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Implementation Guide For Community-Oriented Reproductive Health Approach

- Healthy Mother Project -

Booklet -1-

First Edition

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Contents

Foreword

The Community-Oriented Reproductive Health Project was initiated in February 2005 with the aim of improving reproductive health status in the Union of Myanmar, targeting pregnant women and children under 5.

The Project, known as Healthy Mother Project, has been implemented in two Townships, Kyaukme and Naungcho, in the Northern Shan State, under the joint efforts of DOH/MOH, JICA and JOICFP, for five years until the end of January 2010.

We are very pleased to share with all stakeholders on RH, the achievements and experiences for the practical Community-Oriented RH Approaches, including the "Maternal and Child Health Promoters (MCHP) System", the first system of its kind introduced in Myanmar. All these interventions would be very effective for activating the community-oriented activities.

MCH Promoters, one per 30 households, are working as a bridge between pregnant women and health care providers e.g. the midwives, to promote MCH in the community. Through this system we could produce significant changes in the respective indicators such as coverage of ANC, safe delivery by skilled birth attendants, PNC uptake, and referral to higher level for emergency cases.

There are many places in Myanmar that are facing similar difficulties of RH and maternal and child health as the Project Townships. One area could be under utilization of quality RH services, especially in safe motherhood, which could be considered as one of the causes of maternal and newborn deaths and morbidities. We believe that this Implementation Guide based on the experiences of the Project would be useful and beneficial for everyone trying to tackle such similar difficulties.

Dr. Thein Thein Htay
Deputy Director General (Public Health)
Department of Health
Ministry of Health

Acknowledgement

The Project Team of Community-Oriented Reproductive Health Project would like to express our deep appreciation to Dr. Win Myint, Director General, Department of Health, Dr. Thein Thein Htay, Deputy Director General (Public Health), Department of Health, Dr. Tin Win Kyaw, Director (Public Health), Department of Health, Dr. Khin Maung Lwin, Director (CHEB), Department of Health, for their continuous support for consolidation of this Implementation Guide.

Also the Project Team would like to thank Dr. Theingi Myint, Deputy Director, Maternal and Child Health Section, Department of Health, Dr. Hnin Hnin Lwin, Assistant Director, Maternal and Child Health Section, Dr. Myint Moh Soe, Medical Officer, Maternal and Child Health Section, and Dr. Su Su Lin, Medical Officer, Maternal and Child Health Section, for their tremendous enthusiasm for making this Guide.

Also, this Guide could not be materialized without all the work and activities actually conducted in the two Project Townships, namely Kyaukme and Naungcho Townships in Northern Shan State. In this conjunction, we are also grateful to Dr. Sai San Win, State Health Director, Northern Shan State, Dr. Aye Aye Mu, District Medical Officer, Kyaukme, and Dr. Chaw Chaw Naing, Township Medical Officer, Naungcho, for their dedicated work towards implementation of the Project as well as compilation of this Guide.
We cannot forget to mention about all the concerned persons including the members of Township Working Groups in two Project Townships, headed by Mr. Myo Lwin, Chairperson, Township Peace and Development Council, Kyaukme, and Mr. Aung Kyaw, Chairperson, Township Peace and Development Council, Naungcho, as their strong commitment for improving MCH in their own community greatly contributed for establishing an effective Community-Oriented RH Approach. Furthermore, all the Basic Health Staffs, auxiliary midwives and MCH Promoters in the Project areas are the key players in the CORH Approach introduced in this Guide, and without their huge efforts and contribution towards the entire MCH promotion, this Approach could not be realized.

We would like also to extend our deep gratitude and appreciation for the encouragement and assistance received through JICA and JOICFP.

Project Team
Community-Oriented Reproductive Health Project
(Healthy Mother Project)

Message from Japan International Cooperation Agency (JICA)

With the aim to promote Maternal and Child Health in Myanmar, the Japan International Cooperation Agency (JICA) supported implementation of the Community-Oriented Reproductive Health Project for five years from February 2005 to January 2010. JICA has entrusted the Project Implementation to the Japanese Organization for International Cooperation in Family Planning (JOICFP) under the Japanese Technical Cooperation Scheme in collaboration with the Department of Health. The Project has successfully introduced Community-Oriented Reproductive Health (CORH) approach at the Project areas, namely Kyaukme and Naungcho Townships.

This Implementation Guide is developed based on the implementation experiences of the Project and extensive discussion on applicable approach among both Myanmar and Japanese partners. It provides guidance on how to effectively introduce community RH activities with the leadership of the Basic Health Staff locally. Key elements of the approach are elaborated with conceptual introduction and specific implementation guides. In addition, IEC/BCC materials and reference manuals which the Project has utilized are attached for user's easy reference. I hope this Implementation Guide would be a useful tool for the implementing partners to apply the Community-Oriented RH Approach in the respective areas.

I would like to express my appreciation to concerned officials of the Department of Health, Basic Health Staff of Kyaukme and Naungcho and JOICFP Project team for their endeavor at successfully implementing the Project and developing the Implementation Guide.

It is my wish that the collaboration and cooperation between Myanmar and Japan through the implementation of the Community-Oriented Reproductive Health Project would ultimately contribute to promote the health and well-being of mothers and children in Myanmar.

Mr. Hideo Miyamoto
Chief Representative
JICA Myanmar Office

Message from JOICFP

First of all we at JOICFP would like to say that we are honored to be part of this Project - Healthy Mother Project since February 2005, for 5 years in Myanmar until January 2010. The Project aims at extending the technical cooperation in the field of Reproductive Health (RH) through the Community-Oriented RH Approach.

Since the establishment of JOICFP in 1968, our mission has been to contribute towards the improvement of reproductive health status, and to save the lives and to improve health of mothers and children in the community. Under this Project we have mainly focused on the safe motherhood. For this particular objective, this Project has introduced the Maternal and Child Health Promoters (MCHP) System to improve the status of RH.

In November 2004, a 4-member leading observatory mission from the DOH/MOH visited Japan, in particular, to Kudoyama Town, Wakayama Prefecture in the western part of Japan. There, they had a chance to observe very active community-oriented activities by the Maternal and Child Health Promoters in that area. Then DOH and JOICFP studied the system to see if it could be adapted to the Myanmar context. Actually, this was how the first MCHP System was initiated in Myanmar.
After careful preparation, the system was introduced in two Project Townships in December 2006, with 68 initial trainings of the 1st batch of 1,672 MCHPs. After the 1st batch of MCHPs had completed their 2-year term of activities, we have trained the 2nd batch of 1,654 MCH Promoters in December 2008. After 2 years of teamwork activities with midwives and auxiliary midwives (AMW) in the communities, they are sustained in the areas steadily and firmly, making significant changes in maternal and child health activities, improving the related indicators.

These booklets introduce various strategies and specific guidelines, manuals and materials related to Community-Oriented RH Approach which may be useful for the other areas that have related and similar issues and challenges of reproductive health and maternal and child health.

The Project Team wishes that the experiences through 5 years of Project implementation would provide very useful hints and tips for further improvement of reproductive health and maternal and child health status in respective areas. This would then lead achievement of the national goal of Millennium Development Goals and Reproductive Health Policies.

Last but not the least, we would like to extend our great appreciation to all the people concerned with the Project, who have wholeheartedly supported our Project implementation and management.

Mr. Ryoichi Suzuki
Project Manager
Healthy Mother Project, JOICFP

Introduction of *Implementation Guide*—How to use the *Guide*

(1) Background and Objectives of the Implementation Guide

The contents of the Implementation Guide for Community-Oriented Reproductive Health (CORH) Approach are based on the 5-year Project activities implemented in Kyaukme and Naungcho Townships in the Northern Shan State from 2005 to 2010, under the Community-Oriented Reproductive Health Project, namely Healthy Mother Project.

This Guide was consolidated and edited by the joint efforts of DOH/JICA/JOICFP. It was intended for stakeholders and concerned personnel, who would like to apply the Community-Oriented RH Approach in their jurisdiction such as at Township level in order to improve the RH status, in particular safe motherhood, by increasing the utilization of quality RH services.

DOH/JICA/JOICFP believe that this Implementation Guide would be useful and beneficial for those who are facing similar challenges of RH/MCH like Kyaukme and Naungcho Townships, including insufficient coverage of ANC, PNC, deliveries attended by SBA, timely referral to higher level health facilities, T/T immunization and so forth. All of these need to be improved in order to improve the situation of maternal and newborn deaths and morbidities.

(2) Components of the Implementation Guide

This Guide consists of 3 Parts. Part 1 and Part 2 make Booklet I, and Part 3 makes Booklet II.

Part 1: Project Overview and Achievements

Part 2: Community-Oriented RH Approach } **Booklet I**

Part 3: Specific Implementation Guides **Booklet II**

■ **Booklet I (Part 1 & 2):**

Part 1 stipulates the overview of the Healthy Mother Project and how it was implemented in the Project areas. The achievements based on the Project indicators are also presented here.

Part 2 gives you a clear idea and understanding on what is the "Community-Oriented Reproductive Health Approach," particularly its concept and activity components. The Approach is a comprehensive package designed to strengthen the existing health/administration structure and system of RH as well as safe motherhood activities at the community level.

■ **Booklet II (Part 3):**

Part 3 focuses on the specific and practical strategies to be applied when implementing each activity component of the Approach. The components include the following areas:

1. Skill development of MW – midwifery skills training
2. Skill development of AMWs
3. MCH Promoters System
4. Community support system
5. IEC/BCC skills development – IEC/BCC manual for conducting community-oriented health education focusing on safe motherhood
6. Skills on data collection by MW, AMW and MCH Promoters

(3) How to Use the *Implementation Guide*

It would be better and more effective, if you could apply the CORH Approach in total package, however, depending on your needs, you can choose and start from any sections or components in this Guide. If you already have some kind of community activities, it can also be recommended to use this Guide as a plug-in reference to get some ideas and/or application to your implementation of RH/MCH in your community.

For example;

[1] If you want to re-vitalize the Community Health Volunteers in your areas, you can refer to the sections of "MCH Promoters System" to get some hints on how to keep motivating the volunteers with support by BHS and the community.

[2] If you want to provide some specific skill development or training for MWs and/or AMWs, you can refer to the each skill development component, i.e. midwifery skills training under "skill development of midwives," leadership and management training under "MCH Promoters System," monitoring training for BHS under "Skills on data collection by MW, AMW and MCH Promoters," etc.

[3] If you want to enhance community participation and involvement, you may want to find out how the "community support system" has been promoted in the Project by encouraging all the stakeholders to take part in community activities to improve RH/MCH status in their own community. Good practices might be useful case studies.

List of Acronyms and Abbreviations

AMW	Auxiliary Midwife
ANC	Antenatal Care
BCC	Behaviour Change Communication
BHS	Basic Health Staff
CBO	Community-Based Organization
CHE	Continuing Health Education
CHEB	Central Health Education Bureau
CHW	Community Health Worker
CME	Continuing Medical Education
CP	Counterpart
CPR	Contraceptive Prevalence Rate
DDG (DyDG)	Deputy Director General
DG	Director General
DHP	Department of Health Planning
DMO	District Medical Officer
DOH	Department of Health
EOC (EmOC)	Emergency Obstetric Care
EPI	Expanded Program on Immunization
HA	Health Assistant
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
JICA	Japan International Cooperation Agency
JOICFP	Japanese Organization for International Cooperation in Family Planning
LHV	Lady Health Visitor
MCH	Maternal and Child Health
MCHP	Maternal and Child Health Promoter
MDG	Millennium Development Goal
MMCWA	Myanmar Maternal and Child Welfare Association

MMR	Maternal Mortality Ratio
MO	Medical Officer
MOH	Ministry of Health
MOU	Memorandum of Understanding
MW	Midwife
MWAF	Myanmar Women's Affairs Federation
PCPNC	Pregnancy, Childbirth, Postnatal and Newborn Care
PDC	Peace and Development Council
PHC	Primary Health Care
PHS	Public Health Supervisor
PNC	Postnatal Care
PSC	Project Steering Committee
RHC	Rural Health Centre
RH-MIS	Reproductive Health Management Information System
SBA	Skilled Birth Attendant
SH	Station Hospital
SHU	Station Health Unit
SMO	Station Medical Officer
Sub-RHC	Sub-Rural Health Centre
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
THO	Township Health Officer
THN	Township Health Nurse
TMO	Township Medical Officer
T/T	Tetanus Toxoid
TTBA	Trained Traditional Birth Attendant
TWG	Township Working Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VTWG	Village Tract Working Group
WHO	World Health Organization

Introduction

I Challenges for "Millennium Development Goals (MDGs)" in Myanmar

As the Nation's commitment to attaining Millennium Development Goals (MDGs), special emphasis has been placed to implement the "Making Pregnancy Safer Initiative," launched by WHO in 2000, as one of the high priority components of reproductive health strategy (2004-2009). In order to reduce the Nation's burden of maternal and perinatal morbidity and mortality, safe motherhood initiatives have been expanded into a national movement. Continuum of quality care for maternal and newborn health has then been focused as a priority in preventing maternal and newborn deaths and morbidities. In Myanmar, maternal and child health, including newborn care has been accorded as one of the priority issues in the National Health Plan (2006-2011), aiming at reducing the maternal, newborn, infant and children morbidity and mortality. The MDGs also signify the Nation's commitment to achieving time-bound improvement of the defining MDG targets 4 and 5 in maternal and child health. The Ministry of Health has put emphasis in achieving the MDGs by 2015 in its own capacity with available resources. At the country level, national plan of actions and strategic plans were set out, together with the national as well as global partners.

The reproductive health programme has stimulated growing interest in donor agencies, decision-makers, and implementers. Better cooperation and coordination by national NGOs have been developed in line with the strong political commitment to International Conference on Population and Development (ICPD) goals and MDGs. Community involvement has also become the pivotal action in achieving the development goals. Since the Nation's health system has been set up with a solid infrastructure, implementation of new client-centered approach would be successful through better orientation of health workers. There are also needs for better cooperation and coordination among partners.

Key lessons learnt during the past decade in Myanmar provide sound foundation to further improve the programme. Some of these lessons learnt are as follows:

- Basic health staff are found to be in need of leadership and management skills
- Prioritization must be linked to Result - Based Management
- Development of community ownership needs to be materialized
- Rights and gender basis in Reproductive Health should be ensured
- Coordinated and sustained resource commitment, which support developing Nation-led policy making should be considered

Supervision and monitoring is the most crucial component to fulfill the objectives of maternal care within the context of the current National Health Plan (2006-2011). A supportive supervision scheme to be established at different levels of health care delivery system has been initiated for better management. Health indicators developed for Myanmar Health Vision 2030 in line with MDGs are used in measuring the performance and impact of reproductive health activities.

II Health Situation of Northern Shan State

The State Health Department of the Northern Shan State (N.S.S) is providing comprehensive health services to the entire population residing in the state on behalf of the Ministry of Health covering promotive, preventive, curative and rehabilitative aspects to raise the health status and prolong the lives of the local population. The basic health staffs down to the grass root level are providing these services through Primary Health Care approach. Infrastructure for service delivery is based upon Sub-Rural Health Centre and Rural Health Centre where midwives, Lady Health Visitor and Health Assistants are assigned to provide primary health care to the rural community.

Those who need special care are referred to Station Hospital, Township Hospital, District Hospital and to Specialist Hospital successively. At the peripheral level, i.e. the township level actual provision of health services to the community is undertaken. The Township Health Department forms the backbone for primary and secondary health care, covering 100,000 to 200,000 people.

N.S.S. covers a moderately large area of land (i.e. 22487.47 sq. miles) sharing over 395 miles of border with the People's Republic of China and consists of 24 townships. Kokant and Wa special regions are also included within the N.S.S. There are one 200 bedded State Hospital in Lashio which is the capital, two 150 bedded hospitals, three 100 bedded hospitals, three 50 bedded hospitals, ten 25 bedded hospitals, one 16 bedded Township Hospital and 24 Station Hospitals in the state for curative services. In addition there are one Urban Health Centre in Lashio, 17 MCH teams and 2 School Health teams for promotive and preventive services. To provide primary health care in the rural areas there are 67 RHCs and 242 Sub-RHCs.

The five leading causes of morbidity for the whole N.S.S. are malaria, ARI, diarrhoea, dysentery and TB. Although HIV/AIDS is not yet a public health problem in the state there is however an ever threatening situation of HIV transmission because of the booming border trade across Muse and Gyae Goung. With regards to reproductive health, the percentage of home deliveries by skilled birth attendants in 2008 and AN care coverage were both still rather unsatisfactory.

The main constraints & obstacles encountered by health workers in providing health services in N.S.S. are difficult transportation, high travel costs and language barrier among others. In spite of all these difficulties, our health workers are trying their very best to provide quality health services to the community.

Part 1

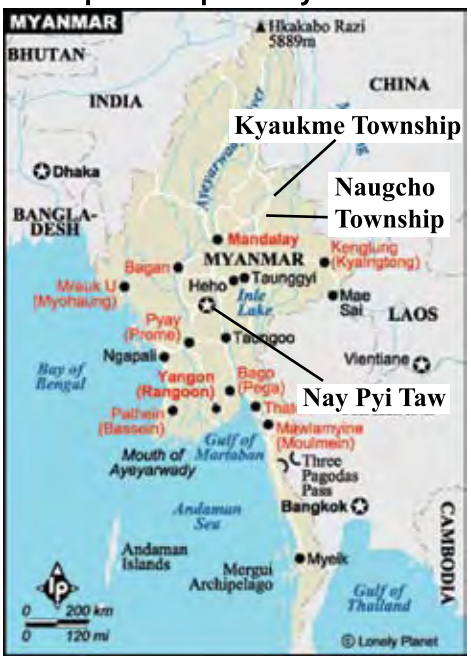
Project Overview and Achievements

I Project Overview

The Community-Oriented Reproductive Health (CORH) Project was initiated in February 2005 for a five-year period, with the aim of improving women's reproductive health in the Union of Myanmar, especially focusing on safe motherhood. The Project has been implemented by the Department of Health (DOH, MCH Section in particular), Ministry of Health (MOH) of the Union of Myanmar, in collaboration with Japanese Organization for International Cooperation in Family Planning (JOICFP) under the Japanese Technical Cooperation Scheme supported by Japan International Cooperation Agency (JICA).

Known as the Healthy Mother Project, the Project takes a "community-oriented" approach in order to promote safe motherhood through community initiatives, which leads to increased utilization of quality RH services in the community. The Project was initially implemented in the selected Townships of Kyaukme (Population: 167,000) and Naungcho (Population: 135,000), Shan State (North), with the outcomes to be further reflected in other areas through national strategies.

Map 1-1 Map of Project Areas



One of the significant approach introduced by the Project is ***"Maternal and Child Health Promoters (MCHP) System"***, in two Townships, as the first trial in Myanmar's MCH history. Some 1,700 of MCH Promoters are working now as health volunteers in the Project areas as a ***'bridge'*** between pregnant women and midwives in every village in the two Townships. Their role is to promote ANC, clean and safe delivery by SBA, and proper PNC. Referral to higher level health facilities can be made if necessary, under strong teamwork with BHS and support from the community authorities.

Outline of Community-Oriented Reproductive Health Project

<u>Strategies of the Project:</u>

The aim of ***Healthy Mother Project*** is to increase the utilization of quality RH services in target areas, which will in future, create the foundation for reduction of MMR in Myanmar community. For achieving this aim, the Project has taken the following strategies:

Strategy 1 Improving the quality of RH services provided by skilled birth attendants (SBAs)

For assuring the better quality of RH services, there are a lot of areas to be improved or issues to be solved. However, in this "Community-Oriented RH Project", we focused on the skill development of BHS, especially of midwives, who are the primarily health care providers in close contact with community people.

Being partly related to the strategy 2, the trainings on midwifery skill as well as communication/counseling skill are prioritized. Because if community people find that the services provided by the SBA are not satisfactory, they may not be willing to come back for another time.

Since MWs are covering many villages and may not be able to provide services to meet all the needs, other midwifery-trained personnel such as AMWs, could play an important role to supplement RH service provision in villages under the supervision of SBA. The Project conducts refresher training for AMWs with emphasis on securing clean delivery.

It will be even more effective if health facilities could be upgraded with minimum basic medical equipments provided, at the same time. It can also facilitate community people's awareness with visible impact, if it is difficult for community people to realize skill improvement of BHS as it is invisible.

Strategy 2 Facilitating the health-seeking behaviour among community people especially women

Even though the quality of service is enhanced by taking the strategy 1, the service coverage may not increase without the awareness/ behavior change of the clients (community people, especially women in reproductive age).

For this to happen, firstly, essential and correct RH information and effective messages have to reach to people in the community. BHS is the most appropriate resource person to provide correct RH information, therefore we put emphasis on the health education skill development of BHS. For making the health education sessions more effective and attractive to community people, it is also necessary to conduct the skill training for BHS which includes many tips, new methods of enter-education and participatory approach, and provide them with appropriate educational materials.

AMWs and MCH Promoters, who are more easily accessible by community people including pregnant women, can also support and further facilitate dissemination of information and messages. One of the important roles of MCHP is to disseminate the correct RH messages to the grassroot people to encourage target group to receive MCH/RH services.

Strategy 3 Building strong teamwork among BHS, AMWs and MCH Promoters for effective collaboration in RH/MCH promotion activities in the community

As you go farther into remote rural area, access to the health services offered at health facilities might become more difficult. Even if the RH services in RHC or Sub-RHC are of good quality, a pregnant woman may not be able to go there if she could not have support by her families. Even if a pregnant woman knows that she should deliver attended by a SBA, she may turn to TBA if she cannot afford the transportation to go to the nearest health center. Under such circumstances, the utilization of RH services will not increase.

Thus, MCH Promoters in the area could effectively link the pregnant woman to the SBA, as they are trained to work as good coordinators to ensure that pregnant women or mothers with children under 5 would receive health care services when necessary, in collaboration with SBA, AMW as well as community leaders and members. Especially, MCH Promoters need to have a strong teamwork with SBAs and AMWs in her area, so that she can know how to make necessary coordination when she finds any case to be referred (either as emergency or not) to SBAs (MCHPs were taught about the danger signs during pregnancy, during and after delivery).

Also for SBAs, MCH Promoters could be of great help as they can collect information on pregnant women or children under 5 in their respective areas, since it may not always easy for SBAs to obtain correct information, otherwise. In some areas, MCH Promoters even assist SBAs at the time of immunization or health education sessions in the community. This teamwork is also highly important in terms of ensuring the sustainability of MCH Promoters, who are purely unpaid volunteers.

For creating the good teamwork among SBA, AMW and MCHP, the training for BHS on leadership and management skill would be effective. In addition, in the trainings for MCHPs and AMWs, the topics of regular reporting and feedback system need to be included.

As for creating wider supporting environment in community, refer to the following strategy 4.

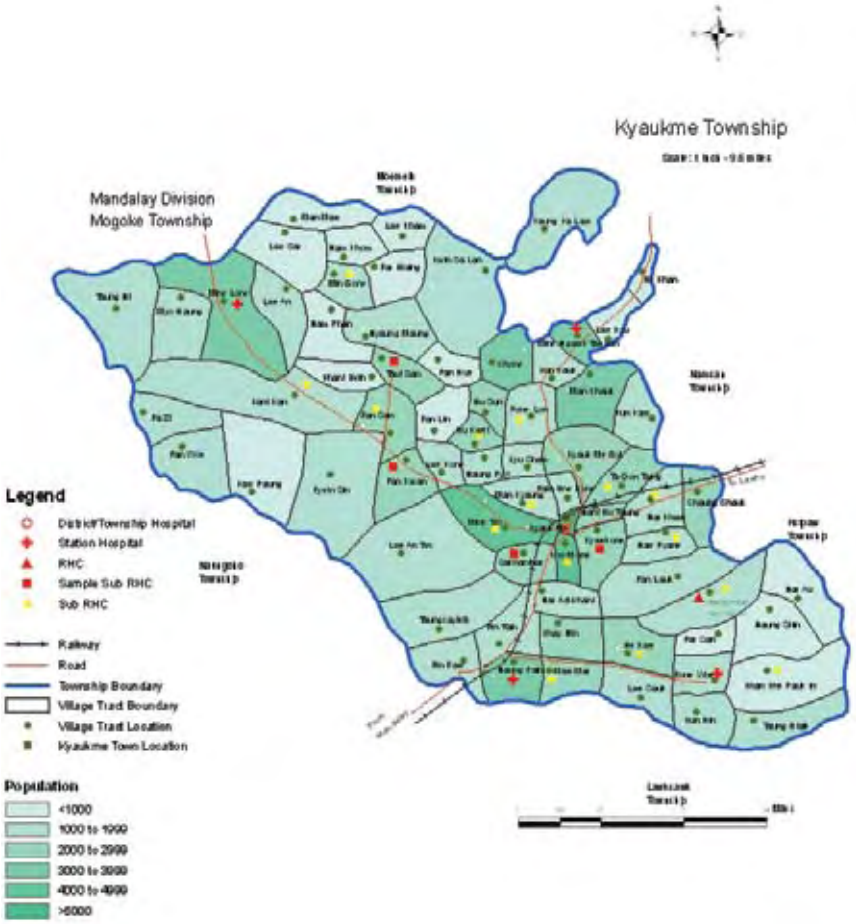
Strategy 4 Strengthening community support mechanism for MCH/safe motherhood activities

As mentioned in the above paragraph on Strategy 3, it is necessary to create supportive environment for MCH/RH promotion activities, involving all community stakeholders, when we try to achieve the aim of increased utilization of RH services.

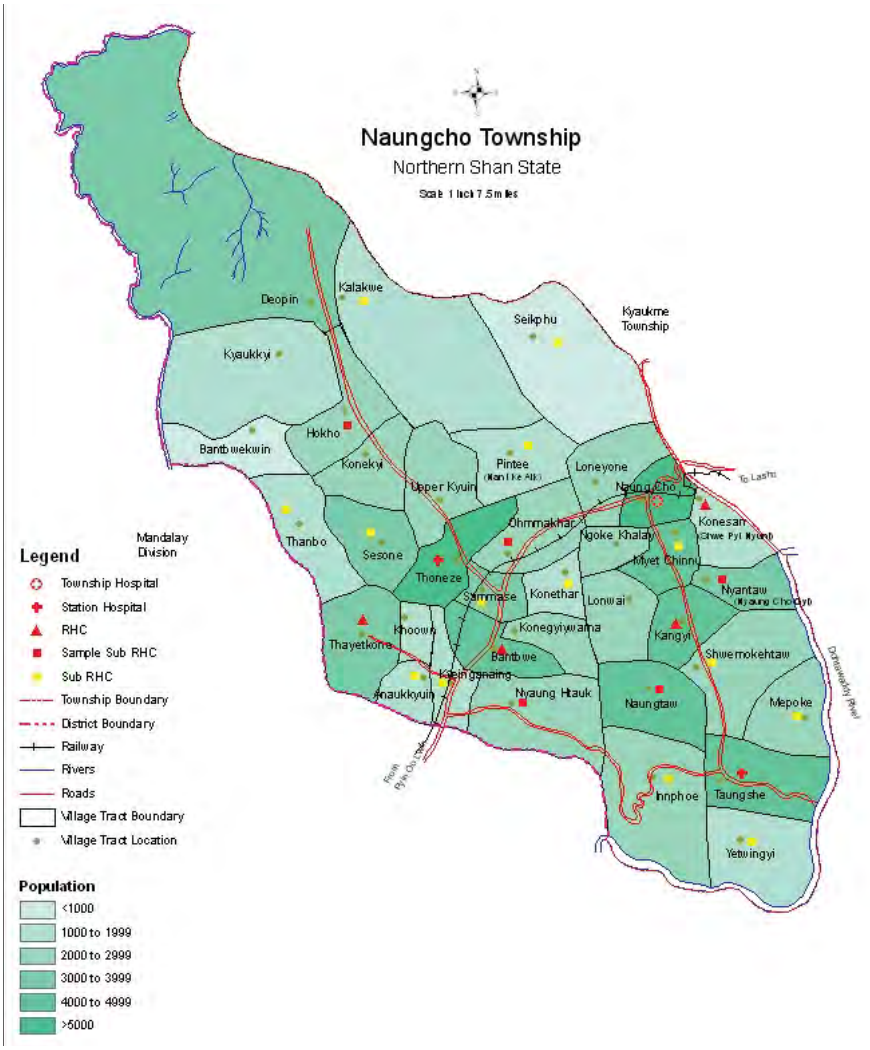
So the Project involves community leaders into Project activities through the working groups at the village tract level from an early stage, by facilitating their understanding on the benefit of the improvement of MCH situation in the community, what are the MCH Promoters, and what kind of roles could be played by community leaders and members for MCH promotion (for example, assisting emergency referral by arranging transportation, making good public announcement on health-related activities and supporting BHS, AMW and MCHP for their smooth activities, etc.).

Another intervention undertaken in the Project is to provide the opportunities to share experiences of good practices among all stakeholders. People tend to follow the good examples or practices when they recognize the need to improve on something and know how they can tackle them. In the Project areas, some good community-based supporting systems, such as community fund for assisting referral cases or poor in-patients, or transportation arrangement in emergency cases. When the community people initiate such kind of system through the experience-sharing among neighboring areas, it is more likely that people will keep their ownership and the system will be sustained in a long run.

Map 1-2 Map of Location of Health Facilities in Kyaukme Township, Northern Shan State



Map 1-3 Map of Location of Health Facilities in Naungcho Township, Northern Shan State



In order to put the strategies mentioned earlier into practice, the Community-Oriented RH Project was implemented with the following outline:

Box 1-1 Project Outline

Overall Goal: Reproductive health (RH) status improves in the Project areas and expanded areas*of the Union of Myanmar

* The areas where community-oriented RH approach is applied.

- Project Purpose: Utilization of quality RH services increases in the Project areas
- Target Group: Women of Reproductive Age (15-49 years old)
- Project Period: February 1, 2005 – January 31, 2010 for 5 years
- Project Areas: Kyaukme Township (Population: 167,000) and Naungcho Township (Population: 135,000) in Shan State (North), the Union of Myanmar.

Project Outputs and Activities planned in detail:

1. Quality of RH services with special focus on safe motherhood is improved in the Project areas

1.1 Conduct the baseline and end line surveys on RH services, health facilities and community perspectives on RH
1.2 Re-train midwifery-trained personnel for ensuring safe delivery including early detection of high risk pregnancy
1.3 Train Basic Health Staff (BHS) on Leadership, Management, and Counseling skills
1.4 Monitor BHS to support for skill development regularly by DMO/TMO and responsible persons
1.5 Train BHS to strengthen referral to higher level health facilities
1.6 Renovate health facilities
1.7 Provide basic equipment

2. Awareness and knowledge on RH issues among community people, particularly women, is improved in the Project areas

2.1 Conduct needs assessment on IEC/BCC materials
2.2 Develop IEC/BCC materials
2.3 Train Basic Health Staff (BHS) on IEC/BCC
2.4 Conduct health education sessions by the trained BHS for community people including pregnant women
2.5 Provide guidance to AMWs and MCH Promoters by BHS for IEC/BCC activities on RH issues

3. The linkage between RH services and community people is strengthened

3.1 Conduct TOTs of BHS on trainings and refresher trainings for MCH Promoters
3.2 Conduct trainings and refresher trainings for MCH Promoters
3.3 Conduct home visits by MCH Promoters to women in the community during pregnancy, delivery and post-delivery period
3.4 Organize teamwork for effective referral from community level to the health facilities by BHS, AMWs and MCH Promoters
3.5 Develop action plan by BHS for effective teamwork with AMWs and MCH Promoters
3.6 Provide necessary knowledge and information by BHS to AMWs and MCH Promoters regularly

4. Mechanism to support community-oriented RH approach is established and functioned

4.1 Establish coordination committees for the effective planning, implementation, monitoring and evaluation of the project activities at each level (Project Steering Committee at central level, Township Working Group at township level and Village Track Working Group at village level)

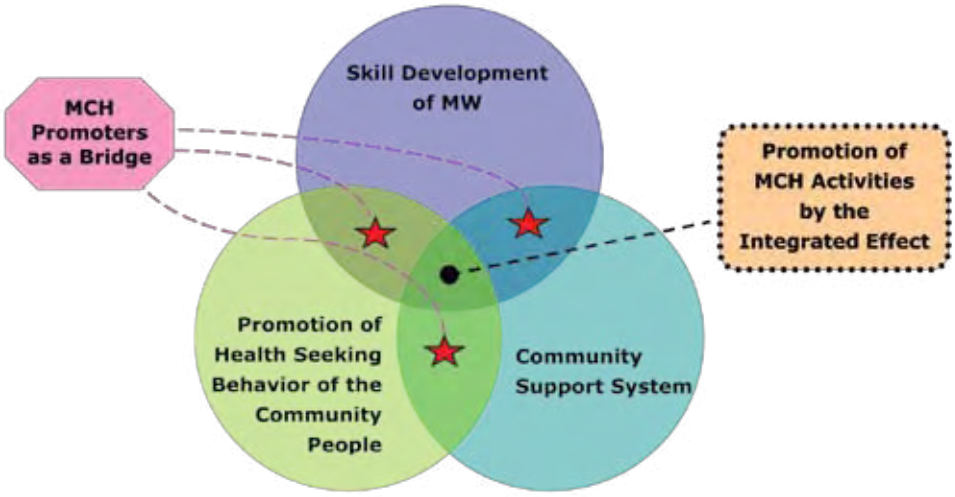
4.2 Develop guidelines for coordination committees
4.3 Organize regular meetings of coordination committees at each level to strengthen collaboration mechanism for community-oriented RH activities including community support system
4.4 Conduct management workshop at township level for community leaders to strengthen capacities for planning, implementation, monitoring and evaluation

5. Applicable community-oriented RH approaches are identified and documented for wider application under RH program in the Union of Myanmar

5.1 Develop guides for project implementers to apply community-oriented RH approaches
5.2 Conduct workshop for sharing experiences at the township level
5.3 Conduct dissemination workshops for sharing the experiences, outcomes and lessons learnt of the community-oriented RH project among the concerned government and non-governmental organizations
5.4 Organize study visits in Japan and other countries to strengthen management capacity in RH program in Myanmar

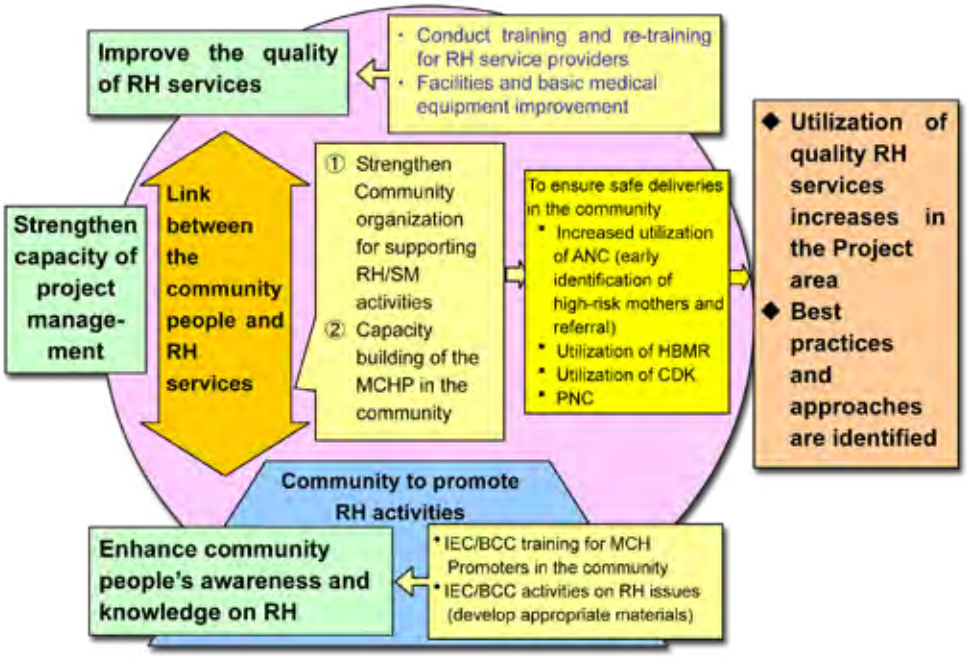
The Project aimed to attain an integrated effect on promotion of MCH activities by three major focuses as indicated in below chart 1-1. MCH Promoters are expected to act as a bridge between these three focuses.

Chart 1-1 Three (3) Major Focuses of Project Input for MCH Promotion



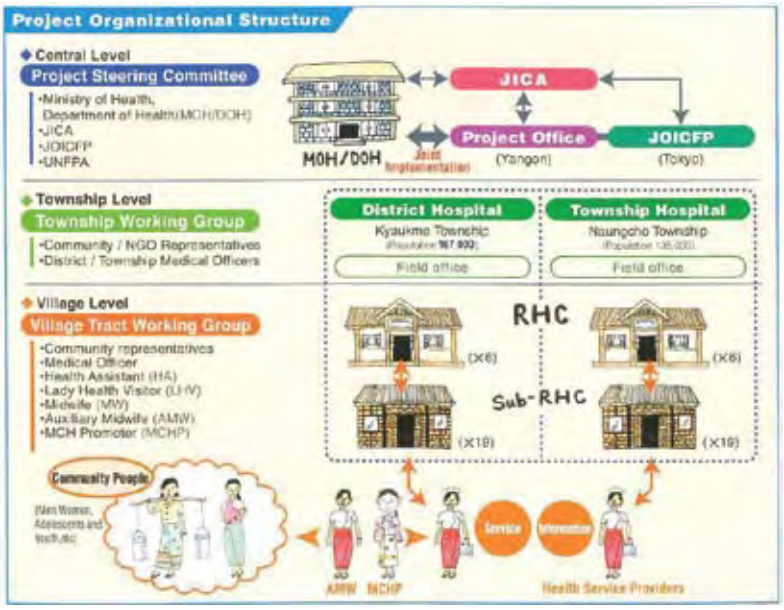
The following chart 1-2 gives you an idea on how the each Project output is linked one another to achieve the Project purpose, and the activities corresponding to each output.

Chart 1-2 Inter-linkages of Project Outputs and Activities



The Project implementation has been undertaken by a structure shown in the chart 1-3. The members of the Project Steering Committee at central level, Township Working Group at township level and Village Tract Working Group at village tract level, are responsible for the planning, implementation and monitoring of the Project activities. Regular meetings were organized at each level to share the progress and discuss on the planned activities.

Chart 1-3 Organizational Structure of the Project Implementation



II Project Achievements

(1) Project Achievements According to Project Indicators

Individual and social behavioral changes have been brought about through the Project inputs. In particular, the intervention of MCH Promoters (MCHP) has shown significant changes in the two Project areas of Kyaukme and Naungcho Townships. MCHP played a role as a ***catalyst*** to facilitate community initiatives while working as a *bridge* to actively link community people, in particular pregnant women and children under 5, to health providers such as MWs.

A significant improvement of MCH-related Project indicators was also achieved, from 2005 to 2008, with significant changes seen after two years since the Project started.

Another achievement from this Project is the finding that the community support system is indispensable to the Community-Oriented RH Approach for safer motherhood. There is significant evidence that people change people, in other words, the MCH Promoters change the community leaders and people, under the same goal of saving lives of pregnant women and newborn babies. It is easy to talk about community participation and involvement. However, in the two Project Townships a lot of effort was made to put the talk into action, e.g. development of a form of community welfare fund, for assisting emergency referral transportation, and teamwork building among MW, AMW and MCHP in their own villages. The good practices in the Project areas suggest that once the people in the community realize the importance of MCH activities, they will initiate an action, which could produce a greater synergistic effect together with the changes caused by the individual MCHP in the respective area. These social changes for health seeking behavior were actually seen in the Project areas.

Since the Project started in February 1, 2005, until the mid-2009, we are very pleased to share the progress and promising evidences observed during that period.

The Project indicators for the Project activities in the revised PDM are as follows:

Table 1-1 Project Indicators for the Project Activities

Project Indicators (average for 2 Project Townships)	Baseline (2006)	End-line (2009)
Total Fertility Rate (TFR)	3.29	2.72
Knowledge on RH (symptoms during pregnancy)	24.8%	66.8%
Knowledge on RH (danger signs during and after delivery)	22.6%	72.5%
Knowledge on RH (risks related to abortion)	11.7%	61.0%
Knowledge on RH (contraceptive methods)	76.8%	93.7%
Percentage of pregnant women who received 4 and more times of AN care	44.1%	47.8%
Percentage of currently married women who have given birth in the last 12 months with skilled birth attendants	47.4%	66.8%
Percentage of pregnant women getting at least two doses of T/T injections	77.7%	82.1%
Percentage of pregnant women who use home-based maternal record (HBMR)	25.5%	52.5%
Percentage of pregnant women who use clean delivery kit (CDK)	69.2%	88.6%
Contraceptive Prevalence Rate (CPR)	41.2%	52.6%
Midwifery skills (counseling) *	54.7%	72.3%
Midwifery skills (AN care) *	40.2%	78.6%
Midwifery skills (delivery) *	70.0%	77.5%
Midwifery skills (PN care: immediate) *	79.2%	87.5%
Midwifery skills (PN care: 2-3 days) *	52.4%	61.1%
Midwifery skills (PN care: 4-6 weeks) *	37.8%	92.2%
Knowledge of midwife (obstetric complication)	43.3%	78.6%
Knowledge of midwife (newborn care)	13.3%	71.4%

* The percentage of cases which SBA completed the procedure properly according to the MOH guideline among all the cases observed.

Box 1-2 Conclusions from the Changes of Project Indictators

- The knowledge of RH/MCH issues among the community people has improved significantly
- Significant improvements in the utilization of RH/MCH services are observed in many indicators
- The midwifery skills and knowledge of BHS are upgraded significantly
- The activities of MCHPs have effects in the promotion of RH/MCH

However, further analysis is needed in terms of the changes in MMR and IMR, because in most cases, these figures are not easily changed within a limited period of time. We need to carefully look into the impact of the

MCHP System and/or other interventions by the Project on the changes in MMR and IMR. We know that every pregnancy and delivery could have some kind of risk. Although we strongly believe that prevention of complications in pregnancy and delivery by ***early detection, timely referral and early treatment*** can definitely contribute to save lives of pregnant women and newborn babies, in some cases, critical situation may not be prevented only by public health intervention. Therefore a comprehensive emergency obstetric care system also need to be established within their reach.

That is why it may take much longer time to attain the desired changes in the MMR and IMR than we would like .

Up to date, the Project has trained approximately 4,000 stakeholders in a total of two Townships, as follows:

Table 1-2 Major Input by the Project

➢	**90 BHS including MWs,** received multiple skill development trainings
➢	**233 AMWs** received the refresher trainings
➢	Accumulated number of **MCH Promoters: 3,326 (1st batch 1,672 and 2nd batch 1,654)** received trainings during 2006 to 2008
➢	**110 Community representatives** including PDC chairpersons and village tract representatives received accumulated workshops and seminars
➢	**26 Counterparts** were dispatched for study visits to Japan and Vietnam upto 2009
➢	**19 RHCs and Sub-RHCs** in total, were renovated during 2006 to 2008
➢	**26 Kinds of basic medical equipment** were provided to the health facilities during 2005 to 2008

(2) Findings of the Project Impacts

The major impacts observed as the result of the Project activities are as follows; -

1. The quality of reproductive health (RH) services has been improved through skills development of BHS and facility improvement:

A series of skill development trainings for BHS and refresher training for AMWs have been conducted as important inputs by the Project. It was acknowledged by the Terminal Evaluation Mission (September 2009) that together with the skill development of the

health care providers, renovation of RHCs and Sub-RHCs, and provision of the basic equipment have greatly contributed to the improvement of quality RH services. This has helped to an increase in service utilization by the community people.

2. Team spirit for safe-motherhood was created:

MCH Promoters, AMWs, PDC chairperson/ community representatives, midwives, and medical professions at the hospital seemed to have developed a strong team spirit for safer motherhood after the introduction of MCH Promoters. In many villages they have started regular meetings with close collaboration amongst themselves to share the progress as well as the issues that need to be tackled.

3. Trainer-and-trainee relationship encouraging trust and credibility:

Basic Health Staffs (BHS) such as HAs, LHVs and midwives were the trainers for MCH Promoters in the initial and refresher trainings. Through these trainings, they have established the relationship with trust and credibility.

4. Support for emergency transportation, and promoting Community Welfare Fund:

Through MCH Promoters, community mobilization was also strongly promoted for access to the referral system assisted by PDC chairperson and community representatives. As in other emergencies, transportation and monetary assistance for saving mothers and newborns have been obtained through the Community Welfare Fund.

5. The gap in the generations among MCH Promoters leads to peer education under the same mission:

Age distribution among the MCH Promoters was wide, ranging from teenage to 60's years of age, with the average being around 35 years old in the Project areas. This wide range of their age was, in fact, an advantage for them in terms of sharing information as well as exchanging ideas

on their work among different generations. It would give them better chance to be able to approach to the wider range of community people including pregnant women in their communities.

6. Enhanced awareness of the community people is leading to behavior change

People's awareness on RH issues has been improved in the Project areas, as shown in the baseline and end-line assessment study results. Many pregnant women and community people received information on RH, as well as referred to the appropriate health care providers due to the activities of the MCH Promoters. There is a tendency that more pregnant women are choosing the RH service providers for the reasons that they are qualified and/or experienced, when they decide where to take ANC and PNC, and to have delivery. Some pregnant women are deciding where or from whom to receive RH services, based on the recommendations by MCH Promoters. It was found that MCH Promoters are more relied on as a source of RH information in rural area than in urban area.

Part 2

Community-Oriented Reproductive Health Approach

I Five (5) Model Steps of Community-Oriented RH Approach

The following model steps for the Community-Oriented RH Approach would be helpful when you apply the Approach in your area. These steps are the suggested example drawn from our experiences of Project implementation in Kyaukme and Naungcho Townships; therefore, you can make necessary adjustments depending on the situation of your township.

(1) The 5 model steps

Step 1: Situation Analysis
Step 2: Planning
Step 3: Advocacy and Sharing the Same Vision
Step 4: Implementation
Step 5: Monitoring and Evaluation

Here is the detail explanation of what is expected to be done in each step:

Step 1 : Situation Analysis

DMO/TMO and BHS to study and analyze the present situation and identify the issues in your township

(i) Skill of SBAs and AMWs

Make a skill assessment of SBAs (such as LHVs and MWs) and AMW for providing quality RH services. If you cannot conduct a full scale assessment, you are at least recommended to make sure what kind of skill needs to be enhanced for providing RH services with better quality.

(ii) Community health volunteers

Is there any community health volunteers in your area? How many of them are active and which areas are being covered? What are the actual activities they undertake?

(iii) Teamwork and collaboration among MW, AMWs and community health volunteers

Is there any teamwork or collaboration among MW and AMWs? In which ways do they actually collaborate? If there are community health volunteers in the area, what is the status of teamwork among all these stakeholders?

(iv) Community support

Are there any activities carried out by the community's initiative to promote RH/ safe motherhood in the area, and in which ways are they carried out? Who are the person(s) or organization(s) providing the support?

(v) Health committee

Are the health committees at township and village levels functioning or active? What are the actual roles and functions of the health committees? Are there any issues?

(vi) Health awareness

What is the situation of community people's awareness concerning health/RH? What kind of information/message is being conveyed to the community people by BHS at the village level, how, and at which occasions? Are there any major or particular issues to be addressed in the area?

This study and analysis could be very helpful for you to know the present situation in your area, and it can give you a good basis for planning. This analysis can also be conducted through monthly meeting of CME sessions, in which all the BHS would be present. Some of the necessary information could be collected by the BHS under the supervision of DMO/TMO.

It is strongly recommended to have the baseline indicators at the time you start implementation, so that you will be able to measure the changes/ improvement objectively by monitoring the changes in such indicators.

Step 2 : Planning

To plan on your goal, steps and method of implementation – using the *Implementation Guide* as a reference

With the issues and challenges identified in Step 1, you will need to identify the priority areas that require more attention. When applying Community-Oriented RH Approach, there is a suggested sequence of activities to follow, though, adjustments can be made according to the situation and needs in your area to tackle specific issues.

We recommend that you refer to the related sections/chapters in this Guide, so that you would know the necessary considerations for your planning. A systematic implementation of the activity components is recommended for gaining the expected outcomes. In other words, you may not have much improvement in RH/safe motherhood situation only by conducting MCH Promoters training. The charts 2-1 (a) and (b) "Sample of Implementation Flow of Essential Components of CORH Approach" (on pages 21-22) might help you to understand the concept and the

essential components of the Approach, together with the suggested flow of implementation, for you to refer especially when you plan as well as actually apply this Approach.

The Essential Components of this Approach are as follows.

(i) Skill Development of BHS

➢ **Leadership and management skill**

Midwives need to be motivated and empowered as leaders in MCH promotion activities at the village level. This skill will also be a basis for building teamwork (*) among midwife, AMWs and MCH Promoters later on.

*** Teamwork building among midwife, AMWs and MCHPs** is one of the key strategies of the Approach.

➢ **Midwifery skill**

It is very important for midwives to be able to provide quality RH/MCH services, especially attending births, when community people seek for their services. Failure to do so may discourage the community people to seek such services in the future.

(ii) Introduction of MCH Promoters (ToT and MCH Promoters Training)

MCH Promoters would act as a bridge between health services and the community people, especially pregnant women, under the effective teamwork with midwife and AMWs in their area. They are also expected to work as a catalyst to bring about changes in their community by disseminating health messages as well as promoting health seeking behavior among the people. Following the Training of Trainers (TOT), BHS need to give 1-day training to MCH Promoters in villages.

(iii) Promotion of Community Support

In the Approach, community members are expected to play a significant role in promoting safe motherhood in their area. MCH Promoters alone, may not be able to handle some difficult situations, i.e. emergency referrals, in which the community could support and cooperate by providing necessary help and assistance to the mother and/or baby.

The community health volunteers including MCH Promoters are able to work effectively and actively in their area, when supported by their community members.

Some time after the introduction of MCHPs in the community (might be 1 or 2 year after), good practices identified at the village/village tract level can be presented in experience sharing workshops, so that other villages can learn and follow them.

For the planning process, it should be encouraged for all the stakeholders

in the area to participate as much as possible. These stakeholders might include local authority, community representatives, local NGOs, etc. This is recommended because they will have a sense of ownership in the activities from the very beginning, and thus will be more likely that they would be committed and take active role at implementation stage.

Step 3 : Advocacy and Sharing the Same Vision

To share the issues and challenges based on the current situation, and at the same time, to advocate the vision on Community-Oriented RH Approach

After the situation analysis on the present situation (Step 1) and planning (Step 2), advocacy to all the stakeholders is necessary. Firstly, advocacy on safe motherhood is essential, and it needs to be addressed to all stakeholders, not only the BHS, but also the community representatives, such as village/village tract leaders and local NGOs. Secondly, the results from the situation analysis, issues and challenges identified, can be shared to make common understanding and have the same agenda among all. In CORH Approach, it is recommended to conduct an advocacy meeting at the initial stage before any activity is started, with all concerned stakeholders being involved.

Step 4 : Implementation

Start small and grow bigger later on

There are few things we want to emphasize when you apply the CORH Approach in your area.

(i) It could be suggested to start small, instead of trying to do everything from the beginning. You can start with small inputs or activities and let them grow bigger later on, especially when not enough resources is available to start a lot of activities at the same time. As for the resources, it could to be sought from the existing resources within own community first, before seeking from the outside.

(ii) It is recommended that you plug-in new structure, system or services into the existing ones where possible, rather than creating a new ones. That way, it is easier to ensure sustainability.

(iii) All the concerned persons and organization need to be fully aware of the activities to be implemented. It would be essential, especially when you are trying to introduce a totally new idea, system or activities, such as

MCH Promoters System. If you fail to do so, those who are not well informed may not be willing to cooperate, since they do not see its significance.

(iv) A focal point person can be assigned at the township level for the implementation. Even though DMO/TMO would take the sole responsibility for the overall implementation, someone else, preferably a person who can work closely with DMO/TMO, should be selected to manage the actual day-to-day activities including monitoring and supervision.

Step 5 : Monitoring and Evaluation

Monitoring and evaluation activity needs to be conducted based on the evidence, to make necessary adjustment for the next steps

Plan - Do - See Cycle is required for any kind of implementation. Without proper monitoring and evaluation, it is difficult to measure the effects or achievement of the activities implemented. Monitoring and evaluation is also effective for sustaining the activities, by making necessary revisions or improvements to achieve better outcomes.

No matter how effective the activities implemented are, the effectiveness may not be sustained over time without proper monitoring and evaluation activities.

(For monitoring and evaluation, please also refer to Part 2, Chapter IX "Suggested Four (4) Monitoring Areas.")

Chart 2-1(a) Sample of Implementation Flow of Essential Components of CORH Approach (1st year)

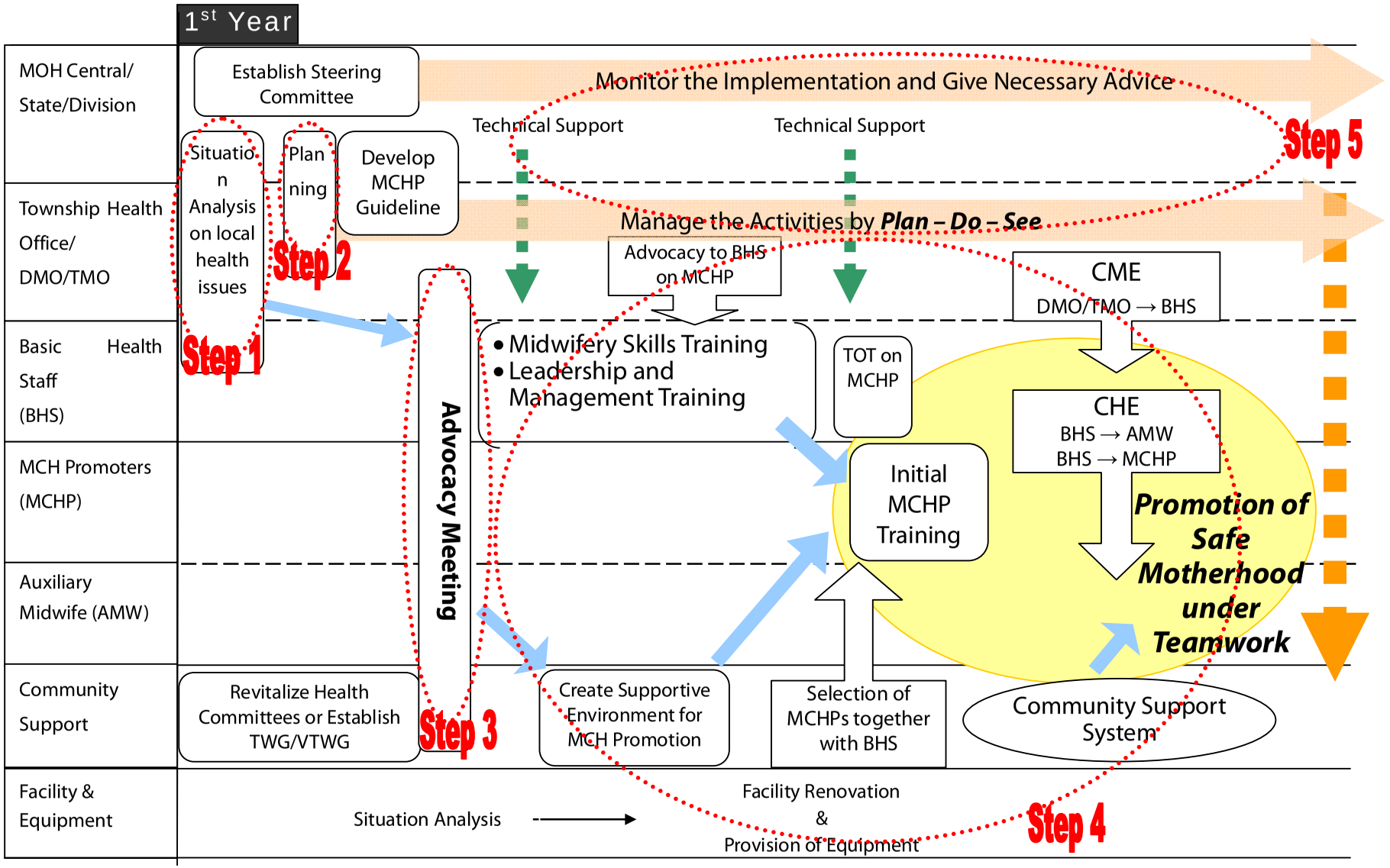
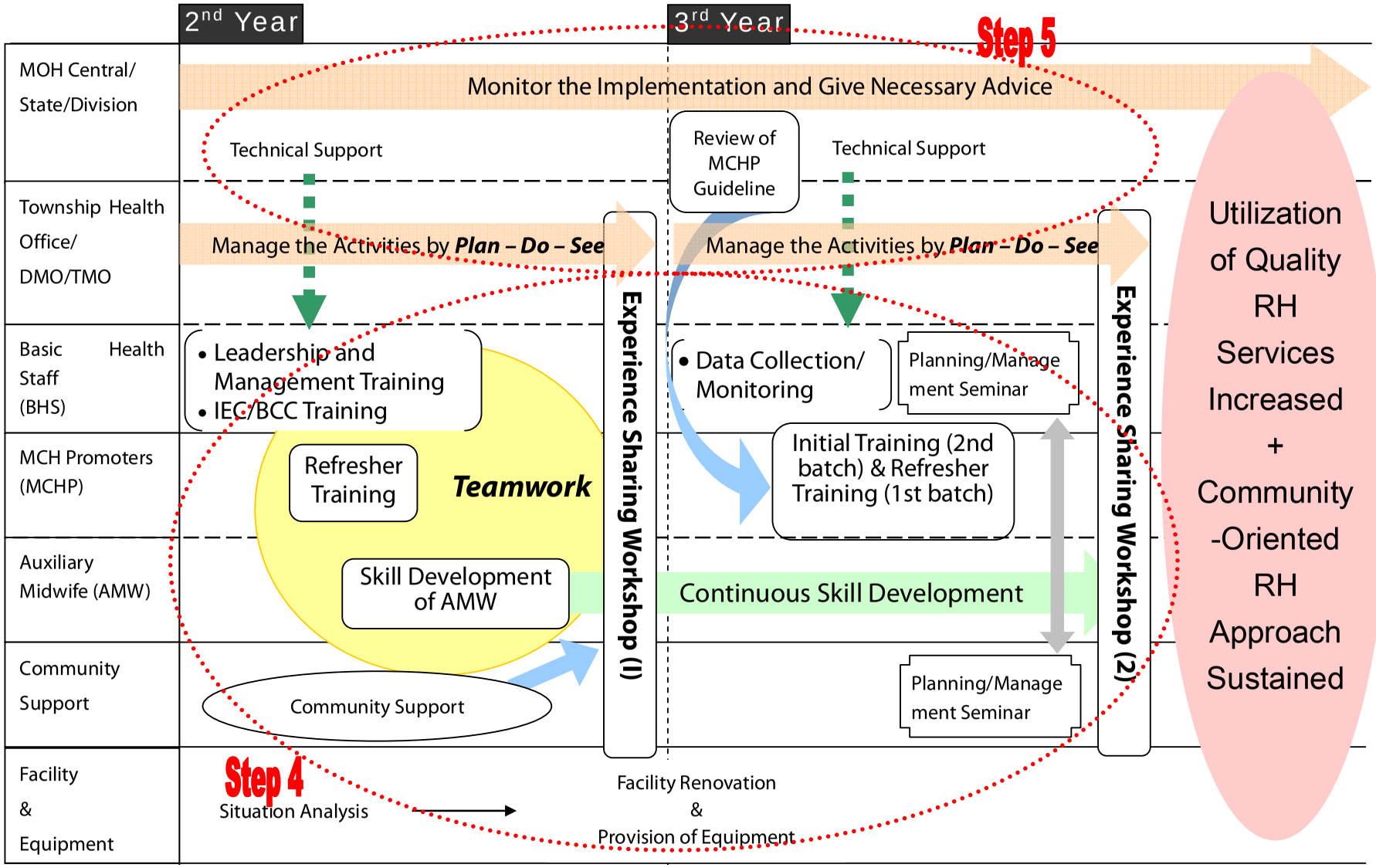


Chart 2-1(b) Sample of Implementation Flow of Essential Components of CORH Approach (2nd- 3rd years)



II Midwife is the Key Person for Community-Oriented RH Approach

(1) Midwife is the Key Person

In the Myanmar health system, the midwife's role and responsibility are vital in many aspects. Whenever and wherever we talk about community-oriented health programs, including maternal and child health at the village level, the midwife is no doubt the most essential health agent. According to the *"Duties and responsibilities of BHS*[1] *",* it appears that almost no public health care activities could be implemented without midwives. However, even by our observation it is evident that the burden and workload of the midwives are heavy beyond description.

The midwives are often seen as a multipurpose workers, and paid health agents in the community, especially at the village level. Analysis of their daily work often shows that about 85 % of their time could be utilized for the other public health issues besides their original midwifery role. Their other responsibilities include immunization, disease control and monitoring, data collection in addition to population count in their jurisdiction. As it is apparent that these situations cannot be improved within a short period of time, and until such time that it can, the midwife will remain as a very important key personnel for all community health activities. Therefore, the immediate problem we now face is how we can reduce this workload and burden of MWs, and what additional intervention can be done to achieve this. Based on this situation, the Project first provided capacity development for the midwives, depending on their capability, and second, it strengthened teamwork by effective utilization of MCH Promoters.

(2) Skill and Capacity Development is Essential

As Project recognized the need to empower MWs in their capacity and skills, we provided them with "on job training" on important components, such as the skill development on midwifery skills, IEC/BCC, counseling, leadership and management, data collection, etc. Especially the leadership and management training was quite effective with the aim for changing MWs' perspectives that they can provide health care more effectively by good collaboration with AMWs, MCHPs and community people, under proper leadership of MWs. It led to the changes in MWs' attitude and behavior, and at the same time, they became recognized as the key persons in health care provision at the village level.

(3) Empowerment of MWs Changes Them a Lot

After the Project implementation for about 5 years with a series of trainings on the subjects mentioned earlier, the midwives gradually changed their behavior and working attitudes. At the same time, the teamwork building among MCH related stakeholders - MWs, AMWs and MCH Promoters, who were trained by MWs, was also encouraged. It was proved that

[1] Duties and Responsibilities of Basic Health Staff and Standard Operating Procedures, First Edition, March 2008, DOH/MOH, JICA

empowerment of MWs in terms of knowledge and information, skills and leadership capacity, and teamwork building, made considerable change in their mind, attitude and behavior, making them think more positively on their roles and responsibilities. Previously many MWs thought of themselves as mere health service providers at the village level. Now they have realized that, with effective teamwork with health volunteers, they can also be leaders for MCH promotion activities in their community. Group dynamics can also be created by the good collaboration of MW, AMWs and MCHPs, which may have a positive effect for their work in terms of encouragement and motivation. Substantial number of MWs found that an effective teamwork could reduce the burden and work load usually shouldered by the MW alone, facilitating community health activities, especially in safe motherhood programs. Thanks to the work of MCHPs and AMWs, they can easily identify the target population in the community such as pregnant women and children under 5. Moreover, MCH Promoters can encourage the target population to receive necessary services including ANC, T/T immunization, delivery, PNC by SBAs, so that MWs can improve their coverage. Another big advantage of effective teamwork is that MCHPs as well as AMWs can make proper and prompt coordination when they find any danger sign in pregnant woman or the baby, so that the client can be referred to MW without much delay.

(4) A Leader is Not Born Naturally

In any society, a leader is not born naturally. It is rather essential that he/she should be brought up by the society, to be well acquainted with its needs. If MWs recognize that community people and health volunteers such as AMWs and MCH Promoters require their help and support, she will not feel that she is alone in the village, and would be glad to help. She surely learn/know about group dynamics and the enjoyment of working as a team, and will also learn to take on the leadership role for the promotion of health in community. At the beginning of the Project we saw that most of the midwives believed that they were the front liners of public health and the midwifery services, but they did not realize that they could be leaders in the community. However, after the leadership training, they began to realize that they have potentials to be leaders, as skilled birth attendants, in their respective community, for the promotion of safe motherhood.

(As for the midwifery skills training, please refer to Part 3 - I "Skill Development of MWs," and for the leadership and management training, please refer to Part 3 – III "MCH Promoters System.")

III Teamwork Building among Midwives, AMWs and MCH Promoters

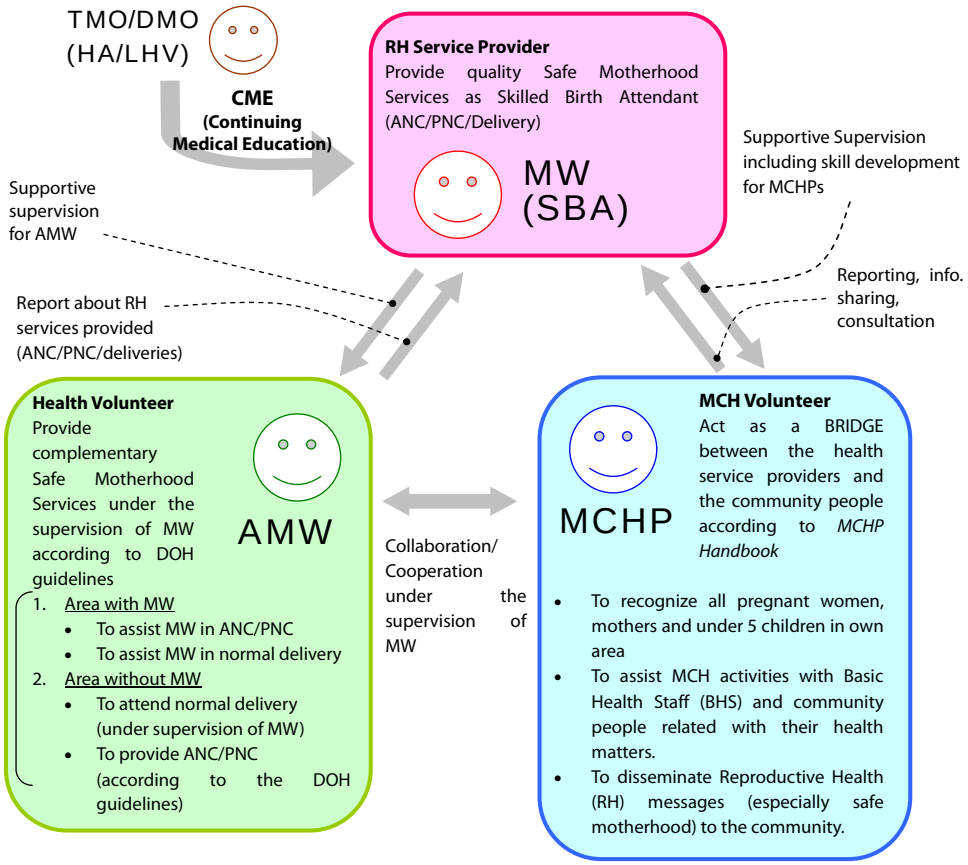
(1) Basic Concept of Teamwork

Before the start of the Project, it was identified that AMWs did not receive sufficient supervision by the midwives, and due to some limitations, MCH services could not always reach to all the people in the community.

In order to tackle this issue, the Project promoted teamwork building among midwife, AMW and MCH Promoters, for strengthening MCH activities, and improve provision of MCH services to the community, especially the pregnant women in the Project areas.

The relationship of the 3 stakeholders is described in the chart 2-2 .

Chart 2-2 Basic Concept of Teamwork



(2) 4 Prototypes of Teamwork

There are 4 prototypes identified through experiences in two Project Townships as per the following charts. They are categorized in 4 different prototypes depending on the availability of MW and AMWs in particular village where the pregnant woman resides. One MCH Promoter is available per around 30 households, which means at least 2-3 MCH Promoters would be available in every village.

In any type MW should be responsible to extend supportive supervision and coaching to AMWs and MCH Promoters and it is also critically required of her to give some technical support and input for the skill development of AMWs.

Prototype 1: Collaboration among MW, AMW and MCH Promoter where both MW and AMW are available in the village

Although this is the most desirable type of collaboration, the Project estimates only approximately 3% out of 620 villages in two Project Townships have this type of collaboration, mostly in urban areas or areas surrounding RHCs and Sub-RHCs.

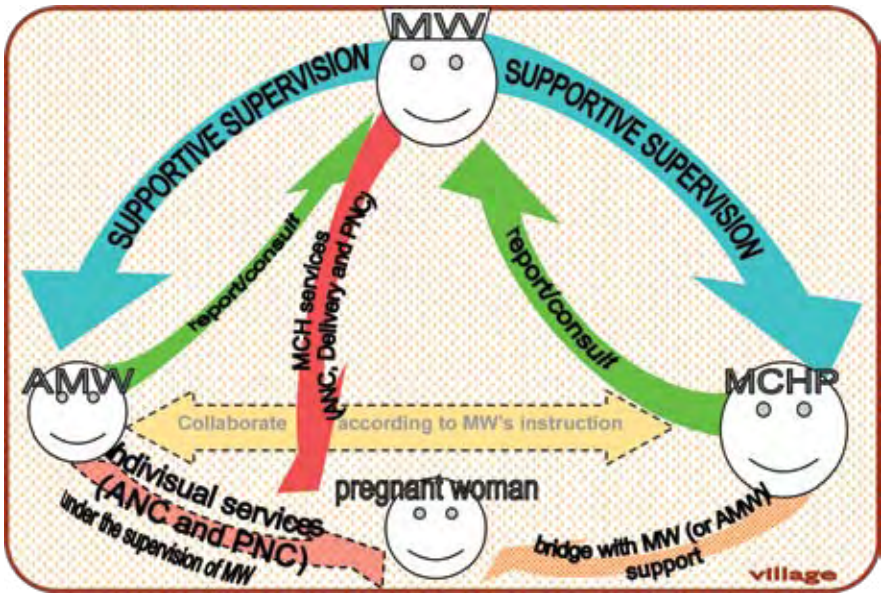
As shown in the figure, AMWs and MCHPs would work under the supervision of MW, to ensure the pregnant women could receive quality RH services by SBA, with occasional support by AMWs.

In order to have sufficient teamwork/collaboration, MW needs to provide monitoring and supportive supervision as well as continuing education to AMWs and MCHPs.

AMWs could provide RH services to pregnant women according to the instructions by the MW, and MCHPs also collaborate with AMWs according to MW's instructions.

Regular reporting as well as consultations to MW from AMWs and MCHPs on their activities is essential.

Chart 2-3 Collaboration for Prototype 1



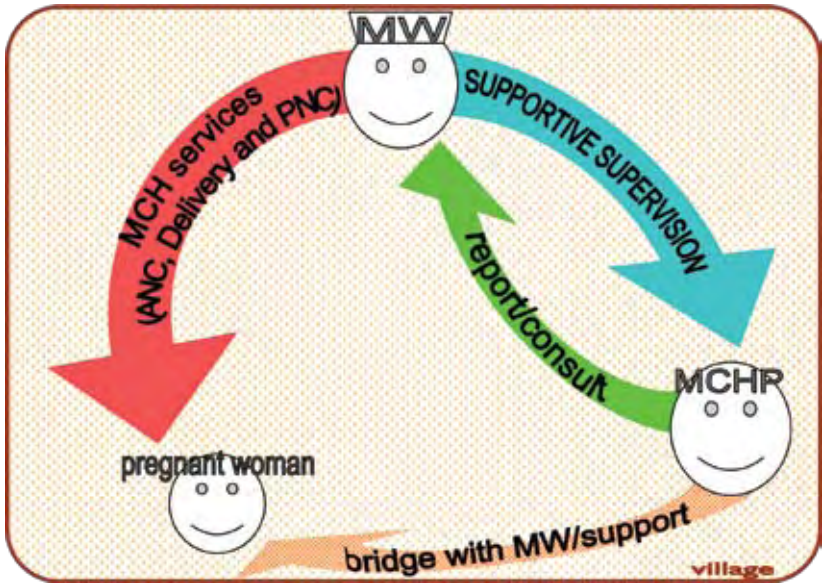
Prototype 2: Collaboration between MW and MCH Promoter where only MW is available in the village

Project estimates approximately 10% of 620 villages in two Project Townships have only one MW available in the village.

In this type of collaboration, MCHPs are expected to encourage all pregnant women to receive quality RH services by the MW, and to provide assistance in case of emergency referral.

MCHPs report to the MW regularly, while receiving supportive supervision as well as continuing education by the MW.

Chart 2-4 Collaboration for Prototype 2



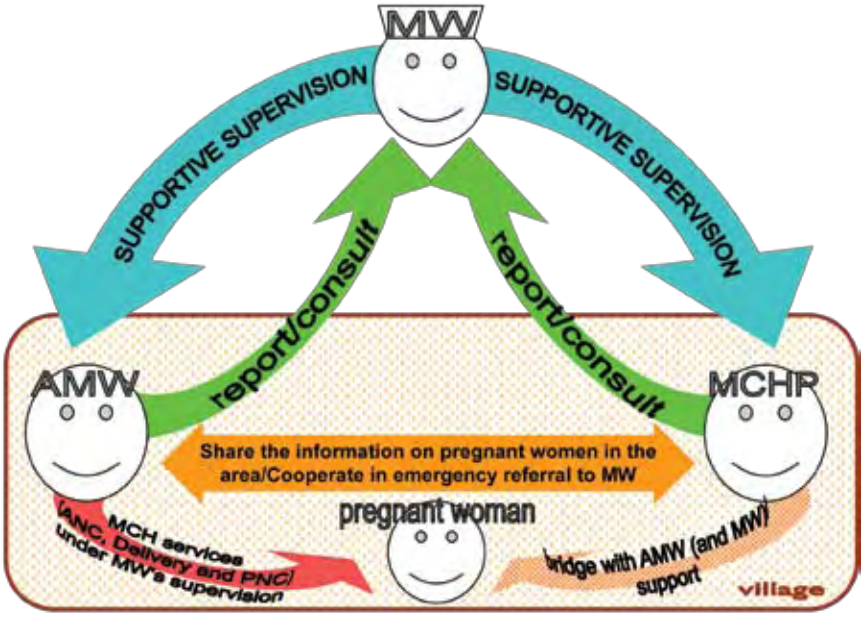
Prototype 3: Collaboration among MW, AMW and MCH Promoter where only AMW is available in the village

Project estimates approximately 36% of 620 villages in two Project Townships have this type of collaboration.

MW in charge of this village has to provide supportive supervision and continuing education to the AMWs and MCHPs, while receiving regular report and consultations from them, so that MW is fully aware of the situation of the pregnant women in the village.

In this type of collaboration, the teamwork among AMWs and MCHPs, including sharing of information on the pregnant women and cooperation in emergency referral becomes quite important, although it doesn't diminish the importance of seeking supervision or instructions from the MW.

Chart 2-5 Collaboration for Prototype 3



Prototype 4: Collaboration among MW, AMW and MCH Promoter where neither MW nor AMW is available in the village

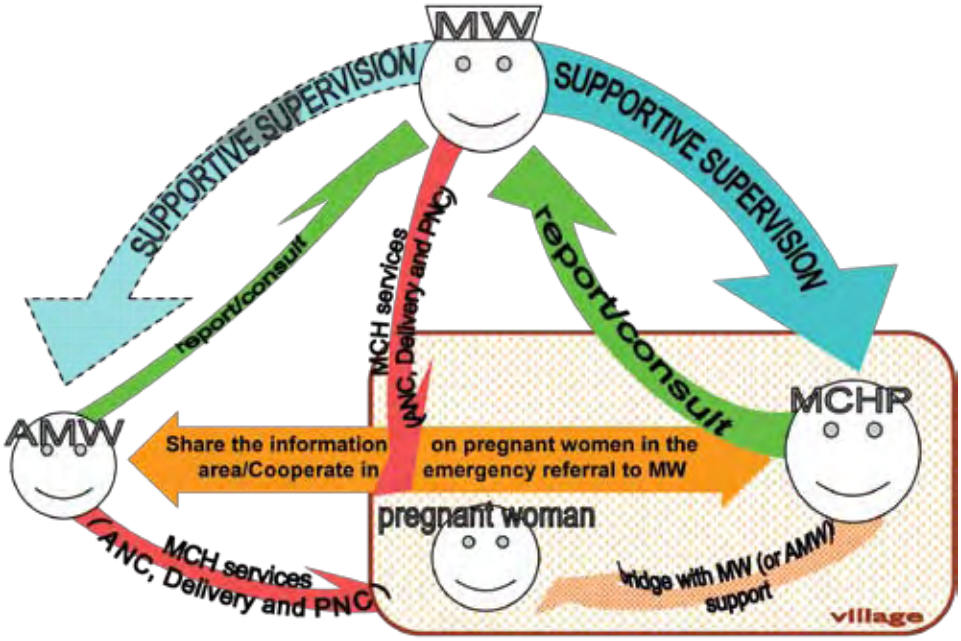
Project estimates approximately 51% of 620 villages in two Project Townships have this type of collaboration.

MW needs to provide supportive supervision to MCH Promoters for effective MCH activities in the village.
MCHPs could encourage pregnant women to receive quality RH services from MW, utilizing the opportunity when the MW comes to the village, once per month.

In case they have AMWs in the near-by villages, MCH Promoters could encourage pregnant women to receive ANC and PNC from AMW, under the guidance of MW.

At the time of emergency referral, MCH Promoters are expected to facilitate necessary support from the community such as arrangement of transportation, etc.

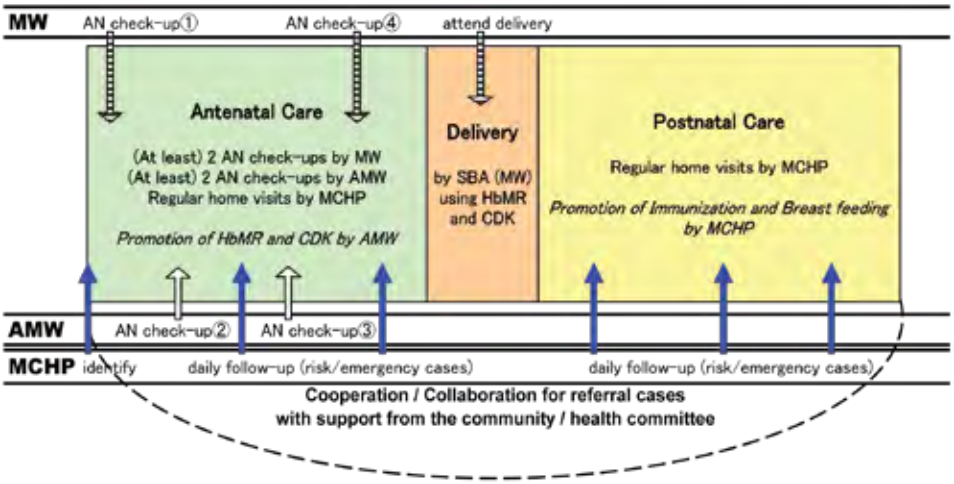
Chart 2-6 Collaboration for Prototype 4



(3) Collaboration for MCH Service Provision

The Project presented the collaboration among MW, AMW and MCHP in more practical way, according to the each MCH service provision such as AN care, delivery and PN care. In the most desirable situation, where MW is available and AMWs and MCHPs are working under good collaboration with MW, AMW might be able to help MW by providing 2 times of AN check-up to a particular pregnant woman. She can even assist MW by helping the delivery assisted by MW, or providing PN care.

Chart 2-7 MCH Teamwork for Quality RH Service according to the Sequence of Services



Where MW is not available or easily accessible, AMW may need to provide most of MCH services, including AN care, delivery and PN care, with cooperation of MCH Promoters, under guidance from MW. Close supervision and consultation by MW would be crucial in these cases.

Chart 2-8 MCH Teamwork for Quality RH Service according to the Sequence of Services
- Places where MW is absent

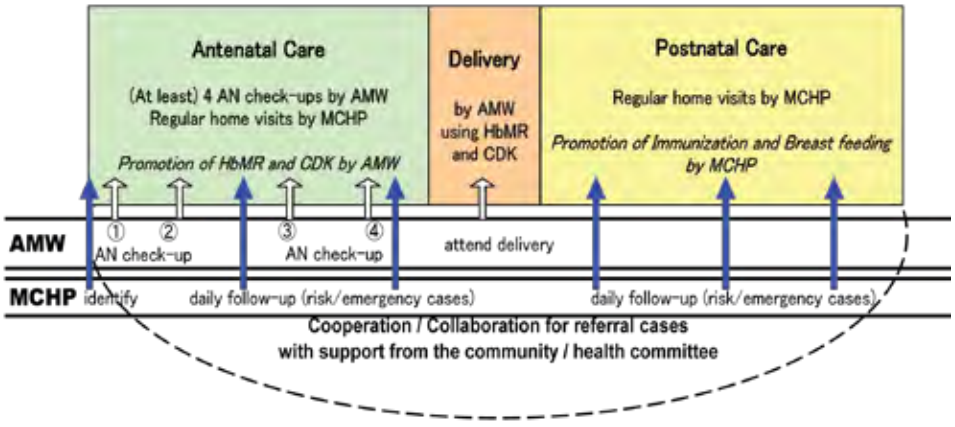


Table 2-1 How to Strengthen Teamwork among MW, AMW and MCHP for Promotion

	Current Situations	Challenges/issues
SBAs (LHV &MW) (8,527 MWs in the country*) * as of Dec. 2005 (71 in the Project areas) <% in Project area> assist delivery 45.6% provide ANC 71.2% provide PNC 51.7% 18 month training	● MWs belong to RHC/Sub-RHC and there are shortages in some area. ● Some community members have difficulty to access to RHC/Sub-RHC.	● Too wide covering area (i.e. 20,000 population in reality).
	● MWs have too much work load.	● Too many tasks (or roles/TOR), handling not only in the field of Maternal and Child Health but also Public Health issues.
	● 75 MWs cover 620 villages and 15 wards (average: 8.5 V&Ws).	● Lack of supportive supervision (and skills for Continuing Medical Education) for AMW and MCHP
	● Monthly salary is K.30,000 ($25).	● Insufficient management skills as a Team leader for Maternal and Child Health.
AMW (28,872 in the country*) * as of Dec. 2005 (228 functioning AMWs in the Project areas) <% in Project area> assist delivery 9.8% provide ANC 4.9% provide PNC 8.7% 6 month training	● AMWs were trained as volunteers to attend deliveries at the time of MW's absence, and one AMW is allocated per 2.7 villages/wards on average (AMWs are volunteers without any regular payment).	● No clear distinction in the roles and functions from MW.
	● The percentage of deliveries assisted by AMWs differs greatly by place and situation (sometime AMWs receive some kind of reward).	● Insufficient skills/capacity/experiences. ● Aging (First batch was trained in 1980's) ● Lack of incentives and less needs leading to high drop out rate.
	● There is insufficient collaboration with MW and MCHP in some area.	● Insufficient supportive monitoring/supervision by the health administration/MW.
	● One AMW covers 2.7 villages on average in the Project Areas.	●Weak community support system at village level.
MCHP (1,654 in Project areas = one in 30 households, 950 (K) and 704 (N)) Started activities after attended one-day training in Dec 06 to Jan 07, being renewed every 2 years	● MCHPs identify pregnant women and under-five children in the assigned area (30 households), conduct household visits, be aware of their health status and assist in emergency referrals.	● A mechanism to make the activities sustainable is required. ● Illiteracy and language barriers (in understanding the training sessions, IEC/BCC activities and record keeping).
	● Their relationship with MWs are generally good, i.e. in promotion/ introduction of RH services or immunizations.	● Transportation is difficult and the village is far from health facilities (RHC/Sub-RHC).
	● Their collaboration with AMWs is a challenge (In the training, it was encouraged to collaborate with AMWs if they don't have MWs in the area).	● MCHPs are busy with their own work such as farming, selling, etc.
	● Some MCHPs have difficulties in making regular reporting because they are unable to write and read.	● Weak reporting system from MCHP to MW.
		● Weak community support system for MCHP.

* No. of population (HH): K: 169,134 (HH29,893) & N: 137,908 (HH21,497)

* More than 321 out of 620 villages/wards in the Project areas have no MW/AMW. [620 - 314 (75 MWs + 239 AMWs)]

of Maternal and Child Health

Recommendations	To strengthen teamwork (activities)
● To enable MW to undertake the work more effectively under the teamwork by sharing tasks and collaboration with AMWs and MCHPs, such as early detection of risk cases, assistance in delivery, promotion of immunization, provision of ANC/PNC by AMWs.	**【Monthly Meeting and any ad-hoc meetings】** To have Monthly Meeting and occasional ado-hoc meetings using the opportunities as many as possible such as immunization sessions for the MCH team at RHC/Sub-RHC unit to facilitate reporting, communication and consultations as well as to enhance collaboration among the members. 1. Report regarding the ANC/PNC/assisting deliveries, referrals, utilization of HBMR and CDK, Tetanus immunization and under 5 children immunization. 2. Share the obstacles and provide possible counteractions/advices. 3. Teamwork will be further strengthened by sustaining the activities with interventions through supportive supervision and CME by MW. ※ *It is essential for MW to feel that she can more effective by the teamwork* ※ *This teamwork will be further promoted by the support from the community such as Health Committee through community welfare fund, transportation for emergency, etc* ※ *Monthly CME (Continuing Medical Education) will be conducted at sub-RHC and RHC levels.*
● To enhance capacity for MW in leadership and management skills for teamwork building.	
● Deliveries need to be attended by MWs (SBA) in principle, but AMW shall take MW's role while MW is absent. At the same time, need to enhance AMWs' skills on ANC/PNC in order to focus on early detection of high risk cases and referrals (for decline of maternal mortality) through promotion of usage of HBMR and CDK → Need clear distinction on the roles with MW. ● To consider the possibilities to upgrade young and experienced AMWs to MWs (by National program).	
● To consider the willingness of herself as well as the reliance from the community members for the selection of MCHPs - some MCHPs are not continuing in the Project areas.	
● To strengthen the collaboration with and supportive supervision by MW through CME. ● To cooperate in referral, especially make MCHP's role in referral be clearer.	
● To ensure community support from TWG, VTWG or Health Committees.	
● Need to strengthen technical sustainability → from MW through supportive supervision through CME. ● To improve MWs' teaching methods to overcome the language barrier as well as innovative teaching materials.	
● To establish a feasible reporting system.	
● To strengthen/ensure the acknowledgement, understanding and support from the community or its representatives.	
● To review the selection criteria (having no infants, having understanding from the families) and the selection method (recommendations from MW or community members in the designated area).	

IV Skill Development of Auxiliary Midwives (AMWs)

(1) Role of AMWs is Essential

In rural areas in Myanmar such as Kyaukme and Naungcho Townships, the role of AMWs is essential since number of midwives is limited and it may not be always easy for each midwife to sufficiently serve all the population in her jurisdiction. According to the Project assessment, 239 AMWs have been functioning in the Project areas.

(2) Actual Situation of AMWs

Based on an assessment, the Project recognized the necessity to provide refresher trainings to AMWs. Most of the AMWs in the Project areas received the minimum initial trainings in 1980's, since when, most of them had no chance to receive further refresher training for skill development. It was found that there is a huge gap among the AMWs on their levels of knowledge, skills and experiences as AMW. Some AMWs are very active having good collaboration with MWs in their work, but some others are not. One of the reasons was that they received only insufficient support they needed including continuing education, information and supportive supervision. The Project also identified some drop-out cases of AMWs after initial training, not attending deliveries anymore. Another issue raised was the aging particularly among the 1st batch of AMWs who were trained in 1980's.

(3) Importance of Refresher Training for AMWs

Refresher trainings were organized for 233 AMWs in total from 2006 to 2007 in 6 groups in each Project township, with the objectives of skills development of clean and safe delivery at home alternatively where midwives are not available. The refresher trainings were conducted by using the manual developed and adopted by DOH according to WHO's PCPNC (Pregnancy, Childbirth, Postnatal and Newborn Care) guidelines, and we had a great chance to recommend for some revisions including a lot of figures and illustrations through using it in the trainings. The revised

manual suggested from the Project is now used in the AMW refresher trainings in other areas after the final revision by the DOH.

(4) Collaboration with Midwife and MCH Promoters

The major role and responsibilities of AMW are to attend the delivery in the villages without any MW, however, through the Project, we also encouraged the teamwork among MW, AMW and MCHPs for promotion of maternal and child health in the preventive aspects. AMW could also work for ANC and PNC under the supportive supervision of MW. It could maximize the provision of reproductive health services in the rural areas with the existing human resources.

(5) Continuous Skill Development and Support is Crucial

One of the lessons learnt from the group training was it could not meet the expected outcome because the levels of each AMW's knowledge, skills and experiences were diverse.

Although refresher training according to the DOH in a group is essential, in order to strengthen capacity and skill development of each AMW based on their level, the Project recommends continuous on-the-job refresher trainings and guidance for AMWs by the MW from the same jurisdiction, timely and need-oriented to individual AMW.

(As for the continuous skill development for AMWs, please refer to Part 3 - II "Skill Development of AMWs")

V Concept of MCH Promoters System

(1) Introduction of MCH Promoters System in Myanmar

(i) Background:

The health of mothers is essential to ensure the health of babies, children, the family and the community. The importance of improving the reproductive health status of women, especially safe motherhood, has been well recognized by the Ministry of Health (MOH) as one of the priority issues, as stipulated in their National Reproductive Health Policy.

In 2004, four-member leading observatory mission from DOH/MOH visited Japan and had a chance to learn about Japanese MCH Promoter System in Wakayama Prefecture. During 2005 and 2006, the Project developed the first concept of MCH Promoters in Myanmar as the strategy to strengthen community health program in a series of consultation and consolidation among the concerned persons.

In order to improve the health status of women and their babies, one approach, introducing the system of MCH (Maternal and Child Health) Promoters in the Union of Myanmar has been developed based upon the applicable lessons and experiences derived from the system of MCH Promoters in Japan. This approach has been introduced firstly in the Project Townships, Kyaukme and Naungcho, Shan State (North), expecting that their experiences in the Project areas to be shared and applied to other areas as the national strategies under the MOH/DOH.

Box 2-1 Strategies identified by MOH/DOH mission to Japan

Following the four-member MOH/DOH leading observatory mission visited to Japan in November 2004, second mission visited Japan in July 2006, just before the introduction of MCH Promoters System in Myanmar. The mission members learned about MCH Promoters System in more practical way and identified the following strategies from Wakayama Prefecture, Japan, to be addressed when implementing the system in Myanmar.

1. MCH Promoters System as the *bridge* or *pipeline* between the community people and health administration in the municipality
2. Role and responsibilities of Public Health Nurses in Japanese health system, paid administrative front liners to supervise the MCHPs supportively
3. MCH Handbook as a *tool of linkage* between the mothers and health administration
4. Strong commitment of the mayor, health service providers and MCH Promoters
5. Emergency referral system concept of curative and preventive integration

(ii) Function of MCH Promoters:

MCH Promoters to be trained as "MCH volunteers" in Myanmar to act as key persons at the village level for better health of pregnant women, mothers and children through **linking** community members and Basic Health Staff (BHS) ***as a bridge*** to promote safer motherhood.

MCH Promoters to work closely with midwives and the community to improve the health status of pregnant women, mothers and children under 5 years old in their community. One MCH Promoter will be in charge of about **30 households**.

MCH Promoters to recognize all the pregnant women in their communities to ensure that every pregnant woman/mother will receive proper antenatal (AN) care, every pregnancy and childbirth in the community be safe and clean delivery, PN care and referral to the health facilities in case of obstetric emergency in cooperation with the community.

(iii) Expected Outcomes:

- Increased utilization of RH services, e.g. coverage of ANC (at least 4 times), safe delivery by SBA, PNC and newborn care;
- Increased awareness and knowledge on RH, e.g. health seeking behaviour by community people, early detection of danger signs and early treatment;
- Ensured timely referrals for obstetric emergency with community support.

(2) Characteristics of MCH Promoters

In order to promote maternal and child health, MCH Promoter becomes a ***"bridge"*** between community people, in particular pregnant women and children under 5, and health providers such as BHS (such as midwives). The situation of rural areas and community may discourage a pregnant woman to come to the MWs and Rural/Sub-Rural Health Centers. We identified that there are several hindering factors such as physical, economical and psychological. The physical and economical reasons might not be solved by individuals, and sometimes we need the community support system, but psychological one could be solved to some extent by MCH Promoters' efforts to encourage pregnant women and their families to take ANC, to have safe delivery by SBA, PNC and to support transportation in emergency referral to the health facilities.

Nowadays in two Project Townships there are about 1,700 MCH Promoters, each MCH Promoter is in charge of approximately 30 households. They are so effectively linked with MWs and AMWs with the support from the community.

(3) Effectiveness of Single-Purpose Volunteer

From the experiences in Japan and other countries on volunteer activities, the **multipurpose volunteers are easy to say but difficult to do and to sustain**. According to the experiences in Japan, if the no-paid volunteers were expected too much, they could not continue and sustain. We have recommended a single-purpose volunteer than a multipurpose volunteer from the very beginning.

Term of 2 years is also suitable in our experiences. Around one third of MCH Promoters chose not to continue after 2 years because of various reasons such as;

1) They are busy in taking care of their own babies and children, household work, agriculture and family business,
2) Their health conditions, and
3) Moving to other area, etc.

One third of vacant position of MCH Promoters could be fulfilled effectively without any delay and their experiences could be shared among the old and new members under the **peer education** concept. We even found that the discontinued members who remained in the same area supported the activities of the 2nd batch MCH Promoters as the peers.

(As for the MCH Promoters System, please refer to Part 3 - III "MCH Promoters System")

Box 2-2 Experience of MCH Promoters System in Japan

MCH Promoters System was initiated in 1968 in Japan by the Ministry of Health and Welfare (MOHW) then in order to promote Maternal and Child Health at the municipal levels. In those days many municipalities such as villages and towns particularly in the rural and remote areas were facing the low acceptance rates of health check-ups for pregnant women such as ANC, PNC and immunizations for pregnant women and babies. And in addition to that, MMR and IMR were still higher in the rural areas than in the urban areas in Japan.

With this background, MOHW recommended all related municipalities to improve this situation by establishing the new system of *"MCH Promoters"* as the volunteers in the respective areas to make a visit to pregnant women soon after the *pregnancy registration* at the municipal office in order to promote health check-ups and immunization.

The **role of municipal office** is as follows:

1) Selection of MCH Promoters in coordination with public health nurses and related community representative, and to issue the certificate of entrust to them by the Municipal Mayor,
2) Giving the regular trainings by the public health nurses and specialists in the municipality,
3) Provision of training venue for the trainings by the municipality, and
4) Preparation of budget by the municipalities and MOHW will give half portion at the beginning as the subsidy from the central government, which is gradually taken over by the municipalities under their ownership.

Currently 110,000 MCH Promoters through out Japan working at the community level, one MCH Promoter taking the responsibility to make home visits to the pregnant women and babies in care among around 100 to 200 households at average based on the request by the municipality. Nowadays they have established their own association as a local NGO at the municipal level for self-managed activities, too. MCH Associations Federation was also organized at the central level.

Their activity was originally started with a single purpose in MCH but they have been also gradually expanding the targets and activities. Some of them are working for adolescent health education to children and young people based on the compiling the experiences as the institutional capacity.

VI Community Support System

(1) Community Support is Vital to Improve RH/MCH Status

Throughout the Project experiences as well as JOICFP's past experiences of project implementations, we found it was extremely difficult to promote reproductive/maternal and child health without the strong community support, because the community people's attitude and practice affected the health status of community people. For example, the primary-level referrals from the villages without medical professional to primary health/medical facilities are largely influenced by the community support system. Especially in the referral cases of pregnant or delivering women at risk, the "three delays" in risk-identifications, decisions by family and transportation could hamper the efforts of medically/midwifery-trained persons to provide better emergency care to the patient. In this context, community people could play the important role in safe motherhood promotion and the efforts to establish the community support system is vital component in improving RH/MCH status.

(2) MCH Promoters can Facilitate Community Support

In the Project areas where the MCH Promoters were introduced, we observed many ***good practices*** conducted by community people with intention to save mothers' and/or children's lives. MCH Promoters are actively working as the ***bridge*** or ***pipeline*** between the pregnant women and health care providers, and many of whom influenced surrounding people (intentionally or unknowingly) and created the favorable environment in MCH promotion. Even though we could say that the mutual help and assistance is commonly seen in the Myanmar's cultural context, especially in the rural area, those mutual-help practices seem to be driven, strengthened or become more systematic in Project areas by the introduction of MCH Promoters.

(3) Community Support will Make MCH Promoters' Work Easier

In such way, when community becomes more supportive to safe motherhood/MCH promotion activities, it is natural that MCH Promoters are able to work in more comfortable conditions as the volunteers. MCHPs feel much more honored with better recognition by community people (especially community authority), and much easier to work when supported by the community in such occasion as emergency referral. Those motivated MCH Promoters could have better influence to the surrounding community and the good cycle for MCH promotion would be established in the community in this way.

(4) Positive Changes Observed in the Project Areas

Actually in the Project area, some of the villages show positive changes in promoting safe motherhood/MCH activities after the introduction of MCH Promoters. The important point is those activities are conducted not only by health personnel but also by other stakeholders in community. Followings are major areas in which we observed the positive change through the Project period.

Box 2-3 Major Area of Positive Changes in the Project Areas

1. **Community Welfare Fund** with specific objectives of assisting MCH-related issues, are newly established (or further strengthened).
2. **Transportation support for emergency referral** are organized in cooperation with the car/trawlogy owners
3. **Functioning MCH stakeholders' teamwork,** especially among MW, AMW, MCH Promoter and community leaders

(5) Sharing the Good Practices of Community Support

It is difficult to formulate the one "model-approach" for establishing such kind of community support system based on our Project experiences, because those good practices are deeply affected by local circumstances. However, it will be of good help especially for planners, implementers and supervisors of the "community-oriented" projects, if we introduce some of the good practices in Kyaukme and Naungcho Townships.

We have to mention that it is also very effective for fostering the community initiative to promote safe motherhood, to share such kind of "practical good experiences" or "good practices," at the occasion of workshop or seminar inviting the community stakeholders. In the Project sites, some of the villages (or village tracts) initiated the community support system such as Community Welfare Fund or Trawlogy Roaster System after the 2-time of "Experience-Sharing Workshop" which aims to give the opportunity for village people (including community authority and residing health staff) to present their good experiences in MCH promotions, and for other participants to learn some applicable lessons learned from neighboring area.

(As for the good practices, please refer to Part 3 - IV "Community Support System.")

VII Strategies for Sustainability of CORH Approach – Technical, Program and Financial

In general, there are mainly three (3) categories of sustainability in our perspectives as follows:

(1) Technical sustainability
(2) Program sustainability
(3) Financial sustainability

These categories could be useful when considering how to ensure the sustainability of the Community-Oriented RH (CORH) Approach.

(1) Technical Sustainability-Continuing Health Education (CHE) as a Strategy for Technical Sustainability

Project promoted the existing system of Continuing Medical Education (CME) at the Township level; monthly education system by DMO/TMO for BHS, to enhance technical sustainability.

Based on this system, the Project has introduced a similar system called Continuing Health Education (CHE), in which BHS provides regular guidance and supportive supervision to health volunteers including AMWs and MCHPs at RHC or Sub-RHC level. It would be called as Continuing Health Education (CHE) since the volunteers are not in medical profession, it needs to be called health education instead of medical education. But the concept is the same as CME, and it means teaching from MWs to the volunteers such as AMWs and MCHPs. The cascade effect would flow through starting from the Central, State, Township and down to the village levels. We have recommended that CME and CHE should have a systematic and strategic action plan and monitoring system at each level.

Box 2-4 Recommendations for CME and CHE

(recommended by the participants of the 6th Project Steering Committee, September 2008):

1. Strengthening of Township level training team.
2. Establishment of Continuing Medical Education (CME) sessions by MW to MCHP at 4 sites twice yearly.
3. Development of bottom-up triad discussion methodology.
4. Sensitization and recognition of AMWs and MCHPs by Township Medical Officer and all BHS.
5. Providing opportunity for skill development among MWs, AMWs and MCHPs.
6. Supportive supervision and coaching at all levels.
7. Assessment of application of knowledge into practice. Map drawing for location of villages, village tracts, MCHPs, AMWs and insertion into GIS.
8. Development of monitoring tools for MWs.
9. Conduct of meetings between MCHPs and MW.
10. Recognition and motivation of MCHPs in terms of different ways such as gifts, caps, bags and special meeting.

11. Development of system to monitor information sharing of BHS (MW) and MCHPs.
12. Findings ways to solve the problems and obstacles for successful implementation of CME sessions according to the local needs.
13. To establish mobile teams for CME.
14. Translation of IEC/BCC materials to local language/dialect. It should be language rather than literature.
15. Distribution of IEC materials to cover all villages in township.

(2) Program Sustainability

It is recommendable to build-in a new system, strategy and approach into the existing program as much as possible, to further strengthen the existing efforts, rather than establishing a new mechanism. By doing so, the newly introduced system is likely to be sustained in conjunction with the existing program. We call it a **"Built-in Effect."** In other words, most of the new ideas or concepts of the Project were built on the existing system, or designed for utilizing the existing system as much as possible. Therefore, even though the concept of CORH Approach may be quite new, the actual activities could be integrated into regular program of RH/MCH services/activities of BHS, which would makes it easier for them to continue the new efforts within their own capacity.

(3) Financial Sustainability

It is one of the most difficult tasks to obtain an assured financial sustainability. Although in the Project we have made our efforts to suggest the most cost effective way, still minimum budget would be required to implement any kind of activity. We tried to find a way to ensure of financial sustainability from the existing resources in the community itself including Community Welfare Fund which the village has the fund for emergency cases based on the needs of the community. Financial support, however, we have recognized the possibility of the local government and NGOs as a source of funding. The Project established Township Working Groups (TWG) to strengthen the existing Health Committees chaired by PDC chairperson and consist of the representatives from MMCWA, MWAF, Education Office, USDA and Township Health Office (DMO/TMO/Medical Officer) as the related stakeholders to coordinate the Project implementation. The TWG and VTWG will be one of the most potential mechanisms for sustainability.

Box 2-5 Strategies for Sustainability of MCH Promoters as Volunteers

One of the challenges of the Project was how to sustain the MCH Promoters as the volunteers in the villages. The Project has found that the following points would be essential strategies to maintain their motivation and commitment of MCH Promoters.

1. Provision of opportunities of continuous trainings, education, updating the information and communication skills

MCH Promoters needs to have continuing refresher trainings regularly and frequently to update their information and skills of communication. We believe that refresher trainings are vital for them to be able to motivate pregnant women to come to the health center. Therefore the Project has been emphasizing that, after the initial training was completed, it is important for midwife to provide continuous input for MCH Promoters since they are the *trainers and coaches* from the beginning. This **"teacher and student relationship"** is effective for them to build a strong teamwork which could sustain for a long time.

2. Creating a sense of achievement and appreciation by the community in general and by the pregnant women in particular

In Myanmar cultural context, the value of **mutual help system** is strong and there is high motivation to work for community and neighbors as one of their values. However, they would feel grateful if appreciated by the community, especially by the pregnant women. Some of the MCH Promoters mentioned that PDC chairperson and community leaders showed their appreciation in front of the community people, an incidence which highly motivated them.

3. Provision of some incentives in kind or in monetary rewards

Through some focus group discussions with MCH Promoters, the Project has identified that from the beginning they had a strong motivation to work for the community and mothers, but continuation of voluntary work is not always easy without any incentives in kind or in monetary rewards such as transportation fee for their activities. They have been selected in the village to work for 30 households and then sometimes pregnant woman lives far and they might need some local means of transportation to visit them. The Project has only provided them with MCH Promoters kit including MCH Promoter Handbook, a notebook, a ball pen, a bag,

and a batch. The MCH Promoters are busy as a wife, as a mother and as an important family member engaging in agriculture or some other family business; therefore volunteer works without any monetary reward could be given low priority gradually, which was identified through Project assessment.

4. Strengthen the teamwork building among the midwife, AMW and MCH Promoters to create the team spirit as the team of MCH promotion in the village

The Project is promoting the teamwork building among the MWs, AMWs and MCH Promoters for promotion of maternal and child health in the village. ***"One person's power is rather weak but team power should be stronger than each individual."*** **Team spirit development** would be one of the strategies for sustainability, which was also proved through the Project.

Through the experiences of the Project, it was realized that there is no single effective strategy to keep motivating MCH Promoters. However, to establish some integrated and multiple strategies could be effective to encourage them more to continue. They are the non-paid volunteers, however, they have the strong pride to contribute to their own communities. We believe, through the Project implementation, that the combination of the above strategies 1. 2. 3. and 4. are effective to encourage volunteer spirit and activities.

VIII IEC/BCC Intervention for Community People

Since the beginning of the Project, IEC/BCC intervention for community people has been carried out mainly through the *health education sessions* at the MCH Centers, RHCs and Sub-RHCs by the midwives and other BHS with support by AMWs and MCHPs regularly.

We believe that the individual behavior change is not so easy but will occur gradually and steadily if regular and frequent health education is conducted. The more efforts were made by BHS, more audiences came to the session. It indicates that the participants found the sessions beneficial to them. Once individuals have changed their behavior, they would change their health consciousness, to "promote their health by themselves" and "early detection and early treatment." They would have confidence that the midwives are always with them in order to support health of pregnant women, mothers and children.

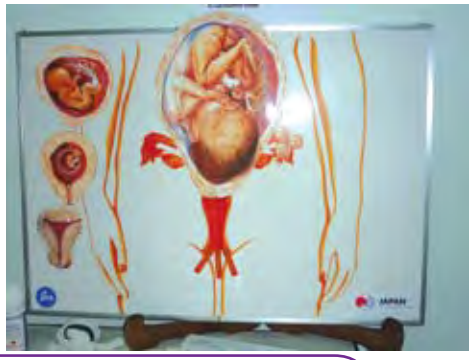
Through this Project MWs are recognized more as the key persons for health of the community people, in particular for pregnant women and their spouses. Recently the extent of male involvement such as participation to the health education sessions by husbands have been increasing.

In the health education sessions, the Project recommended three major kinds of materials that enable more effective education sessions as follows;

Box 2-6 Three Major Kinds of IEC Materials

1. **Magnel Kit** (A kit for teaching reproduction processes and mechanism, etc)
2. **Pregnancy Simulator** (A kit for experiencing the pregnancy, which is useful for male participation/involvement)
3. **Puppet** (A puppet being hand-made with a pair of gloves for *enter-education sessions*, which could be effective for emotional appeal to audiences)

The Project also distributed the various educational materials such as pregnancy calendar, pamphlet, poster calendar, etc., through BHS as the tools for supporting pregnant women and community people to understand the health messages better.



IX Suggested Four (4) Monitoring Areas

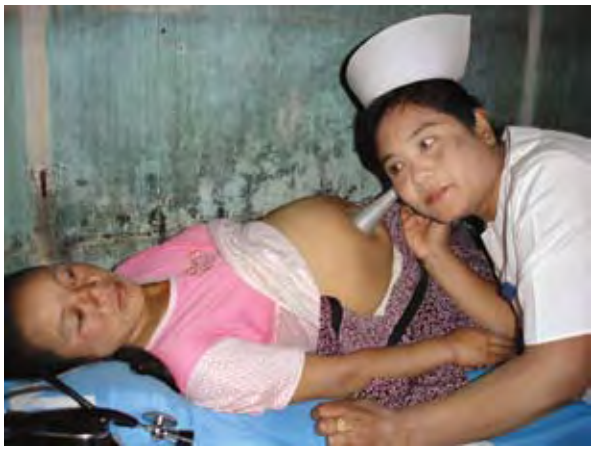
The word "monitoring" has a wide meaning and it has been utilized in many ways. We need to be careful when using the word, as sometimes it can cause confusion. From the Project, we would suggest 4 monitoring areas as a basis for all the monitoring activities as follows.

(1) Monitoring on RH Data and Indicators

It is important to measure the progress and achievements based on the figures/statistics, to be evidence-based. By monitoring the changes in data and indicators, you could know the impact of the activity more objectively. In the Project, while we collect the official statistics regularly, we also put much focus on the skill development of MWs on monitoring, particularly on data collection, so that more accurate data could be collected at the township level to be utilized for performance/ achievement monitoring as well as proper analysis for further interventions.

(2) Technical Monitoring on Skill of Health Service Providers and Conditions of Health Facilities

This monitoring should be conducted along with supportive supervision by technical adviser(s) so that appropriate assistance/instructions based on the findings can be provided for further improvements. In the Project, experts together with the township health personnel such as DMO/TMO and focal point person, conducted regular monitorings to monitor the effectiveness of the technical inputs provided. It was done by visiting the health facilities, interviewing the BHS, AMWs, MCHPs and/or community people, sometimes using questionnaires.



(3) Monitoring on Overall Management of Activities

Monitoring on overall implementation is essential to manage the activities to ensure you are making progress towards the set goal according to the plan of operation. If there is any issue, you need to make necessary adjustments following cause analysis. As for the Project, this was undertaken by the Project experts together with the DOH personnel

at township level in regular meetings as often as possible, with the progress, achievements and issues being shared and discussed at the central level once in every half a year, to decide the way forward.

(4) Monitoring on Community Activities

This area of monitoring is necessary especially in Community-Oriented RH Approach, to capture any changes happening in the community, so that you can know if the expected outcomes are achieved by the implemented activities. At the same time, good practices identified in some villages shall be further promoted and later they can be even shared to other areas to be followed in experience sharing workshops. In the Project, good practices have been collected regularly through monitoring visits as well as written reports by BHS, which gave a good basis for experience sharing workshops in the Project areas.

For conducting these 4 areas of monitoring activities, a monitoring team needs to be formed. A monitoring team shall consist of the concerned personnel primarily from health sector, such as DMO/TMO, focal point person, THN, THO and/or HA1, as the "basic members." Then other stakeholders such as community representatives could join on ad-hoc basis when necessary, depending on the monitoring area, e.g. it would be useful for monitoring on community activities.

Explanation on each monitoring area including responsible persons and suggested timing is indicated in the Table 2-2 "Suggested Monitoring Area under Community-Oriented Reproductive Health Approach" on pages 47-48.

Tabel 2-2 Suggested Monitoring Areas under Community-Oriented Reproductive Health Approach

	Area	General Purpose	Steps to be taken	Possible Persons in Charge	Suggested Frequency
1	Monitoring on RH Data and Indicators	To assess the outcomes of CORH Approach from the figures and indicators related to reproductive health and maternal and child health.	At the beginning stage of applying CORH Approach, you are recommended to settle the "monitoring indicators" by which you could monitor the process/progress in RH/MCH related areas. Possible indicators are the coverage of ANC (antenatal care), PNC (postnatal care), and T/T (Tetanus Toxoid) immunization, and percentage of deliveries attended by SBAs, etc.	DMO/TMO, HA1 (possibly supported by DOH Central)	Monthly data collection and quarterly review
2	Monitoring on Skill of Health Care Providers	To assess the skill of health care providers who are trained under CORH Approach.	If you are planning to conduct CME-based regular skill improvement sessions targeted to BHS, or to conduct ad-hoc skill training for health care providers under CORH Approach, you are also recommended to assess their skill before and after the training. The assessment would be better conducted when you follow the rigid procedures or settled protocols (e.g. DOH guidelines). Under CORH Approach, the vital component is the strengthened skill of MW on the leadership/teamwork building. In addition to the skill on health care service provision, you should also check the MW's skill improvement in these areas and monitor the activities conducted by community health volunteers (AMW and MCHP) through the BHS's reporting. The most important point is that you don't necessarily conduct any special examination or big-scale performance checking test to assess the skill of health care providers. Under CORH Approach, we recommend you to maximize the opportunity of monthly CME, and to organize the monitoring team which visits health centers regularly, and conduct "supportive supervision and monitoring." It will encourage health care providers with the appropriate feed back from upper level supervisors.	DMO/TMO, THN/HA1	Monitoring on each health-center and give supportive supervision to BHS, possibly by each quarter

	Area	General Purpose	Steps to be taken	Possible Persons in Charge	Suggested Frequency
3	Monitoring on Overall Activities	To monitor the progress and achievements made in target areas, in order to collect necessary information for review and revision of plan of activities under CORH Approach	Based on the suggested flowchart of CORH Approach (Chart 2-1; pages 21-22), you are recommended to develop annual plan of operations in detail. After applying CORH Approach in your area, you are recommended to monitor the overall progress according to the plan of operations by quarterly.	DMO/TMO	Annual planning and quarterly review
4	Monitoring on Community Activities	To monitor the community-based good practices (which means the community-initiated activities for supporting RH/MCH promotion) and document those practices for future expansions in neighboring areas	After the introduction of MCHP System, you could start to collect the information about good practices initiated by community people (In the Project model areas, there identified the establishment of Community Welfare Fund, trawlorgy roaster system, exemption given to MCHP from other voluntary work). Those good practices are to be documented and shared with all stakeholders in your townships, for future expansion.	DMO/TMO, BHS and VTWG members	Monthly reporting from BHS to Township Health Department / Necessary information could be collected by monitoring team as well (shown in 2. Monitoring of Skill)

Implementation Guide For Community-Oriented Reproductive Health Approach

- Healthy Mother Project -

Booklet -2-

First Edition

January 2010

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Contents

Part 3: Specific Implementation Guides

Part 3

Specific Implementation Guides

I Skill Development of MWs - Midwifery Skills Training

(1) Background

Midwifery skills are one of the competencies for midwives. Development of competence requires regular, repeated, supervised, hands-on practice in the clinical area and assessment of the competencies acquired (UNFPA, 2008). However, lack of systematic continued education in midwifery has until recently received little attention and in most cases remains inadequate.

Midwifery education is generally categorized as initial course or refresher course. It is confined to refresher course in this guide. One of the major challenges among low-income countries is the gap between the midwifery school, its theoretical teachers and supervisors, and the clinical reality. It is crucial to reduce or eliminate this gap (Lugina, 2001). Midwifery education in Myanmar also has the gap between theoretical supervisors and the clinical reality. It seems to be issues for the discretion in dealing with midwifery skills, such as medication, and for overloaded duties and responsibilities.

Furthermore, financing health care and worker incentives are of particular concern, given the shortage of human resources in the first place. One of the target of the Millennium Development Goals, which is "to reduce by three quarters the maternal mortality ratio," includes an indicator "the proportion of births attended by skilled health personnel." As the shortage of health personnel is also seriously worsening in Myanmar, it is difficult to improve indicators unless there are professionals, who practice with guaranteed quality.

"Going to scale with professional skilled care" suggests that the main obstacles to the expansion of care are the dire scarcity of skilled providers and health systems infrastructures; substandard quality of care, and women's reluctance to use maternity services where costs are high and poorly exposed to services (Koblinsky et al, 2006).

(2) Inputs by the Project for Challenging the Issues

The assessment of midwifery skills among LHVs, Midwives (MWs) and Auxiliary Midwives (AMWs) was done, particularly in the following:

(i) LHV's and MW's (AMW's) knowledge about danger signs

LHVs, MWs and AMWs had less knowledge of danger signs in every period in pregnancy, especially in antenatal, postnatal and neonatal periods.

(ii) Influencing factors of referral judgment by LHVs and MWs (AMWs)

The attitude of referral judgment by LHVs and MWs (AMWs) were appropriate.

(iii) LHV's and MW's (AMW's) performance of ANC, Intrapartum care and PNC

The LHV's and MW's performance of ANC, intrapartum care and PNC were basically at sufficient levels. But maintaining regular supply of essential drugs and necessary equipment were the bigger issues for their performances.

(iv) LHV's and MW's experiences and capabilities to manage danger signs

Majority of LHVs and MWs recognized and felt that they lack experience and are not fully capable to manage 6 danger signs in intrapartum and neonatal period.

(3) Outputs by the Project including Achievement and Recommendations

Technical advice was provided to conduct trainings on midwifery skills based on the outcomes of the assessment. The refresher training on midwifery skills was conducted and the lessons learned were suggested as follows;

Offering the contents that reflects participant's readiness

The big difference in test scores among the trainees indicates that the contents of training should be offered reflecting the participants' readiness, although they are taught in principle according to the manual.

Realizing the revision of newborn resuscitation techniques

Current algorithm for newborn baby resuscitation techniques in Myanmar is expected to be revised from the global standard perspective.

References:

UNFPA (2008). Investing in Midwives and Others with Midwifery Skills. Saving the Lives of Mothers and Newborns and Improving their Health. http://67.205.89.177/webdav/site/global/shared/documents/publications/2008/midwives_eng.pdf Retrieved on February 6, 2009.

Koblinsky M,et al. (2006). Going to scale with professional care. The Lancet Maternal Survival Series. 41-50.

Lugina H. (2001). Women's postpartum concerns and midwives' reflection on postpartum care: Studies on Dar es Saalam, Tanzania. Doctoral Thesis, Uppsala University, Sweden.

Attached:

Annex 1. Trainers Manual Session 1: Management of Problems during Pregnancy, Childbirth and Postpartum
Annex 2. Trainers Manual Session 2: Newborn Care
Annex 3. Programme on the Refresher Training for LHV and MW on Midwifery Skills
Annex 4. Check List of Midwifery Skills for LHV and MW

Annex 1

A Training Course on Midwifery Skills for *Midwives and Lady Health Visitors*

TRAINER'S MANUAL

Session 1: Management of Problems during Pregnancy, Childbirth and Postpartum

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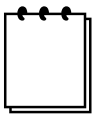
Session1: MANAGEMENT OF PROBLEMS DURING PREGNANCY, CHILDBIRTH AND POSTPARTUM



Materials needed for this session:

- Prepared flip charts
- Handout No. 1.1 (refer to p. 7 - 8 of this manual) “Emergency signs and action to take”
- Stationery: Blank flip chart paper; marker pens
- Several complete midwifery kits as used by rural midwives in Myanmar, enough for one among 3 participants
- Pelvis and baby model (with placenta); if possible, an adult resuscitation model
- Check list for “Session 1: management of problems during labour and delivery” (p. 1 - 12 in “Annex 4. Check list of Midwifery Skills for LHV and MW” of this Chapter)

Review: D14-18 of PCPNC (“Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice (2nd edition), (WHO, 2006))”; "Chapter 6: Classification of Practices in Normal Birth" in "Care in Normal Birth: A Practical Guide (WHO, 1996)"; and midwifery education modules on eclampsia, obstructed labour, postpartum haemorrhage, puerperal sepsis.

Time: 9:45 to 15:45

☎ **REVIEW clinical observation roster**

Purpose of this session

- To ensure that all birth attendants can quickly recognise signs of deviation from normal pregnancy, childbirth and postpartum, and know what measures to take, including first aid and referral.

1. **Warm up:** if necessary.
2. Display the session 1 objectives on prepared flip chart No. 1.1 and ask a participant to read them out. Keep this flip chart displayed during the whole session, as you will refer back to it at the end.

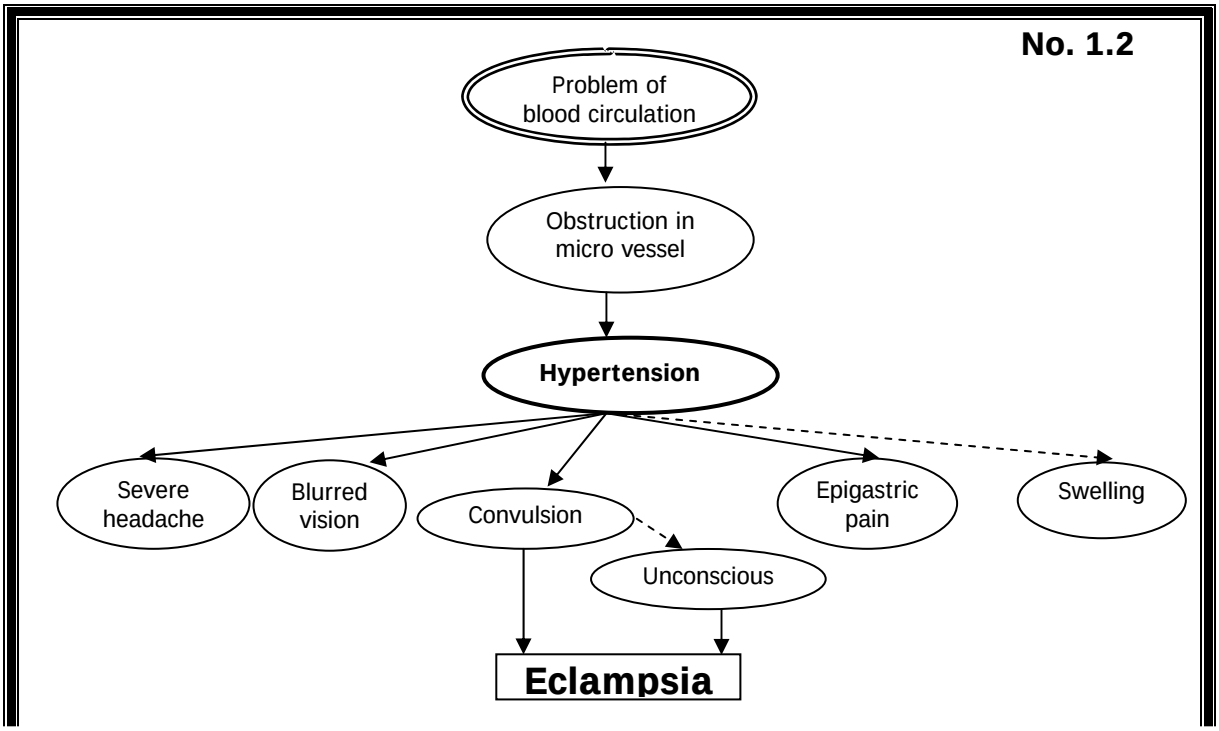
By the end of the session 1, the participants will:

- **recognise danger signs and problems during pregnancy, childbirth and postpartum.**
- **know how to manage problems and how to provide obstetric first aid.**
- **know when to refer and how to organise referral.**

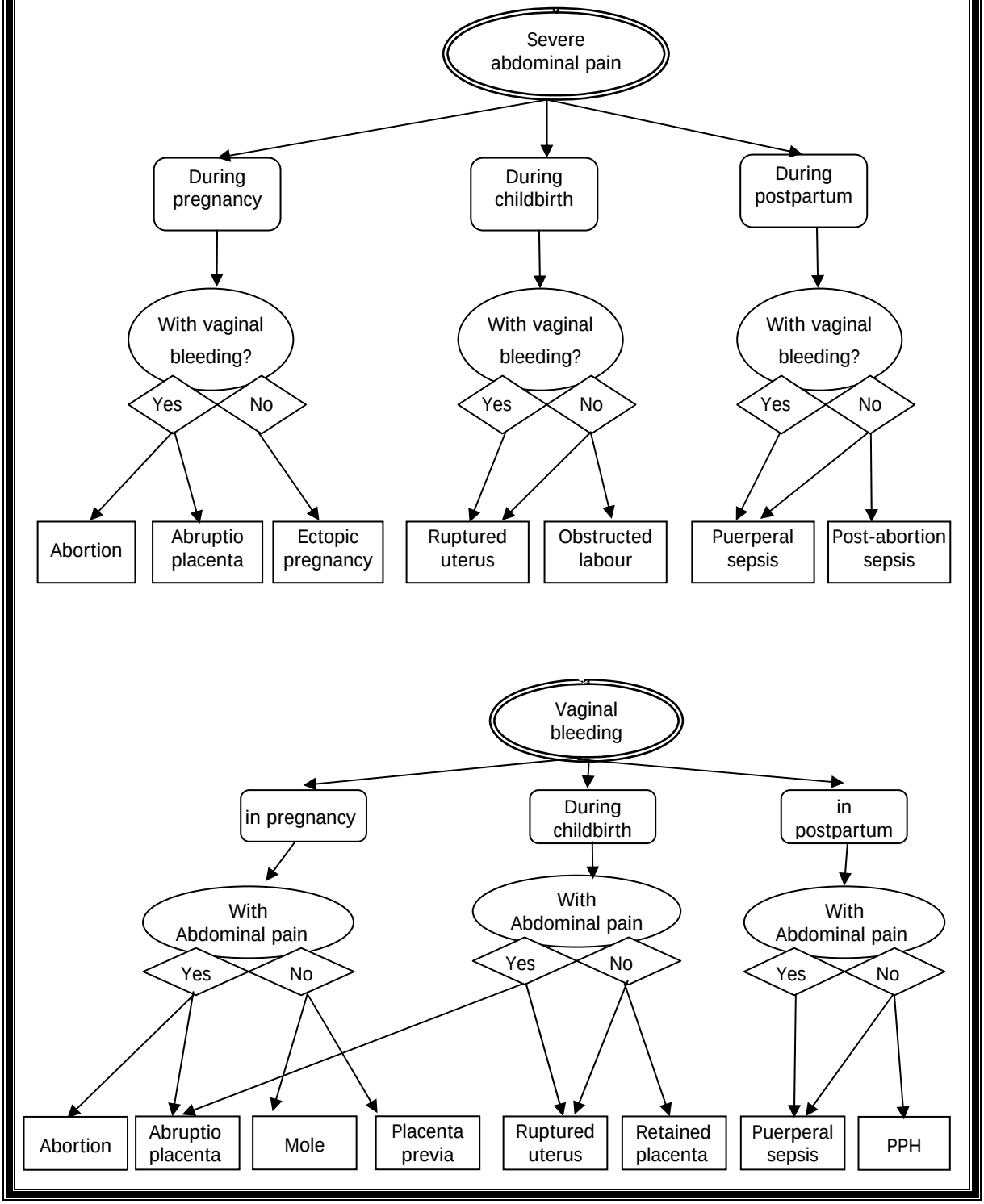
No. 1.1

3. Ask if objectives are clear and clarify as necessary.
4. Ask the participants to suggest some problems during pregnancy, childbirth and postpartum that they have faced in their practice.
5. **Now say to the participants, "we are going to classify some danger signs, such as eclampsia, severe abdominal pain and vaginal bleeding according to causes, pregnancy status and severity."**
6. Put up each flow chart included in the flip chart No. 1.2 in order, with the danger signs covered by pieces of blank paper. Ask participants to answer the proper danger signs hidden by the paper. Suggest pointing to the danger sign that can be associated with the diagnosis as many as possible as below:

No. 1.2



No. 1.2 (continued)



7. Take off the piece of blank paper covering the danger sign when you get proper answer from the participants.

8. **Now say to the participants, *"as you know a danger sign may not be due to a single cause and may be multifactorial. That's why we need to assess each sign and corresponding causes comprehensively, and then, to give appropriate management."* Read the facts on flip chart No. 1.3.**

Although most pregnancies and births are uneventful, approximately 15% of all pregnant women develop a potentially life-threatening complication that calls for skilled care.

The main causes of maternal death and disability are complications arising from:

- ❖ **Haemorrhage**
- ❖ **Unsafe abortion**
- ❖ **Eclampsia**
- ❖ **Sepsis**
- ❖ **Obstructed (prolonged) labour**

No. 1.3

9. **Now say to the participants, *"the aim of emergency obstetric care at the primary level is to classify the problem, stabilise the woman, and arrange for transport to the nearest facility capable of managing and treating the complication."***

10. Put up prepared flip chart No. 1.4 and ask a participant to read it out.

REMEMBER – BE PREPARED

- ⇨ **Everyone at the health facility or in the home must be ready to help if there are signs and symptoms of an obstetric emergency.**
- ⇨ **The emergency tray or midwifery kit should be restocked after each use.**
- ⇨ **All instruments and supplies should be decontaminated, cleaned and fully disinfected or sterilised immediately after use.**

No. 1.4

☺ **Now take a 15 minutes break**

11. Put up the prepared flip chart No. 1.5 and remind participants about 'quick check' and rapid assessment and management (RAM) that were presented in the antenatal care session.

When attending a pregnant woman in labour:

PERFORM A QUICK CHECK:

- **Ask, check record – what is the problem?**
- **Look, listen, feel – any danger signs?**
- **Classify – routine or emergency?**
- **Treat – if emergency, use rapid assessment and management chart**

RAPID ASSESSMENT & MANAGEMENT

- **Used for all women of child bearing age on arrival, and during pregnancy, labour, delivery and postpartum period.**
- **Assess for all emergency and priority signs and give appropriate treatments.**
- **Refer urgently to hospital and complete the referral form.**

No. 1.5

12. **Say to the participants, *"an obstetric emergency may develop while you are attending the woman in labour, or she may have an obstetric problem on admission. For all obstetric emergencies, it is important to identify and manage the problem quickly."***

13. Put up prepared flip chart No. 1.6 and ask a participant to read it out.

WHAT TO DO IN AN EMERGENCY

- **Stay calm**
- **CALL FOR HELP FROM OTHERS - do not leave the woman alone**
- **Assign tasks to staff or people who are with the woman**
- **Ask staff to fetch emergency tray and supplies, or have the midwifery kit close by**
- **Perform a quick check and rapid assessment (if newly arrived)**
- **TAKE ACTION to stabilise the woman's condition**
- **Organise referral**

No. 1.6

14. **Say to the participants, *"there are a number of danger signs which all birth attendants should recognise and take action immediately. It is difficult to gain 'hands-on practice' under supervision, in managing all obstetric complications, so we shall have 'a role-play session' to illustrate some obstetric problems and the action to be taken for each. The checklists will help you to remember what to do even if you have never experienced a particular problem before."***

15. Put up the prepared flip chart No. 1.7 (also **handout No. 1.1**). Do not read it out but leave it displayed.

Distribute handout No. 1.1 (flip chart No. 1.7), emergency signs and action to take.

EMERGENCY SIGNS	ACTION
1. Difficulty breathing, signs of shock (cold moist skin, weak fast pulse)	**Clear airway if obstructed; lift her chin to open airway; ventilate with bag and mask if not breathing; insert IV line and give fluids.** **REFER URGENTLY TO HOSPITAL**
2. Convulsions or unconscious	**Take blood pressure, temperature; protect from injury and clear airway; put on left side; insert IV and give fluids slowly; give magnesium sulphate; if fever >38° also take action for dangerous fever (See B13 & 14 for doses and route).** **REFER URGENTLY TO HOSPITAL unless birth is imminent**
3. Dangerous fever	**Take temperature; insert IV and give fluids slowly; give 1st dose of ampicillin & artemether or quinine (See B15 & 16 for doses & route).** **REFER URGENTLY TO HOSPITAL unless birth is imminent**
4. Severe abdominal pain	**Take blood pressure, temperature; insert IV line and give fluids. If temperature >38°C take action for dangerous fever. If blood pressure <90 mm Hg take action for shock.** **REFER URGENTLY TO HOSPITAL unless birth is imminent**
5. Fetal heart <120 or >160 beats per minute **(See D14)**	**Put woman on her left side. If in early labour and fetal heart rate remains the same after 30 minutes observation,** **REFER URGENTLY TO HOSPITAL**
6. Cord visible at vulva (prolapsed) **(See D15)**	**Look at or feel the cord gently for pulsations. Check for transverse lie. Do vaginal examination to determine progress of labour if necessary. If in early labour & cord pulsating: push presenting part out of the pelvis and hold 1st above the pelvis with your hand on the abdomen. Ask**

EMERGENCY SIGNS	ACTION
6. Cord visible at vulva (prolapsed) (cont'd)	someone to help position the woman with her buttocks higher than her shoulders. **REFER URGENTLY TO HOSPITAL** Maintain until caesarean section is performed. If patient is in late labour & cord pulsating: expedite delivery as quickly as possible and prepare for newborn resuscitation.
7. Continuous contractions, constant pain, ridge across abdomen, labour >24 hours, transverse lie (obstructed labour)	Insert IV line and give fluids; if in labour >24 hours give 1st dose of ampicillin (See B15 for doses & route) **REFER URGENTLY TO HOSPITAL**
8. Soft body parts felt on vaginal examination; legs or buttocks presenting at perineum (breech presentation)	**If early labour:** **REFER URGENTLY TO HOSPITAL** If late labour: see D16 for step-by-step method for delivering breech.
9. Shoulders stuck (dystocia) (See D17)	See D17 for step-by-step method for delivering shoulders. If still stuck, try putting woman in all fours position. If still stuck, insert right hand into the vagina and hook the posterior shoulder or arm downwards and forwards through the vagina.
10. Multiple births (mostly twins) (See D18)	See D18 for step-by-step method for delivering 2nd or more babies. Note: prepare for newborn resuscitation, check for prolapsed cord, make sure all babies are delivered before giving oxytocin, observe closely for PPH.
11. Vaginal bleeding, placenta not delivered	If placenta is not delivered 1 hour after the baby, despite massage, oxytocin and CCT, remove the placenta manually. See B11 for step-by-step method. If still not delivered, **REFER URGENTLY TO HOSPITAL**
12. Vaginal bleeding, placenta already delivered (See B10)	Massage uterus and expel clots, apply internal bimanual compression, apply aortic compression, give oxytocics. See B10 for step-by-step methods.
13. Puerperal infection (Temperature >38° plus any, Very weak, Abdominal tenderness, Foul smelling and/or profuse lochia, Uterus not well contracted, Lower abdominal pain, History of heavy vaginal bleeding)	Insert IV line and give fluids rapidly. Give 1st dose of appropriate IV/IM antibiotics (Ampicillin 2g IV, Gentamicin 80 mg IM and Metronidazole 500 mg IV infusion) before referral. If referral is delayed or not possible, continue antibiotics IM/IV for 48 hours after the woman is fever free. **REFER URGENTLY TO HOSPITAL** No. 1.7 handout No. 1.1

16. Divide the participants into groups of 5 and explain them how to review all the emergency signs. Also refer the groups to the appropriate checklist. Explain how one group member will be 'the client' and another 'the provider', while the third member will guide the other two referring to the checklist. Allow participants to practice their clinical simulation (role play), using the models and midwifery kit if appropriate. They can refer to the relevant sections of the PCPNC for details.
17. The trainers should move around the groups, correcting and guiding the participants as necessary.

◔ **Allow about 15 minutes for the above activity.**

18. **Say to the participants,** "We are going to take lunch break and are going to review detailed management of some danger signs according to prepared cases from afternoon."

☺ **Now take a 60 minutes break for a lunch**

19. **Say to the participants,** ***"it is obviously difficult to replicate or to practice some of these techniques on a model but it is important to remember the principles of the actions needed."***
20. Divide the participants into 5 groups. Distribute a case (puerperal sepsis, placenta previa, Eclampsia, PPH, Dystocia) to each group.
21. Say to the participants, "we are going to discuss diagnosis and management of some danger signs, and have presentation according to some points." Explain to participants about contents of presentation as below;
    * their way of assessment (How did you assess women's condition? what kind of data do you take for the assessment?)
    * diagnosis
    * sequence of management in detail (kind of medicine, dosage)
    * harmful practice for such cases

◔ **Allow 20 minutes for the above activity.**

22. Ask each group to make a presentation for the results for discussion. After the presentation, point out parts not covered, and after further discussion with participants, distribute handouts (PCPNC protocols; B-10, 11, 13, 14, 15, 16, D-14, 15, 16, 17, 18 and [management of infection and haemorrhage protocols]) and case sheet not to have received.
23. Ask all participants to find the relevant section in their PCPNC and slowly explain each step of the procedure. Use the model if it helps to clarify anatomical points.

Case 1:

Ma Khine is 24 years old, who had a 5-year-old daughter. Everything had been normal during her first pregnancy and delivery. During this pregnancy she received antenatal care regularly. She was immunised against tetanus.

When her labour pains began Ma Khine went to the local Rural Health Centre for delivery. The midwife washed her hands before delivering the baby but the Centre had run out of soap, so she used only water.

The placenta came out slowly and the membranes looked ragged so the midwife checked the uterus for pieces of membrane and blood clots. The midwife wore gloves, but they had been re-sterilised several times and there was a small hole in one of the gloves.

Six hours following delivery, Ma Khine felt strong enough to go home. On the 2nd day postpartum, she felt hot and was shivering. On the 3rd day, she felt weak, had a headache and a fever, and on the 4th day her blood loss smelt very unpleasant.

Ma Khine went back to the Rural Health Centre.

Points:

- What is the diagnosis?: puerperal infection
- How does SBA assess Ma Khine's condition and how does she explain the result of the assessment to the patient?
- What kind of treatment (antibiotics) does SBA give Ma Khine?

Case 2:
Ma Thu Zar Myint was a 38-year-old woman. She had two healthy daughters, but she and her husband wanted a son. She had a miscarriage during her 3rd pregnancy. This was her 4th pregnancy, and she was 8 months pregnant.

Although she had been for antenatal care, she missed her last appointment at the RHC as it was planting season and she was busy in the fields.

One day, she felt tired, dizzy and had vaginal bleeding. But she had no abdominal pain. Everybody was busy in the fields she decided to rest at home at that time. Once the bleeding stopped she returned to the fields.

Two days later, she had vaginal bleeding again while at work and fell down in the fields. She was carried to the RHC.

Points:
- What is the diagnosis?: Placenta previa
- How does SBA assess the condition of Ma Thu Zar Myint and explain the result of assessment to her?
- What kind of treatment does SBA give Ma Thu Zar Myint?

Case 3:
Ma Win was a 28-year-old woman, pregnant for the first time. She ran a tea stall and her husband works away in Yangon.
Two weeks before Ma Win was due to deliver, she developed oedema around her legs and ankles. She went to the local healer and he gave her some herbs to drink.
A week later, her face and hands were swollen and she was suffering from a severe headache and vomiting. As her husband was away her mother-in-law took her to the RHC, where the health staff checked her urine. As it was loaded with protein, they advised her to go to the local township hospital immediately.

Ma Win returned home as her mother-in-law wanted to contact her husband before taking her to the hospital, but they were unable to reach him by phone that day. The next day Ma Win suddenly started having fits and became unconscious. Her mother-in-law brought her to the RHC.

Points:
- What is the diagnosis?: Eclampsia
- How does SBA assess the condition of Ma Win and explain the result of assessment to Ma Win's mother-in-law?
- What kind of treatment does SBA give Ma Win?

Case 4:
Ma Moe Moe Aye was a gravida 4. Her labour was very quick and although the AMW was present, there was no time to move Ma Moe Moe Aye to the place in her home that had been prepared for delivery. Wearing gloves, the AMW delivered the baby, handing the baby to a family member.

The placenta came out five minutes after the baby was delivered. The AMW checked cervical tear and perineal and lower vaginal laceration, and did not find any injury.

Then the patient started to have heavy vaginal bleeding. The AMW asked Ma Moe Moe Aye's family to call the midwife. The midwife rushed to Ma Moe Moe Aye's home with midwifery kit and some emergency drugs.

Points:
- What is the diagnosis? : PPH (Atonic bleeding)
- How does SBA assess the condition of Ma Moe Moe Aye and explain the result of assessment to Ma Moe Moe Aye and her family?
- What kind of treatment does SBA give Ma Moe Moe Aye (kind of drug)?

Case 5:
Ma San was a 20-year-old woman pregnant for the first time. She intended to deliver the baby with TBA at her home. She was already ten months pregnant, but the labour had not started.
After one week, her labour pains begun at 4 am and her family called the TBA at 6 am. The progress of labour was smooth and the baby's head came out from vagina at 12 pm. Although TBA tried to deliver the anterior shoulder with the contraction, it was not successful. The TBA tried it again but she failed. TBA asked Ma San's family to call the midwife, and the midwife rushed to Ma San's home.

Points:
- What is the diagnosis? : Dystocia
- How does SBA assess the condition of Ma San and how did she explain the result of assessment to Ma San'?
- What kind of procedure does SBA give Ma San?

Now take a 15 minutes break

24. **Say to the participants, *"as we have seen, there are actions you must take in an emergency situation which will either solve the problem or at least stabilise the condition while you urgently refer the woman to a higher level of care.* But it is obvious that there are a lot of difficulties during prompt referral that must be overcome."**

25. Put up prepared flip chart No. 1.8 and ask different participants to read out each point.

REFERRAL

- **After emergency management, discuss the decision to refer the woman to hospital with her and her relatives.**
- **Ask someone to help you to organise transport and money if necessary.**
- **Accompany the woman yourself or send someone with her.**

Also take:

- **a relative who can donate blood**
- **the baby if possible**
- **essential emergency drugs and supplies (see B17)**
- **referral note (see N12)**
- **during the journey make sure you monitor the IV infusion, give any further treatment needed and record any IV fluids, and medications given**

No. 1.8

26. Display and explain the protocols for management of infection and for haemorrhage.

27. Put up prepared flip chart No. 1.9 and ask the different participants to read out each point.

Key point summary

Key point summary for management of problems

1. **During pregnancy, childbirth and postpartum, an obstetric problem or complication can arise and the signs must be quickly recognised.**
2. **In an emergency situation, the skilled provider must remain calm, seek help from others and take action.**
3. **Although a skilled provider may have had no experience in handling a particular complication, such as a twin delivery, the actions to be taken can be practiced and learnt using models, role-play and checklists.**
4. **In any obstetric emergency, actions to stabilise the woman's condition ('first aid') must be taken. This may solve the problem but often the woman will need urgent referral to a higher level of care for further treatment.**
5. **Preparations for urgent referral to hospital must include means of transportation, adequate funds, and essential emergency drugs and supplies. Keep mother and baby together if possible. A health worker trained in delivery care should always accompany the woman.**

No. 1.9

28. Recall the participants' list of obstetric problems that they have experienced in their practice. Ask participants if they feel more confident in managing such complications after this session.
29. Draw the attention of participants to the session objectives displayed and review them - see if they have been achieved?
30. Remind participants to place any new questions or comments and thank them for their contributions throughout the session.
31. Confirm the schedule for the next training session if necessary.

End of the session

MANAGEMENT OF INFECTION AND HAEMORRHAGE PROTOCOLS

INFECTION (DANGEROUS FEVER)

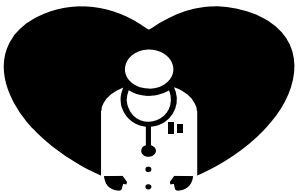
Give 1st dose of antibiotic before referral. If referral is delayed or not possible, continue antibiotics IM/IV for 48 hours after the woman has no more fever. Then give amoxycillin orally 500 mg 3 times daily for 7 days.

CONDITION	*ANTIBIOTICS to be given*
Severe abdominal pain Dangerous fever Severe febrile illness Complicated abortion Uterine infection	• Ampicillin 1st dose 2g IV/IM then 1g every 6 hours • Gentamicin 80 mg IM every 8 hours • Metronidazole 500 mg IV every 8 hours (or 800 mg orally then 400 mg 8 hourly)
Postpartum bleeding Upper urinary tract infection Pneumonia	• Ampicillin 1st dose 2g IV/IM then 1g every 6 hours • Gentamicin 80 mg IM every 8 hours
Manual removal of placenta Risk of uterine infection In labour >24 hours	• Ampicillin 1st dose 2g IV/IM then 1g every 6 hours

▲ If allergic to ampicillin give erythromycin 500 mg IV/IM every 6 hours.

▲ If signs persist or woman becomes weak or has abdominal pain postpartum, REFER URGENTLY TO HOSPITAL.

OXYTOCICS FOR POSTPARTUM HAEMORRHAGE



IF HEAVY POSTPARTUM BLEEDING GIVE OXYTOCIN

INITIAL DOSE	*CONTINUING DOSE*	*MAXIMUM DOSE*
IM/IV 10 IU oxytocin	IM/IV repeat 10 IU after 20 minutes if heavy bleeding persists	Not more than 3 litres of IV fluid containing oxytocin
IV infusion 20 IU oxytocin in 1 litre at 60 drops per minute	IV infusion 10 IU in 1 litre at 30 drops per minute	Not more than 3 litres of IV fluid containing oxytocin

If heavy bleeding in early pregnancy or postpartum bleeding give ergometrine (after giving oxytocin).
DO NOT GIVE IN CASES OF ECLAMPSIA, PRE-ECLAMPSIA OR HYPERTENSION.

INITIAL DOSE	*CONTINUING DOSE*	*MAXIMUM DOSE*
IM/IV 0.2 mg slowly	IM repeat 0.2 mg after 15 minutes if heavy bleeding persists	Not more than 5 doses (total 1.0 mg)

Annex 2

A Training Course on Midwifery Skills for *Midwives and Lady Health Visitors*

TRAINER'S MANUAL

Session 2: Newborn Care

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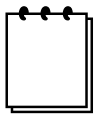
SESSION 2: NEWBORN CARE



Materials needed for this session:

- Prepared flip charts
- Handout No. 2.1 (refer to p. 8 - 9) steps for newborn resuscitation
- Stationery: Blank flip chart paper; marker pens
- Resuscitation model of baby
- Mucous extractors (De Lee type preferably with a filter)
- Check list for "Session 2: newborn care and resuscitation" (p. 13 - 14 in "Annex 4. Check list of Midwifery Skills for LHV and MW" of this Chapter)

Review: J2-11 and K2-14 of PCPNC; "Basic Newborn Resuscitation: A Practical Guide - Revision (WHO; 1999)"; and "Thermal protection of the newborn: a practical guide (WHO, 1997)."

Time: 9:15 to 14:15

☎ **REVIEW clinical observation roster**

Purpose of this session

- To review the routine examination of the newborn and care of babies with special needs.
- To improve the quality of newborn resuscitation techniques and other vital newborn care procedures.

1. **Warm up:** if necessary
2. Display the Session 2 objectives on prepared flip chart No. 2.1 and ask a participant to read them out. Keep this flip chart displayed during the whole session, as you will need to refer back to it at the end.

By the end of the Session 2, the participants will:

- **have reviewed routine examination of the newborn as part of integrated postpartum care.**
- **know how to care for babies with special needs.**
- **have practiced newborn resuscitation techniques.**
- **recognise newborn danger signs.**
- **know how to manage newborn problems and when to refer.**

No. 2.1

3. Ask if objectives are clear and clarify as necessary.
4. Put up the prepared flip chart No. 2.2 and ask a participant to read it out.

NEONATAL MORTALITY

Almost 4 million newborn babies die every year, and an additional 2.6 million are lost just before or during birth. 98% of these deaths occur in developing countries. Every minute somewhere in the world, eight (8) newborn babies die, and five (5) of these die within a week of being born. Why do these babies die? The four (4) major causes of neonatal mortality are:

- **Prematurity**
- **Birth asphyxia**
- **Infection**

Most of these deaths are preventable. It is estimated that about 70% of neonatal deaths can be prevented using known interventions during pregnancy, delivery and the newborn period.

No. 2.2

5. Give all the participants a piece of coloured card and ask each one to write down just **one** activity they think are vital that a maternity service provider performs during pregnancy, childbirth or postpartum to help protect the health of the newborn (for example, treating maternal anaemia, resuscitation of the newborn, immunisation etc). Ask them to write in large, clear letters.
6. Collect the completed cards. Read out each card then stick it up on a flip chart or board. Tell the participants that we will return to their list later.
7. **Say to the participants, *"as maternity care providers we know how closely related the health of the newborn is to the health of the mother. Here are some of the effects of poor maternal health on the health of the newborn and the key mother focused interventions to prevent newborn death or disability.*"**

8. Put up prepared flip chart No. 2.3 and ask different participants to read out each point.

MATERNAL HEALTH = NEONATAL HEALTH

- ✖ **Poor maternal nutrition, malaria, anaemia, syphilis ⇨ low birth weight, death**
- ✖ **No maternal tetanus protection ⇨ neonatal tetanus, death**

IF MOTHER DIES,

HER BABY IS 3 TIMES MORE LIKELY TO DIE IN INFANCY

ANTENATAL CARE: key interventions

- ✔ **Treatment & prevention of anaemia by iron-folate supplementation**
- ✔ **Malaria treatment and de-worming**
- ✔ **Prevention of neonatal tetanus through maternal immunisation**
- ✔ **Screening and treatment of syphilis, HIV**
- ✔ **Counselling on nutrition and infant feeding**

SKILLED CARE AT DELIVERY to prevent birth injury and asphyxia: key interventions

- ✔ **Increasing the number of and access to skilled attendants and updating their life saving skills**
- ✔ **Organising functional referral systems and transportation**
- ✔ **Providing emergency and essential obstetric care, including the use of the partograph**

POSTPARTUM CARE: key interventions

- ✔ **Identifying and managing danger signs**
- ✔ **Counselling on breastfeeding and other feeding practices**
- ✔ **Providing vitamin A to mother**
- ✔ **Recording birth weight**
- ✔ **Counselling on the prevention of HIV infection or re-infection**
- ✔ **Counselling on birth spacing**

No. 2.3

9. **Say to the participants, *"as we have covered all of the mother focused points above in this training course already, we will now focus on actions that are specifically directed at the newborn."***

10. Put up prepared flip chart No. 2.4 and read it out yourself.

NEWBORN CARE

Key interventions in the skilled care of the newborn include:

- **Attention to the initiation of breathing and resuscitation when needed**
- **Clean delivery and cord care**
- **Keeping the baby warm and dry, to prevent hypothermia**
- **Eye care (tetracycline 1%)**
- **Immediate and exclusive breastfeeding**
- **Care of low birth weight babies**
- **The identification and management of illness (e.g. jaundice)**
- **Immunisation**

No. 2.4

11. **Say to the participants, *"the newborn should be assessed after birth and during the first week of life as part of a postpartum check. Never miss the opportunity to check both the mother and the baby at the same time during the postpartum period."***

12. Put up prepared flip chart No. 2.5 and ask different participants to read out each point.

ASSESSMENT AND CARE OF THE NEWBORN OF NORMAL WEIGHT (>2500 gm)

Always examine the baby in the presence of the mother.

- **Wash hands before and after handling baby.**
- **Listen to the heart rate (around 120-140 beats per minute).**
- **Count breaths (less than 60 per minute) and listen for grunting.**
- **Look at movements - are they symmetrical?**
- **Check for any birth injuries, particularly the presenting part.**
- **Check for any malformations.**
- **Does the baby feel warm? The room should be at least 25°C with no draught. The baby should be dressed or wrapped and its head covered by a hat or cloth. Keep in close contact with mother. If the baby feels cold or very warm, take temperature.**
- **Encourage immediate breastfeeding. Help mother with positioning and attachment (see J3). Is the baby feeding well (8 times over 24 hours)? Support exclusive breastfeeding, no supplements of any kind.**
- **Check the cord. Wash hands before and after cord care. If stump is soiled, wash with soap and water and dry thoroughly. Put nothing on the stump and keep loosely covered with clean clothes. Teach mother how to give cord care and explain that she should seek care if the umbilicus is red, draining pus or blood.**
- **Do not bathe the baby before cord drops, if necessary, only after 6 hours old and do not remove vernix.**
- **Weigh the baby.**
- **Apply antimicrobial to the baby's eyes (e.g. 1% tetracycline).**
- **Immunise if due (see K13).**
- **Advise mother on routine visit at 2-3 days and on danger signs.**
- **Record findings.**

No. 2.5

13. **Say to the participants, *"some babies have special needs, such as a baby born prematurely, a baby whose birth weight is below 2500 gm or is a twin*."**

14. Put up prepared flip chart No. 2.6 and read it out yourself, explaining each point fully.

SMALL BABIES THAT NEED ADDITIONAL CARE

- **Very small baby**
  Birth weight <1500g
  Very preterm <32 weeks or >2 months early
  REFER URGENTLY TO HOSPITAL
- **Small baby**
  Birth weight 1500-2500g
  Preterm baby 32-36 weeks or 1-2 months early
- **Twin**

CARE AND MONITORING OF A SMALL BABY OR TWIN (SEE J11)

- **Small babies need more frequent breastfeeding (every 2-3 hours).**
- **Give the mother special support to ensure baby sucks effectively and assess weight gain daily.**
- **Ensure additional warmth; keep the baby in skin-to-skin contact with mother.**
- **Assess daily the temperature and breathing (less than 60 per minute); look for chest in-drawing and grunting.**
- **Look for jaundice, if present urgently refer.**
- **Respond to any maternal concerns.**

No. 2.6

15. **Say to the participants, *"There are also the babies with other special needs (infection, jaundice, local infection, swelling, bruises and malformation). Could you tell us what other needs are?*"**

16. Put up prepared card that is written special need and ask participants how to manage it. Fill in the blanks of flip chart paper when you got the answer from participants according to PCPNC (infection_J5 and K12, jaundice and local infection_J6 and K13, swelling, bruises and malformation_J8).

Now take a 15 minutes break

17. **Say to the participants, *"only a small proportion of newborns do not start breathing immediately (3-5%). As we cannot be sure in advance which newborns will need to be resuscitated, we must be prepared at every birth. We are now going to look at the steps to be taken to resuscitate a baby correctly*."**

18. Put up prepared flip chart No. 2.7 (also handout No. 2.1) and ask a different participant to read out each step.

No. 2.7 handout No. 2.1

RESUSCITATION FOR BIRTH ASPHYXIA

(failure to initiate and sustain breathing)

- **Dry the baby with a warm clean towel then wrap the baby in another.**
- **If the baby is not breathing or is gasping for breath within 1 minute of birth, immediately start resuscitation.**
- **Inform mother and make sure someone is watching her, particularly for vaginal bleeding.**
- **Observe universal precautions to prevent infection.**
- **Put the baby on its back on a clean, dry firm surface under a heater or over warm cloths near the mother.**
- **Dry thoroughly, remove wet towels.**
- **Place a small roll of cloth about 1 inch under the shoulders and position the head so it is slightly extended.**
- **Clear the airway by suctioning 1st the mouth then the nose – this may be enough to start breathing (use DeLee L trap if mechanical suction equipment is not available).**
- **If there is still no breathing, start ventilating keeping the neck slightly extended.**
- **Place face mask on the baby's face so that it covers the chin, mouth and nose, forming a tight seal.**
- **If using a tube fixed to the mask, gently blow and watch for the rise of the chest.**
- **Ventilate with a frequency of around 40 breaths per minute for about 1 minute (better more than less).**
- **Stop briefly and look for spontaneous breathing but do not remove mask and bag.**

- **If there is no breathing or it is weak, continue to ventilate, making sure the head is in the correct position and there is a tight seal between the mask and the face.**
- **If the newborn starts crying, stop ventilating but do not leave and observe for normal breathing for 1 minute.**
- **If breathing is slow (less than 30 per minute) or there is severe chest in-drawing, continue ventilating and ask for help in arranging referral.**
- **If there is no gasping or breathing at all after 20 minutes of ventilation, stop ventilating.**
- **If there was gasping but no spontaneous breathing after 30 minutes of ventilation, stop ventilating.**

No. 2.7 handout 2.1 (continued)

Distribute handout No. 2.1 (also flip chart No. 2.7), steps of newborn resuscitation.

19. Demonstrate how to clear the airway of mucus using the DeLee extractor and then how to correctly ventilate the dummy baby.
20. Divide the participants into pairs and give each pair the checklist for newborn resuscitation.
21. One of each pair should carry out resuscitation on the model while the other checks off the steps against the checklist. When both have had a turn at resuscitation, then they should discuss any points on the checklist that they did not carry out correctly. If there is time, then those who did not conduct the steps correctly should try again.
22. Monitor participants carefully, guiding and assisting where necessary.

Allow 60 minutes for the above activity or until all participants have practiced correct resuscitation on the model.

Now take a 60 minutes break for a lunch

23. **Say to the participants,** ***"during a postpartum check or visit, as well as looking for and recognising danger signs in the mother, you should look for and recognise danger signs in the baby too."***

24. Put up prepared flip chart No. 2.8 and ask the participants to fill in the blank.

DANGER SIGNS IN THE NEWBORN

- **Fast breathing >60 breaths per minute**
- **Slow breathing <30 breaths per minute**
- **Severe chest in-drawing**
- **Grunting**
- **Convulsions**
- **Tone floppy or stiff**
- **Fever (temperature >38° C)**
- **Low temperature <35° C or not rising after re-warming**
- **Umbilicus draining pus or redness of surrounding skin; bleeding from stump**
- **More than 10 skin pustules, or swelling, redness, hardness of skin**
- **Early jaundice**

GIVE 1st DOSE OF BOTH AMPICILLIN AND GENTAMYCIN IM IN THIGH

(for dosage see K12 or protocol)

and

REFER URGENTLY TO HOSPITAL

No. 2.8

25. Display and explain the protocols for "caring for the newborn" and "treating danger signs in the newborn."

26. Put up prepared flip chart No. 2.9 and ask a different participant to read out each point.

Key point summary

Key point summary for newborn care

1. **Appropriate care in pregnancy, delivery and the neonatal period is critical not only for the survival of neonates, but also for the prevention of disabilities that can permanently damage a significant number of infants that survive the first month of life.**
2. **Routine examination of the newborn is an important part of integrated postpartum care.**
3. **Small babies have additional special needs, such as more frequent feeds and extra warmth.**
4. **All trained birth attendants must be prepared to resuscitate a baby who is having difficulty establishing breathing. This must be done carefully, observing universal precautions.**
5. **The maternity care provider must recognise danger signs in the newborn, such as abnormal temperature, fast or slow breathing, and redness or pus at the umbilical site.**
6. **Newborn problems require immediate management and may need urgent referral to hospital for further treatment.**

No. 2.9

27. Return to the participants' list of vital activities a maternity service provider performs during pregnancy, childbirth or postpartum to help protect the health of the newborn. Ask participants to group them in order of importance, according to what they have learnt today. Are there any they would like to add to the list?
28. Draw the attention of participants to the session objectives displayed and review them- have they been achieved?
29. Ask any questions or give comments. If any questions need more time or research, tell participants that you will try to find an answer for them by the next day.
30. Thank them for their contributions throughout the session.

End of the session

CARE OF THE NEWBORN PROTOCOLS

CARE OF THE NEWBORN

Always check the baby in the presence of the mother.

Always wash hands before and after handling baby.

- **Check:** breathing (between 30-60 breaths per minute)
- **Look at:** movements and tone: symmetrical, not floppy or stiff
- **Look for:** birth injuries, malformations
- **Check temperature:** keep warm and dry and close to mother
- **Check the cord:** keep clean and dry. Do not bandage or bind
- **Weigh the baby**
- **Apply:** 1% tetracycline to eyes within 1 hour of birth
- **Immunise:** according to schedule
- **Support:** immediate and exclusive breastfeeding
- **Advise mother:** danger signs, time of routine visit
- **Record:** findings, treatment, advice

EXTRA CARE FOR SMALL BABIES

- More frequent breastfeeding (every 2-3 hours)
- Keep warm: skin-to-skin contact with mother
- Assess breathing daily: check for grunting and chest in-drawing
- Look for jaundice
- Provide extra support to mother

TREATING A NEWBORN WITH DANGER SIGNS

Signs of possible serious illness:

- **Breathing: >60 or<30 breaths per minute**
- **Severe chest in-drawing, grunting**
- **Convulsions**
- **Tone: floppy or stiff**
- **Temperature: >38° C or <35° C and not rising after re-warming**
- **Umbilicus: bleeding, redness of surrounding skin, pus**
- **Skin: >10 pustules, swelling, redness, hardness**

WHAT TO DO: Give 1st dose of two antibiotics IM in thigh before URGENT referral for serious illness.

- **AMPICILLIN Give 50 mg per kg. Add 2.5 ml sterile water to 500 mg vial (=200 mg/ml).**
- **GENTAMICIN Give 5 mg per kg. 20 mg per 2 ml vial (=10 mg/ml).**

BABY'S WEIGHT	ANTIBIOTICS to be given
2.0-2.4 kg	• Ampicillin 0.6 ml IM • Gentamicin 0.9 ml IM
2.5-2.9 kg	• Ampicillin 0.75 ml IM • Gentamicin 1.35 ml IM
3.0-3.4 kg	• Ampicillin 0.85 ml IM • Gentamicin 1.6 ml IM
3.5-3.9 kg	• Ampicillin 1 ml IM • Gentamicin 1.85 ml IM

Use a new needle and syringe for each antibiotic.

Annex 3: Programme on the Refresher Training for LHV and MW on Midwifery Skills

Date / Time	Min.	Objectives and activities	Contents	Teaching methods	Responsible lecturer	Materials
DAY 1:						
9:00-9:45	45	**Opening ceremony** - Opening speech - Training expectation - Pre-test				- Pre-test
9:45-10:45	60	**Session 1: Management of Problems during Pregnancy, Childbirth and Postpartum part: danger signs during pregnancy, childbirth and postpartum**				
		Specific Objectives: - To become aware of multifactorial causes of danger signs. - To know the importance of classification according to period and severity.	**[making sequence of events]** - Put up the blanked flow chart. - tell about making trees of danger signs (eclampsia, severe abdominal pain and bleeding). - Ask participants to answer proper danger signs in the blanks. - Suggest to pointing to danger sign that can be associated with the diagnosis as many as possible. ✻**Convulsions or unconscious**(Eclampsia) ✻**Severe abdominal pain** (abortion, abruptio placenta, ectopic pregnancy, ruptured uterus, obstructed labour, puerperal or post-abortion sepsis) ✻**vaginal bleeding** (abortion, ectopic pregnancy, mole, placenta previa, abruptio placenta, ruptured uterus) ✻**Difficult breathing** (shock, Malaria, pneumonia, URI, TB, chronic lung disease) ✻**Convulsions or unconscious** (eclampsia or cerebral hemorrhage) ✻**Dangerous fever** (infection-: Malaria, pneumonia, UTI, meningitis, septicemia, uterine and fetal infection)	- Q&A - Lecture (if needed)	DMO/TMO	- blank flip chart - prepared card

Date / Time	Min.	Objectives and activities	Contents	Teaching methods	Responsible lecturer	Materials
10:45-11:00	15	Tea break				
11:00-12:00	60	**Session 1: (cont'd): Management of Problems during Pregnancy, Childbirth and Postpartum Part 2: quick check and rapid assessment & management**				
		- To know what measures to take, including first aid and referral. - To ensure SBA can quickly recognize signs of deviation from normal cases.	**[Review of the quick check and rapid assessment of women]** - Check according to the following algorithm ✻Ask, check record: what is the problem? ✻Look, listen, feel: any danger signs? ✻Classify: routine or emergency? ✻Treat: if in emergency, use rapid assessment and management.	- Q & A	DMO/TMO	- flip chart - midwifery kit - pelvis and baby model (with placenta)
12:00-13:00	60	Lunch break				
13:00-14:15	75	**Session 1: (cont'd): Management of Problems during Pregnancy, Childbirth and Postpartum Part 3: first aid before referral (1)**				
		Specific Objectives: - To be aware of the importance of remembering the principles of the actions needed.	**[First aid before referral <1>]** - Divide participants into 5 groups. - Give each group at least 1 emergency sign. - Explain how one group member will be 'the client' and another 'the provider', while the other members will guide the 'client' and 'provider' using check list. - Allow participants to practice their clinical simulation, using model and midwifery kit.	- clinical practice (small group)	DMO/TMO	- midwifery kit - pelvis and baby model (with placenta)
14:15-14:30	15	Tea break				

Date / Time	Min.	Objectives and activities	Contents	Teaching methods	Responsible lecturer	Materials
14:30-15:45	75	**Session 1: (cont'd): Management of Problems during Pregnancy, Childbirth and Postpartum** **Part 3: first aid before referral (2)**				
		Specific Objectives: - To realize the importance for establishment of a cooperative framework on referral cases with stakeholders in community.	**[First aid before referral <2>]** - Distribute the case (puerperal sepsis, placenta previa, eclampsia, PPH, dystocia) to each group. - Ask each group to discuss diagnosis and management (20 min.). - Explain to the participants about contents of presentation. **∗their way of assessment (how did you assess the woman's condition?, what kind of data do you take for the assessment?).** **∗diagnosis** **∗sequence of management in detail (kind of medicine, dosage, and so on).** **∗harmful practice for the case.** - Ask each group to make a presentation for the result of discussion. - Point out parts not covered after discussion with participants.	- Q & A - group discussion & presentation	DMO/TMO	- A0 paper - pen - case sheet
15:45-16:00	15	**Questions answers for the today's sessions** **Confirmation of schedule for the next day**				
DAY 2:						
9:00-9:15	45	**Recap for the previous day's sessions**				
9:15-10:30	75	**Session 2: Newborn Care** **part 1: review of the routine examination of the newborn and care of babies with special needs**				

Date / Time	Min.	Objectives and activities	Contents	Teaching methods	Responsible lecturer	Materials
		Specific Objectives: - To review the "routine examination" of the newborn and care of the babies with special needs.	**[The routine examination of the newborn]** - neonatal mortality - Maternal health = neonatal health - Care of the new born protocols - assessment and care of the newborn of normal weight **[Care of the babies with special needs]** (<2500g, twin, infection, jaundice, local infection, swelling, bruises and malformation)	- Q & A - Lecture (if needed)	Pediatrician	- flip chart
10:30-10:45	15	Tea break				
10:45-12:00	75	**Session 2: Newborn Care part 2: newborn resuscitation techniques**				
		Specific Objectives: - To improve the quality of newborn resuscitation techniques.	**[Resuscitation for birth asphyxia]** - read out each step. - Demonstrate the resuscitation technique. - Request the participant to demonstrate how to clear the airway of mucus using the DeLee extractor and how to correctly ventilate the dummy baby. - Divide participants into pairs and refer each pair to the check list for newborn resuscitation.	- clinical practice	Pediatrician	- flip chart - baby model - DeLee extractor - tube mask
12:00-13:00	60	Lunch break				
13:00-14:15	75	**Session 2: Newborn Care part 3: danger signs in newborn**				
		Specific Objectives: - To improve the quality of other vital newborn care procedures.	**[Danger signs in the newborn]** - display and explain the protocols for "caring for the newborn" and treating newborn danger signs. - read out each point.	- Q & A	Pediatrician	- flip chart
14:15-14:30	15	Tea break				
14:30-14:45	30	**Questions and answers for the whole session**				
14:45-15:00	15	**Post-test**				- Post-test
15:00-15:30	30	**Closing** - closing speech				

Annex 4: Check List of Midwifery Skills for LHV and MW

Session 1: management of problems during labour and delivery

Skill Checklist No. 1
Care during an emergency: difficulty breathing, shock

A. Makes sure everything is clean and ready	**Yes ✓**	**No ✖**	**Comment**
• Emergency equipment and supplies, including adult and newborn resuscitation, are ready			
B. Begins each emergency care visit:			
• Introduces self and asks name of woman			
• Encourages companion to stay with woman			
• Explains all procedures, asks permission and keeps woman informed as much as possible			
• Ensures and respects privacy during examination and discussion			
• If woman has brought baby and it is well, ask someone to take care of it during examination and treatment			
• Performs Quick Check and RAM			
C. Difficulty breathing, signs of shock (cold moist skin, weak fast pulse)			
• Clears airway if obstructed and lifts chin to open airway			
• Ventilates with bag and mask if not breathing			
• Measures blood pressure and pulse			
• Inserts IV line and gives fluids rapidly			
• Keeps woman warm (covers)			
• Treats for shock			
• **REFERS URGENTLY TO HOSPITAL**			
• If birth imminent, transfers woman to labour room and proceeds to delivery			

Skill Checklist 2
Care during an emergency: convulsions or unconscious

A. Makes sure everything is clean and ready	**Yes** ✓	**No** ✖	**Comment**
• Emergency equipment and supplies, including adult and newborn resuscitation, are ready			
B. Begins each emergency care visit:			
• Introduces self and asks name of woman			
• Encourages companion to stay with woman			
• Explains all procedures, asks permission and keeps woman informed as much as possible			
• Ensures and respects privacy during examination and discussion			
• If woman has brought baby and it is well, ask someone to take care of it during examination and treatment			
• Performs Quick Check and RAM			
C. Convulsions or unconscious			
• Clears airway if obstructed and lifts chin to open airway			
• Measures blood pressure, temperature and pulse			
• Puts woman on left side			
• Inserts IV line and gives fluids slowly			
• Gives magnesium sulphate IM			
• If fever >38° C also take action as for dangerous fever			
• **REFERS URGENTLY TO HOSPITAL**			
• If birth imminent, transfers woman to labour room and proceeds to delivery			

Skill Checklist 3
Care during an emergency: dangerous fever

A. Makes sure everything is clean and ready	**Yes ✓**	**No ✖**	**Comment**
• Emergency equipment and supplies, including adult and newborn resuscitation, are ready			
B. Begins each emergency care visit:			
• Introduces self and asks name of woman			
• Encourages companion to stay with woman			
• Explains all procedures, asks permission and keeps woman informed as much as possible			
• Ensures and respects privacy during examination and discussion			
• If woman has brought baby and it is well, ask someone to take care of it during examination and treatment			
• Performs Quick Check and RAM			
C. Dangerous fever (>38° C), very fast breathing, stiff neck, lethargy, very weak			
• Measures temperature			
• Inserts IV line and gives fluids slowly			
• Measures blood pressure and pulse			
• Gives 1st dose of antibiotics (see protocol)			
• Gives artemether or quinine			
• **REFERS URGENTLY TO HOSPITAL**			
• If birth imminent, transfers woman to labour room and proceeds to delivery			

Skill Checklist 4
Care during an emergency: severe abdominal pain

A. Makes sure everything is clean and ready	**Yes ✓**	**No ✖**	**Comment**
• Emergency equipment and supplies, including adult and newborn resuscitation, are ready			
B. Begins each emergency care visit:			
• Introduces self and asks name of woman			
• Encourages companion to stay with woman			
• Explains all procedures, asks permission and keeps woman informed as much as possible			
• Ensures and respects privacy during examination and discussion			
• If woman has brought baby and it is well, ask someone to take care of it during examination and treatment			
• Performs Quick Check and RAM			
C. Severe abdominal pain (not normal labour)			
• Measures blood pressure, pulse and temperature			
• Inserts IV line and gives fluids			
• If temperature more than >38° C gives 1st dose of antibiotics (see protocol)			
• If blood pressure < 90 mm Hg treats for shock			
• **REFERS URGENTLY TO HOSPITAL**			
• If birth imminent, transfers woman to labour room and proceeds to delivery			

Skill Checklist 5
Care during an emergency: fetal heart <120 or >160 beats per minute

A. Makes sure everything is clean and ready	**Yes** ✓	**No** ✖	**Comment**
• Emergency equipment and supplies, including adult and newborn resuscitation, are ready			
B. Begins each emergency care visit:			
• Introduces self and asks name of woman			
• Encourages companion to stay with woman			
• Explains all procedures, asks permission and keeps woman informed as much as possible			
• Ensures and respects privacy during examination and discussion			
• Performs Quick Check and RAM			
C. Fetal heart <120 or >160 beats per minute			
• Puts woman on her left side			
• Inserts IV line and gives fluids			
• If temperature more than >38° C gives 1st dose of antibiotics (see protocol)			
• If blood pressure < 90 mm Hg treats for shock			
• **REFERS URGENTLY TO HOSPITAL**			
• If birth imminent, transfers woman to labour room and proceeds to delivery			

Skill Checklist 6
Care during an emergency: Cord visible at vulva

A. Makes sure everything is clean and ready	**Yes** ✓	**No** ✖	**Comment**
• Emergency equipment and supplies, including adult and newborn resuscitation, are ready			
B. Begins each emergency care visit:			
• Introduces self and asks name of woman			
• Encourages companion to stay with woman			
• Explains all procedures, asks permission and keeps woman informed as much as possible			
• Ensures and respects privacy during examination and discussion			
• Performs Quick Check and RAM			
C. Cord prolapse			
• Looks at or feels the cord gently for pulsations			
• Feels for transverse lie. If so, **REFERS URGENTLY TO HOSPITAL**			
• Does vaginal examination to determine status of labour			
- If cord is pulsating (fetus alive) and early labour:			
• Pushes head or presenting part out of the pelvis			
• Holds presenting part above pelvic brim with hand on abdomen			
• Asks someone to help position woman's buttocks higher than shoulders			
• **REFERS URGENTLY TO HOSPITAL**			
• Keeps pressure off the cord until caesarean section is performed			
• If birth imminent, transfers woman to labour room and proceeds to delivery			
• Prepares for newborn resuscitation			

Skill Checklist 7
Care during an emergency: Continuous contractions (obstructed labour)

A. Makes sure everything is clean and ready	**Yes** ✓	**No** ✖	**Comment**
• Emergency equipment and supplies, including adult and newborn resuscitation, are ready			
B. Begins each emergency care visit:			
• Introduces self and asks name of woman			
• Encourages companion to stay with woman			
• Explains all procedures, asks permission and keeps woman informed as much as possible			
• Ensures and respects privacy during examination and discussion			
• Performs Quick Check and RAM			
C. Continuous contractions, constant pain, ridge across abdomen (Bandl's Ring), labour >24 hours, transverse lie (obstructed labour)			
• Inserts IV line and gives fluids			
• If in labour for >24 hours give 1st dose of ampicillin			
• **REFERS URGENTLY TO HOSPITAL**			

Skill Checklist 8
Care during an emergency: breech delivery

A. Makes sure everything is clean and ready	Yes ✓	No ✖	Comment
• Emergency equipment and supplies, including adult and newborn resuscitation, are ready			
B. Begins each emergency care visit:			
• Introduces self and asks name of woman			
• Encourages companion to stay with woman			
• Explains all procedures, asks permission and keeps woman informed as much as possible			
• Ensures and respects privacy during examination and discussion			
• Performs Quick Check and RAM			
C. Soft body parts felt / legs or buttocks presenting (late labour)			
• Feels fetal head in fundus			
• Feels leg or buttocks on vaginal examination			
• Calls for additional help			
• Confirms full dilatation of cervix by vaginal examination			
• Ensures bladder is empty; catheterises if necessary			
• Prepares for newborn resuscitation			
D. Delivers the baby			
• Assists the woman into position to allow baby to hang down (all fours or supported with buttocks on edge of bed)			
• When baby's buttocks have entered the vagina, performs an episiotomy			
• Allows buttocks, trunk and shoulders to deliver spontaneously			
• Lays the baby astride left forearm with limbs hanging on each side			
• Places the middle and index fingers of the left hand on the baby's cheekbones and applies gentle downwards pressure to flex head			
• Places two fingers of right hand over the baby's shoulders and head to aid flexion			
• Asks assistant to apply pressure above mother's pubic bone as head delivers			
• When hairline is visible, raises baby upward and forward until mouth and nose are free			

Skill Checklist 9
Care during an emergency: Shoulders stuck (dystocia)

A. Makes sure everything is clean and ready	Yes ✓	No ✖	Comment
• Emergency equipment and supplies, including adult and newborn resuscitation, are ready			
B. Begins each emergency care visit:			
• Introduces self and asks name of woman			
• Encourages companion to stay with woman			
• Explains all procedures, asks permission and keeps woman informed as much as possible			
• Ensures and respects privacy during examination and discussion			
• Performs Quick Check and RAM			
C. Head is delivered but shoulders are stuck			
• Calls for additional help			
• Prepares for newborn resuscitation			
• Positions woman with legs tightly flexed against her chest and knees wide part			
• Performs adequate episiotomy			
• Asks assistant to apply continuous pressure downwards on abdomen directly above pubic bone			
• Maintains continuous traction on fetal head (does not pull too hard)			
If shoulders still not delivered:			
• Assists woman to adopt all fours position			
• Wearing HLD or sterile gloves, introduces right hand into vagina along baby's back			
• Applies pressure to the posterior shoulder to bring it downwards and forwards through the vagina			

Skill Checklist 10
Care during an emergency: delivery of 2nd baby

A. Makes sure everything is clean and ready	Yes ✓	No ✖	Comment
• Emergency equipment and supplies, including adult and newborn resuscitation, are ready			
• Extra equipment and supplies are available			
• Ask for additional assistance			
B. Begins each emergency care visit:			
• Introduces self and asks name of woman			
• Encourages companion to stay with woman			
• Explains all procedures, asks permission and keeps woman informed as much as possible			
• Ensures and respects privacy during examination and discussion			
• Performs Quick Check and RAM			
C. First baby delivered, resuscitated (if necessary) and labelled (1)			
• Asks helper to care for baby (1)			
• Palpates uterus to determine lie of 2nd baby			
• If oblique or transverse, gently turns baby abdominally to head or breech position			
• Checks the presentation by vaginal examination			
• Checks the fetal heart rate			
• Awaits return of strong uterine contractions and spontaneous rupture of 2nd bag of membranes (up to 1 hour)			
• Stays with woman and continues to monitor her and fetal heart intensively			
• Removes wet cloths from beneath her and keeps warm if necessary			
• After membranes rupture, checks for prolapsed cord			
• Encourages mother to push when ready			
• Delivers 2nd twin			
• Resuscitates (if necessary) and labels (2)			
D. Checks for empty uterus before giving oxytocin			
Observes closely for PPH			

Skill Checklist 11
Care during an emergency: vaginal bleeding postpartum

A. Makes sure everything is clean and ready	Yes ✓	No ✖	Comment
• Emergency equipment and supplies, including adult and newborn resuscitation, are ready			
B. Begins each emergency care visit:			
• Introduces self and asks name of woman			
• Encourages companion to stay with woman			
• Explains all procedures, asks permission and keeps woman informed as much as possible			
• Ensures and respects privacy during examination and discussion			
• If woman has brought baby and it is well, ask someone to take care of it during examination and treatment			
• Performs Quick Check and RAM			
C. Vaginal bleeding: placenta not delivered 1 hour after baby despite oxytocin, massage and CCT			
• Prepares to remove placenta manually			
• Inserts IV line and gives fluids			
• Gives diazepam 10 mg IM/IV			
• Wearing clean gloves, washes vulva and perineal area			
• Ensures bladder is empty, catheterises if necessary			
• Washes hands and forearms and puts on long HLD or sterile gloves			
• OBSERVES UNIVERSAL PRECAUTIONS			
• Holds cord gently and moves into horizontal position			
• Inserts right hand into uterus			
• Lets go of cord and uses left hand to support fundus and provides counter traction			
• Moves the fingers of the hand in the uterus sideways until edge of placenta is located			
• Detaches placenta by keeping fingers tightly together			
• Proceeds gradually around the placental bed until whole placenta is detached			
• Withdraws right hand from uterus slowly bringing placenta with it			
• Continues to provide counter traction to fundus through abdomen to avoid inversion of uterus			

• Explores the inside of the uterine cavity to ensure all placental tissue has been removed			
• Examines placenta for completeness			
• Gives a repeat dose of oxytocin 10 IU IM/IV			
• Massages fundus of uterus to encourage contraction			
• Gives 1st dose of antibiotics (see protocol)			
• Monitors vital signs, contraction of uterus and bleeding every 30 minutes until stable			
• If cannot separate placenta from uterine surface **REFERS URGENTLY TO HOSPITAL**			
D. Vaginal bleeding: placenta already delivered			
Massages uterus and expels clots - Places cupped palm on uterine fundus and feels for contraction - Massages fundus in circular motion with cupped palm until well contracted - Places fingers behind fundus and pushes down in one swift action to expel clots - Collects blood in a container placed close to vulva - Measures or estimates blood loss and records			
• Gives 10 IU oxytocin IM (see protocol)			
• Inserts IV and gives fluids			
If bleeding continues despite uterine massage and oxytocin, applies bimanual uterine compression - Wears sterile or HLD gloves - Puts right hand into the vagina, makes a fist - Puts fist with knuckles in anterior fornix and back of hand posteriorly - Places the other hand on the abdomen behind the uterus and squeezes the uterus between the two hands - Maintains compression until bleeding stops			
If bleeding continues despite uterine massage and oxytocin, applies aortic compression - Feels for femoral pulse - Applies pressure above umbilicus sufficiently until femoral pulse is not felt - Continues pressure until bleeding stops			
• **If bleeding persists, applies aortic compression while transporting woman to hospital**			

Session 2: newborn care and resuscitation

Skill Checklist 1
Care of the newborn

A. Makes sure everything is clean and ready	Yes ✓	No ✖	Comment
• Emergency equipment and supplies, including newborn resuscitation, are ready			
• Room is at least 25° C with no draughts			
B. At delivery:			
• Wipes fluids from baby's mouth and nose using clean cloth or gauze			
• Dries with cloth from head to toe			
• Removes the first wet cloth			
• Covers with another dry cloth or places baby skin to skin with the mother			
• Covers both mother and baby to prevent heat loss, including baby's head (uses hat if available)			
• Positions baby with head slightly lower than body to drain fluids from air passage			
• Checks breathing and heart rate			
• Resuscitates if necessary			
C. After delivery			
• Does not remove vernix			
• Does not bathe the baby (for at least 6 hours)			
• Washes hands before handling baby			
• Checks breathing (around 60 breaths per minute)			
• Checks for grunting, in-drawing of chest			
• Checks tone and movements			
• Checks for any malformations, birth injuries			
• Checks ligatures on cord (no bleeding)			
• Loosely covers cord with clean clothes (does not bind or bandage or apply any substance)			
• Puts 1% tetracycline in baby's eyes			
• Weighs baby			
• Helps mother put baby to breast			
• Advises mother on newborn care, danger signs, when and where to seek care, next visit			
• Ensures someone will stay with mother and baby for first 24 hours			
D. Records findings, treatments on labour record, partograph and home based maternal record			

Skill Checklist 2
Newborn resuscitation

A. Makes sure everything is clean and ready	Yes ✓	No ✖	Comment
• Emergency equipment and supplies, including for newborn resuscitation, are ready			
B. Baby fails to initiate and sustain breathing:			
• Starts resuscitation if baby is not breathing or gasping for breath within 1 minute of delivery			
• Informs mother and asks companion/assistant to observe her for vaginal bleeding			
• Observes universal precautions			
• Places baby on its back on clean, dry surface			
• Keeps baby wrapped in dry cloth/towel except for face and upper chest			
• Places light and heat source over or near baby			
C. Resuscitates baby			
• Positions head in a slightly extended position			
• Clears the airway by suctioning **first the mouth then the nose**			
• Suctions any blood or meconium from baby's mouth and nose to prevent aspiration			
• Reassesses baby: if starts crying or breathing, no further action taken (proceeds to normal newborn care)			
• If still not breathing, starts ventilating			
• Rechecks baby's position with neck slightly extended			
• Selects face mask suitable for baby (size 1 or 0)			
• Positions face mask on baby's face and checks the seal			
• Mask covers chin, mouth and nose			
• Blows gently down tube			
• Observes rise of the chest			
• Ventilates with frequency of 40 breaths per minute			
• Continues for at least 1 minute, observing rise and fall of chest			
• Looks for spontaneous breathing without removing mask and bag			
• Continues to ventilate until regular breathing is established			
D. REFERS URGENTLY TO HOSPITAL if breathing is not regular after 20 minutes			
• Transfers with mother if possible			
• During transfer keeps baby warm and ventilated			
E. If there is no gasping or breathing at all after 20 minutes of ventilation: (baby is stillborn)			
• Stops ventilating			
• Provides support and counselling to the mother and her family			
F. Records actions and outcome on partograph, labour record and home based maternal record			

II Skill Development of AMWs

(1) Background

AMWs had been trained since 1986 with the aim to support MW and to replace TBA. The number of AMW was 28,872 in the country as of December 2005. Although there were 239 functioning AMW in the Project area as of 2007, there is lack of balance in AMW's allocation. One AMW covers 2.7 villages/wards on average, according to calculation. However, some of villages have two to three AMWs in one village. There is an enormous disparity in their function among AMWs. There seems to be issues of the selection criteria at the initial training. In addition to that, they have been substitute personnel in remote areas where MW are not available, although they are trained as volunteers without any regular payment and they have no opportunity to get continuous education.

Nowadays, AMW is categorized as "trained health personnel," and they are excluded from the category of skilled health workers statistically. Unfortunately, there is lack of system of continuous education and carrier ladder for AMW even though some of skillful AMW could have status of SBA. All AMW who work for the community people continually, must have opportunity for continuous education. It is highly necessary for AMW to consider the way of continuous education based on the assessment of midwifery skills among AMW. In its turn, positive influence would be encouraged for dissemination of quality care for mothers and children in remote area.

(2) Inputs by the Project for Challenging the Issues

The assessment of midwifery skills among AMWs was done, particularly in the following;

(i) AMW's knowledge about danger signs in antenatal, delivery and postnatal period

Knowledge of danger signs in antenatal, delivery and postnatal period, which majority of AMW possessed was hypertension, vaginal bleeding and anaemia.

(ii) AMW's performance level of antenatal, delivery and postnatal care

The AMW's performance of antenatal, delivery, postnatal neonatal care was insufficient in terms of delivery and neonatal care and PNC at 4-6 weeks.

(iii) Capabilities to manage danger signs

AMWs who work actively in remote area had experienced and

known appropriate management skills for some danger sing such as APH, prolonged labor, shoulder dystocia and retained placenta, despite the fact that they didn't know the causes of all the danger signs. Moreover, they had not experienced some danger signs such as severe abdominal pain and PPH, and they did not know how to manage it.

Overall, midwifery skills among AMWs were lower than expected, even the performance for normal cases. Especially for AMW who work actively in remote areas where MW are not available, they have faced difficulties in abnormal cases even though they have to manage it by themselves. To conclude, there was no doubt that all the stakeholders must recognize the need for offering opportunities for relearning perinatal care both in theory and practice. Setting several options and exploring opportunities for routine work would do a lot to help achieve their ambition.

(3) Output by the Project including Achievement and Lessons Learned

The feasibility of systematic continuous education for AMW was concerned. The hearings with stakeholders such as DOH and DMO (TMO), focal point person, HA, LHV, MW and AMW in the Project area was conducted. As a result of that, a stratified framework of continuing midwifery training for AMWs would be suggested as follows;

[1] Conducting refresher training

- Human resource: DMO (TMO) would be a key person and would coordinate whole of the training. The instructors would be chosen according to the utilization of health personnel, such as THO, THN, HA1 and SMO in each of the townships. Also LHV would be better to perform as a lecturer, as one of the stakeholders in front line.
- Financial resource: fund-raising business for the training must be a tough problem. DMO, the organizer could request for financial support from UN agencies, INGO and NGO (MMCWA). The organizer may have to consider charging a small amount of participation fee from AMW.
  The organizer would be able to take a flexible approach as funds permit, e.g., participants could be divided into some groups, not to hold the training at one time.
- Materials: PCPNC manual for AMW that DOH developed is available for the training. The organizer should

consider distribution of the participant handbook as funds permit. Teaching materials such as models (baby, placenta, cord, pelvic and so on) for demonstration could be made by the organizer and participants if it is not available.

- Evaluation: Pre/post course questionnaire and checklists in the PCPNC manual for AMW are available.

[2] Implementation of monthly Continuing Health Education (CHE) through SBA

- Human resource: SBA, especially midwives, could make arrangement for regular meeting with AMW, at least exploring the opportunity for monthly immunization. SBA would be able to tell the contents of CME to AMW.
- Financial resource: It is not necessary to prepare the budget for implementation of monthly CHE.
- Materials: SBA would share the brochures and leaflets when needed.
- Evaluation: Communication record that includes the date, topic and attendance should be listed by SBA.

[3] Conducting practical on-the-job-training (OJT) I in routine work

Existing OJT done by midwives is also one of the continuous education for AMW, as prescribed in the job description.

- Human resource: MW will be the organizer for the OJT. LHV can give supervision to MW.
- Financial resource: It is not necessary to prepare the budget for implementation of practical OJT. Printing cost of teaching contents would be needed.
- Materials: PCPNC manual for AMW would be utilized as teaching contents in OJT.
- Evaluation: Checklists in the PCPNC manual for AMW are available.

[4] Conducting Intensive OJT II

AMWs who work in remote areas where MWs are not available have lack of opportunity for OJT in routine work. For this reason, their need of continuous education for midwifery skills is certainly strong. Those AMWs and experienced SBAs living under the same roof will perform midwifery care for 2-3 months. SBA takes AMW learning to a higher level through the practice utilizing PCPNC manual for AMW. AMW will have opportunity for the presentation of achievement and lessons learnt through the OJT at the end of the training, and may get a higher status than AMW.

- Human resource: Experienced LHV and MW who was recommended by DMO will be a facilitator. HA will assume a role of supervisor.
- Financial resource: Personal costs of facilitators have to be concerned. Printing cost of teaching contents would be needed.

MMCWA could support those kinds of costs. Accommodation costs shall be borne by AMW.

- Materials: PCPNC manual for AMW would be a guideline for the supervision of AMW
- Evaluation: Checklists in the PCPNC manual for AMW are available.

Reference matrix of continuing midwifery training for AMWs is shown in Table 2-1.

Table 2-1 Matrix of continuing midwifery training for AMWs

No.	Type of continuing midwifery training	Human resource	Financial resource	materials
[1]	Refresher training	organizer: DMO (TMO) instructor: DMO (TMO), THO, SMO, THN, HA1, HA, LHV	UN, INGO, NGO (MMCWA)	Manual for PCPNC
[2]	Continuing Health Education (CHE)	organizer: MW Instructor: LHV, MW, MCHP	FOC	when needed
[3]	On the Job Training I	organizer: MW instructor: MW	FOC (needed only printing cost)	Manual for PCPNC
[4]	On the Job Training II	organizer: LHV and MW (only experienced) instructor: HA	NGO (MMCWA)	Manual for PCPNC

Those who are able to participate in the framework should be only "active AMW." The focus of building a framework of continuing midwifery training for AMW is to open the door of opportunity to all AMW who engage in Maternal and Newborn Health (MNH) activities in community. It is not necessary to set the qualification such as only those who are birth attendant and type of participation (private or public expenses). The chart 2-1 diagram on page II-5 describes how the various stakeholders would take roles in this framework.

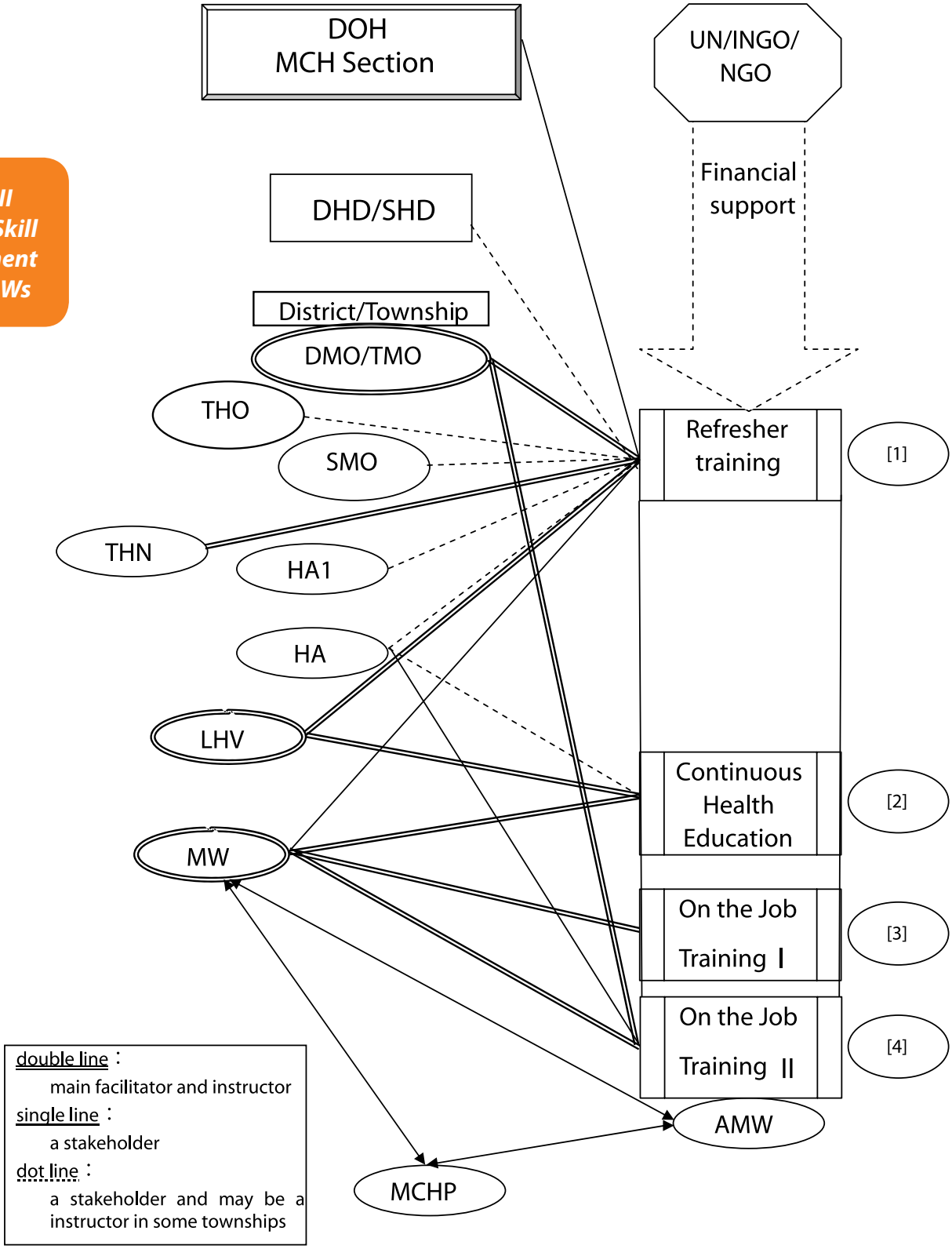
(4) Recommendations through the Project Implementation

(i) **Strengthening of capacity building for supervision of AMW** should be promoted simultaneously with continuous education of AMW. Improvement of leadership and management skill by SBA, especially for MW will be the key factor for the successful continuing education for AMW (See the pages for "Leadership and Management Training" under Chapter III "MCH Promoters System", page III – 1).

(ii) **Ensuring implementation cost** would be one of the key elements of fulfillment of the framework for improving midwifery skills for AMW.

(iii) **Competency-based refresher training** should be conducted along the same lines as securing the training opportunities for AMW. Evaluation of the training should be conducted, at least using prepared pre-post test in the AMW refresher training manual.

Chart 2-1 Diagram of Continuing Midwifery training for AMWs



Manual for On-the-Job Training for AMW

Objective:
To help community-based maternity service providers to better care for the reproductive health of women and their newborn

Specific objectives:
1. Understand importance of ANC and practice ANC by themselves in the community
2. Manage normal childbirth and recognize danger signs during intrapartum period
3. Understand importance of PNC and practice PNC themselves in the community
4. Understand importance of newborn care and practice it by themselves in the community

Type of training: on the job training
Facilitator: experienced LHV and midwife
Supervisor: experienced HA
Duration: 2-3 months

Steps of the training

Step1: Share the training goal between facilitator and trainee.

↓

Step2: Shadowing (trainee spend a few days following, or "shadowing," facilitator as they go about their regular work).

↓

Step3: Attend ANC, intarapartum care and postnatal care under the supervision of facilitator. Count number of cases that AMW conducted and evaluate AMW's performances. Hold mini-conference with facilitator weekly at least, and interview with supervisor monthly.

↓

Step4: Set up opportunities for trainee to report the result of their training.

↓

Step5: Give AMW the certificate.