Internal Appraisal 2014

Myanmar

1. Brief Description of Process

This Internal Appraisal was conducted through the review of the APR and other relevant documents by the technical reviewer in consultation with the country responsible officer (CRO). It was further revised based on responses from the country to questions about the APR. It was then circulated within the GAVI Secretariat and to partners for comments.

The Appraisal covers the final HSS disbursement of the 2011-15 Grant – US$ 14,124,749 to cover remaining activities for 2015. It also covers renewal of Pentavalent vaccine for US$ 8,342,000.

2. Achievements and Constraints

Myanmar's EPI programme has reached high coverage with traditional vaccines via routine immunization, and has succeeded in maintaining DTP3 coverage at > 80 % since 2007. Maternal and neonatal tetanus were eliminated in 2010 and there has been no wild polio virus reported since 2007. There are no gender coverage discrepancies.

The programme faces the persistent challenge of limited access to conflict areas which hampers its ability to improve coverage rates further. DTP3 coverage, which was trending slightly downwards, from 90% in 2009 to 85% in 2012, fell to 73% in 2013, mainly due to DTP1/DTP3 dropout rate increasing from 3% to 17%.

The increase in dropout rate is multifactorial. EPI services were not functional in many areas of Rakhine State due to ethnic tensions there. Some border areas of Kachin, Shan and Kayin States remain inaccessible due to conflict. Further, the national political reform process has been associated with significant population displacements to urban areas resulting in large numbers of children being lost to routine EPI. An increase in the health budget from multiple sources led to a sudden increase of uncoordinated health related activities causing health workers (HW) at village level to miss EPI training sessions. Frequent health staff transfer has also affected EPI coverage, and some health workers were not clear on the switch over plans from DTP to Penta, resulting in some children missing DTP second and third dose.

Some of these factors, such as access to conflict areas and a trend of increasing population displacements may worsen in coming years, and are in any case beyond the remit of the MoH to address. Disorganized health related activities are a consequence of an influx of a new and diverse set of development partners and a flood of money. The MoH is now managing US$ 1000 million in international assistance over the next 5 years, and the Minister of Health has been vocal about the need for coordination among partners and reducing overlap of resources. Myanmar signed IHP+ in 2014.

The GAVI HSS programme began by intervening in 20 townships (districts), which was too small scale to contribute to EPI achievements nationally. Myanmar has 330 townships. Additionally, the HSS budget is spread uniformly over the 4 years of the grant, whereas the activities are not – they require more funds in the second half of the implementation period. To afford this level of scale-up the country has had to re-programme other activities. Recent independent mid-term evaluation after two full years of implementation showed promising results in the 20 initial townships however. (please refer to HSS Section 8 below). The programme will expand to 180 townships in 2014-15.

3. Governance

There is a National Health Steering Committee (NHSC) as well as an ICC. The NHSC meets quarterly and is chaired by the Director General of the Department of Health with broad membership (over 30 members) drawn from MOH, development partners and CSOs such as

Myanmar Red Cross and the Myanmar Maternal and Child Welfare Society. States are not represented. ICC membership is smaller, mainly MoH, WHO and UNICEF.

The re-programming of HSS activities were approved at the 6th NHSC in March 2014. The 7th NHSC on 7th May 2014 discussed the 2013 APR and endorsed it prior submission to GAVI. It also provided an update of the HSS infrastructure component and construction plan. A few days later on the 12th May 2014, an ICC meeting took place in which EPI achievements in 2013 were discussed, progress with new vaccine applications for PCV and MR campaign updated, cold chain analysed and the APR endorsed. So the APR was approved by both NHSC and ICC.

Minutes show that participants understand the issues, although discussion is not in depth and there is not much feedback. Conclusions and actions are clearly stated however, and cooperation is good between partners and the MoH.

4. Programme Management

The cMYP 2012-2016 was reviewed in 2013 to reflect policy changes for elimination of Measles and Rubella and control of congenital rubella syndrome. The cMYP changes are fully costed, and the new budget including shared costs and financing for EPI activities is US$ 220 million. The principal cost driver, at almost 50%, is vaccine supply and logistics. The cMYP is a comprehensive document that includes current trends and builds on past performance and immunisation challenges.

The APR provides information on baselines, current performance and future activities. . Activities are generally implemented to schedule and budget with often 100% execution during the planned year. The one HSS area where there was a substantial delay is the construction of 30 health centers, which has been subcontracted to the Myanmar Red Cross Society (MRCS). An FMA of MRCS was required, and the tripartite Grant Agreement between GAVI, MoH and MRCS took time to negotiate. The first tranche of US$ 682,000 was finally sent in early June.

5. Programme Delivery

The 2011 EVM improvement plan set out a number of activities to be undertaken together with ranked priorities. Most of the activities have been or are in the process of completion.

The current HSS programme, which ends in 2015, had very limited cold chain inputs. The ICC has strongly recommended that the new HSS application (US$ 100 million has been allocated for 2016-20) should focus on addressing health system barriers to immunization. This is particularly relevant since Myanmar is planning to introduce new vaccines such as Rubella and IPV in 2015, PCV in 2016, (and Rota, JE, and HPV in the longer term), as well as conducting an MR campaign in late 2014.

There is currently sufficient cold chain capacity for the MR campaign and IPV introduction, but not for PCV, for which the February 2014 IRC has requested a comprehensive cold chain assessment as well as a replacement and expansion plan. Both WHO and UNICEF recently hired cold chain and logistics experts to work on this.

The 2012 dual Penta/MSD introduction proceeded smoothly, and benefited EPI by reducing DTP wastage rate by 20% to 15% (open multi-dose vial policy), reformulating the cMYP, and strengthening the FDA for fast track licensing. Myanmar also achieved the target of no stock outs of essential supplies in the last 6 months in all of the Regional Health Centers in the GAVI investment area (achievement 344 with a target of 344).

The APR shows an overstocking of measles vaccines which according to data from ICC meetings, could last 15 months from May 2014 when it was reported.

6. Data Quality

There is a longstanding population data problem in Myanmar, and all stakeholders have concerns about population data quality. Health information systems are weak, no census has been

conducted for 30 years. Population estimates, or speculation, ranges from 48 to 60 million. All EPI figures are based on estimates given by the government, which can only be validated once the country completes the Nationwide General Census begun this year. Hopefully target setting will be easier after results are published.

There is an effort however by EPI to validate their annual figures through health workers counting children less than one year in their catchment areas on an annual basis, which results in lower figures than the official estimates. The head count is also limited though, as health workers are not able to include areas not accessed by the EPI such as conflict and other hard to reach areas. The last EPI survey was in 2009 and covered cohort of 2008. The country has no discrepancy between admin data and WUENIC, but has low (1 star) grade of confidence (GoC) on DTP3 WUENIC estimates in 2012.

A DHS is planned in 2014/15 with USAID support, and a coverage survey will follow the MR SIA in late 2014. The MOH recognises that the Data Unit at national level needs to be strengthened. It is also planning to support townships with computers and data entry software to minimize entry errors, and there is a plan to collect monthly immunization and disease surveillance data from the private sector in Yangon and Mandalay.

7. Global Polio Eradication Initiative, if relevant

The last case of wild polio virus was reported in Myanmar in 2007.

8. Health System Strengthening

The programme began in 20 townships in 2011-2012 and will eventually expand to 180 by 2015, to cover half of the country. Townships were selected using a combination of criteria: DTP3 coverage below 80%, SBA below 60% and hard to reach/remoteness. Focus was on both immunization services and broad MCH intervention delivered by auxiliary midwives and community health workers. Aims were to accelerate DTP coverage for children (under 12 months old) from 70% to 90% at a national level, and increase the assistance of Skilled Birth Attendants (SBA). There was also demand side financing through an MCH voucher scheme and a Hospital Equity Fund targeting the township poor, also focusing on MCH services.

The activities under the HSS grant are well documented and on budget. There are impact and output indicators by objective and explanations when targets are not achieved. Initial execution rate was slow due to the establishment of a new delivery system agreeable to the country but is now gathering pace. The burn rate was 31% in Y1, 18% in Y2, 60% in Y3 and 25% in Q1 of this year. The programme is expanding geographically from 60 townships in 2013 to 180 in 2015, which warrants the final disbursement as requested by Myanmar (US$ 14,124,749). Given the recent drop in DTP3 coverage, GAVI will request the country to focus on immunization coverage and equity improvement in the last year of the grant, as well as on strengthening the immunisation component of the MCH voucher scheme. An end of grant evaluation is budgeted for late 2015.

Recent independent mid-term evaluation after two full years of implementation showed promising results: in the target townships, the outreach services contributed to increased coverage of key indicators such as ANC, TT2, SBA, DTP3 and BCG. GAVI's HSS model is beginning to be emulated as best practice by other newly-arrived development partners.

WHO and UNICEF are the recipients of HSS grant funds, though all HSS GAVI funds are included in the National Health Sector Budget. The bulk of the HSS is managed by the MOH with technical support from WHO, which received US$ 6,844,749 in 2013. This was spent on management and administration, provision of technical assistance including cross cutting support in capacity building, research, planning and monitoring and evaluation together with recruitment of technical staff and international consultants.

The country points out that one of the challenges of implementation has been working through WHO given delays in disbursement and complex financial and management processes. The MOH is requested to submit a proposal for each of the activities to be implemented. WHO

incorporates those in their detailed work plans after which it conducts a technical proposal review before processing the transfer of funds.

The Myanmar Maternal and Child Welfare Association and the Myanmar Red Cross Society (MRCS) are the two civil society organisations involved in the implementation of this HSS grant. MRCS is subcontracted for the infrastructure building component, and will build 30 health centers in remote areas. Other CSOs involved include the Myanmar Women's Affairs Federation, (which facilitates community mobilization to access a package of EPI, MCH and nutrition services), the Myanmar Medical Association and local NGOs who participate in quarterly review meetings held at district level.

Next GAVI HSS Grant

The next grant, covering 2016-20, will have a ceiling of US$ 100 million, of which US$ 84 million may be budgeted initially and the remainder will be for performance based payment. Given the grant's large size, and the need to align agencies according to IHP+ principles, the Minister of Health has recently agreed to postpone submission of the grant proposal from September 2014 to January 2015, to allow time to develop a strong and inclusive proposal.

GAVI Secretariat has suggested to the Minister that a multi-partner Workshop be conducted with Alliance and other donors (World Bank, 3MDG Fund, Global Fund) in Yangon in Q3, to discuss the scope of the GAVI HSS grant, in the context of other sources of funding, and start proposal development. The Minister is also aware of GAVI's potential interest in collaborating with the World Bank's Results Based Financing (RBF) programme.

9. Use of non-HSS Cash Grants from GAVI

Myanmar expected an ISS award for 2013 but vaccine targets have not been reached. There is no CSO grant. A vaccine introduction grant of US$ 2.4 million was received in 2012 for the joint Penta/MSD launch. No VIG was received in 2013.

10. Financial Management

Historically, all cash support has been channelled through WHO and UNICEF. At MoH request, WHO continues to manage year 3 and 4 of the HSS Grant, as the Ministry of Health has limited capacity. However the next GAVI HSS Grant for 2016-20 will need to be channelled directly through the Ministry. An FMA is scheduled for early 2015.

An FMA of the Myanmar Red Cross Society for the HSS component was carried out in June 2013 and finalized in October 2013. Its recommendations guided the construction Grant Agreement between GAVI, the MoH and MRCS. Signing of the Partnership Framework Agreement occurred in April 2014.

The MOH has made references to disbursement delays due to bureaucratic and slow disbursement process from WHO, as mentioned in Section 8 above. Expenditure of cash grants in 2013 was low (US$ 100,000 out of 2.2 million for NVS) and for ISS a similar low expenditure of US$ 375,309 in 2013 of an available US$ 1,759,812.

11. NVS Targets

Targets for both Penta and Measles for 2015 and 2016 seem appropriate for the stated number of children vaccinated with the first dose. As raised earlier, the size of population will be adjusted once the census results are available.

Penta and MCV2 were introduced in November 2012. Penta3 coverage targets remain high: 96% for 2014, 94% for 2015 and 95% for 2016. These now look ambitious given the recent drop in coverage to 73%. Reported MCV2 coverage was 76% in both 2012 and 2013. Forecasted coverage for 2014 and 2015 is 80%. This remains a reasonable target.

N.B MSD Shipments – the country postponed 2013 shipments to 2014, and 2014 shipments to 2015. It has confirmed that there is already sufficient supply in-country for 2015 needs, and is therefore not requesting approval of additional doses.

Myanmar has an ambitious vaccine introduction plan which includes an MR catch-up campaign in late 2014 followed by introduction of MR into routine immunisation in January 2015. The country has plans to apply for IPV by September 2014 aiming at reaching hard to reach and conflict areas. By the end of 2014, all recommended immunisation strategies for measles and rubella elimination will have been implemented.

Immunization Decision Support will draft the dose calculations for 2015 for all NVS programs using the approved targets (numbers of infants & wastage). The number of doses to be shipped in 2015 for the programme pentavalent is based on the approved targets (2015) as well as the reported opening stocks (Jan 2014), shipment plan (2014) and target closing stocks (2015). For all other programmes, a stock analysis is carried out to determine the right level of stock to be deducted from 2015 allocation. Syringes and safety box calculations are derived from dose calculation. This is all done in consultation with the Vaccine programme manager and (if there are any significant changes) the country, and signed off by the CRO.

12. EPI Financing and Sustainability

The government is largely reliant on external donors to finance its EPI programme and despite a secure contribution of USD 91.53 million (according to cMYP 2013) where government supports 20% of costs and GAVI 6%, the gap remains at 59% if the above funds are secured. The government investment in EPI is will remain at 20% over the 2014-2016 period. GAVI funding is not included in the health sector budget.

The country is not currently in a position to consider sustainability, as it is planned to leverage funds from new and traditional donors to be able to fund the next multi-year plan. Myanmar has however requested technical assistance for developing financial sustainability strategies and for resource mobilization for its EPI program.

Myanmar intends to tap into its manufacturing capacity for TT and Hep B vaccines to start a 'vaccine sufficient initiative' for potential self-reliance in a few traditional vaccines, using cost efficiencies for vaccine support or to co-finance other high value vaccines. This is not for the short or even medium term, but in the long term it may help make the country's EPI future sustainable.

13. Renewal Recommendations

Topic	Recommendation
NVS	Approve Pentavalent vaccine funding of US$ 8,342,000 for 2015.
HSS	Approve the final tranche of HSS funding of US$ 14,124,749 for 2015

14. Other Recommended Actions

Topic	Action Point	Responsible	Timeline
Immunization Funding	Myanmar is recommended to start progressively increasing its government funding of traditional vaccines.	EPI	2015 onwards
Population data and vaccine target adjustment	Once the 2014 census results are disseminated, population figures and targets should be adjusted accordingly.	EPI	2015