M-CCM Oversight Field Visit 7-8 October 2011

Introduction:

According to the M-CCM Oversight plan, the first oversight field visit was conducted between 07-08 October 2011 in Yangon and Mon State. The selection of site was carried out in consultation with the GF round 9 Principal recipients (PRs) and the Ministry of Health, with consideration for accessibility, number of projects for three diseases and managed by different PRs. Members of the mission were selected according to consensus from the M-CCM constituencies. The ToRs of the oversight visit and mission member list are attached as Annex 1. The visit covered nine sites in Yangon, Mawlamyine and Mudon townships in Mon State, with detailed programme in Annex 2.

Summary of findings:

The oversight mission did not identify any major risk of fraud in all sites visited; however, the mission members raised attention to the following issues:

- The filing system is not consistent and not always in good order. It is suggested to have a standard operational manual, and improved thorough and continued training with such a manual, to guide the SRs in filing and sorting of attachments.
- Some storage for pharmaceuticals does not have needed air-conditioning, thus putting the temperature-sensitive drugs and test kits in risk. In many cases, the batch numbers are not properly recorded. It is suggested to have proper review of all the storage condition and quality of the stock card.
- The current fund flow mechanism and procedures in practice, particularly for government implementers, contain some deficiencies from both sides. The form and attachments were not always reaching the required standards, and the procedures can be a bit complex, with limited operational advance that each FFA can hold. It is suggested to speed up the process of finalizing the pending reimbursement request and start training of the new FFM procedures by PR-UNOPS. It was learnt from PR-UNOPS that bilingual and more simpler forms are now developed and the operational advance for FFA has been increased in the new FFM.
- The gaps for the delayed pharmaceuticals (i.e. ART) are now filled by 3DF and other partners, but concern raised when 3DF will eventually wrap up their programme in the future. The delayed procurement of Insecticide-KO tablets for net treatment has already been identified by implementers as a factor delays implementation. Suggest to look into the improved arrangement of PR-UNOPS in procurement and to avoid any potential stock outs.

In terms of lessons learnt in organizing the M-CCM Oversight visit:

- Involving PR and National Programme Managers is a good practice and shall be continued
- The preparation of the visit need improvement: There could be a brief profile prepared by PR for the relevant SR in the site visit, so that mission member can quickly focus on specific questions, based on the information regarding targets, performance record, etc. The current checklist need to be revised based on the lessons learnt from this first oversight visit, for use of the next one.

Yangon part

1) Rattana Metta Organization HIV/AIDS Programme (SSR of SR Alliance, ART, OI, Care and support, income generation)

RMO was formed in 2004 initiated by 9 Buddhist organizations. In 2005, RMO applied for formal registration with MoHA and in 2010 formal registration was granted. RMO provides humanitarian assistance as follow: (i) HIV/AIDS Programme; (ii) CP/CRC and OVC Programme and (iii) Livelihood Programme. RMO represents CSOs at the Myanmar Country Coordinating Mechanism for the Global Fund.

RMO ART programme is carried out with the support of three sources of funding: 3DF, local donor, and GF Rd 9 (through SR HIV/AIDS Alliance). The care and support programme comprises OI, HBC, counseling and income generation. For GF Round 9, RMO provides ARV treatment to 48 clients as well as comprehensive care: food support, hospitalization support and referral services.

Some challenges at the beginning of the implementation period include delayed procurement of drugs which resulted in need to arrange for loans from other organizations. The procurement is delayed until present. In the upcoming years, the plan is to shift the 3DF targets to GF R9 (450 patients receiving ART and 800 patients receiving OI treatment).

<u>Programme targets achieved:</u>

- BCC and ART targets

At the moment, 470 patients are receiving treatment at 2 clinics (Lower Pazudaung Road and Tarmwe clinic). 25 new patients are received each quarter. Of these, in 2012, 450 will be shifted to GF R9.

- All targets were achieved; however, some only at 85% such as HBC resulting from delay in fund disbursement, plus 2 months to train personnel and set up programme.

<u>M&E and Reporting:</u>

RMO follows record keeping and data collection structure set up since 3DF project. All activities (counseling and treatment) have records. The visit team reviewed the peer outreach workers records, procurement records, and inventory records in the data store room. RMO does not use a database to record treatment cases. NAP suggested that they can share a database which is currently being developed with WHO.

RMO follows an M&E framework with each staff having responsibility to keep record of their activities. RMO has a variety of M&E activities including (i) donor and funding agency M&E; (ii) organizational M&E committee; (iii) project monitoring system; and (iv) qualitative review meetings. RMO's SR, Alliance, helps out as well. RMO and Alliance have a partnership agreement and Alliance provides technical support on M&E.

RMO keeps 6 month buffer of ARVs.

RMO's suggestions to M-CCM

- Goods from international procurement were not received upto the time of the visit, but on loan from other organizations.
- RMO has received visits from SR and PR to set up programme and also from SR to provide technical support to RMO (this is very useful and should be maintained); However, RMO has not yet received any formal feedback from PR after their visit; More meetings between RMO and SR would be welcome, and RMO would appreciated more technical support from PR and SR (need to sustain frequency of meetings);
- Need more medicines (currently there are only 18 drugs under the MoH guidelines and patients need more to deal with ART side-effects). RMO requests revision of the ARV treatment guidelines to reflect the current need of patients to deal with side effects;
- RMO has difficulty accessing e-mail, therefore communication should be faxed as well to ensure proper receipt.
- There seems to be some confusion regarding the exact targets for ART by year, as SR Alliance maybe in a better position to distribute treatment case load among SSRs.

2) AFXB PLHIV Care and Support (HIV care and support, income generation, SR)

AFXB provides care and support for PLHIV. The programme offers new clients with psychosocial support, risk assessment and treatment. It provides information and support programmes to clients through a "Sunday Empowerment Group". Clients receive information, referrals for STI/TB services, internal clinic care for OI, counseling which covers general counseling, pre-and post-testing counseling, ART adherence, CD4 monitoring. AFXB also provides community home-based care including home visits by core SEG members. In addition, AFXB also addresses issues of OVC, child protection, youth, livelihood security, and human trafficking and income generation in order to ensure sustainability of ART provision. The income generation programme enables HIV positive clients to make handicrafts for sale. AFXB provides a showroom for selling products. AFXB also partners with private sector to raise funds and seek contributions for support to the programme. For Round 9, AFXB is managing budget of US$230,000 per year; however, in 2011 the budget is US$ 1.8 million.

Programme achievements for Round 9:

- Target for ART provision is 500 patients on ART. Already have 250 from 3DF funding. At the moment, 333 are on waiting list for ART.
- For HBC, planned to reach 150 people (headcount) per quarter. Now reaching more than 200, up to 250. The people targeted in the HBC programme include those living with HIV as well as family members.

Challenges to programme implementation:

- Kyat-US$ exchange rate: in 2008 the rate was 1200 Kyat per 1 US$; now it is 700 Kyat. This makes it difficult to carry out the activities as planned.
- However, programme achievements are satisfactory, sometimes AFXB even overshoot the targets.

Procurement and other project implementation rules and regulations

- AFXB does not do any procurement, UNOPS covers all the procurement.
- Storage of medicine follows guidelines of AFXB and NAP (with two locks for the drug storage cabinet, kept by two staff members separately)
- There is 1 quarter buffer from ART.
- AFXB follows a project implementation manual, developed for project implementation in particular.
- M&E system is firmly in place (3 levels M&E system)
- Re-programme needs has been addressed by PR to cover the cost of peer educator programmes. AFXB have already appointed 7 PLHIV as peer educators and would like to expand the programme.

3) Mingalardon Specialist Hospital (HIV-ART)

The hospital provides ART programme and care for PLHIV. The adult ART programme started in June 2005 and the pediatric ART programme started in June 2006. Treatment follows the “National Treatment Guidelines for HIV patients” published in 2003 and revised in 2011 (based on WHO guidelines). The new guidelines allows initiation of ART in adults whose CD4 count is less than 350; WHO clinical stage 3 or 4 (irrespective of CD4 counts); all TB cases with CD4 below 500 and all HBV co-infected persons if HBV requires treatment.

Targets as at end of August 2011	No. of Patients
No. receiving ART	2,843
No. adults receiving ART	2,564
No. children receiving ART	279
No. of adults on 2nd line ART	36
No. of deaths	375
No. of loss to follow-up	177
No. of pregnant women on ART	24

Overall, there are more than 2,800 patients receiving ART and less than 5% are lost to follow-up. There are 24 pregnant women receiving ART. Mingalardon Hospital is reaching its targets for Round 9. For Year 2, the target is 4,000 patients on ART.

Storage systems for medicines and financial management systems are in place. A CD4 machine has been procured and is in use, however, the proper maintenance of such a machine need special attention.

The hospital does not hold budget from GF Round 9 grant; the system of payment is carried out through direct disbursement by PR or investigation re-imbursement arrangement, with NAP Yangon get direct involvement in reporting. Mingalardon has three recent investigation re-imbursement request ranged from 1.5 to 2.7 million Kyats, with some delays for re-imbursement to come through. NAP is requesting budget statement from PR and to explore the possibility of reprogramming the "saved" fund to cover the costs of CD4 testing before initiation of ART.

Mon State Part

1) Meeting at the State Health Department

A briefing meeting was organized by the State Health Director, during which, three Medical Officers for Malaria, TB, HIV/AIDS programs and MMA provided updates.

The Malaria Medical Officer made a presentation on the key activities under different funding such as 3 DF, Global Fund and UNICEF, their collaboration with different INGOs, UN agencies and NGOs. The key problems in implementing the Global Fund are tight timeline for implementation due to delayed fund transfer, communication difficulties, complicated forms to fill and vacancies of the some positions that are yet to be recruited. Frequent changing of the workplan, delay in disbursement/re-imbursement and low daily allowance rate and TA rate also post as challenges in program implementation.

The TB Medical Officer presented the collaborative activities with different key players in various townships. He mentioned that case detection rate in Mon Sate is better than other States and Divisions. For a particular activity related to World TB Day, there is delay in disbursement and only two townships out of ten townships got reimbursement at the time of the visit. In some townships transportation costs since April 2011 are yet to be reimbursed. There are similar problems and difficulties to the Malaria program.
It was informed by UNOPS after the visit that most of the claims in the state have been cleared after receiving proper documentation.

The STD team leader made a short presentation on the activities, achievement and challenges of the HIV/AIDS activities in Mon State. There are 6 townships in Mon State which have HIV/AIDS activities led by the National AIDS Program. Mawlamyaing township has the most activities such as TB/HIV co infection activities, PMCT, ART and home based care funded by the Global Fund. Among the townships, Ye township has the highest rate of HIV testing among pregnant mothers (90%). It also has the highest percentage for getting the test result (99.7%) and highest HIV positive percentage (0.95%). 14 children and 89 adults are getting ART and there are about 80 people on the waiting list. Positive people have regular meetings with the support of the Global Fund.

The presentations were followed by questions and answer session and recommendations were made. The key issues discussed are:

- Reporting system and collaboration among different key players

On the question about collaboration and reporting by the different partners on three diseases, the State Health Director mentioned that there is a very good collaboration among different partners who have regular coordination meetings and they have good reporting system. It was also discussed by the monitoring team that private partners such as GPs should also be in the meeting and they should also report to the national programs. It was suggested having clear reporting formats which are to be shared and explained during the coordination meetings to the partners.

- Long waiting list for ART

Upon the question on the long ART waiting list and the potential solution, it was proposed that stronger collaboration with different players in other areas can improve the condition. The partners also started practicing referral systems to other townships where they have more ART service providers. It is expected that this problem can be solved by scaling up ART service through Global Fund grant in near future. It was also mentioned that there are altogether about 500 PLHIV on waiting list in the whole Mon State. For the time being, priority is given to those who have low CD 4 count.

- Slow reimbursement

The group discussed on the reasons for slow reimbursement and identified the possible solutions to solve the problem. One of the reasons was the complicated claim forms. Some responsible persons at the regional level and even some FFAs are not familiar with the requirement and procedures. Delay in reporting also came up as one of the causes of delay disbursement. UNOPS PR suggested providing pending list to them and it is promised to be solved as soon as possible.

- General advice and the suggestions

Dr. Saw Lwin gave advices and suggestions to all the programs to have better records, filing system, tracking system and reporting so that it can be easily tracked to know who the beneficiaries are (i.e. the number of trainees covered, rather than townships covered), how many items have been distributed, to whom, etc. The team also mentioned having better collaboration so that different partners can avoid duplication and compliment each other.

- Sub-depot

It was raised that as there is no Sub-Depot in Mawlamyaing, partners need to travel to Yangon for test kits, etc, and hoping to have one in town. NAP manager suggested that the Sub-Depot in Pha-An, Kayin State, should also cover Mon State.

<u>Hnee Pa Daw RHC (malaria LLINs, case management, training of volunteer)</u>

Rubber plantation is the main business for the area, which is linked with Malaria transmission. Because of the mass media activities, malaria case management and distribution of LLINs, malaria cases are decreasing and in the last three years, there has been no mortality. However, migrant community still facing malaria problem.

- Future activity to treat bed nets with insecticide.

The activity will be carried out soon once the insecticide tablets arrive. It was advised by the mission that the activity will be more effective for the activity to be carried out before May, when the peak malaria season starts (through out June and July).

- Testing for Malaria

Concerning who should be tested for malaria, the midwife from the center responded that those who have signs and symptoms of malaria are asked to get malaria test. Dr. Saw Lwin commented that in future to perform testing for everyone who has symptoms such as headache, fever and flu like symptoms. It was also advised to think about

performing blood test and provide treatment to migrant workers who are about to go back to their origins.

- Local vs migrants

Health care providers also observed that migrant workers and their family members are more prone to get malaria than local communities. Thus, it was advised to ensure migrant community also got bed nets and access to other malaria services.

- Drug resistant malaria

The mission members checked whether the basic health staff and volunteers can give malaria treatment correctly. The staff in the center was advised to perform microscopic blood test on the third day of the treatment for some cases to know the condition of drug resistant malaria, as requested by the protocol which is followed in selected sites for drug resistance studies.

- Volunteers

Four trained volunteers were interviewed to check their level of knowledge and roles in malaria control activities. Volunteers demonstrated their skills on testing and treatment. It was advised to have on-the-job training and to have the written treatment protocol on the wall of their house since they hardly see malaria patients in past few months.

- Medicine storage and logistic management

The team checked how the health center manages the stock and did the pill count, which confirmed the stock matches the record. Volunteers also confirmed that they update and change fresher drugs from other service providers to avoid drug expiry in their hands without being used.

- Documentation

The team checked the records, filing system, tracking system and reports at the center. Dr. Saw Lwin pointed out weak points and provided guidance for improving recording and reporting. LLINs were distributed to the local family as well as to the migrant community. Each family got two mosquito nets. It was also checked whether the family members use the nets. Beneficiaries appreciate the bed nets and believed that they have less malaria cases because of the nets. However they think the height of the nets are low and wish to have higher ones.

<u>Mudon township hospital (HIV, VCCT, PMCT)</u>

The Township medical officer presented township health profile and activities of the three diseases. He referred to challenges of stock out of HIV test kits in the past but the issue has been resolved. In the following discussion, the following issues were discussed

- VCCT services for pregnant mothers during ante-natal care

Mission members stressed the importance of strengthening counseling survives during ante-natal care since about 50% of pregnant women did not get HIV testing. This has been the missed opportunities. Since the test result can be given back on the same day and ante-natal coverage is already good in Mon State, additional effort on counseling service will definitely increase the number of pregnant women who got testes.

- Male involvement

In response to a question whether spouses also get HIV testing when their pregnant wife get the testing, the TMO responded that the rate of husbands who got HIV test is low because of many reasons such as husbands usually are migrant workers working in Thailand, pregnant women themselves are migrant workers or accompanies of their migrant husbands but come back only when it is time for delivery. However it was agreed that strengthening counseling service will increase male involvement.

- Cross referral with Mawlamyaing

UNOPS PR explored and confirmed existence of cross referral between Mudon and Mawlamyaing.

- PCR test for babies and treatment

It was mentioned that babies of the HIV positive mothers can get PCR test in Yangon and transportation fee is provided by the Global Fund Grant. Children tested positive are also getting pediatric ART treatment.

- Involvement of PLHIV

PLHIV representative of the mission mentioned that there are strong self help groups in Mudon and Mawlamyaing who received a series of training and they are willing to volunteer for peer counselling, ART counseling and to provide other support. Suggestions were made to strengthen the participation of PLHIV.

The team checked the medical store, documentations, tracking systems, filing system, reports, pill counted and found no major problem.

TB program Mon State

The health staff explained the TB activities such as cases finding, sputum examination and Chest X Ray for patients who fall into two categories direct and referred. The number of direct patients is more than the number of referred patients. It was mentioned that the team has to take care of both Kayin State and Mon State. Following were the key discussion points

- Coordination and collaboration

The activities are carried out with linkages between key partners. There are regular monthly meetings and the key issues discuss in such meetings include referral, registered cases and “defaulters”.

- Workload

The mission explored the workload at different level and found that the workload is manageable given the current human resources level which includes volunteers. Volunteers are assigned to cases and they help other volunteers’ cases as well and share the workload.

- Free service

TB patients under the Global Fund project are getting free services.

- Drug Storage

The medical store for TB drugs is spacious. The possibility of sharing the medical store with other programs was positively discussed. Some of the medicine are about to expire and suggestion was made to use them first, or return to Sub-depot i(close to three month before expire date). The batch number was missing in some of the shelf card.

- Reports and records

Reports and records were checked. It was found that the system of registration and keeping the records of the patients is good.

- Rules of withdraw of funds by FFA allows only from the banks in the township where the event is held

It was particularly mentioned that this rule may cause problems in the case when events were held (or closed) in two nearby township on the same day, the FFA was not able to carry out direct disbursement because the limited business hour of the local banks (i.e. 10am-2pm). Suggest to allow cash withdraw from banks in neighborhood township to allow more efficient operation of direct disbursement.

Minn Ywar village (IOM SR, HIV, TB and Malaria)

IOM staff, village health committee members from four villages and basic health staff briefed the mission. Key activities discussed were

- Collaboration with different partners and roles of community people

It was mentioned that the roles of the community is more on supervision and controlling the finance and the volunteers take responsibilities for health talks, case finding and referral. Save the Children PR encouraged stronger collaboration to get the maximum impact.

- Malaria case management

Upon the information that suspected malaria cases were sent to the town for investigation and treatment, Dr Saw Lwin commented that since basic health staff in the village also have the test facilities and medicines, it is better for the patients to get treatment from the basic health staff by strengthening collaboration within the village rather than being referred to town. It was also stressed to pay more attention to the migrant communities and to find ways to perform blood test and proper treatment before they go back to their place of origin.

- HIV testing

Mission member raised the question on implementing partners' plan to increase HIV testing. The volunteers mentioned to increase health talk to get more people tested for HIV. It is also effective for further reducing stigma and discrimination in the community. It was found out that there are not much problems to talk about sexuality and condom usages in the village. Both local community and migrant community are comfortable to participate in health talks and discuss about sexuality and condom usage. The villagers also shared their experience with exhibition booths and believe such activities can reduce stigma and discrimination as well as increase HIV testing.

- Malaria and rubber plantation

UNOPS PR pointed out there is no malaria data from Kywe Chan Kone village although they have cases on HIV and TB. The villagers responded it is because the village does not have rubber plantation which has strong linkage with malaria transmissions because rubber collectors need to be in the field during the peak time of mosquito bites. It was suggested finding better ways to prevent malaria among rubber collectors.

Zar Ni Bwar Clinic (Through SR-MMA, malaria case management)

Zar Ni Bwar Clinic is a private clinic/hospital run by a local doctor who is a member of MMA. Through the clinic, MMA's malaria activities are carried out. MMA works with GPs in Mon State and representatives from MMA monitor the activities of the member GPs monthly. The following were the key issues discussed:

- Consultation fees

It was mentioned that consultation fee for malaria cases under the project is free. They only charge a nominal fee of 500MMK for ACT and 200MMK for RDT. S informed by UNOPS: 50% of this is paid back to MMA as revolving fund for grant activities.

- Reporting

The mission explored the procedure and system of reporting to donors, National Malaria Program and MMA. There is established system for reporting and the system tried avoid double counting and reporting. The mission also checked the reporting formats and gave suggestions on the weak areas such as to have a separate column to record mixed infection.

- Patients background

Further discussion on the background of the patients, the MMA representatives mentioned that most of the cases are from Myawaddi the border town with Thailand. Among the adult patients they observed more male than female but among under five children they observed more girls than boys among malaria patients, reasons of which unknown.

- Types of Primaquene tablets

Comparing 7.5 mg and 15 mg tablets, both have advantages and disadvantages. 15 mg tablets are much cheaper but have to be divided into two for children. It was advised to buy according to the demand. Since 85% of the malaria patients are adult, it is to consider having 20% of 7.5 mg tablets and 80% of 15 mg tablets.

- HIV testing and counseling

The clinic has facilities for HIV testing for referral cases but does not provide counseling service.

Annex 1

Objective of the M-CCM Oversight field visit

As part of the M-CCM oversight function, the oversight visit aims to provide an opportunity for CCM members to directly observe the SRs/SSRs' work in a real case scenario, and get an understading of their achievement, challenges, suggestions and to identify any signs of "risks" to prevent fraud, possible conflict of interests and other misconducts, in areas which has been documented in common lessons learnt of the Global Fund Office of Inspector General.

Terms of Reference of Site Visit Team Members

1) Participate in site visit organized by the M-CCM secretariat;
2) Together with other Oversight Visit Team members, obtain information about grant implementation (program management; financial management; procurement, achieveemnts of program targets; constraints and recommendations for resolving issues);
3) Prepare visit reports including completing the standard questionnaire and report form;
4) Submit the final report of the site visit to the M-CCM (may also require making presentation at the M-CCM meeting on the site visit).

1st Site Visit Team Members

CCM Members / Alternate	Yangon	Mon State
Dr Saw Lwin (Gov)	X	X
Dr Soe Lwin Nyei (Gov)	X	X
Dr Julia Kemp (Donor)	X	
Mr John Hetherington (INGO)	X	
Prof Samuel Kyaw Hla (LNGO)	X	X

U Kyaw Zayya (PLWH)	X	X
Dr Sun Gang (UN)	X	X
NPMs		
Dr Khin Ohnmar San (AIDS)	X	X
Dr Thandar Lwin (TB)	X	X
Dr Kyi Lwin (Malaria)		X
PRs		
Dr Faisal Mansoor	X	X
Dr Esther Sedano	X	X
UNAIDS		
Ms Tina Boonto	X	
Dr Soe Naing		X

Annex 2

Programme of M-CCM Oversight Visit
(7th – 8th October 2011)

Friday, 7 October 2011 (Yangon)

8:30	Start from Traders Hotel
8:45 – 09:45	Visit Ratana Metta, 406, Pazuntaung Lower Street
	SSR – Ratana Metta, HIV (ART, care and support)
10:15 – 11:15	Visit Kha Paung Street Clinic in Hlaing Township
	SR – AFXB, HIV (OI, ART dispensing, care and support)
11:45 – 13:00	Visit Mingalardon Hospital in Mingalardon Township
	SR – NAP, HIV (ART)
14:30 – 19:00	Travel to Mawlamyaing

Saturday, 8 October 2011 (Mawlamyaing/Mudon)

08:00 – 09:00	Courtesy call visit to State Health Department
	SR – Brief presentation from State Health Director, ATM & MMA
09:00 – 11:00	Visit Nhee-Pa-Daw RHC in Mudon Township
	SR – NMCP, Malaria (Case-Management, Insecticide treated nets (ITNs), LLINs Distribution, VHW Trainings)
11:00 – 12:00	Visit Township Hospital in Mudon Township
	SR – NAP, HIV (PMTCT)
12:00 - 13:30	Lunch at Mawlamyaing Township
13:30 – 15:00	Visit Min Ywar Village in Mawlamyaing Township
	SR – IOM; HIV, TB, & Malaria (prevention, community case

	management)
15:30 – 16:30	Visit Zarni-Bwar Clinic in Mawlamyaing Township
	SR – MMA, Malaria (Case-Management)
17:00	Arrive back at the hotel

Annex 3

Key informants met during the visit

U Myint Swe, RMO
U Nyi Nyi Aung, RMO
Daw Kathy Shein, AFXB
Dr. Soe Tun Aung, Medical Superintendent, Mingalardon Hospital
Dr Tin Aung Soe, Treatment expert, Mingalardon Hospital
Dr. Aye Nyein, Mon State Health Director
Dr. Sethu Ye Naung, Mon State Malaria Medical Officer
Dr. Win Naing, Mon State TB Medical Officer
Dr. Thant Zin Min, Mon State STD team leader
U Zayut, Nhee-Pa-Daw RHC, Mudon Township
U Aye Htut, Project Manager, IOM, Min Ywar Village project
Dr U Khin Kyi, Zarni-Pwar Clinic