residents living in primitive bamboo and thatched huts tightly packed together between the road and a steep, rocky range of hills. Various Karen factions, Burmans and other ethnic groups live together in the community, with markets, shops and services of all types available. There is a steady electricity supply and a primitive piped water system. The camp residents raise chickens and intensively cultivate vegetables in every open patch. (RDM/A's avian influenza program has supported establishment of surveillance and reporting of AI human and animal events and provided training for responding to outbreaks in nine migrant camps).

The clinic is centrally located in a series of low, bamboo, thatched-roof buildings, with a single new surgical/delivery building—the camp’s only permanent masonry structure (completed with special permission at the senior levels of the Ministry of Interior, which runs the camps). The temporary nature of the clinic structures—open, with no solid walls or screening, and with patients, accompanied by family members, lying on mats on the floor, challenges maintenance of sterile or hygienic conditions. The clinic also operates with backup from a small French-run (Medcins du Monde) hospital with surgical capabilities, and with the Planned Parenthood of Thailand (PPAT) family planning clinic, both of which are also located in the camp.

Like the Mae Tao clinic, the camp clinic has a heavy patient load, which is primarily managed by non-professional—but regularly- trained and skilled—“medic” staff. There are two expatriate physicians providing technical and management leadership—one Dutch obstetrics-trained (but not certified) and a German pediatrician. They, with the assistance of other visiting specialists, have progressively trained the medic staff and encourage them to take the greatest responsibility possible in dealing with the in-patient and out-patient load, providing comprehensive preventive and curative services, and the full range of MNCH care. Family planning counseling is given in the clinic, but other services are provided at the camp’s Thai Planned Parenthood clinic. There are also specialized services, such as an ultrasound and a neonatal premature unit run by the migrant medics. Most deliveries—including complicated ones, and post-abortion care, are provided in the clinic. Only Cesarean deliveries are referred to the small French hospital in the camp. Because of the distance from Mae Sot town, emergency referrals to the district hospital are less frequent. Travel to and from the district town requires passing five or six armed security posts, where guards carefully scrutinize passengers, slowing travel.

In villages adjacent to the camps, SHIELD has constructed neat, bamboo-thatch Village Health Posts, staffed by Border Health Workers (trained for six months with a modest salary), to serve migrants in the areas outside the camp, provide first aid and family planning supplies, test for malaria, provide health information and refer or take patients to the camp clinic. In some cases, they might also accompany patients to the district hospital. The Border Health Worker in Mae La Klo Village was born in Thailand of Karen parents, so speaks both Thai and Karen languages. He said he saw 7-10 patients a day, has a regular family planning clientele, and takes blood smears from suspected malaria patients. As he walked with the consultants through his village, he noted the homes of a number of Thai residents—all permanent wooden structures, in contrast to the migrant huts. Next to his Village Post is another simple hut, which he explained is a newly-built malaria screening post set up because villagers who go into the forest to gather wood and food often come down with malaria. OPH’s malaria specialist explained that in many areas of the region, malaria transmission has declined, but is still an important problem for “occupation-related” transmission, such as work in the forest as described by the Health Worker. The network of Border Health Workers and a larger group of Community Health Volunteers work in close cooperation with the camps.

The Mae Sot District Hospital, with 317 beds and 45 doctors and 316 nurses, is an unusually large and modern structure for a district with a Thai population of 120,000 (of which 17% are ethnic minorities) and an estimated 100,000 migrants, including the camp residents. The hospital is heavily utilized as a referral center from the district's 22 health centers and from other nearby districts, and also because the Mae Sot is a busy, prosperous commercial trade hub. The head of the hospital's Community Medicine, whose team coordinates support for the migrant population, explained that the hospital provides a wide range of preventive and curative services to the migrant population. Of a total 369,000 clients receiving all types of services from the hospital in 2009, 66,828, or 17%, were provided to Burmese migrants. Migrant patient numbers have increased about 20% over the past five years. The Community Medicine director also presented data showing that the hospital cost to provide services to migrants totaled B43.6 million (over \$1.3 million) in 2009, most of which, he complained, was not reimbursed by the Ministry of Health.

The Community Medicine Department coordinates the hospital's technical and logistic support to the Mae Tao Clinic from various hospital departments and has established health posts in Mae Sot town. It supports key maternal and child health programs for the migrants, including: employing a team of community health workers and volunteers (equipped and funded by IRC); training migrant health volunteers and traditional midwives; and providing MCH services in the hospital and by outreach teams.

In both migrant health clinics visited, it is clear that responsive, client-oriented comprehensive care—with a surprising level of quality given the temporary structures and human and financial resource restrictions—has been established and is competently serving large portions of the migrant communities. Because of limited access to the Thai health network, the migrant health care system has emphasized self-sufficiency, based on training a variety of highly-motivated, non-professional migrant service providers who form the backbone of the system. There are many lessons to learn from this system: the migrant populations arrived with serious problems reflecting the dire conditions and lack of services in their home territory, and now have fair access to an indigenous service network which has had an impact on improving their health. The irony is that the self-reliant health system of non-certified professionals is probably responding to the migrant population's needs more effectively than would be possible from the established MOH facilities. It is also clear that the service providers in the migrant health facilities visited are eager for further training and any additional technical assistance to improve skills and service quality, and would likely be receptive to and make productive use of USAID technical support and best practices.