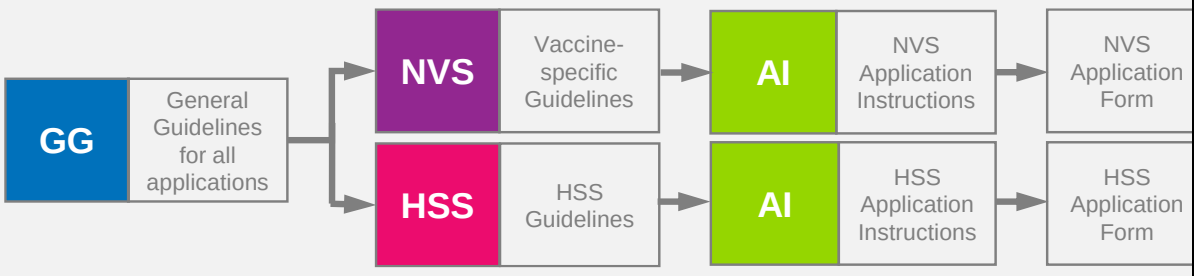
Application Form:
Health System Strengthening (HSS) Support in 2016

Deadlines for submission of application:
15 January 2016
1 May 2016
9 September 2016

Document dated: October 2015
(This document replaces all previous versions)

Application documents for 2016:

Countries applying for all types of Gavi support in 2016 are advised to refer to the following documents in the order presented below:



HSS Application Form

Purpose of this document:

This application form must be completed in order to apply for Gavi's HSS Support. Applicants are required to read the HSS Application Instructions prior to completing this application form and are advised to refer to these instructions whilst completing the application form. Applicants should first read the General Guidelines for all types of support as well as the HSS Guidelines before this document.

The application form, along with any attachments, must be submitted in English, French, Portuguese, Spanish, or Russian.

Weblinks and contact information:

All application documents are available on the Gavi Apply for Support webpage: www.gavi.org/support/apply. For any questions regarding the application guidelines please contact applications@gavi.org or your Gavi Senior Country Manager (SCM).

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PART A: SUMMARY OF SUPPORT REQUESTED AND APPLICANT INFORMATION

1. Applicant information		
Total funding requested from Gavi (US $)	**US$ 52,000,000.00**	
Does your country have a finalised and approved National Health Sector Plan?	Yes ☐	No √ ☐
	*Indicate the **end year** of the NHSP* ***Provide Mandatory Attachment #8: NHSP***	
Does your country have a finalised and approved comprehensive Multi-Year Plan (cMYP)?	Yes √ ☐	No ☐
	Indicate the end year of the cMYP *Provide **Mandatory Attachment** #**11**: cMYP*	
Proposed HSS grant start date:	**1st January 2017**	
Proposed HSS grant end date:	**31st December 2019**	
Joint appraisal planning:	**To be conducted annually between May and June, and the report to be reviewed during the High Level Review Panel (HLRP) review meeting in July.**	

2. Application development process *(Maximum 2 pages)*

Provide an overview of the collaborative and participatory application development process.

*Include the following **Mandatory Attachments: #4**: Minutes of HSCC meeting, at which the HSS application was endorsed; **#5**: Last 3 minutes of HSCC meetings; and **#15**: TOR of HSCC*

The overall proposal development process was facilitated by the Central Expanded Programme for Immunization (CEPI), Department of Public Health (DoPH), Ministry of Health (MOH) with technical support from UNICEF and WHO under technical guidance and support from ICC, which is chaired by Director General (DG), DoPH.

Myanmar interest for a new proposal development started in May 2014, when the country submitted an [1]expression of interest (EOI)' for the application of the Gavi Health System Strengthening (HSS) and Introduction of new vaccines (Rota and HPV). Initially the country was planning to submit the proposal in September 2014. However, due to delay in completing the Gavi HSS1 project, it was recommended to delay the process, and as the result the MOH requested to extend current project until end of 2016. In November 2014

[1] file:///C:/Users/Hp/Downloads/Myanamr%20%20EOI%20to%20GAVI2%20(1).PDF

[2]Gavi country mission visited Myanmar and clarified the focus of the Gavi HSS2 proposal while requesting the closure for the Gavi HSS1 by limiting scaling up to new townships and continue to focus on the current 120 Townships. In an ongoing country dialogue with Gavi, UNICEF and WHO country offices, Myanmar decided to submit the HSS2 application proposal in January 2016.

In October 2015 Myanmar Health Sector Coordination Committee (MHSCC) members were briefed on the application process and were requested to provide the necessary support. In November 2015 a consultative meetings were held with all key divisions in the DoPH Including Directors from child health, maternal health, health education, nutrition, administration and finance, procurement and supply, Central EPI, central epidemiology unit, UNICEF and WHO. Its purpose was to present the key process and highlight key bottlenecks identified by CEPI in consultation with other partners. Aside these meetings, there have been ongoing informal consultations between the – HSS1 Focal person, CEPI as well as UNICEF and WHO.

Consultants held meetings with partners including UNICEF, WHO, UNOPS/3MDG, World Bank (WB), John Snow International (JSI), Clinton Health Access Initiative (CHAI), Japanese International Cooperation Agency (JICA) and Department for International Development (DFID) in December 2015. This was followed by a two-day consultative meeting was held in Nay Pyi Taw, on 14th and 15th December 2015 attended MOH divisions and health partners. During this meeting, the Assistant Secretary, MOH, presented the result of the mid-term evaluation of Gavi HSS1 on the achievements and challenges of implementation 120 townships. In addition, The Deputy Director General (Public Health) made a presentation on Myanmar Universal Health Coverage (UHC) stressing the need to ensure that Gavi HSS2 proposal is linked with ongoing initiatives for UHC scaling-up.

All these mentioned consultative activities were carried out in a participatory approach and in collaboration with other Divisions at the MOH and other health partners such as Myanmar Red cross Society (MRCS) and Myanmar Maternal and Child Welfare Association (MMCWA). During the consultative meetings health partners shared their experience on how MNCH related interventions are implemented at community level and how they could contribute to reach hard to reach population in term of social mobilization and promotion of community participation.

During the consultative meetings, officials from Ministry of Finance, Auditor General Office and Foreign Economic Relation Department of Ministry of National Planning and Economic Development were also invited. They elaborated on procedural requirements for procurement such as import, tax exemptions and budget allocation to be submitted to president office and parliament. Also, the Ministry of Finance representative highlighted on the required processes for securing funds to support recurrent cost through the government budget. Data and information necessary for proposal developed were collected through participatory mechanisms. MOH undertook the Effective Vaccine Management (EVM) assessment followed by the development of the EVM improvement plan with participation of state/regional staff and technical support from UNICEF. Further, the country conducted the [3]health facility assessment, and the Penta vaccine post-introduction evaluation in 2014. Long and short term activities identification including selection of unreached/under-reached

[2] file:///C:/Users/Hp/Downloads/Gavi%20Followup%20Letter%20to%20Minister%20of%20Health%20Myanmar%205%20Dec%2014%20(00000002).pdf

[3] https://www.dropbox.com/s/luqkofnmoawqx68/Health%20Facility%20Assessment%20Report_publication%20version.pdf?dl=0

locations and possible strategies to deliver services were based on information obtained through SWOT analysis conducted in bi/annual EPI reviews which was initiated at township level with participation from Basic Health Staff (BHS), then at state/regional level with participation of Township Medical Officers and Township EPI focal persons and finally at central level with participation of state/regional health directors and deputy state/regional health directors together with Special Disease Control Unit (SDCU) team leaders together with UNICEF and WHO country and field offices staff.

Furthermore, a consultative discussion on the Gavi HSS proposal 2017 – 2019 was held with the State/Region Public Health Director and Special Disease Control Team Leaders from all 17 state/regions during the annual work planning process jointly coordinated by CEPI, UNICEF and WHO in December together with Health & Nutrition specialist/officers of UNICEF field offices, 3 MDGs senior staff and representatives of 3 Millennium Development Goals (3MDGs) partners who are also responsible for implementing complementary activities in support to BHS in hard to reach Townships.

There is exist the technical working group on supply chain management which is composed of official from MOH and other partners like 3 MDG Fund, Population Service International (PSI), CHAI and USAID supported Supply Chain Management System (SCMS). The task force meets bi-monthly. The Deputy Director Generals and Directors in the Department of Public health are the members of the Executive Committee (EC) of DOPH and National ICC and technical working group on supply chain management. Most of these directors participated in the consultative discussions during the proposal development.

Both UNICEF and WHO have been actively involved in providing technical assistance to CEPI, including support of existing Gavi grants, new vaccine introductions, implementation of the nationwide mass measles-rubella (MR) campaign, conducting EVM assessment, preparation of cMYP and preparation of proposals for HSS. A team comprised of CEPI staff, other DoPH officials, UNICEF, WHO and UNICEF/WHO consultants participated in the development of the proposal including facilitating technical discussions with various stakeholders Most of the important documents supporting the proposal were made possible because of the ongoing technical support from UNICEF and WHO.

A national ICC meeting was held on Monday, 11th January 2016 to present, review, discuss and endorse the proposal (*Attachments include the minutes of the meeting which endorsed the proposal, last three ICC minutes and terms of reference of the ICC*).

3. Signatures

3a. Government endorsement

*Include Minister of Health and Minister of Finance endorsement of the HSS proposal – **Mandatory Attachment #2.***

We, the undersigned, affirm that the objectives and activities of the Gavi proposal are fully aligned with the national health strategic plan (or equivalent), and that the funds for implementing all activities, including domestic funds and any needed vaccine co-financing, will be included in the annual budget of the Ministry of Health.

Minister of Health (or delegated authority)	**Minister of Finance** (or delegated authority)
Name:	Name:
Signature:	Signature:
Date:	Date:

3b. Health Sector Coordinating Committee (HSCC) endorsement

*Include HSCC official endorsement of the HSS proposal – **Mandatory Attachment #3***

Include a signature of each committee member in attendance and date.

Mandatory Attachment #3: HSCC Endorsement of HSS Proposal

We the members of the HSCC, or equivalent committee met on the _____ (date) to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes of the meeting endorsing this proposal are attached to this application.

Please list all HSCC members	**Title / Organisation**	**Name**	**Sign below to confirm:**	
			Attendance at the meeting where the proposal was endorsed	**Endorsement of the minutes where the proposal was discussed**
Chair				
Secretary				
MOH members				
Development partners				
CSO members				
WHO				
UNICEF				
Other				

4. Executive Summary *(Maximum 2 pages)*

Myanmar has made steady progress in improving health outcomes over the past three decades. Life expectancy at birth increased for both males and females increased from 55 (males 53.7 and female 56.5) in 1980 to 65.2 (males 63.5 and female 66.9) in 2011, along with an increase in the child immunization coverage and declining in infant and under-5 mortality rates and maternal mortality ratio.

DTP3 coverage has improved substantially. In 2014 there was an increase in 15% DPT3 from 2013 (CEPI Annual Reports), this achievement was due to implementation of special interventions in low performing and hard to reach Townships aiming at reaching all un-immunized children.. However there needs for reliable data sources to confirm improvements in the medium and long term given that the country is both introducing new vaccines and have a denominator issue.

Given the immunization system has not kept pace with growth and only 22% of Rural Health Centres have cold chain available; immunisation services are dependent on outreach services through midwives who have other competing priorities in MCH and use out of pocket expenses to collect vaccines from Townships. Utilisation of immunisation services has been hindered by inadequate awareness on the importance and immunisation services availability. . The limited capacity in the of the cold chain and logistics system management has also compromised routine immunisation services in some areas. Township medical officers (TMOs) have limited or no micro planning capacity and management skills and information system limitations including outdated survey data In addition, the major impediment to access and provision of routine immunisation services is the inadequate number of health facilities especially in hard to reach areas. Access is also hindered in communities cut off during rainy seasons, hard to reach migratory populations and among communities affected by conflict.

This proposal intends to address the above highlighted bottlenecks through the following objectives:

Objective 1: To strengthen the demand for immunisation services through the development and implementation of a communication plan, effective participation of the community and civil society organizations to increase DTP3 coverage to at least 85% by 2019. By creating demand for routine immunisation services particularly in the 199 prioritized townships to address equity related barriers and improve immunisation coverage. Demand creation will be tailor made to ethnic and other groups and translated in seven different local languages.

Objective 2: To improve immunisation service quality and availability for hard to reach and underserved populations through the implementation of the cold chain expansion and improvement plans in all of the prioritized areas by 2019. This objective aims at strengthening the immunisation supply chain, vaccine management and build resilient cold chain systems at all levels.

Objective 3: To strengthen leadership management capacity and coordination of the priority focused areas and contribute to universal health coverage by improving population and service coverage to 85% by 2019. This will be achieved through capacity building of managers in the prioritised states/regions and townships and supported regularly to provide quality leadership. The performance of the EPI programme will be enhanced to integrate Primary Health Care (PHC) package and achieve the Universal Health Coverage (UHC) targets Immunisation services through trained NGOs/CSOs and Ethnic group volunteers (Kachin/WA) will increase coverage and equity.

Objective 4: To improve equitable access to service delivery in prioritized areas by the increase of DTP3 coverage to at least 85% by 2019. Target populations are urban/peri-urban, mobile/migrant workers and physically and geographically hard to reach. Fixed sites will be increased through establishing immunisation services in hospitals, MCH clinics and UHC through outreach services to reach the un-immunized children.

Objective 5: To strengthen EPI data management, monitoring and evaluation systems through the establishment of electronic reporting system in 50% of townships by 2019. CEPI is planning two EPI Coverage Surveys during the life cycle of the HSS grant. In this proposal the data quality self-assessment will be conducted annually. Regular EPI Review Meetings will be organised quarterly at states, regions and townships and biannually at the national level. Regular monitoring and supportive supervisory visits will be carried out using an updated a national supervisory checklist.

Activities have been prioritized to provide focused support to 199 prioritized townships which have been categorized as follows; a) 100 low performing townships which have attained less 80% DTP3 coverage between 2012 and September 2015; and b) additional 99 hard to reach Townships *(Optional attachment # 13).*

DoPH, MOH will manage the implementation and will be directly responsible for; recruitment & deployment of the various human resources, operational support for scaling up provision of the immunisation services in conjunction with CSOs and other implementing partners.. The CSO will be responsible for community mobilisation and sensitization through the use of existing network of community based volunteers. UNICEF will be responsible for procurements and strengthening immunization supply chain , cold chain and effective vaccine management as well as technical guidance and support to CEPI and CSO in strengthening efforts for communication and demand generation, while WHO will undertake provision of technical support, trainings, strategic information, surveillance and data management activities.

Funds will be channelled through MOH, WHO and UNICEF Funds disbursed to the MOH will be channelled through the existing account managed by DoPH , from where it will be released for implementation of activities. It is being proposed for the CSO to receive funding through the DoPH specific account after signing an MOU, while funds to the UNICEF and WHO shall be channelled through their headquarters in New York and Geneva respectively. Most of the procurements especially the cold chain equipments, shall be done by using UNICEF systems. Annual audits will be performed by the Government Auditor General office.

The monitoring and evaluation of the performance of this proposal will be based on the HSS grant M&E performance framework and will use the national systems processes and sources of data to track most of the indicators. Quarterly analysis and reporting of immunisation data extracted from the HMIS system data base shall be done collaboratively between CEPI and State/Region and Townships focal persons. CEPI with technical assistance and support from WHO will compile annual reports that shall be collectively reviewed and discussed within the ICC before submission to Gavi. Major programmatic issues arising following the review of this data will then be used to guide programming for the subsequent period. The performance of Gavi HSS2 will also be monitored and evaluated through EPI coverage verification survey, EPI program review and end of grant evaluation.

5. Acronyms

Provide a full list of all acronyms used in this application.

Acronym	Acronym meaning
AEFI	*Adverse Events Following Immunization*
AERF	*Annual EPI Reporting Format*
AMW	*Auxiliary Midwife*
ANC	*Antenatal care*
APR	*Annual Progress Report*
BHS	*Basic Health Staff*
bOPV	*Bivalent Oral Polio Vaccine*
CBO	*Community Based Organisation*
CC	*Cold Chain*
CCR	*Central Cold Room*
CCKP	*Cold Chain Key Person*
CEPI	*Central Expanded Programme on Immunization*
CEU	*Central Epidemiology Unit*
CHAI	*Clinton Health Access Initiative*
CHN	*Community Health Nurse*
CHW	*Community Health Workers*
cIP	*Comprehensive Improvement Plan*
CMSD	*Central Medical Stores Depot*
cMYP	*Comprehensive Multi-year Plan*
CRS	*Congenital Rubella Syndrome*
CSO	*Civil Societal Organization*
CTHP	*Coordinated Township Health Plan*
DF	*Deep Freezer*
DFID	*Department for International Development*
DG	*Director General*
DHS	*Demographic and Health Survey*
DHISII	*District Health Information Systems II*
DQS	*Data Quality Survey*
DMC	*Department of Medical Care*
DPT	*Diphtheria-Pertussis-tetanus*
DoPH	*Department of Public Health*
DQAS	*Data Quality Self-Assessment*
DUNS	*Diseases Under National Surveillance*
EHSAP	Essential Health Services Access Project

eHMIS	*Electronic Health Management Information System*
eLMIS	*Electronic Logistics Management Information System*
EHSAP	*Essential Health Services Access Project*
EOI	*Expression of Interest*
EPI	*Expanded Programme on Immunization*
EVMA	*Effective Vaccine Management Assessment*
EVM	*Effective Vaccine Management*
FBO	*Faith Based Organization*
FIC	*Fully Immunized Child*
FM	*Financial Management*
FMA	*Financial Management Assessment*
Gavi	*Gavi Alliance for Vaccines and Immunization*
GDP	*Gross Domestic Product*
GF	*Global Fund*
GGE	*General Government Expenditure*
GGHE	*General Government Health Expenditure*
GHE	*General Health Expenditure*
GIVS	*Global Immunization Vision and Strategy*
GSM	*Global System Management*
GVAP	*Global Vaccine Action Plan*
HA	*Health Assistant*
HACT	*Harmonized Approach for Cash Transfer*
HLRP	*High Level Review Panel*
HMIS	*Health Management Information System*
HPA	*Health Poverty Action*
HPV	*Human Papilloma Virus*
HRT	*High Risk Township*
MHSCC	*Myanmar Health Sector Coordination Committee*
HSS	*Health System Strengthening*
HW	*Health Worker*
ICC	*Interagency Coordinating Committee*
IDA	*International Development Agency*
IDP	*Internally Displaced People*
IEC	*Information, Education and Communication*
IFFIm	*International Financing Facility for Immunization*
IIP	*Immunisation in Practice*
ILR	*Ice-Lined Refrigerator*

IPC	*Inter Personal Communication*
IPV	*Inactivated Polio Vaccine*
ISS	*Immunization System Strengthening*
JA	*Joint Appraisal*
JANS	*Joint Assessment of National Health Strategy*
JE	*Japanese Encephalitis*
JRF	*Joint Reporting Format*
JSI	*John Snow International*
KAP	*Knowledge Attitude Practice*
LHV	*Lady Health Visitor*
LMIS	*Logistics Management Information System*
MCH	*Maternal and Child Health*
MCV	*Measles Containing Vaccine first dose*
M & E	*Monitoring and Evaluation*
MDG	*Millennium Development Goal*
MDHS	*Myanmar Demographic and Health Survey*
MHAA	*Myanmar Health Assistant Association*
MICS	*Multiple Indicators Cluster Survey*
MLM	*Mid-level Manager*
MMA	*Myanmar Medical Association*
MMCWA	*Myanmar Maternal and Child Welfare Association*
MNCH	*Maternal Neonatal and Child Health*
MNMA	*Myanmar Nurse and Midwifery Association*
MNT	*Maternal and Neonatal Tetanus*
MO	*Medical Officer*
MoF	*Ministry of Finance*
MOH	*Ministry of Health*
MoU	*Memorandum of Understanding*
MR	*Measles and Rubella*
MRCS	*Myanmar Red Cross Society*
MW	*Midwife*
NCDP	*National Comprehensive Development Plan*
NCIP	*National Committee for Immunization Practices*
NGO	*Non-Governmental Organization*
NHP	*National Health Plan*
NID	*National Immunization Day*
NPT	*Nay Pyi Taw, Capital of Myanmar*
NRA	*National Regulatory Authority*

NT	*Neonatal Tetanus*
NVI	*New Vaccine Introduction*
OOP	*Out of Pocket (expenditure)*
OPV	*Oral Polio Vaccine*
PBF	*Performance Based Funding*
PBI	*Performance based Incentive*
PCV	*Pneumococcal Conjugate Vaccine*
PHC	*Primary Health Care*
PHD	*Public Health Department*
PHS	*Public Health Supervisor*
PIE	*Post Introduction Evaluation*
PQS	*Prequalified Standard*
PR	*Primary Store*
PSI	*Population Service International*
REC	*Reaching Every Community*
RED	*Reaching Every District*
RHC	*Rural Health Centre*
Rota	*Regional Health Department*
RHD	*Rotavirus Vaccine*
RTC	*Road Transport Corporation*
SARA	*Service Availability and Readiness Assessment*
SC	*Sub Centre*
SCDU	*Special Disease Control Unit*
SCMS	*Supply Chain Management System*
SD	Sub depot
SN	Sub national Store
SOP	Standard Operating Procedures
S/R	State/Region
SDCU	*Special Diseases Control Unit*
SH	*Station Hospital*
SIA	*Supplementary Immunization Activity*
SNID	*Sub National Immunization Day*
SSB	*Social Security Board*
SWOT	*Strength, Weakness, Opportunity, Threat*
TA	*Technical Assistance*
TBA	*Trained Birth Attendant*
Td	*Tetanus and Diphtheria Vaccine*
THA	*Township Health Assistant*

THN	*Township Health Nurse*
TMO	*Township Medical Officer*
tOPV	*Trivalent Oral Polio Vaccine*
TT	*Tetanus Toxoid*
ToR	*Term of Reference*
UHC	*Universal Health Coverage*
UHC	*Urban Health Centre*
UN	*United Nations*
UNICEF	*United Nations Children Fund*
UNOPS	*United Nation Operational Service*
USAID	*United States Agency for International Development*
USD	*United States Dollar*
VAR	*Vaccine Arrival Report*
VDPV	*Vaccine Derived Polio Virus*
VHW	*Voluntary Health Workers*
VIG	*Vaccine Introduction Grant*
VPD	*Vaccine Preventable Disease*
VVM	*Vaccine Vial Monitor*
WPV	*Wild Polio Virus*
WHO	*World Health Organisation*

PART B: BACKGROUND INFORMATION

6. Description of the National Health Sector *(Maximum 1 page)*

*Provide **Attachment #8**: NHSP or equivalent and reference which sections describe the national health sector. If no existing approved national document describes the national health sector, provide a concise overview of the national health sector.*

Myanmar Health Care System and role of providers have been evolving with changing political and economic system. It has a pluralistic mix of public and private system. However, (MOH is the major player as a governing agency as well as a provider of comprehensive health services.

Service delivery, including public, private and CSOs: The Department of Medical Care (DMC) and DoPH under MOH are the major public service providers and currently managing the network of hospitals and health centres which extends down to village level: 1056 Hospitals, 1738 Rural Health Centres(RHC), 87 Primary and Secondary health centres, and 384 Mother and Child Health Center (MCH). Other ministries also provide health care to their employees and their families. The commercial private sector mainly provides ambulatory care with some inpatient facilities in major cities. In 2010, there were

103 private hospitals, 192 special clinics and 2891 general clinics. CSOs provides ambulatory care with some outreach and preventive services[4].

Workforce and human delivery, including the role of community health workers: the country has 31,542 medical doctors with more than 50% working with the private sector), 29,530 nurses: 29,532, trained midwives (MW) out of which around 12,000 are appointed in DoPH, 652 public health supervisors 1 (PHS1): 4, 998 Public Heath Supervisor 2 (PHS2): 4,998. DoPH is planning to increase the number of PHS2 to be equal to the number of MWs for future immunization tasks to be shared. Nearly 40,000 [5]Community Health Workers (CHWs) and Auxiliary Midwives (AMWs) have been trained as voluntary health workers (VHW) to support Basic Health Staff (BHS) in communities. MW is the focal person based in RHC and sub-centres to deliver basic health package which includes pregnancy management, growth monitoring and supplementation of micronutrients, case management of common childhood illness, and locally endemic diseases. As there are 64134 villages in 330 townships in Myanmar, average facility ratios are: 6 RHC/township, 5 to 6 sub-center/ RHC while one MW needs to serve 3479 people living across 7 villages. Population density in Chin is only 13/km2 while that is 200/km2 in Mandalay, MW in remote ethnic bordering areas need to travel more than 20 km to deliver essential services every month (in average midwives in some areas can reached within 2 days of walking).

Community and local actors: CSOs such as the Myanmar Maternal and Child Welfare Association (MMCWA) and the Myanmar Red Cross Society (MRCS) play key roles in service provision at community level. [6]There are 17 national Health NGOs. The current policy for immunization allows limited number of NGOs/CSOs to act as immunization providers however.

Procurement and supply chain management system: With the split of the MOH, the Central Medical Stores Department (CMSD) is reporting and providing support largely to the DMS with minimal support to DoPH. DoPH established the P&S division which however, currently has only 12 staff at national level out of the 97 approved vacancies while at regional level no staff has been assigned yet. The supply system is currently fragmented, supported by various partners including the Global Fund. UNICEF continues to provide support to the MOH in vaccine and cold chain forecasting, procurement, shipment, clearance, storage and distribution for traditional and Gavi supported vaccines. USAID funded Supply Chain Management System (SCMS) in collaboration with MOH is planning to strengthen the entire health supply chain system through the creation of a new supply chain unit within the MOH. However, this strategy remains unfunded.

Legal, policy and regulatory, including laws/ policies guaranteeing rights to health care: Policy guidelines for health services and development is contained in the constitution, where it was stated that every citizen shall, in accordance with the health policy laid down by the union, have the right to health care, it was also stated that mothers, children and expectant women shall enjoy equal rights as prescribed by law[7],[8].

Health and community systems financing: The government used to be the main source of financing, until user charges were introduced in the form of cost sharing in 1993. The General Government Health Expenditure (GGHE) as a percentage of general government

[4] The Republic of the Union of Myanmar Health System Review, Health Systems in Transition Vol. 4 No. 3 2014

[5] Health in Myanmar

[6] Health System Assessment for UHC in Myanmar, December 12th 2012, WHO

[7] Health in Myanmar 2014, the MOH, The Republic of the Union of Myanmar

[8] http://www.moh.gov.mm/file/HEALTH%20POLICY,%20LEGISLATION%20AND%20PLANS.pdf

expenditure (GGE) was low, at 1% between 2003 and 2011. It was gradually increased up to 3.65% in 2015-16. The government is planning to scale up public financing to increase the GHE as a percentage of GDP to 2.0%. Consequently, OOP has been reduced from 78.8% in 2011 to 54.3% in 2013. Only 20% of the population is covered by prepayment and risk-pooling scheme and 1% by the social security board (SSB). A number of international and local partners introduced community-based financing. However, these initiatives had limited coverage and unable to generate sufficient revenue to cover essential health services to the poor.

7. National Health Sector Plan (NHSP) and relationship with cMYP (*Maximum 2 pages)*

Describe the relationship of the cMYP to the national health strategy.

Provide: ***Mandatory Attachment #8****: NHSP and* ***#11:*** *cMYP; and if available:* ***Attachment #18****: Joint Assessment of National Health Strategy (JANS); and* ***Attachment #19****: Response to JANS.*

Based on Primary Health Care approaches the MOH had formulated four yearly People's Health Plans from 1978 to 1990 followed by the National Health Plans from 1991-1992 to 2006-2011. These plans have been formulated within the frame work of National Development Plans for the corresponding period. National Health Plan (2011-2016) in the same vein was formulated in relation to the fifth five year National Development Plan. It is also developed within the objective frame of the short term first five year period of the National Comprehensive Development Plan (NCDP) – Health Sector, a 20 year long term visionary plan.

The MOH under the guidance of the national health committee chaired by the Vice-President, developed a National Heath Vision for 2030 to meet future health challenges. In line with this vision, Five Yearly National Health Plans have been prepared and focuses mainly on the following key strategic areas: a) Widespread dissemination of health information and education to reach rural areas; b) Enhancing disease prevention activities; and c) Providing effective treatment of prevailing diseases. Vision and five year plans are to contribute one of four overarching state social objectives: **"**uplifting health, fitness and education standard of the entire nation". It included the national objectives (i.e. political, economic and social objectives of the country) guiding the country short-term national health plans development.

The two main objectives of the comprehensive NHP (UHC 2030 vision) are: 1) to enable every citizen to attain full life expectancy and enjoy longevity and, 2) to ensure that every citizen is free from diseases. It is envisaged that, the cMYP will directly contribute in realizing the second objective of NHP as the prevention of vaccine preventable diseases will further protect citizens and ensure that they are free from diseases. Furthermore, the NHP is directed towards: i. solving priority health problems of the country; ii. Rural health development; iii. Realizing sustainable development goals; iv. Strengthening health system; and v. Improving determinants of health.

Myanmar is in the process of developing a new National Health Plan 2017 – 2021 and is expected to be completed by end of 2016. However, the draft plan of DoPH part of NHP where the Expanded Programme of Immunization (EPI) components articulated is already available (copy attached as mandatory attachment # 8). Therefore, this section has been drafted making reference from cMYP 2017 -2021 and the draft DoPH part of the comprehensive NHP.

Communicable diseases have been identified as a key health priority and therefore it is one of the 7 public health programme areas of the draft NHP. The main objectives of the communicable disease programme is "to reduce morbidity and mortality from communicable diseases so as to eliminate them from arising as public health problems and to mitigate subsequent social and economic problems". It is also important to note that there are twelve projects under this programme and (EPI) is one of these projects.

The main focus of EPI programme is to reduce the morbidity and mortality due to vaccine preventable diseases. The Central Expanded Programme on Immunization (CEPI) in the Ministry is responsible for policy formulation planning, management of vaccine and cold chain, immunization logistics, monitoring of immunization activities implemented by Regions and States, Surveillance of Vaccine Preventable Diseases and responding to Vaccine Preventable Diseases outbreaks. All of the functions of CEPI contributing significantly in realizing the NHP objectives as well in the control of communicable diseases.

To align to the five yearly NHPs and Global Vaccine Action Plan (GVAP), CEPI has been developing cMYPs, the current one will be end in 2016. To ensure continuity, CEPI has already developed a new cMYP or the period 2017-2021 to accompany this application with the following key objectives:

1) To strengthen immunization programme management, human resources, financing and service delivery to provide equitable service to all target population including special strategy for different hard to reach and conflict areas
2) To improve demand creation and ownership towards immunization through community participation and communication
3) To strengthen immunization supply chain, vaccine management and build stronger cold chain systems at all levels
4) To achieve the goals of eradication, elimination and control of VPDs including maintaining zero polio cases (both WPV and VDPV) and MNT elimination status as well as achieving elimination of measles, control of rubella and CRS by 2020.
5) To strengthen and maintain strong surveillance system for AEFI and other priority VPDs
6) To introduce new and underused vaccines and new technology into routine immunization supported by evidence of disease burden.

CEPI with the guidance of the DoPH has been keen in ensuring that all key cMYP objectives and set indicators become an integral part of the draft DoPH component of the NHP (refer the attached draft DoPH component of comprehensive NHP). It is with this background that the Gavi HSS2 proposal is being prepared for the period 2017 to 2019 because the comprehensive NHP has not been finalized. Although no JANS has been done, the strategies and plans of the MOH are generally consistent the current ongoing efforts to address priority health problems. The objectives and strategies of the NHP will address the health system challenges elaborated in the description of national health sector.

8. Monitoring and Evaluation Plan for the National Health Plan *(Maximum 2 pages)*

Provide background information on the country M&E arrangements.

The development of the NHP 2017-2021 is currently ongoing as previously stated. The Monitoring and Evaluation framework of the NHP will highlight and describe the mechanisms for tracking the performance of the sector. The Gavi HSS2 proposal framework is aligned with the cMYP and the draft portion of the DoPH/EPI section of the Myanmar NHP.

The DoPH monitoring and evaluation (M&E) system relies mainly on data collected through routine information systems (DHIS/HMIS including EPI data reporting). Midwives at sub-centres (SCs) prepare monthly reports (including EPI data) and submit to the RHC. Health Assistants (HAs) at RHCs compile all SCs reports and prepare the Heath Centre Monthly Report and submit to Township Public Health Department, where the TMO working under their capacity as Township Public Health Officer (until this cadre is hired), compiles all RHCs monthly reports into a Townships summary report and subsequently submits to the States/Regions Public Health Department (PHD). Statisticians and Assistant statisticians at the States/Region PHDs are compiling and editing all Townships monthly reports for submission to the HMIS Division in DoPH.

There is no dedicated staff at the CEPI responsible for regular review and analysis of EPI data reported through the HMIS Division to monitor trends in EPI performance and provide feedback. However, there are different levels of supervision for surveillance and immunization activities, central, states/regions, township and RHCs. The Central level supervisors are the CEPI deputy director, two assistant directors and two medical officers. The States/regions supervisors are directors, deputy directors, health officers and team leaders of special diseases control units. The Townships supervisors are TMOs, Townships Health Assistants (THAs) and Township community health nurses (THNs) and at the RHCs level, the HAs and Lady Health Visitor (LHV) are the supervisors.

Since 2010 until 2013, the HMIS Division has conducted annual data quality audit/assessment, which included data flow and consistency between township and RHCs, RHCs and SCs, and SCs and respective registers. The consistency between the registers and clients was also checked and assessed. In addition to assessing the data consistency, the audit assessed five data Items (Antenatal Care, Delivery, Measles vaccination, Tetanus Toxoid (TT2+) vaccination, and Outpatient Department Services). There have been households and health surveys conducted in the past including specialized surveys such as health facility assessments as well as Service Availability Readiness Assessment (SARA) supported by UNICEF and WHO respectively. One of the main challenges is the lack of periodic surveys to assist with monitoring the performance of the programme. For instance, through UNICEF support, the last Multiple Indicator Cluster Survey (MICS) was conducted in 2008/2009 and also it is important to note that the last EPI review was conducted in Myanmar in 2008. Likewise, the Integrated Household Living Condition Survey in Myanmar was conducted in 2009-2010. To overcome these challenges, the Ministry of Health with support from partners and funding support from USAID is currently conducting a Demographic and Health Survey (DHS) with preliminary results expected early 2017.

There are two annual evaluation meetings held at townships, States/Regions and national levels, the first annual review meeting is the community healthcare evaluation meeting (which discuss the overall performance related to general health care attendance, neonatal, maternal, reproductive, child health, environmental and sanitation, other disease control activities and hospital performance and demographic data). The second evaluation meeting is the annual EPI evaluation held at all levels starting with townships compiling health facility based EPI coverage reports into the township annual EPI evaluation report. Townships reports are submitted to State/Region level for consolidation into the States/Regions specific EPI annual evaluation reports which are presented in the annual EPI evaluation meeting.

These meetings bring together all states/regions Health Directors and SCDU Team leaders and/ or EPI Focal Persons. During the annual evaluations, the states/regions categorizes the performance of their respective townships based on Reaching Every Community (REC) classification using the pentavalent/DPT coverage and drop-out rates. The annual evaluation data is mainly used to inform planning for the following year EPI based on the findings identified through a strength, weakness, opportunity, threat (SWOT) analysis, updated cold chain and logistic inventory, and VPDs surveillance data. The EPI review meetings especially at central level are supported jointly by WHO and UNICEF, and the main areas of support include review of the performance for each state and region and provide guidance on how to improve the coverage particularly on prioritization of areas and interventions needed. At Region/State and Townships, WHO and UNICEF are represented by the Regional Surveillance Officers (RSO) and Heath Specialist respectively who work closely with the state/region health department to prioritize Townships according to performance and design intervention to support low performing Townships.

Annual evaluation of community health care project are done from townships, region and states as part of the yearly evaluation of NHP. Data are collected for monitoring forms and formats of HMIS from the smallest health units of SCs with selected performance indicators and update of basic and volunteer health manpower. The content of the community health care project report is comprehensive including health manpower data, and volunteer health workers, performance of basic health staff in the facility and the outreach, reproductive care and neonatal and child health care, immunization achievement data together with vaccine wastage, other data on the locally endemic diseases and disease control activities. Hospital performance activities are also compiled. Vital statistics data are collected which is regularly collected year round and population head count is made at the end of a year. From this report, population head count and wastage rate are vital for forecasting for following year at different levels, while achievement data was analysed in terms of accessibility, utilization or both and categorized to formulate appropriate strategies such as REC/Crash etc., Thereby, required vaccines are allocated (pushed) to sub-depots from central to be ready for lower levels, while townships collect (pull) vaccines from sub-depot based on planned requirements at different time. Other major diseases control projects such as tuberculosis, vector borne diseases control project and trachoma and prevention of blindness are yearly evaluated separately. Although annual evaluation report is not issued, annual report named as “Health in Myanmar” is yearly published to share the progress of the National Health Plan with updated statistics of demography, vital data and health expenditures.

*Provide **Mandatory Attachment #9:** National M&E Plan (for the health sector/ strategy**),** as well as any sub-national plans, as relevant**.** If this does not exist, explain how the National Health Plan is currently monitored and provide a timeline for developing an M&E Plan.*

*If available, provide **Attachment #16:** Data quality assessment report; and **Attachment #17:** Data quality improvement plan.*

***Pooled fund** applicants are required to attach the National M&E Plan and any documentation on the joint review process, including terms of reference, schedule etc.*

9. Alignment with existing results based financing (RBF) programmes (where relevant) *(Maximum 1 page)*

*Indicate whether your country will align HSS support with existing results based financing (RBF) programmes. If yes, provide **Attachment #30:** Concept Note/ Programme design of relevant RBF programme, including Results Framework and Budget.* N/A

PART C: APPLICATION DETAILS

10. Health System Bottlenecks to Achieving Immunisation Outcomes *(Maximum 3 pages)*

Provide a description of the main health system bottlenecks. If such analysis has recently been conducted, attach ***Optional Attachment 33:*** *Health system bottleneck analysis.*

Equity and barriers related to immunisation coverage

Myanmar has made steady progress in improving health outcomes over the past three decades[9]. Life expectancy at birth increased for both males and females increased from 55 (males 53.7 and female 56.5) in 1980 to 65.2 (males 63.5 and female 66.9) in 2011; along with an increase in the child immunisation coverage; and declines in infant and under-5 mortality rates, and maternal mortality ratio. Between 2001 and 2011 Myanmar was able to reduce infant mortality rate from 59.7 to 40, under-five mortality rate from 77.77 to 52 and maternal mortality ratio from 2.55 to 1.7, all per 1,000 live-births *(see attached UHC-Policy brief 2013).*

No significant difference can be found in immunization coverage between urban and rural areas, or between male and female children. There is no clear association between immunization coverage and wealth level of the households. While the percentage of 12-23 months-old children with all recommended immunizations does not vary notably between children of mothers with primary (97.2 per cent) and secondary or higher education (98.7 per cent), there is a small gap down to children of mothers with no education, of whom 90.6 per cent have all recommended immunizations *(Myanmar Multiple Indicator Cluster Survey 2009 – 2010).* However, the geography, ethnicity and long years of internal conflict have made the provision of universal health care a challenge. Although the DPT3 vaccination coverage has increased by 15% in 2014 compared to 2013 and there is discrepancies and difference in coverage across Townships *(JRF), and one of the* challenges with immunization coverage data is related to unreliable denominator. The head counting that midwives conduct every year may not include hard to reach population, population in conflict zone and migratory population *(EPI Evaluation 2014)*. This poses issue for the MOH given that the Government is committed to achieve universal health coverage as part of its vision 2030, defined as 'the provision of optimal quality of health care for everyone in the country that is accessible, efficient, equitably distributed, adequately funded, fairly financed and appropriately used by an informed and empowered public' (*MOH 2014, 'Strategic Directions for Universal Health Coverage).*

The EPI evaluation undertaken in 2012 by CEPI, found that 40% of low performing RHC were geographically and/or socially hard to reach. Security challenges and absence of health workers were also the cause for no immunisation activities in 25% of the instances. Lack of vaccine (global supply availability) contributed to 15% and higher/faulty target setting contributed to 16% of the causes for low coverage *(Progress Report on the implementation of Intensification of routine immunization in Myanmar 2013).*

Despite all available efforts in reaching all children with quality immunisation services, about 100 townships (out of 330 nationwide) have continuously reported DTP3 coverage of under 80% for two consecutive years between 2012 and 2015 *(prioritized townships list)*. The townships have been prioritized bases on 2 criteria: 1. DTP3 coverage successively lower (below 80%) from 2012 to 2015, two dips in DTP3 coverage even though it was higher than

[9] Health System Review, Health Systems in Transition Vol. 4 No. 3 2014, Myanmar

80% in one year during this period, declining coverage trend (total100 townships) 2. Geographically hard to reach areas (total 99 townships). Low coverage rates have resulted in measles outbreaks in 2012, with over 2,188 cases and 15 deaths and sporadic cases of diphtheria are reported each year. Recently the country has experienced outbreak of circulating vaccine-derived polio virus in Rakhine state due to low population immunity in the area. The main reason for low immunization coverage *(2012- Year of intensification of RI action plan) was* mobile population/hard to reach population, lack of human resources, geographically hard to reach population and low/no local community involvement. The six key determinants for sub optimal routine immunization coverage in the country have been identified as: access, resource availability (skilled human resources, vaccines, cold chain etc), service delivery, information use, managerial capacity , management of adverse event following Immunization *(2012- Year of intensification of RI action plan)*

Demand Creation

Inadequate knowledge and demand for immunisation services by caregivers and limited interpersonal communication skills (IPC) of Basic Health Staff (BHS) has created limited demand generation*)*. The general public is not well informed about the importance of vaccines and immunisation services. The existing communication and demand creation activities are not tailored to special groups limiting demand for services targeted advocacy for populations with high dropout rates and migrant populations are not enhanced followed by limited involvement of NGOs *(PIE-2014)* However, campaigns are successful due to intense support in terms of funding logistics, operations and social mobilization.

Human resources for health

According to the *2014 Joint Appraisal (JA)*, contextual barriers to immunisation includes intermittent geographical access due to poor road and communications, insecurity in some areas, remoteness contributing to large extent the lack of adequate numbers of BHS in remote areas and border regions. The Government has not yet approved or fulfilled the vacant positions resulted from the creation of the new DoPH. *The EPI evaluation 2014* pointed out the over-workload of BHS, disproportionate ratio of BHS and population size, extension of city/urban areas without change in human resource and vacant post as well as lack of performance incentives.

Service delivery

More than 80% of immunization services are provided through outreach. There is no housing facility for midwives to stay at RHC & SCs. There is no regular or inadequate number of outreach services in hard to reach, conflict and peri urban areas. The micro plan does not cover poor, migratory population and are developed without participation of community *(cMYP and EPI evaluation 2014).* The limited access to immunisation services is compounded by limited number of facilities equipped with cold chain services (<22% according to EPI data). Rural health centres have only grown 15% during the period 1988 to 2012 *(there are only 1,738 RHCs when the national requirement is 3,000 facilities based on the recommended allocation of 20,000 population per RHC)*[10]. As mentioned in the description of the health sector, out of more than 21,000 trained midwives only 12,000 have been appointed resulting in work overload often limiting their availability to provide immunisation services beyond a day or two a month through outreach. This set up has increased the wastage given that vaccines are only able to be kept in the cold chain for a few days. Vaccine product related waste disposal was also reported to be a problem. In hard to reach, areas of conflict and border areas where access is limited, there are expected lower levels of coverage. Lack of vaccine transportation and operation cost results in low

[10] Health System Assessment for Universal Health Coverage in Myanmar, December 2012

service delivery *(EPI evaluation 2014 and cMYP).* Outreach services not integrated with other services *(HSS assessment report)*

Finance

The health system has been reliant on out of pocket expenditures (OOP) as the system has been chronically underfunded. Weak public financial management at all levels of the system due to limited or no funds available for operational costs. According to the 3MDG Fund *(2014 Annual report)*[11]*,* structural challenges persist and out of pocket payments remain the major source of funding. In fact even the collection of vaccines and outreach is partly funded by midwives collecting salaries and attending meetings at township level and often self-funding outreach visits hence immunisation opportunities are infrequent particularly in hard to reach, geographically dispersed and in conflict areas. Migrant and hard to reach populations are often missed.

Supply Chain System

The Myanmar EVM Assessment and the comprehensive improvement plan (cIP) (copies attached), point out to the lack of cold chain capacity, vaccine management skills and maintenance capacity has not kept pace with population growth or with increased storage demands for new vaccine introductions (Rota and HPV are planned to be introduced in 2018). Dry store capacity requirement will also double by 2018. As mentioned above, only 22% of facilities are equipped with cold chain outreach, immunisation services are limited. The information management system is well kept but in a manual form which prevent the EPI from having real time information on stock availability. The capacity of the appointed cold chain key person (CCKP) in townships cold chain stores and sub-depots is limited as they have not undergone formal training on EVM, standard operating procedures (SOPs), cold chain management and temperature monitoring to name a few. The number of engineers dedicated to cold chain management is only limited to 8 people who are expected to provide nationwide support but have limited or no skills in preventive cold chain maintenance. Given that the country has embarked on a cold chain expansion and replacement of cold chain equipment over 10 years old, the number of engineers is significantly insufficient.

Institutional

The new MOH structure (2015) in which resulted in 6 departmental divisions including the DoPH and the DMC?? As a consequence, departments work separately from each other with different physical and human resource structures bringing a new set of challenges. For instance, the TMO is part of Medical Care, however, they are also assigned to Public Health though limited support is given to public health hindering immunisation services as these services are not provided in hospitals. The Central Medical Stores Depot (CSMD) (now under DMC is no longer housing the EPI's dry goods. The MOH/Procurement and supply division under the DoPH will now require to provide these services, however, this division is severely under resourced.

Data quality and information systems

The denominator used for administrative coverage needs to be reviewed in light of the census. The census was carried out in 2014 and results were published in 2015, however, the denominator from the reported head counts by the BHS is higher than census data. This could be due to the fact that some of the areas were not covered during the population census. However, efforts have to be made to ensure that the denominator used for administrative coverage is reviewed in light of the census. On top of that, the annual EPI

[11] http://3mdg.org/images/Library/3MDG_Background_documents/3MDG_AnnualReport_2014_WEB.pdf

evaluation of 2014 further pointed out that head count is not adequately leading to accurate target setting for example migrant population are not counted. Population data in geographically hard to reach and conflict are not always available. EPI data auditing and verification are limited also. Information systems are mainly manual and there is a requirement for dual reporting.

Annual national EPI review meetings are held to review the immunisation programme performance of states/ regions. However, there are no quarterly EPI review meetings at state/ regions and township levels to monitor the data quality, implementation of work plans and assess the performance of the programme regularly. Data quality self-assessment has not been used frequently as a toolbox of methods to evaluate different aspects of the immunisation monitoring system at township and rural health centre levels. [12] The post *introduction evaluation (PIE)* for pentavalent vaccine identified a number of challenges which required corrective actions: tracking of drop outs, missed opportunities, validating headcounts and standardization of denominator.

Leadership, management and coordination

Lack of integration of essential public health interventions and limited success in reaching mobile peri-urban populations and geographically and socially hard to reach areas. Limited absorptive capacity of funds at township level and below due to limited management systems development. There is a need for regular township assessment in order to support annual coordinated Township Health Plan and to judge progress *(HSS evaluation report*). Rapid turnover of township medical officer, through mandatory transfer or rotation every 2-3 years should be evaluated. Continuity of township leadership is essential for rural health systems development in Myanmar. The BHS and TMOs lack of regular refresher training on immunization. Quality of training through well-equipped training facility is important *(cMYP).* There is inadequate human resource responsible for financial management in the Admin and Finance section in DoPH. Financial managements are mainly done manually causing delays in timely transfers and reporting.

Pooled fund *applicants are required to provide a reference to the relevant section and pages in the NHSP which outline how lessons learned from the previous NHSP have been incorporated into the current NHSP plan. If available, attach documentation on lessons learned implementation of the pooled funding mechanism, including relevant sections from joint annual reviews (JAR), mid-term evaluations etc.*

11. Health system bottlenecks to be targeted through Gavi HSS support *(Maximum 2 pages)*

To address inequities and limited access to immunisation services, bottlenecks were prioritised to ensure the Gavi HSS2 proposal addresses these bottlenecks by strengthening delivery systems. This prioritization is consistent with the objectives set in the 2017-2021 cMYP. Activities have been prioritized to provide focused support to 100 low performing townships which have had under 80% DTP3 coverage in two years between 2012 and September 2015 data and an additional 99 hard to reach townships of which 87 of them have also a DTP3 coverage of under 80% during the criteria selection period (*The list of townships and map is provided as an attachment).*

[12] Report on Post Introduction Evaluation (PIE) of Pentavalent Vaccine in Myanmar 2014

1. Demand Creation

According to the CEPI (RHC 2012 data), reasons for unvaccinated children include mobile population/socially hard to reach (26%), midwife vacancy/ absent/imbalanced proportion (19%) and physically hard to reach (16%). However, through the measles campaign it was demonstrated that it is possible to reach the unreached children with additional operational costs and mass communication and mobilization campaigns as well as continued community dialogue. The MOH has recently developed a Communication Plan of Action for Strengthening Routine Immunisation 2016-2020 in which the use of different communication approaches such as the identification of communication barriers, appropriate communication strategies, training needs especially on improving the Interpersonal communication (IPC) skills of Basic Health Staff (BHS) and community participation in routine immunisation. The community based volunteers will play a very important significant role in community mobilisation, demand generation and community empowerment through dialogue as they will play a significant role in linking with both the basic health staff and caregivers.

2. Supply Chain Management

Myanmar continues to introduce new vaccines into routine immunization. In coming years Myanmar will introduce JE, Rota, HPV and other vaccines *(cMYP).* Both the recent Effective Vaccine Management (EVM) June 2015 Report and its subsequent Improvement Plan December 2015 point out to a number of significant system weaknesses hampering access to immunisation services at all levels. As most of SCs are not collecting vaccines from RHCs, depending on the more accessible convenient travel route SC are collecting vaccines from Townships and hence additional resources are required and multi-dose vial policy cannot be applied leading to more wastage of vaccines. Expanding cold chain to the prioritized facilities will result in vaccines available at RHC level, increased services and less wastage. The increased Cold Chain capacity will accommodate storage requirements for new vaccine introductions planned up to 2018. Improving the capacity of DoPH in customs clearance, storage and transport to sub-depot level will improve knowledge, system efficiency and supply chain visibility. The increased capacity of the CCKPs will ensure that vaccines are managed as per SOPs.

The provision of transportation to midwives to enable collection of vaccines from townships and outreach activities is important to guarantee improved coverage. Acknowledging different geographies and reasons for hard to reach populations (not only geographical), transport provision through motorcycles will be given to areas where this is an appropriate solution and in other areas such as mountainous areas, modest transport costs will be provided to complement those provided by the IDA loan (details on the loan in the gap analysis section). Midwives will also receive mobile phones to report immunisation data. This is an ongoing project with 3MDG and UNICEF, however, existing resources are insufficient to cover 12,000 midwives.

3. Leadership, Coordination and Management

Investing on training of the Regional EPI Focal Person, TMOs and Township Health Management Teams in Mid-Level Managers workshops and supportive supervision will develop their leadership, managerial and supervisory skills. The training will help them to understand the coordination of health programmes and the integration of essential health interventions will help in optimal utilization of township limited resources.

Micro planning at township level will have integrated work plans and at state level will result in better planned outcomes. Immunisation services through trained NGOs/CSOs and Ethnic group volunteers (Kachin/WA) will increase coverage and equity. Continuous advocacy and resource provision supporting special regions and reward improvement through

performance based incentive (PBI). Township health assessment will be implemented in prioritized areas. Local specific township health plan will be developed, coordinated and integrated with essential health interventions and UHC plans. Capacity of admin and finance staff will be strengthened and the financial management system will be computerized.

4. Service Delivery

Shifting gradually from vaccinating children and pregnant women in outreach services to offering routine immunisation in fixed sites in an integrated programmatic package with MCH and other essential health interventions. This will sustain and increase access to immunisation and will also result in frequent immunisation opportunities. Increased coverage is expected by addressing specific populations in different settings such as urban/peri-urban, mobile/migrant workers and physically and geographically hard to reach areas. The provision of EPI services through fixed posts at hospitals, MCH clinics and urban health centres (UHC) and through outreach services will reach the unreached children. As recommended by the Gavi HSS1 team, outreach services in hard to reach villages are a vital programme component that should be sustained and improved as an important transitional mechanism especially emphasising on the need to strengthen health systems in these areas for improved delivery of immunization services and other integrated essential health interventions. Gavi HSS2 resources will therefore be utilized to shift from outreach-based immunisation to routine immunisation services with complementary outreach.

5. Data and Health Information Systems

Improvements in the reliability and data quality will have a positive effect in EPI data auditing and verification. Undertaking operational research, household surveys and other EPI related studies, will increase CEPI's programme knowledge. Through the investment in information systems both to automate EPI data management (integrated in the MCH package) and to have quality data integrated into the HMIS.

Supporting regular EPI review meetings at different levels will help CEPI and states/ regions teams to monitor the programme implementation and improve data quality. Investing on a data management team with a computerized system at different levels will increase the efficiency of the programme in having timely reports, and CEPI will be able to provide feedback and use data for action. One of the main functions would be strengthening of HMIS, tool development, capacity building, and logistics support, regular/monthly reporting, and recording electronically to HMIS section. Strong VPD surveillance system in place and expand to include other VPD to existing VPD surveillance system which provides timely and accurate information. Given the current challenges associated with immunization supply stock management, the proposed plan to establish the electronic data management will be linked with the establishment of the automated logistics management information system for EPI , this will ensure that vaccine stock levels at all level are monitored which will contribute in preventing stock-out and over-stocking of vaccines and injection materials. In addition, the use of mobile applications by midwives for data collection and use will strengthen the integrated data management through scale-up of CommCare initiatives. Midwives will use CommCare to track and support their clients in a range of services including antenatal care, labour and delivery, essential newborn care, family planning, infant and child care, routine immunization, and nutrition (refer optional attachment # 20).

Pooled fund *applicants are <u>not</u> required to complete this question.*

12. Objectives of the NHSP and application *(Maximum 2 pages)*	
Present specific objectives to address the identified bottlenecks, explaining how each aligns with objectives in the cMYP and/ or specific health system strengthening policies/ strategies being implemented. These objectives have to be listed in the same order in ***Attachment #6*** *- Detailed workplan, budget and gap analysis.* ***Pooled fund*** *applicants are not required to prepare separate objectives, rather to list the key objectives from the NHSP, including ones relevant to immunisation.*	
Objectives	**Description**
Objective 1 **To strengthen the demand for immunisation services through the development and implementation of a communication plan, effective participation of the community and civil society organizations for the increase of DTP3 coverage to at least 85% by 2019**	This objective aims at creating demand for routine immunisation services particularly in the 199 prioritized townships[13] to address equity related barriers and improve immunisation coverage. Demand creation will be tailor made to ethnic and other groups and translated in seven different local languages. This objective resonates directly with the cMYP Objective 2 aiming at improving demand creation and ownership towards immunisation through community participation and communication. a. The caregivers will have more knowledge on the importance of immunisation and hence demand for the services even if they are not widely available. Increased interaction between Basic Health Staff and the caregivers will build more trust, minimize chances of refusals due to adverse events following immunisation. In addition, the community based volunteers will help in disseminating key messages on the benefits of immunization and integrated service delivery. In addition, this objective is related to strategic areas 6 of the Myanmar Strategic Direction for Universal Health Coverage which highlight the need to strengthen the community engagement in health service delivery and promotion *(UHC documents – executive summary page 3).*
Objective 2 **To improve immunisation service quality and availability for hard to reach and underserved populations through the implementation of the cold chain expansion and improvement plans in all of the prioritized areas by 2019**	Improving the availability of cold chain infrastructure and supply chain management systems is also an aim of the cMYP. Specifically the objective is to strengthen immunisation supply chain, vaccine management and build resilient cold chain systems at all levels. a. Scaling up cold chain in hard to reach areas and also in urban areas including hospital will contribute in increasing the number of immunisation sessions and hence contribute in decreasing drop-out rates. b. Safety of vaccines guaranteed, as vaccine will be kept in refrigerators compared to current practices where vaccines are kept in passive equipments (vaccine carriers and cold boxes) for more than 3-5 days. c. Training those involved in the expanded supply chain where an increased number of sites would have cold

[13] See the optional attachment # 13 – prioritized Townships

	chain would provide the basis for sustainable operational systems. This objective is also linked with the Effective Vaccine Management Assessment (EVMA) report and its improvement which was developed in December 2015 and most of the interventions proposed in addressing this objective are drawn from the improvement plan. In addition, the UHC strategic direction document highlight the need for ensuring availability of quality, efficacious and low cost essential medicines, equipments and technologies including supply chain management and infrastructure at all level.
Objective 3: **To strengthen leadership management capacity and coordination of the priority focused areas and contribute to universal health coverage by improving population and service coverage to 85% by 2019**	To ensure health and immunisation system managers of the prioritised states/regions and townships are trained and supported regularly to provide quality leadership. This objective will enhance the performance of the immunisation programme within the integrated Essential Health Services/Primary Health Care (PHC) package and achieve the Universal Health Coverage (UHC) targets and contribute to positive immunisation outcomes. Micro-planning at township level will have integrated work-plans and at state level will result in better planned outcomes. Immunisation services through trained NGOs/CSOs and Ethnic group volunteers (Kachin/WA) will increase coverage and equity.
Objective 4: **To improve equitable access to service delivery in prioritized areas by the increase of DTP3 coverage to at least 85% by 2019**	Expansion of EPI services through fixed posts at hospitals, MCH and UHC and through outreach services will reach the unreached children. The issue of poor micro-planning and lack of integration of EPI with other PHC services was also raised in the Penta Vaccine Post Introduction Evaluation in 2014. Target populations are urban/peri-urban, mobile/migrant workers and physically and geographically hard to reach. Fixed sites will be increased through establishing immunisation services in hospitals, MCH clinics and UHC and through outreach services to reach the un-immunized children. *In addition, this objective will contribute in strengthening health systems in hard to reach areas for improved delivery of immunization services and other essential public health interventions.* The inequality in the distribution and retention of health worker in hard to reach will be addressed by recruiting and training MWs and BHS from local residents. Furthermore, the service will be strengthened and scaled to reach the hard to reach, conflict affected and migrant population who are more likely to miss the immunization services. In addition, the program will ensure that the immunization services are accessed and utilized equally by boys and girls in all areas of the country regardless of geography, ethnicity, religion or economic status.
Objective 5: **To strengthen EPI data management, monitoring and evaluation systems through the**	CEPI is planning two EPI Coverage Surveys during the life cycle of the HSS grant. In this proposal the data quality self-assessment will be conducted annually. Regular EPI Review Meetings will be organised quarterly at states, regions and townships and biannually at the national

establishment of electronic reporting system in 50% of townships by 2019	level. Regular monitoring and supportive supervisory visits will be carried out using an updated a national supervisory checklist. Gavi HSS2 end of grant evaluation is included in this objective. Supportive supervision, monthly report reviews and feedback on the immunisation performance of prioritized townships and state/regions levels will improve the commitment and accountability of the health and immunisation teams. The existing immunization supply stock management is managed manually, there its logistics information management system (LIMS) will shift from manual based to automated system from central to service delivery level gaining visibility of the entire supply chain and therefore able to address supply and demand imbalances and prevent stock interruptions. CEPI will strengthen coordination with private sector through Myanmar Medical Association (MMA) in advocacy for routine immunization, provision of tools for reporting on data for RI and VDP surveillance.

13. Description of activities *(Maximum 3 pages)*	
Describe the key activities which will lead to achievement of objectives set out in Question 12. Please ensure that the activities described align with the activities that are included in ***Attachment #6*** *- Detailed budget, gap analysis and work plan.*	
Objective / Activity	**Explanation of link to improving immunisation outcomes**
Objective 1: To strengthen the demand for immunisation services through the development and implementation of a communication plan, effective participation of the community and civil society organizations for the increase of DTP3 coverage to at least 85% by 2019	
Activity 1.1: Advocacy at central, state/regional, district, township levels and in self-administrative regions	*Using advocacy at all levels in all states/regions for endorsement and commitment to reach every child including 14 townships in 4 self-administered regions for demand creation. This will be implemented in year 1 and year 3 to orient the key decision makers at the beginning of activities and also at the end to share achievements.*
Activity 1.2: Update and implement communication plan of action for strengthening routine immunisation including tailor made approaches for specific groups	*Addressing special groups in their language and through own community leaders (Actv.1.6) will generate support and interest and address equitable immunisation.*
Activity 1,3: Develop locally appropriate communicate packages for different target audiences	*It will redress inadequate messages and perception gaps on disease prevention and immunisation benefits. Support from community ensure increase of immunisation coverage*
Activity 1.4: Roll out of communication campaign on strengthening routine immunisation through multiple communication channels	*Intensive communication campaigns with appropriate materials in Myanmar and ethnic languages (together with the support of local leaders would result in demand creation.*

Activity 1.5: Capacity development of IPC skills of BHS and provision of job aids	*It will enable effective interactions and dialogue and use of effective communication approaches to inform the benefits of immunisation, increasing the motivation to get children fully immunized*
Activity 1.6: Enhance active engagement of immunisation volunteers in prioritized villages through training of one volunteer per village on IPC skills. Assignation to villages for community mobilization and develop standard operation procedures (SOPs)	*Strengthening interaction between volunteers and caregivers and strengthening community dialogue by using appropriate messages and immunisation knowledge will enhance positive immunisation seeking behaviours. Through the use of mobile phones volunteers will be able to exchange health related messages.*
Activity 1.7: Establish the caregiver and child friendly information education and communication (IEC) corner at under 5 clinics	*Increase dissemination of information about immunization services will increase risk perception among caregivers and motivate them to demand for the services and subsequently contribute to coverage improvement.*
Activity 1.8: Mobilize local community based organization (CBO), CSO, faith based organization (FBO) and locally influential partners	*Approach will be for immunisation services support or advocacy for demand creation*
Activity 1.9: Assessment on knowledge, attitude and practice (KAP) for different geographic areas and different ethnic groups	*Identification of barriers preventing children to get fully immunized and motivating factors which encourage access to immunisation services responding to diversity in cultural believes and myths. A KAP survey will ensure tailor made approaches and lead to demand creation thus addressing equitable access to immunisation.*
Activity 1.10: Performance based incentives to reward facilities with an increased number of fully immunized children.	*A modest health facility incentive provided in appropriate fora will motivate facilities in the continued provision of immunisation services in catchment areas through both fixed and outreach approaches*
Activity 1.11: Supervision and monitoring on communication activities	*Through MOH, partners and CSO/NGOs ensure the demand creation strategy works effectively*
Activity 1.12: Orientation to health facility or village track health committees toward full immunisation	*Involvement of community in planning, implementation and monitoring of EPI related activities to achieve full immunisation*
Activity 1.13: Monitoring and evaluation of multi-channel communication interventions.	*Effectiveness, appropriateness and uptake of communication interventions resulting in increased DPT3 coverage.*
Objective 2: To improve immunisation service quality and availability for hard to reach and underserved populations through the implementation of the cold chain expansion and improvement plans in all of the prioritized areas by 2019	
Activity 2.1: Equip central and sub-depots and expanding cold chain to the prioritized townships with appropriate cold chain equipment and other cold chain temperature monitoring equipment	*With improved access to cold chain infrastructure where previously there was none, will effectively expand fixed sites able to provide immunisation services contributing to higher coverage rates. The selected RHC or SC in the prioritized Townships will be equipped with cold chain equipments especially solar in areas where basic health staff need to travel a long distance (for more than 2 days) to collect vaccines. This will ensure that vaccines are available*

	whenever needed especially during the rainy season where access is always a challenge
Activity 2.2: Cold chain replacement of non-functioning and/or aged equipments over 10 years old	*Contribute to building a robust immunisation supply chain system and contributing to a reliable and a well-functioning cold chain system.*
Activity 2.3: Construction of new storage facilities at central level for cold rooms and dry goods	*No adequate space at national vaccine store for dry goods and as more vaccines are introduced, central stores will reach saturation point by 2017.*
Activity 2.4: Provision of temperature monitoring devices and strengthen temperature monitoring	*The effective monitoring of vaccine temperatures in the supply chain will lead to reduced wastage and improved efficacy*
Activity 2.5: Strengthen the capacity of MOH to effectively manage vaccine arrivals, storage and distribution	*Outsourcing of services to private sector operators. Efficient receipt of goods, storage and delivery will have a positive impact on vaccines availability. The details are elaborated in the EVM improvement plan.*
Activity 2.6: Strengthen the capacity of MOH to effectively manage cold chain maintenance	*With only 8 MOH engineering staff, outsourcing maintenance services would ensure the expanded cold chain will be operational according to WHO standards*
Activity 2.7: Procurement of motorcycle where they can be used and/or provision of a modest transport allowance to midwives in the prioritised townships for vaccine collection and outreach	*Support of MWs to undertake outreach particularly in hard to reach and geographically dispersed areas addressing issues of inequity in immunisation access and increase coverage.*
Activity 2.8: Capacity building for EPI and Procurement and Supply chain section within the MOH on contractual arrangements, procurement practices and supply chain management	*Empowering the MOH/EPI and the procurement and supply chain section will build in house capacity and increase vaccine access and effective contractual management*
Activity 2.9: Technical assistance (TA) to support vaccine supply chain improvement.	*National and international TA to complement and enhance existing MOH capacity. TA will expedite supply chain improvements and facilitate the cold chain inventory update, cold chain capacity gap analysis and conducting effective vaccine management assessment.*
Activity 2.10: Monitoring and supervision of the supply chain system functioning as well as vaccine management practices	*M&E activities will directly contribute to tracking improved coverage and equity rates. EVM assessment every 3 years to monitor trends to implementation of the EVM improvement plan*
Activity 2.11: Capacity building of CCKPs at all levels and the existing cold chain engineers including provision of SOPs and job-aid,	*Systematic capacity building will enhance skills to perform their functions as needed given that CCKPs have been recruited without the prior cold chain or immunisation knowledge*
Activity 2.12: Provision of modest transport (reimbursement) for midwives to collect vaccines/dry goods and conduct outreach.	*Midwives' motivation and performance will improve as there will be timely collection of vaccines and outreach will be implemented according to agreed schedule and hence improve the coverage,*
Objective 3: To strengthen leadership management capacity and coordination of the priority focused areas and contribute to universal health coverage by improving population and service coverage to 85% by 2019	
Activity 3.1: Update and develop Immunisation training materials, (master trainers and support the establishment of	*Immunisation training materials are developed and updated and used to train MWs and BHS, health workers, medical officers and volunteers. The*

Immunisation Training Centres at central level and 3 other regions within the existing training centres)	*immunization training centres will be embedded in the existing training centres and they will be also offering training aiming at integrated approach to delivery of basic health services and health system strengthening as a whole.*
Activity 3.2: Mid-Level Managers (MLM) Training in prioritised townships and states/regions for TMOs and Immunisation Focal Persons.	*Strengthen leadership and management of TMOs and States/Regional EPI Focal Persons in townships targeted.*
Activity 3.3: Immunisation in Practice (IIP) for Township Immunisation Focal Persons, MWs, BHS, other HWs, NGOs and CSOs	*Update knowledge and skills of Townships EPI focal persons, Midwives, and BHS, and that will improve the quality of the immunisation services.*
Activity 3.4: Held Quarterly EPI Review meetings and biannual national reviews in prioritised townships, Regional/States	*Monitoring and follow-up of the EPI programme implementation plans in state/region and townships.*
Activity 3.5: Township, states, regions and national Immunisation Operational Plans	*Annual national immunisation operation plans are developed improve EPI planning and ensure the implementation of all RED/ REC strategy components.*
Activity 3.6 Provision of 20 vehicles (3 for central level and 1 each for 17 regions/states EPI teams) to reach hard to reach in each region and state	*Transport availability will strengthen programme performance through effective supervision and sustained monitoring by reaching more areas to improve planning and coordination.*
Activity 3.7 Strengthen financial management system in the Ministry of Health	*Strengthening the capacity of Admin and Finance Unit in the DoPH will guarantee effective management of Gavi grant. Existing human capacity at all level will have enhanced capacity financial management of Finance assistants for central, State/Region Public Health Departments will be deployed to provide needed support.*
Objective 4: To improve equitable access to service delivery in prioritized areas by the increase of DTP3 coverage to at least 85% by 2019	
Activity 4.1: Ensure continued availability of services in hard to reach areas with limited access to health services through designing additional and alternative strategies for integrated service delivery	*Adequate number of vaccinators (MWs/ BHS/CSOs/NGOs/volunteers) are available from local residents, trained to vaccinate in integrated outreach activities and health facilities located in hard to reach areas. The continued support of BHS will contribute in delivering integrated services.*
Activity 4.2: Establish hospital based integrated immunisation services, starting in prioritised townships, regions and states to increase the number of fixed sites	*Increased fixed sites offering integrated vaccination and other MCH services in prioritized townships, regions and states.*
Activity 4.3: Integrate immunisation services in Coordinated township Health Plan (CTHP) (i.e. essential health interventions which include MCH/ ANC, Nutrition, Malaria, etc.).	*Increased access and utilisation of immunisation services in prioritized townships to develop quality CTHP integrated with immunisation services with support from State/Regions.*
Activity 4.4: In areas where MWs cannot reach, use the services of BHS, NGO/CSOs and volunteers to offer vaccination services.	*Trained BHS, NGO/CSOs staff and volunteers from local residents to offer immunisation services in areas that beyond the reach of MWs.*
Objective 5: To strengthen EPI data management, monitoring and evaluation systems through the establishment of electronic reporting system in 50% of townships by 2019	

Activity 5.1: Upgrade and integrate EPI health information system to the electronic Health Management Information System (eHMIS) and expand electronic database and reporting system to the remaining townships (140), as well improving immunization supply stock management through automation Logistics Information Management System (eLMIS) at central, townships and service delivery levels through the introduction of information systems compatible with other MOH programmes	*Standardised immunisation data reporting system and harmonised reporting. Data quality enhancement and timely reporting. Data will be disaggregated by location (type of settlements especially in urban areas), gender (which will involve revision data collection tools to capture disaggregated data..* *An automated LMIS system will generate real time information through mobile technology used by midwives enhancing data visibility enabling adequate vaccine stock management. In addition, Scale up of Phone App (CommCare) to 6000 midwives (mobile app and operational cost) will improve reporting by MW and also the stock of vaccines utilized at the service delivery point will be tracked easily.*
Activity 5.2: Work with BHS, community volunteers, NGO/CSOs to conduct head counts and get data on children and pregnant women in hard to reach areas	*Up to date information on hard to reach areas database, underserved communities with children and pregnant women who are not vaccinated or partially vaccinated and given priority.*
Activity 5.3: Health facilities and outreach teams with vaccination cards, registers, and reporting forms, record and report immunisation data and ensure defaulters are found and vaccinated.	*Improved EPI data collection and reporting will enhance quality of routine data and contribute in increasing coverage.*
Activity 5.4: Strengthen integrated (VPDs) surveillance and response	*Strengthen integrated surveillance, 30 medical officers and 30 data assistants at the central, regional, states EPI office, will be recruited to ensure efficiency and timely reporting of VPDs.*
Activity 5.5 To conduct relevant studies and evaluation	*Support periodic evaluations and provide grants to studies on immunisation and VPD, generating evidence-based for better planning improving programme quality and performance.*

14. Results chain *(Maximum 4 pages)*

*Complete the **Results Chain** using the template provided below. For each objective defined in Question 12, provide information on: (i) activities (as noted in Question 13); (ii) intermediate results; (iii) immunisation outcomes; (iv) impact; and (v) assumptions for the achievement of results.*

*Once the Results Chain has been developed, the next step is to complete the **Performance Framework** (for all HSS applications i.e. including for applications for pooled fund support). This can be accessed through the Gavi country portal: www.gavi.org*

***Pooled fund** applicants are not required to complete this template, but must provide a a summary of how Gavi HSS funds will contribute to improve immunisation outcomes in the context of the NHSP*

Results chain

Objective 1: **➔ To strengthen the demand for immunisation services through the development and implementation of a communication plan, effective participation of the community and civil society organizations for the increase of DTP3 coverage to at least 85% by 2019**

Key Activities:	Intermediate Results:	Immunisation Outcomes:
▪ Update and implement communication plan of action for strengthening of routine immunisation including tailor-made approaches for specific groups ▪ Capacity development of IPC skills of Basic Health Staffs ▪ Performance based incentives to reward facilities with an increased number of fully immunized children	▪ Demand increased for immunization ▪ BHS motivated to reach children in hard to reach area	• % of surviving infants receiving three doses of DTP containing vaccine • % of surviving infants receiving first dose of measles containing vaccine • % of townships with ≥80% DPT3 coverage ▪ Difference in DPT3 coverage between lowest and highest wealth quintile ▪ % point drop out between DPT1 and DPT3 coverage
Related Key Activities Indicators: ▪ Communication plan of action with detailed budget, work plan and performance framework updated and approved by MOH/EPI. ▪ Percentage of BHS trained on IPC skill ▪ Number of facilities rewarded for performance	**Related Intermediate Results Indicators:** • Proportion of caregivers knowing benefit of immunization (KAP survey) • Number of fully immunized facilities	

Objective 2: **➔ To improve immunisation service quality and availability for hard to reach and underserved populations through the implementation of the cold chain expansion and improvement plans in all of the prioritized areas by 2019**

Key Activities:	Intermediate Results:	Immunisation Outcomes:
▪ Equip central and sub depot and expand cold chain to the prioritized townships with appropriate cold chain equipment and cold chain temperature monitoring equipment ▪ Replacement of non-functioning or over 10 years old cold chain equipment	▪ Adequate cold chain facility available at RHC and SC of prioritized Townships. ▪ Functioning cold chain system at all level ▪ Capacity of EPI and cold chain staff enhanced on cold chain and vaccine management	• % of surviving infants receiving three doses of DTP containing vaccine • % of surviving infants receiving first dose of measles containing vaccine • % of townships with ≥80% DPT3 coverage

▪ Capacity building of EPI and Cold Chain key persons to effective cold chain and vaccine management maintenance		▪ Difference in DPT3 coverage between lowest and highest wealth quintile ▪ % point drop out between DPT1 and DPT3 coverage
Related Key Activities Indicators: ▪ Number of health facilities with cold chain and temperature monitoring equipment in prioritised townships. ▪ Number of facilities with replaced cold chain equipment. ▪ Number of staff trained on cold chain and vaccine management.	→ **Related Intermediate Results Indicators:** ▪ Proportion of RHCs and SCs in prioritised townships equipped with adequate cold chain capacity ▪ Proportion of facilities with equipment less than 10 years ▪ Proportion of EPI and Cold Chain staff able to carry out activities as per SOPs	
Objective 3: ➔ **To strengthen leadership management capacity and coordination of the priority focused areas and contribute to universal health coverage by improving population and service coverage to 85% by 2019**		
Key Activities: • Update and develop Immunisation Training materials and support the establishment of Immunisation. Training Centres at central level and 3 other regions • Organize Mid-Level Managers (MLM) Training in prioritised townships and states/regions. • Township, states, regions have Immunisation Operational Plans.	**Intermediate Results:** ▪ Mid-level managers capable of managing immunization program ▪ Better mobilization of resources	**Immunisation Outcomes:** • % of surviving infants receiving three doses of DTP containing vaccine • % of surviving infants receiving first dose of measles containing vaccine • % of townships with ≥80% DPT3 coverage ▪ Difference in DPT3 coverage between lowest and highest wealth quintile ▪ % point drop out between DPT1 and DPT3 coverage
Related Key Activities Indicators: ▪ Number of Training centres established ▪ Number of prioritised townships, states and regions managers and EPI Focal Persons trained in MLM ▪ Number of Townships with annual immunization operational plan.	→ **Related Intermediate Results Indicators:** ▪ Proportion of TMOs managing immunization program as per ToR ▪ Proportion of township with adequate resources for immunization	→

Objective 4: **➔ To improve equitable access to service delivery in prioritized areas by the increase of DTP3 coverage to at least 85% by 2019**

Key Activities	Intermediate Results:	Immunisation Outcomes:
• Use additional and alternative strategies in hard to reach areas with limited access to health services. • Establish hospital based integrated immunisation services starting in prioritized townships, state and regions to increase number of fixed sites	▪ Service availability in hard to reach areas ▪ Availability of integrated hospital based immunization service	• % of surviving infants receiving three doses of DTP containing vaccine • % of surviving infants receiving first dose of measles containing vaccine • % of townships with ≥80% DPT3 coverage ▪ Difference in DPT3 coverage between lowest and highest wealth quintile ▪ % point drop out between DPT1 and DPT3 coverage
Related Key Activities Indicators: ▪ Number of townships with hard to reach areas implementing new and additional strategy. ▪ Number of hospitals with integrated immunization services in prioritised townships	**Related Intermediate Results Indicators:** ▪ Proportion of Townships with increased immunization session.in hard to reach area ▪ Proportion of the hospital in prioritized townships with integrated immunization services	

Objective 5: **➔ To strengthen EPI data management, monitoring and evaluation systems through the establishment of electronic reporting system in 50% of townships by 2019**

Key Activities:	Intermediate Results:	Immunisation Outcomes:
▪ Upgrade and integrate EPI health information system to the electronic Health Management Information System (eHMIS) as well improving immunization supply stock management through automation Logistics Information Management System (eLMIS) ▪ VPDs surveillance and response	▪ Townships with available electronic reporting system (eHMIS) and eLMIS ▪ Functional VPD surveillance	• % of surviving infants receiving three doses of DTP containing vaccine • % of surviving infants receiving first dose of measles containing vaccine • % of townships with ≥80% DPT3 coverage ▪ Difference in DPT3 coverage between lowest and highest wealth quintile ▪ % point drop out between DPT1 and DPT3 coverage
Related Key Activities Indicators: • Number of townships with eHMIS and eLMIS reporting system • Number of outbreaks responded	**Related Intermediate Results Indicators:** • Proportion of Townships that introduced eHMIS and eLMIS.	

	• Proportion of township achieved targeted indicators for VPD	

IMPACT: *Provide an impact statement and indicator(s)*:

- Reduced infant and child mortality rate
- Eradication, elimination and control of VPDs
- Reduced incidence and prevalence of vaccine-preventable diseases

ASSUMPTIONS (*List any assumptions)*

- Government commitment to the immunisation programme continues to be strong
- Government increased funding for immunization on regular basis and develops sustainability plan
- Programme implementation and monitoring are effective, with strong technical support from WHO and UNICEF.
- NGOs, CSOs, CBOs and FBOs support for the immunisation programme activities will increase especially in hard to reach areas and communities
- Government will ensure flow of funds to Townships for the health and immunisation system to function.
- The Government will implement all key recommendations resulting from the Financial Management Assessment (FMA) and able to receive funds directly from GAVI.

15. Monitoring and Evaluation (M&E) *(Maximum 2 pages)*

The monitoring and evaluation of the proposed activities will be based on the result chain and the HSS grant performance framework. *The intermediate Result and immunization outcome indicators to be used for tracking the progress are outlined in the HSS performance framework.* .Some of the indicators to be tracked are similar to the one already included in the M&E framework of the draft NHP. Therefore, the program shall use the national processes and sources of data to track most of these indicators. The HMIS and planned sector performance reviews including EPI program reviews shall form the foundation for monitoring the performance.

Assessments and surveys will be conducted in the first year of implementation to establish baseline statistics particularly for intermediate Result and immunization indicators which are not captured by the existing national M&E systems.

To ensure that the performance of the grant is tracked effectively the following will be planned and implemented during through the grant lifecycle.

a) ***Communication and demand creation activities under objective one will mainly*** be monitored and evaluated through the (KAP) survey will be conducted in 2017 to establish the baselines to monitor the outcome indicators under this objective. In addition, the activity Implementation reports will also become part of the data source for some intermediate indicators. The budget and work plan includes a special activity for implementing the KAP survey.

b) ***The cold chain systems and effective vaccine management as stipulated in objective two of the proposal will be measured*** through periodic cold chain inventory updates based on the cold chain expansion, replacement, repair and maintained at all levels, continued cold chain capacity gap analysis based on the forecasted population of the catchment areas against the estimated volume of vaccines needed to be stored at a specified level. Furthermore, the EVM assessment will be planned and implemented in 2018 to determine the extent of progress in the implementation of the EVM improvement plan of which most its related activities are proposed to be funded through Gavi grant. *In the proposal activity 2.9 (sub-activity 2.9.2 Operation cost for conducting EVMA assessment and develop IP will mainly contribute towards assessment of objective 2).*

c) **The intermediate result for objective three and four of this grant related to EPI program management and service delivery** respectively will be assessed by using supervision and monitoring tools designed to capture key intermediate result indicators aiming at measuring the effectiveness of training and capacity building initiatives for line managers as well as micro-planning process.. The State/Region and Township level supervisors will be oriented, mentored and coached on regular basis on how to use these tools for data collection and prepare quarterly, mid-year and annual progress reports. These reports will be presented and discussed during quarterly States/Regions and Townships review meetings. Furthermore, biannual national review meetings will be organized to review and monitor the implementation and the annual report all achievement made on realizing the key intermediate result will be consolidated and shared at all levels.

d) This proposal will also complement the current efforts being made by DoPH through piloting of electronic HMIS (eHMIS) as part of the District Health Information System

II (DHIS II) in four Townships [14]. The reporting through eHMIS will start from RHCs to Townships level and subsequently reports submitted to the next level. There is a plan to scale up the eHMIS to additional 20 Townships in early 2016, and once this becomes operations, the Global Fund (GF) has already plans in place to roll over to cover additional 190 Townships. Taking in to consideration the need for a nationwide coverage, it is being proposed to use Gavi HSS2 grant to cover the remaining 140. The eHMIS will improve and enhance the quality of recording, timely reporting, data management and feedback and therefore improve the effectiveness in monitoring the performance of the grant. In addition, the strengthened immunisation eLIMS (LMIS) will monitor the performance of the immunisation supply chain. To ensure that eLMIS is well integrated and linked with other health system strengthening initiatives a detailed plan of action will be developed highlighting the key steps and milestones on how the integration will be effectively undertaken. In addition, the current initiatives being supported by UNICEF on introduction of use of mobile technologies through use of smart phone for frontline workers (MW) will contribute in strengthening the health information management systems. ***Therefore, the key intermediate result under objective five of this proposal will mainly monitor the roll-out of eHMIS and eLMIS.***

Considering the challenges encountered in **the quality of routine administrative data** and since the National EPI program has opted using this source of data for performance based financing of Gavi grant, MOH with the technical support and guidance from WHO is **planning to undertake various interventions aiming at improving the quality of administrative data** including: *a)* addressing the challenges related to denominator through annual head counts and comparing with population projections of specified catchment area; b) support Data Quality Self-assessment (DQS); d) mid-year and annual reviews to ensure that the routine data are adequately analysed to document key achievement, success, gaps, and lessons..

To ensure that there is an effective system for monitoring the key immunization outcome indicators, the MOH will make use of the ongoing Myanmar DHS to set the baseline[15]. In addition, the ministry is planning to conduct an EPI Coverage verification Survey in 2017. The end of grant evaluation will be conducted to track the progress made on intermediate results and immunisation outcomes.

As stipulated in other sections, MOH is committed to ensure that both girls and boys have equal access to quality immunization services therefore to achieve survey data will be analysed disaggregated by sex, location, wealth quantiles and education levels. The Ministry will attempt to revise the tools used for routine data collection to enable disaggregation to start right from the data collections point.

This progress will be reported annually through the joint appraisal mechanisms, the report will be presented for endorsement by ICC before submission to Gavi.

[14] Information provided by Dr. Thet Thet Mu, Director HMIS – The Townships includes 1- Patheingyi and 2-Madaya in Mandalay Region, 3-Chaung Oo in Sagaing Region, 4- Naunglaybin in Bago Region.

[15] There are two DHS indicators related to child health and vaccination; one is vaccination by source of information and the second one is vaccination by background characteristics.

16. PBF Data verification option	
Choose which data verification option to be used for calculating the performance payments.	
Data verification option	**Select ONE**
Use of country administrative data	√
Use of WHO/ UNICEF estimates	☐
Use of surveys	☐

PART D: WORK PLAN, BUDGET AND GAP ANALYSIS

17. Detailed work plan, budget narrative and gap analysis *(Maximum 3 pages)*

*Complete **Mandatory Attachment #6: Detailed work plan, budget and gap analysis,** which can be accessed at the online country portal.*

*Detailed instructions to fill in the budget template are available in the first worksheet of the Excel template. Once the budget template and financial gap analysis has been completed, provide a **budget and gap analysis narrative** here.*

The detailed budget and work plan is provided as attachment four in the ***Gavi HSS Budget, Gap Analysis and Work plan template.*** Besides the costing assumptions used in the Myanmar CMYP 2017-2019, past and current expenditures carrying out similar activities informed costing of this proposal. Estimates for cold chain equipment along with most supplies/commodities to be procured using this grant are based on standard cost projections of UNICEF and WHO, who have previously made these procurements on behalf of the National EPI program. Cold chain equipment models and costs were also calculated using the UNICEF supply and WHO PQS catalogue.

Operational costs for routine immunisation services (fixed, outreach and mobile), supervision activities as well as training are based on past expenditures and adjustments from current practices. Regarding the training cost, it is important to note that, unit cost are different depending on the level where the training is being conducted (central level will be higher than state/region and Township level). In addition, MOH, UNICEF and WHO Personnel costs for staff and consultants are based on the established scales and levels. The most expensive unit costs are those related with; a) procurement; b) construction, c) outsourcing services; d) conducting surveys; e) introduction and scale up the use of mobile technologies. These costs have been informed by MOH, WHO and UNICEF cost estimates based on existing previous financial expenditures. The justification of activities costing more than US$ 500,000 are provided in details in separate template.

The detailed two year work plan has been provided with clear timelines on the key activities to be implemented in the first year of the grant.

According to budget estimates, it is anticipated that nearly 42% of the overall budget will be channelled directly to MOH and about 49% through UNICEF and WHO. Furthermore, about 4.3% of the total budget has been allocated to the activities envisaged to be implemented by the CSO and more specifically the MMCWA.

Nearly 17% of the total budget under this proposal is allocated for strengthening the M&E system and implementation of M&E related activities as this is critical in tracking the implementation and performance while strengthening the overall DoPH M & E system.

The programme management cost have been included to mainly support the key implementing agencies to effectively manage the funds directly channelled by Gavi as advised by MOH. Some of the cost to be covered include the overall operations and financial management, general support cost for grant management, operations and human resource involved in grant management. In addition, the program support cost which are recovery cost paid directly to WHO and UNICEF HQ.

The technical assistance will be provided mainly through WHO and UNICEF to contribute to effective implementation. This will include deployment of Immunization, Cold Chain/EVM, Data management and Diseases Surveillance specialist/consultants. Whilst it is envisaged that the Ministry will continue recruitment for all the vacant positions in the EPI and other relevant unit in DoPH, these new and existing staff will require continuous support from UNICEF and WHO to fully accomplish most of the competing tasks. The key areas of support will include; a) Communication and social mobilisation to create demand and increase community participation through advocacy, development and implementation of communication action plan; b) Support for cold chain system strengthening and effective vaccine management; c) Scale up interventions for the increasing immunization coverage in prioritized Townships; d) Strengthening EPI routine administrative data management including planning and implementation of EPI coverage verification survey, operational research and end of grant evaluation; and e) building the capacity of CSO in immunization service delivery to ensure that activities allocated to CSO are implemented effectively. The detailed budget on the human resource needs for the consultants and long term technical assistance are well reflected in the budget template and justifications are provided.

Furthermore these technical teams will be responsible for the implementation of all aspects of the grant that will be channelled through UNICEF and WHO. They will collaboratively work with MOH on day to day basis in the implementation of the grant which will contribute to technical and institutional capacity to sustain gains of the project. Although there is no formal TA plan, The MOH in collaboration with UNICEF and WHO, have established mechanisms for continued consultation on various aspects of immunization service delivery through annual planning exercise, annual and mid-year review as well as regular technical working group meetings where most of the technical assistances needs are identified and request submitted accordingly.

Gap analysis and Complementarity

The total resource requirements for all the five objectives of this proposal over the duration of its implementation are informed by projections of cost estimates from the Myanmar cMYP 2017-2021. Whilst other partners including MOH annual budget are expected to compliment the support from Gavi towards the implementation of the proposed activities to achieve minimal 80% of all EVMA criteria. However, it is important to note that MOH still envisages significant funding gap and hence the need for Gavi support and complementarity from other sources. Following a detailed gap analysis, MOH has requested Gavi a contribution of US$ 52,000,000 for the period 2017 to 2019. This request will contribute to nearly 30% of the total cMYP needs 2017 – 2019.

The main development partners that will contribute to and complement the activities implemented under this proposal include the UN agencies (mainly UNICEF and WHO), World Bank, 3 MDG Fund managed by UNOPS and Global Fund. In addition, other support from Gavi especially new vaccine introduction grants and operational cost for implementing campaign will also compliment activities in this proposal.

The World Bank, IDA Financed 'Essential Health Services Access Project' (EHSAP)' is a $100 million USD loan aiming at increasing coverage of essential health services of adequate quality with a focus on maternal, newborn and child health (MNCH). These funds will mainly contribute to the overall delivery of essential health services with indirect contribution to immunization service delivery, however this support would not be sufficient to cover all the needs especially support in hard to reach and low performing Township which requires additional resource. *It is envisaged that World Bank Support will indirectly compliment activities under objective 3 & 4 related to outreach services*[16]*,* for additional recurrent cost to expand service delivery coverage and for added cold chain logistics network and eHMIS and eLMIS at different level.

The 3 MDG Fund (3MDG) managed by the United Nations Office for Project Services (UNOPS) to contribute towards the country's efforts to achieve the three health related Millennium Development Goals by *pooling the contributions of seven bilateral donors - Australia, Denmark, the European Union, Sweden, Switzerland, the United Kingdom and the United States of America*. During the period 2015 to 2017, the fund made support for cold chain system strengthening through UNICEF. *The 3 MDG support will mainly compliment in the first year of this grant (2017) and contribute towards objective 2, 4 and 5 of the proposal, in addition, most of the integrated outreach activities currently supported through 3 MDG in 42 Townships will be funded through this proposal for the period 2018 & 2019 once the 3 MDG comes to an end in 2017.*

It is estimated that Global Funds will support about US$ 400,000 USD for 2016-17 to expand the DHIS2 to additional 190 Townships (currently in 30 Townships). Nearly US$ 250,000 will be made available in 2017 to support DHIS2. The GF support will compliment objective 5 of this proposal.

Furthermore, support from WHO and UNICEF based will compliment all five objectives of this proposal through the use of existing funds. UNICEF will *contributing mainly to objectives one, two and four while* WHO will leverage the existing interventions to EPI program *to contribute to objective three, four and five*.

During the duration of this proposal (2017-2019), the MOH is anticipating to continue receiving Vaccine Introduction Grants (VIGs) for introduction of the Japanese Encephalitis (JE), HPV and Rota vaccines as well as the operational cost for implementation JE immunization campaign. *This Gavi support will compliment objectives 1, 2, 4 and 5. The detailed operational plans for introduction of the mentioned vaccines and the campaign will be developed during the period May 2016 to September 2017.*

***Pooled fund** applicants are <u>not</u> required to complete the work plan, budget and gap analysis template. Instead, specific information on the sector wide annual work plan and budget should be provided.*

18. Sustainability *(Maximum 2 pages)*

Describe how the government is going to ensure programmatic sustainability of the results achieved by the Gavi grant after its completion. If the country requests recurrent activities, describe steps to reduce further reliance on Gavi funding for recurrent costs. Provide a summary of the country's policy and approach to sustainability.

[16] The WB project appraisal document is included as attachment

As the country transitions politically, from a centrally directed closed economy to a market-oriented one and from 60 years of conflict to peace in the border areas, GDP grew at an average rate of 5.1% per year between 2005-06 and 2009-10 and at 6.5% since the transition began (World Bank data). Despite progress the situation remains fragile and the next government may demonstrate the strength of the new democratic system. It is within this background that Myanmar is seeking to build its structures to continue its prosperity and lessen dependence. The Universal Health Coverage in Myanmar aims to a. improve health outcomes and b. reduced financial burden on the poor and vulnerable due to health expenditures**.** One of its strategic areas (number 5) focuses specifically on sustainable strategies: 'the development of alternative health financing methods and risk pooling mechanisms to expand the fiscal space for health in order to alleviate the catastrophic health care expenditure of the community and enhance financial protection'. The Government has increased its health spending eight-fold over the past five years, with large capital investments in health infrastructure and a free essential medicine program accounting for most of the increased spending *(UHC – a policy brief).* The Government has set itself a target of increasing health expenditures by 1% of GDP annually between 2011 and 2015 (currently 2.4% of GDP), primarily by increasing public expenditures on health (currently 3.5% of total government expenditures). The Government also plans to extend social security benefits coverage to all Government employees, establish social health protection schemes to vulnerable populations with support from development partners and provide priority to ensuring universal coverage of maternal, neonatal and child health (MNCH) as well as essential drugs. Additionally, the Government is exploring other options both to (a) increase the resources available to health sector and (b) improve the efficiency, effectiveness and equity of health care services. The Government is open to public-private partnerships as one of the approaches to achieving UHC, acknowledging the large role that private financing and provision already play in the health sector of Myanmar *(UHC- A Policy Brief).*

In a significant step towards sustainability on vaccine procurement, the MOH has for the first time included a budget line for the purchase of their own routine traditional vaccines from 2016 (April to March 2017) and thereafter. Up to now, routine vaccines were purchased by UNICEF. Myanmar however has always met with their Gavi co-financing obligations.

The newly developed cMYP (2017-2021) among other objectives, aims to 'develop a financial plan for immunisation' with plans for the creation of a vaccine trust fund by 2018 mainly to sustain new vaccines introduction. The government is planning to include the temporary position created into its regular system. On a programmatic level, as a matter of policy, the Ministry of Finance will only sign off on plans which it considers to be financially sustainable. In terms of capital expenditures, the MOH standard operating procedures for maintenance of buildings and logistics will apply to all capital investments made under this application. All maintenance and overheads (e.g. phone line charges and electricity for computers) are to be covered from the regular budget. The MOF has assured continuous support to maintain vehicles, fuel cost as well as other recurrent cost *(ICC meeting minutes).*

The MOH will be discussing with the World Bank in early 2016 strategies for sustainable immunisation finance and future self-reliance. Strategies to be used to ensure that the activities/interventions will be sustained include: a) Develop financial sustainability plan – attaining financial efficiencies, financial reviews to assess needs, recommended mechanism and modalities for resource mobilization to achieve financial efficiency; b) Advocacy and lobbying with senior MOH officials to ensure there is an increased budget for subsequent years; c) Documenting best practices and lessons learned which will generate evidence on the impact and what needs to done to sustain the interventions; d) Continued

advocacy with members of parliament especially social service committee at all levels to increase their awareness on the need to invest more on the proposed activities once the Gavi funding ends; e) Support state/Region and Township health authorities in planning for interventions with a more focus on sustainability including capacity on budgeting for utilization of Government resources; f) Developing and implementing plans to attain operational efficiencies; and g) Partnership with private institutions for resource mobilization

The government will also ensures that the activities planned to be financed with HSS support will not result in the creation of parallel posts or systems at any level of the health system. All strategies, activities implementation, monitoring and evaluation will follow and build upon the existing health care system of the country. Under decentralization, the local government are gradually assuming the costs of human resources management, outreach services and many basic health services. Once Gavi support ends, the MOH will continue to pay for training, data analysis, and overheads, while local communities will cover daily operating costs. Capacity building through skills upgrading will help to maintain the impact of the initiatives being proposed, both in terms of sustained high immunization coverage rates and quality for expanding access to a full range of EHCS. Skill upgrading with accompanying promotion will improve retention of experienced health staff especially in rural remote areas and sustain quality health services at the sub-district level. As most of the activities will be implemented through the existing health care delivery system, enhancement of technical capacity will lead to long lasting effect. Investment made on the training of township health community will lead to improved local resource mobilization and more effective budget allocation from the local development annual budget. This, in turn, will help reach and sustain an improved level of local health services.The experience shows that provision of quality services will generate demand from the communities for health services, and contribute to getting community leaders more engaged in supporting local health services. In addition to mobilising more funds for health, the presence of higher quality services increases the effectiveness of social mobilization and behaviour change strategies. Upgrading the skills of the Basic health staffs will improve their retention, and will contribute to sustaining high immunization coverage rates, as they are the primary vaccinators in communities. Support for community-based interventions is extremely high among partners, and no lack of technical support is envisioned for supporting the strengthening of BHSs. Only financial constraints have hindered a more rapid progression of upgrading the skills of these health workers.

Weakness in the current HMIS includes lack of timely reports from several townships due to inadequate data management and reporting infrastructure. Filling these critical gaps will put into place monitoring of progress on progress of the objectives. The infrastructure investments in filling in the gaps in the health communication network will be complemented by technical training and HMIS support from other partners, maximizing the value of this investment.

Pooled fund *applicants are required to provide existing documentation that addresses sustainability. List which documents have been provided and reference the relevant sections.*

PART E: IMPLEMENTATION ARRANGEMENTS AND RISK MITIGATION

19. Implementation arrangements *(Maximum 2 pages)*

The implementation of the Gavi HSS2 grant will be managed through existing mechanisms in the country, the National Health Committee is the highest decision making body on health sector policy and will be responsible for providing general oversight and guidance to the management of the Gavi HSS2 grant. However, most of the decisions are made by MOH based on technical recommendations of the ICC for EPI and National Committee for Immunisation Practices (NCIP). The ICC is the executive body for financial and implementation management and the NCIP acts as a decision-making mechanism for technical recommendations proposed by MOH.

Overall management for the implementation of this grant will be the responsibility of the DoPH at the MOH. The department will be supported by WHO and UNICEF in areas in which they have comparative advantage as has been the case with the current GAVI HSS grant and all other immunization interventions in Myanmar. The activities will be coordinated and supervised through the ICC who will also review the work plans, approve the programme budget allocation and proposed changes. ICC meetings are and will continue to be held quarterly to ensure HSS' activities are well co-ordinated with UNICEF, WHO and other health partners supporting immunisation service delivery. EPI technical working group[17] meetings will be held monthly to facilitate the co-ordination of the activities and monitor grant performance on a regular basis. The technical working group is also responsible for facilitating the development of annual immunisation work plans at all levels, consolidated centrally and submitted for endorsement to the ICC. However, in relation to health system issues, if a policy decision is required through HSS research or programming, the matter could be put up for discussion to the National Health Committee through the office of the Minister of Health. The DoPH will be the main implementing department and will coordinate closely with the related units.

At the State and Regional Levels, the focal point for HSS investments will be the State/Regional Public Health Directors who will delegate technical responsibility for monitoring, supervision, training and planning to State/ Regional EPI team leader. At the *Township level*, the TMO will be responsible for planning and implementation, as well as monitoring and evaluation, in collaboration with the Township Health Team. According to the Ministry guidelines, all funds will be received in the DoPH account. The grant will be allocated to the implementing partners, the responsible units of DoPH and CSOs respectively. From the DoPH account, funds will be disbursed directly to the States and Regions and to the Townships by fax or by bank draft to the Government Bank Accounts at each level. State and Regional Public Health Directors are the drawing officers for all government funds supported by administrative staff. At the Township level, the TMOs are the drawing officers supported by administrative staff. At the Central level, the Administration and Finance Directorate as part of the DoPH is responsible for Finance, Internal Audit and Procurement and Supply Division. The logistics and procurement will be done through the Procurement and Supply Division or where appropriate, through the procurement services of WHO and UNICEF. The MOH will follow standard procedure as per in country procurement rules such as for tendering, bid selection and contract management.

Director General of DoPH will propose approval of budgets for each activity to MOH. The Auditor General (Ministerial Level) conducts an external audit of the budgeting, finance and functions of all Ministries on biannual basis. There is an internal auditing system within DoPH conducting audits biannually and will be responsible to monitor and evaluate the progress of the activities at each level. Under DoPH Administration and Finance Directorate.

[17] Members include: MOH/EPI, Central Epidemiology Unit, WHO and UNICEF

Taking into consideration the previous arrangements for HSS1, MOH will also request Gavi to channel some of the resources through WHO and UNICEF. These two agencies have been providing technical support in managing Gavi resources on behalf of the MOH especially the vaccine introduction grant and operations cost for implementation of immunisation campaigns.

UNICEF will support the strengthening of routine immunisation by demand generation through support to the MOH in the development of culturally appropriate communication packages, capacity building on interpersonal communication for BHS and volunteers, active participation of CSOs and roll out of evidence informed multi-channel communication campaigns. The comprehensive national communication plan will include the tailored communication interventions for hard to reach areas and underserved populations. UNICEF will also use its comparative and competitive advantage of existing global and regional experts on communication and demand generation to share experience and provide the need technical support to the Ministry of Health. In addition, UNICEF will provide technical support and assistance to the Ministry in cold chain and effective vaccine management including capacity building of cold chain key persons, cold chain engineers and facilitate the procurement, distribution and installation of cold chain equipments including repair and maintenance. Furthermore, UNICEF will assist in period assessment related to effective vaccine management, cold chain inventory updates as well as establishment of automated immunisation supply stock management. This will be made possible through the support of UNICEF Supply Division, UNICEF programme division – the immunization unit as well as its regional office. In addition UNICEF will provide continued support to the Ministry of Health, the procurement and supply section in the Department of Public Health to strengthen the capacity immunization supply chain management to ensure that they require necessary skills related to immunization supply chain including linkages and coordination with other ongoing initiatives related to overall supply chain strengthening in the country.

WHO will provide technical support in developing training package on various topics, establishment of standard training centres, conduction of MLM training, data management and other capacity building training, development of policy, guidelines and various strategic documents as guided by the program. The support will also be provided to strengthen VPD surveillance, EPI annual and periodic review and PIE evaluation and assessment. Introduction of new vaccines and development of innovative tools and technologies will also be supported by the WHO.

Additionally, regular review meetings will be conducted at each level to review the performances, constraints and challenges, successes and way forward against the planned activities. JRF will be prepared and submitted to WHO every year. Furthermore, as the lead implementing agencies, both UNICEF and WHO will coordinate closely with the Ministry of Health to ensure timely reporting of the grant performance both financially and technically. Mid-year and annual reports will be prepared by both agencies, discussed and approved by the ICC or other relevant bodies before consolidation in one country report for submission to Gavi.

Pooled fund *applicants are required to provide documentation of the implementation arrangements of the sector wide mechanism, if appropriate. List which documents have been provided and reference the relevant sections.*

20. Involvement of Civil Society Organisations (CSOs) *(Maximum 2 pages)*

Describe how CSOs will be involved in the implementation of the HSS grant.

Gradually Myanmar has seen a rise in the number of NGOs and CSOs working nationally and as the country continues to evolve and further strengthen their community structures it is envisaged that more active participation (and role) will be placed on national actors. According to Government 'Health in Myanmar' publication (2013 p.150), there were 37 international NGOs relevant to health working in Myanmar and 14 national non-governmental organizations including MMCWA, MRCS, traditional medicine, dental and nursing associations among others.

Increasing coverage through routine, outreach and campaigns will not be possible without the support of CSOs, NGOs, INGOs and community-based volunteers in hard to reach, conflict affected and self-administrative areas. With the complex landscape of remote, geographically dispersed, non-government control and border areas together with migrant and other ethnic groups, increasing access to immunisation is only successful through the involvement of CSOs and NGOs. In particular, Myanmar Maternal and Child Welfare Association (MMCWA) support the MOH in all townships through a network of more than 20,000 volunteers to support social mobilization and demand generation. Myanmar Health Assistant Association (MHAA) and Myanmar Nurse and Midwifery Association (MNMA) support the MOH in conflict affected areas, mainly Rakhine state where they facilitate transport costs and other operations for the Basic Health Staff (BHS) and provide community mobilization support.

Health Poverty Action (HPA) has focused their work in self-administrative regions of WA (North and Shan East) as well as in Kachin State where they been directly involved in recruiting, training and supporting vaccinators to provide immunisation services. HPA has also been provided solar refrigerators to maintain cold chain with UNICEF support. HPA is the only NGO that has been allowed by MOH to provide direct immunisation service delivery while other NGOs mainly facilitate movement/transport of BHS and social mobilization while the immunisation service delivery remain the duty of the MOH, State Health Department and Township Health Authorities. However, more advocacy is required in areas where MOH cannot reach to allow the use of third party organizations, either CSOs, NGOs and/or INGOs to provide direct immunisation services where MOH cannot reach and allow the use of third party local actors to provide direct immunisation services.

According to its organizational structure, Myanmar Maternal and Child Welfare Association (MMCWA) is organized in Central, State/Regional, District, Township level and branches associations throughout the country. The organization has formed ten household volunteers for implementing immunisation activities more smoothly and effectively. MMCWA members always contribute to MOH activities, especially reproductive health, safe motherhood programme, immunisation emphasis on EPI, nutrition promotion, prevention and control of communicable diseases and non-communicable diseases, personal and environmental hygiene and traditional medicine. Members of Myanmar Maternal and Child Welfare Association are involved at village level and in many areas, they organize (10) household leaders to reinforce the health and all routine activities of the association. MMCWA provides vouchers for MVS project. It assists in assessing mothers as early as possible enhancing the potential for relevant demand side financing activity. MMCWA has 135 Maternity Homes throughout the country and immunisation for pregnant mothers, new born and under five children are some of the major activities of the Maternity Homes.

Central MMCWA has organized Mobile Clinics at remote villages in townships around Nay Pyi Taw since 2010. These Mobile Clinic activities have been carried out in each State/Region and District level association since 2012. At the Mobile Clinic, dissemination

health education on AN and PN care, communicable and non-communicable diseases, personnel hygiene, ARH and Human Trafficking and also providing proper medical treatment to the community and elderly.

Both MMCWA and MRCS represent civil society in the ICC. However MHAA and MNMA are active participants in the health cluster coordination both at central and state levels where most of the issues related to emergency health service delivery among the conflict and emergency affected areas are discussed including the provision of immunisation. These active health cluster members work closely with CEPI/DOPH as well as coordination with WHO, UNICEF and other UN Agencies, NGOs and other INGOS as active members.

Since Myanmar is undergoing political and health sector reforms it is high time for active engagement of the CSO especially in ensuring a strong link between communities and health systems at all levels. The CSOs have a comparative and competitive advantage of any existing network of volunteers in most communities who are already trusted by the caregivers and at community at large. They could be the reliable source for community mobilization and demand generation. In addition, it has been proven that in conflict affected area and self-administrative region, CSO can play a very important significant in bridging the gap in service delivery. The MOH will consider engaging CSO in these areas to provide direct service delivery as well as providing support in mobilization of caregivers to increase uptake of immunisation and other maternal and child health related interventions.

In particular, MMCWA will lead the roll out of implementation of the communication plan of action for strengthening routine immunization contributing mainly to objective one of this proposal through the use of more than 20,000 volunteers (1 volunteer per village) and 10 household volunteers (one volunteer for each of the 10 household in the village). More and more role of CSOs is important to achieve full immunization coverage especially in hard to reach, peri urban and conflict areas. The CSO support will continue for social mobilization in routine immunization by improving the skills in IPC and dissemination of message received in the mobile phone. They will also implement transit media and village health talk using street theatre, folk dance and road shows to contribute in building community ownership for full immunization.

Pooled fund *applicants are required to summarise the role of CSOs in the implementation of the sector wide programme.*

21. Risks and mitigation measures *(Maximum 2 pages)*

If available, provide Attachment #35: Health Sector Risk Assessment. If such an assessment is not available, provide an analysis of the risks of not achieving the objectives in this application.

Complete the table below for each of the proposed objectives outlined in Question 12. If the risk is categorised as 'high', please provide an explanation as to why it is 'high'.

Description of risk	***PROBABILITY*** ***(high, medium, low)***	***IMPACT*** ***(high, medium, low)***	***Mitigation Measures***
Objective 1 To strengthen the demand for immunisation services through the development and implementation of a communication plan, effective participation of the community and civil society organizations for the increase of DTP3 coverage to at least 85% by 2019			
Institutional Risks:	*Low*	*Medium*	*Capacity building at all levels will be provided to enable*

Inadequate capacity in implementing community mobilisation and Interpersonal communication (IPC) activities at all levels			*Central, S/R townships and RHC's to implement social mobilisation and IPC activities successfully particularly with ethnic and migrant groups*
Fiduciary Risks: Limited capacity of implementing partners in donors' financial rules and regulations and fund flow mechanisms due to unfamiliarity with foreign grants.	*Medium*	*Medium*	*Use the existing opportunities of UN Harmonised Approach for Cash Transfer (HACT) mechanisms and the WB initiatives in building the capacity of MOH in financial management.*
Operational Risks: Limited number of CSOs, i/NGOs and local actors involved in EPI.	*Medium*	*Medium*	*Demand creation strategies include the involvement of volunteers, community influential people, religious leaders and CSOs and i/NGOs* mostly in hard to reach and conflict area
Programmatic and Performance Risks: Stability in border areas and Self administrative region limits access to and use of immunisation services**.**	*Low*	*High*	*Gaining access through local groups, volunteers and civil society to gain access*
Other Risks:			
Overall Risk Rating for Objective 1	*Medium*	*Medium*	*The comprehensive demand creation strategy is designed to mitigate some of the above risks.*
Objective 2 To improve immunisation service quality and availability for hard to reach and under served populations through the implementation of the cold chain expansion and improvement plans in all of the prioritized areas by 2019			
Institutional Risks: Limited resource capacity to undertake the cold chain expansion plan and other activities.	*Medium*	*Medium*	*Both technical assistance and outsourcing of services including maintenance aim to mitigate limited HR dedicated to supply chain functions*
Fiduciary Risks: Limited capacity in the procurement processes including forecasting, tendering, etc.	*Low*	*Medium*	*Used of combined strategies, the immediate procurement to be facilitate through UNICEF especially the cold chain equipments. In additional capacity building of MOH in procurement processes.*
Operational Risks: CMSD no longer undertakes supply chain functions for Public Health and CEPI. The Procurement and Supply unit in the DoPH have inadequate	*Medium*	*Medium*	*Rental facilities and/or third party operators are being sought for dry goods storage, customs clearance and distribution. The central cold store has additional cold rooms programmed and this grant has*

capacity to management of vaccines and dry goods.			*an allocation for purpose built warehouse in 2017.*
Programmatic and Performance Risks: Cold chain expansion to prioritized townships requires technical support for the appropriate maintenance and functioning of fridges. Limited technical support available for national coverage.	*Medium*	*Low*	*Outsourced cold chain maintenance contracts will be initiated and recipients of cold chain equipment trained.*
Other Risks:			
Overall Risk Rating for Objective 2	*Medium*	*Medium*	*Strategies to mitigate likely risks are addressed through this proposal.*
Objective 3 To strengthen leadership management capacity and coordination of the priority focused areas and contribute to universal health coverage by improving population and service coverage to 85% by 2019			
Institutional Risks: Some TMOs have Inadequate capacity to coordination essential health interventions and implement HSS2 grant activities in Hard to Reach Areas	Medium	Medium	Organizing MLM and supportive supervision training workshops. - Regular visits and monitoring of CEPI, states/ regions supervisors, partners technical staff to prioritized townships with hard to reach areas. Establishing states, regions, Township EPI task force committee (MOH, Partners, Stakeholders) for coordination and monitoring of activities implementation
Fiduciary Risks: There is a chance that used funds in prioritized states, regions, and townships with underserved areas will be poorly recorded	Low	Low	Training of financial officers on financial management to be able to track funding.
Operational Risks: Inadequate human resources in townships with hard to reach areas will delay the implementation of the HSS2 grant activities	Medium	Medium	Recruiting and training health workers from the local residents. Recruit retired and seasonal health staff to fill gaps. Mobile teams will be used to reach areas without health facilities and staff
Programmatic and Performance Risks: Shortage of trained and experienced managers and programme leaders in townships with hard to reach areas and CRASH townships	Low	Low	New managers will be trained in MLM, supportive supervision and financial management
Other Risks:			
Overall Risk Rating for Objective 3	Low	Low	

Objective 4 To improve equitable access to service delivery in prioritized areas by the increase of DTP3 coverage to at least 85% by 2019			
Institutional Risks: Inadequate capacities to use funds allocated for activities in townships with hard to reach and CRASH areas and lack of coordination to use scarce resources optimally	Medium	Low	Prioritised states, regions managers and TM Os will be trained to build their capacities to use funds efficiently. CEPI, states/regions supervisors & partners will follow-up to monitor funds utilisation
Fiduciary Risks:	None identified	None identified	
Operational Risks: Limited number of trained data managers at CEPI, states, regions ad townships levels	Medium	Medium	Proper training to data managers at all levels and provide computers, access to internet and mobile phones
Programmatic and Performance Risks: Low capacity at prioritised states, regions, and townships levels to monitor the programme and provide supportive supervision	Medium	Medium	MLM and supportive supervision Training for managers and EPI focal persons to monitor the programme and provide supportive supervision
Other Risks:	None identified	None identified	
Overall Risk Rating for Objective 1	Medium	Medium	
Objective 5 To strengthen EPI data management, monitoring and evaluation systems through the establishment of electronic reporting system in 50% of townships by 2019			
Institutional Risks: The pilot and expansion of electronic HMIS is not progressing, then the poor EPI data collection and quality persist	Low	Low	Global Fund supports the expansion to 190 townships. WHO will support the expansion to the remaining 141 townships. Under this proposal, the expansion of the eHMIS will be supported
Fiduciary Risks:	None identified	None identified	
Operational Risks: Limited number of trained data managers at CEPI, states, regions ad townships levels	Medium	Medium	Provision of training and computers, internet access and mobile phones to data managers at all levels
Programmatic and Performance Risks: Low capacity at prioritised states, regions, and townships levels to monitor the programme and provide supportive supervision	Medium	Medium	MLM and supportive supervision Training for managers and EPI focal persons to monitor the programme and provide supportive supervision
Other Risks:	None identified	None identified	
Overall Risk Rating for Objective 5	Medium	Medium	

Pooled fund *applicants are required to provide any risk mitigation plan under the sector wide/ pooled funding mechanism.*

22. Financial management and procurement arrangements

Describe the proposed budgetary and financial management mechanisms for the grant

The overall management of Gavi HSS2 funds will be the responsibility of the Department of Public Health, Ministry of Health, which will be carried out in accordance with government guidelines and procedures laid down by the MOF. At the Central level, the DG of DOPH will be responsible for approving budgets for each activity at the MOH. The MOH is proposing to receive the funds directly from Gavi for the first time.

As stated in the implementation arrangements (section 19), funds will be allocated to the implementing partners, the responsible units of DOPH and CSOs. From the DOPH account, funds will be disbursed directly to the states, regions and townships by fax or by bank draft to the Government Bank Accounts at each level. State and Regional Public Health Directors are the drawing officers for all government funds supported by administrative staff. At the Township level, the TMOs are the drawing officers supported by administrative staff.

As also elaborated in other section, the MOH is proposing about 49% of the funds to be channelled by Gavi directly to WHO and UNICEF. Therefore, since each of the receiving parties have a different financial management system. Each of these agencies will use their specific financial management arrangements. The utilization of these funds will be based on the joint work plan developed in consultation with the CEPI and DOPH. 190This has also been the case for the current GAVI HSS grant and other Gavi supported activities such as operational support for implementing measles-rubella campaign and vaccine introduction grants for pentavalent, measles second dose and Inactive Polio Vaccine (IPV). WHO managed portion of funds shall be disbursed directly by Gavi to WHO/HQ in Geneva which then links these funds to WHO Myanmar through the Global System of Management (GSM) of the WHO. Funds will then be requisitioned, used and reported on against the planned activities in the work plan. UNICEF managed portion of funds will be disbursed through UNICEF HQ in New York, then Programme Budget Allotments made to UNICEF Myanmar Country Office. Procurement of supplies will be based on supply forecasting, procurement and distribution plan developed jointly with the MOH.

The logistics and procurement will be done through the Procurement and Supply Division of DOPH or the procurement services of WHO and UNICEF will be used. The standard procedures for the procurement services of MOH will be strictly followed such as tendering, bid selection and contract management. In addition, some of the procurement will be managed directly through UNICEF especially the cold chain equipments and other supplies as indicated in the procurement plan.

The Auditor General (Ministerial Level) conducts an external audit of the budgeting, finance and functions of all Ministries on biannual basis. There is also an internal auditing system within DOPH at each level which is carried out biannually.

Describe the main constraints in the health sector's budgetary and financial management system.

The CEPI has had experience with managing direct financial transfers from WHO and UNICEF during previous Measles-Rubella and Polio campaigns. However DoPH still has human resource gaps at central as well as regions/states levels responsible for financial

management. Some of the constraints encountered with regard to budgetary and financial management systems include the following:

a) The existing human resource especially at state/Region and Township level have limited capacity in donor funding management including budgeting, planning and donor financial policies and procedures.

b) The existing system of budgeting and financial management system is not computerized making it difficult to have access to real time data related to financial expenditures.

To assist the HSS2 focal person (i.e. the EPI focal persons at central, regions and states levels) to manage the routine budget during the life cycle of the grant, it would be beneficial to identify financial assistants at each level. The financial assistants will work closely with the focal points at all levels to ensure that funds are disbursed on time and expenditure are based on approved budgets. To enhance the capacity in financial management based on government regulation, the quality of financial management and documentation will be audited periodically by external and internal auditors and recommendations will be implemented as per agreements.

There is plan to support strengthening of finance unit at all level. The strengthening could be in form of capacity building training to finance staff, development of financial software and recording and reporting tools, logistics support such as computers for electronic registration of finance.

*Complete the **Budgetary and Financial Management Arrangements Data Sheet** (below) for each organisation that will directly receive HSS grant finance from Gavi.*

*Provide **Mandatory Attachment #7**: Detailed two-year Procurement Plan*

***Pooled fund** applicants are required to provide relevant documents for financial management and procurement under the pooled funding arrangement*

Budgetary and Financial Management Arrangements Data Sheet	
Any recipient organisation/country proposed to receive direct funding from Gavi must complete this Data Sheet (for example, MOH and/or CSO receiving direct funding).	
1. Name and contact information of Focal Point at the Finance Department of the recipient organisation.	Daw Khine Khine Kyi, Director (Finance), DOPH
2. Does the recipient organisation have experience with Gavi, World Bank, WHO, UNICEF, GFATM or other Development Partners (e.g. receipt of previous grants)?	YES
3. If YES: • Please state the name of the grant, years and grant amount. • For completed or closed Grants of Gavi and other Development Partners: Please provide a brief description of the main conclusions with regard to use of funds in terms of financial management performance. • For on-going Grants of Gavi and other Development Partners: Please provide	• (1) ISS grant (2) NVI grant (3) Mass immunisation campaign grant (4) HSS1 grant • NA • FMA was done in 2008/2009 for HSS1. • External audit report on Gavi funds utilization and expenditure statements are necessary to be attached in Annual Progress Report (APR)

	a brief description of any financial management (FM) and procurement implementation issues (e.g. ineligible expenditures, mis-procurement, misuses of funds, overdue / delayed audit reports, and qualified audit opinion).	
Oversight, Planning and Budgeting		
4.	Which body will be responsible for the in-country oversight of the programme? Please briefly describe membership, meeting frequency as well as decision making process.	Internal Audit of DOPH (Director, internal audit is also a member of ICC) As ICC, biannually
5.	Who will be responsible for the annual planning and budgeting in relation to Gavi HSS?	HSS focal person and Technical working group for EPI to present to ICC
6.	What is the planning & budgeting process and who has the responsibility to approve Gavi HSS annual work plan and budget?	ICC members need to endorse the Gavi HSS annual work plan
7.	Will the Gavi HSS programme be reflected in the budget of the Ministry of Health submitted every year to the Parliament for approval?	YES through Ministry of Finance
Budget Execution (incl. treasury management and funds flow)		
8.	What is the suggested banking arrangement? (i.e. account currency, funds flow to programme) Please list the titles of authorised signatories for payment release and funds replenishment request.	The suggested account currency is USD. The funds is to be flowed to DOPH account. Authorized person-
9.	Will Gavi HSS funds be transferred to a bank account opened at the Central Bank or at a commercial bank in the name of the Ministry of Health or the Implementing Entity?	The bank account is opened for DOPH which is the implementing entity at Nay Pyi Taw Myanmar Economic Bank.
10.	Would this bank account hold only Gavi funds or also funds from other sources (government and/or donors- “pooled account”)?	No. Both government and donors
11.	Within the HSS programme, are funds planned to be transferred from national to sub-national levels (provinces, districts etc.)? If YES, please describe how fund transfers will be executed and controlled, including stating what time of year (month/ quarter) funding must be received at the national level in order to disburse to sub-national levels in a timely manner.	YES The grant will be allocated from national and sub-national from the DoPH account, funds will be disbursed directly to the States and Regions and to the Townships by fax or by bank draft to the Government Bank Accounts at each level. State and Regional Public Health Directors are the drawing officers for all government funds supported by administrative staff. At the Township level, the TMOs are the drawing officers supported by administrative staff.
Procurement		
12.	What procurement system will be used for the Gavi HSS Programme? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other	A combination of procurement systems: According to national guidelines, procurement under a certain threshold will be procured in country. However all Cold Chain and other

Development Partners' procurement procedures)	equipment and major procurements will be procured directly through UNICEF.
13. Are all or certain items planned to be procured through the systems of Gavi's in-country partners (UNICEF, WHO)?	Yes. Procurement of vehicles for central EPI and R/S EPI teams and motorcycles for Midwives is planned to be through UNICEF and WHO.
14. What is the staffing arrangement of the organisation in procurement?	Director leads Procurement and Supply Division of DOPH. There is the focal person for all the formal procedures of procurement process.
15. Are there procedures in place for physical inspection and quality control of goods, works, or services delivered?	YES. The physical inspection of goods is done by a committee with concerned Directors and Procurement and Supply Division of DoPH.
16. Is there a functioning complaint mechanism? Please provide a brief description.	YES it is mainly with functioning complaints for cold chain equipments. As soon as complaint was received, the cold chain engineers needed to go, check and repair till it was functioning. But the bottleneck is with inadequate cold chain engineers.
17. Are efficient contractual dispute resolution procedures in place? Please provide a brief description.	YES The matter needs to be presented to the Executive Committee of the MOH who decide the course of action. UNICEF as the procurement agent for significant procurement in this proposal has defined and active contract resolution dispute mechanisms in place.
Accounting and financial reporting (incl. fixed asset management)	
18. What is the staffing arrangement of the organisation in accounting, and reporting?	Internal auditor of DoPH and External Audit from Auditor General Office
19. What accounting system is used or will be used for the Gavi HSS Programme? (i.e. Is it a specific accounting software or a manual accounting system?)	Manual accounting system
20. How often does the implementing entity produce interim financial reports and to whom are those submitted?	The financial report is submitted to MOH with cc to each programme after each auditing.
Internal control and internal audit	
21. Does the recipient organisation have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures?	YES
22. Does an internal audit department exist within recipient organisation? If yes, please describe how the internal audit will be involved in relation to Gavi HSS.	YES the internal audit department assessed all the activities of EPI and DoPH including the implementation under Gavi HSS.
23. Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations?	YES

External audit	
24. Are the annual financial statements planned to be audited by a private external audit firm or a Government audit institution (e.g. Auditor General)?[18]	YES Auditor General
25. Who is responsible for the implementation of audit recommendations?	The implementing or recipient organization is responsible to take audit recommendation and the reaction and report go through MOH to be back to Auditor General

[18] If the annual external audit is planned to be performed by a private external auditor, please include an appropriate audit fee within the detailed budget.