Joint appraisal report

Country	Myanmar
Reporting period	*2014*
cMYP period	*2012-2016*
Fiscal period	*1st April – 31st March*
Graduation date	*Not Applicable*

1. EXECUTIVE SUMMARY

1.1. Gavi grant portfolio overview

GAVI commenced programming in 2002, and has commitments until 2017, valued at $158.6 million, of which $102.5 million has been disbursed to the country by March 2015. Main areas of program support from GAVI are as follows:

- Health System Strengthening
- Immunization Services Strengthening and Injection safety Support
- New Vaccine support including hepatitis B vaccine, pentavalent (2012-2016), measles 2nd dose (2012-2016), MR campaigns (2014), IPV introduction (2015) and approved PCV introduction (2016).

The Gavi investment, although significant in absolute terms, relatively speaking, is a lower proportion of overall national and international investment than in previous years. Government investment in the sector has increased substantially in recent years, and international aid flows have also expanded since political reforms were implemented. According to one source, health spending per capita has increased from $1 in 2008/2009 to $11 per capita in 2013/2014 (World Bank Appraisal Document 2014). New aid partners including the World Bank are now complementing the ongoing investments of the multi donor 3MDG Fund and the Global Fund and of Gavi. Despite these wide sector developments and investments, the Gavi proportion of funding of the EPI program is very high, and is likely to expand with additional vaccine introductions (IPV 2015, PCV 2016). APR expenditure tables indicate that 63% of program costs were financed by Gavi in 2014.

The Gavi investment in Myanmar is strategic in terms of health program outcomes and impacts, in so far as existing initiatives such as the reaching every community strategy and the HSS coordinated planning approach focus on the unreached or hard to reach as the primary population target. The refocus of HSS on cold chain and logistics and developing skills of PHC cadre (Public Health Supervisors II) is also strategic, in so far as it prepares the grounds for future vaccine introductions, as well as in the longer term developing the health workforce capability to sustain immunisation service improvements. The focus of HSS on coordinated planning is also strategic in so far as it seeks to leverage coordinated technical effort, resource allocation and public service delivery at township level and below to support improved health care access for hard to reach or unreached populations (PHC package). The substantial coverage improvement in 2014 (an increase in 15% DPT3 from the previous year - official estimates only), including the identification of 541 zero immunisation cases across the country, provides promising evidence of the impact of these approaches. More evaluative evidence will need to be gathered in the coming years to validate these outcomes through coverage surveys, HSS evaluation, and EPI Reviews). [1]

[1] There is inconsistency in the use of denominators for 2014 coverage rates, which may explain much of the 15% jump in DTP3 coverage. This is linked to the 2014 census data. Annex F has more background. (SCM note).

1.2. Summary of grant performance, challenges and key recommendations

Grant performance (programmatic and financial management of NVS and HSS grants)

Achievements

- Improved immunisation coverage in 2014 (88% DPT3 compared to 73% in previous year)
- Disease control and elimination targets being reached (polio, tetanus, measles, rubella control)
- Innovations in sector strategy (HSS Coordinated Planning) and program strategies (Reaching Every Community strategy)

Challenges

- Addressing persisting or emerging Inequities in immunization coverage and access (rural & urban) This includes challenges in reaching children in areas affected by long term conflicts, and geographically hard to reach areas as well as in the self-administrative regions
- Ensuring Cold Chain capacity and vaccine management skills keep pace with increased storage needs for vaccine introductions
- Addressing systems issues of human resources availability and mix, and health system development in remote and border regions
- Limited absorptive capacity of HSS and VIG grants at Township level and below due to limited management systems development

Key recommended actions to achieve sustained coverage and equity (list the most important 3-5 actions)

- Implementation of reaching every community strategy to improve equity in immunization with emphasis on improved quality and quantity sessions and micro-planning based on the local context.
- Strategically focus HSS on sustaining immunisation improvements in the context of an integrated PHC planning and delivery system
- Implement Vaccine Management assessment and cold chain expansion and replacement plan, and conduct follow up monitoring to prepare system for additional vaccine introductions, including scaling up cold chain systems in hard to reach RHC and sub RHC areas
- Improve data quality through implementation of quality improvement activities and coverage surveys (also, increasing frequency and regularity of supportive supervision and feedback on the immunization performance to lower levels: central to state/regions, then State/regions to Townships)
- Developing the technical capability of a wider PHC workforce (Public Health Supervisors II) to deliver quality immunisation services

1.3. Requests to Gavi's High Level Review Panel

Grant Renewals

New and underused vaccine support

- Pentavalent, 10 dose(s) per vial, LIQUID
- Measles second dose, 10 dose(s) per vial, LYOPHILISED
- PCV is already approved for 2016

Health systems strengthening support

- No request

1.4. Brief description of joint appraisal process

The Annual progress report was developed in country in May 2014. A consultant used this APR report, in conjunction with other documentation including sector reports, cMYP 2012-2016, cold chain assessments in 2014, PIE evaluation 2014 and evaluations and coverage data, in order to compile a draft Joint Appraisal. This was then circulated to the MoH and in country partners for review and revision.

2. COUNTRY CONTEXT

2.1. Comment on the key contextual factors that directly affect the performance of Gavi grants.

General Context

The Union of Myanmar is characterized by both complexity and diversity in terms of geography and ethnicity. There are four main ecological zones – hilly regions, plains, Delta and coast, with a land mass that stretches from the Himalayan region to southern Thailand. There are over 200 language groups. Despite some improvements in recent years, over the last 30-40 years, the country has been beset with long running internal conflicts in regions and States bordering China and India. These contextual factors directly impact the performance of the immunization program and of GAVI investments, by presenting major policy and operational challenges in ensuring universal access to immunization services, as illustrated by the significantly lower coverage results in these areas. Fundamental contextual barriers to immunization access include intermittent seasonal geographic access due to poor road and communications, insecurity in some areas, remoteness, and lack of the correct numbers and mix of PHC human resources in remote areas

Political and Social Reform Context

Recent constitutional reforms have opened up new health sector and program pathways in Myanmar. Administrative systems are becoming more decentralized, NGOs are becoming more active, policy reforms such as social protection are beginning to emerge, and there has been a substantial increase in international development assistance aid flows and government health investment. These developments present both opportunities and challenges to the EPI program and GAVI investment. The main opportunity presented is increased resourcing for health system development and operational delivery of public services, and expanded opportunity for peace agreements with populations in conflict. The main threat is lack of absorptive capacity by sub national institutions that have limited systems (planning, budgeting, M & E) to manage and direct larger operational budgets. The political reform context has also generated higher levels of population mobility and urban drift, presenting major contextual challenges in terms of the growth of urban poor settlements, as well as making it more difficult to calculate population denominators and identify populations at risk of not being immunized (see later sections for discussion of data quality).

Health System and Program Context

The health system in Myanmar is very well structured with the tiered system focused on a Township Health System, with Rural Health Units, sub RHC and a network of volunteers forming the backbone of the PHC system. As mentioned above, the main health system supply side constraint relate to insufficient numbers and inappropriate mix of health human resources in some areas. An inadequate mix of human resources has also meant that the burden of immunization delivery has fallen on the midwife, with inadequate numbers of other PHC staff (Public Health Supervisors and Nurses) to taking up the immunization role. The national immunization program is managed through the National Epidemiology Unit in the Ministry of Health, with active partnerships formed with UN agencies (WHO, UNICEF) and NGOs, facilitated through regular ICC meetings. The vaccine delivery and cold chain system is operated through a three tier system of central stores, regional stores and sub depots with monthly immunization sessions at the service delivery point. Most cold chain equipment and

vaccines are provided through international financing, with operational funds for delivery funded through a mix of government and development partner budgets. The fundamental contextual challenge here is developing the adequate programmatic and health system budgeted planning strategies at Township level and below to ensure universal access to immunization, particularly in the most remote, insecure or less developed Regions and States. As suggested by the most recent coverage results (Official estimates 88% DPT3), and as described below, the national immunization program, particularly over the last year, has been largely successful in meeting many of these contextual challenges.

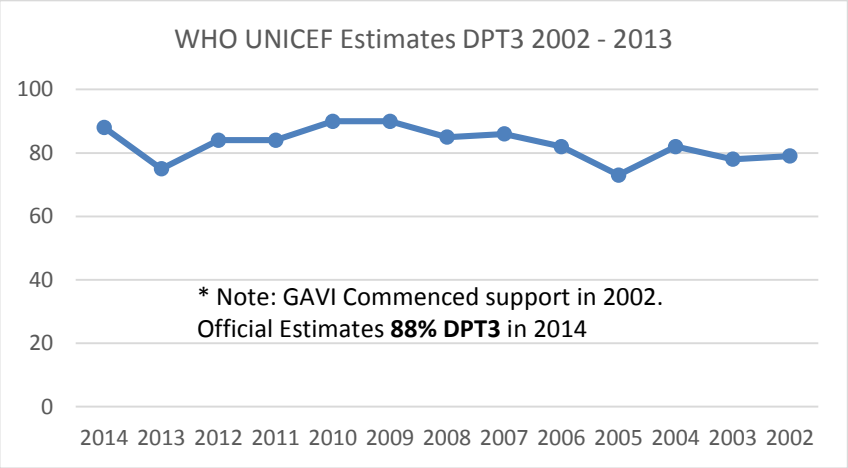
3. GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS

3.1. New and underused vaccine support

3.1.1. Grant performance and challenges

Immunization Coverage

Immunization coverage has remained steady since GAVI commenced programming in 2002. Coverage declined in 2013 to 75%, with a 15% drop out between DPT1 and DPT3. Official estimates in 2014 indicate however a substantial coverage improvement to 88%, although WHO UNICEF estimates are not yet available for 2014 (see figure below).



Immunization Inequities

Of 330 Townships in the country, 273 (80%) have DPT3 coverage that is greater than 80% in 2014. This is an improvement on the 147 Townships (45%) that achieved coverage greater than 80% DPT3 in 2013. However, only 106 out of 330 Townships (32%) reached the MCV1 target of greater than or equal to 95% in 2014 (WHO IVD Website)

Implementation Progress

Given the contextual challenges highlighted above, implementation progress in Myanmar has been very good. The most recent official estimates point to improved coverage. The last reported immunization coverage survey was 2008 (MICS Survey 2008 which indicated high coverage of 98% DPT3). Campaign strategies have been successfully implemented for MR, and underutilized vaccines (hepatitis B, pentavalent, measles 2nd dose, MR vaccines) have been introduced nationwide. Communicable disease reports indicate vaccine preventable diseases are well controlled, with only 122 measles case reported in 2014 (WHO VPD Website). The reporting of neonatal tetanus cases (32 cases) and JE cases (50 cases) in 2014 does point to the need for ongoing surveillance and investigation of VPDs. ICC minutes of June 2015 also indicate that diseases "were emerging in areas with low herd immunity while sporadic cases and outbreaks of VPD (Diphtheria and Neonatal Tetanus) which need individual immunity were found in areas with low immunization coverage and among mobile populations." (ICC Minutes June 2015)

Implementation highlights in 2014 have been as follows:

- In 2014, HSS support has been expanded to 120 Townships, with a mix of wider health system and specific immunization services support. A recent health sector review (Planning System Review 2015) and evaluation ((MOH, WHO, IHPP Thailand, 2014), has reported on improved access of services for hard to reach populations as a result of health system support
- In 2014, a post introduction evaluation was conducted of the pentavalent vaccine introduction and preparations for the MR campaign were made (conducted in Jan/Feb 2015).
- The APR acknowledges the challenges with immunisation coverage and equity, and is implementing a reaching every community strategy to identify communities at risk and design strategies to reach them.

Implementation Bottlenecks and Corrective Actions

- **Immunization inequities according to geographic areas and populations at risk:** The PIE evaluation (MoH 2014) indicated that migrant and hard to reach populations are often missed, and that there are sometimes missed opportunities for vaccination due to bi monthly immunisation sessions. The ICC minutes of June 2015 quotes a survey that indicates that 22% or one child out of five children among migrant population did not receive EPI services Although more in depth evaluation is required of the effectiveness of the approach, the corrective action currently being undertaken is implementation of a reaching every community strategy, and planned implementation of a communication strategy in 2015 (ICC Minutes, June 2015)
- **Health system reforms and fragmented planning** – The Township Health Planning Review conducted in early 2015 (MoH, 2015) indicated that there are multiple planning, information and budgeting systems operating in single Townships, presenting major management and coordination challenges for Township health management. The recommended corrective action is development of policy directed comprehensive planning and budgeting systems. The issue of poor micro-planning and lack of integration of EPI with other PHC services was also raised in the PIE Review in 2014 (MoH 2014).
- **Low absorptive capacity of HSS Funds at Township level** and inadequate HR for HSS, has meant a slower than expected utilization of HSS Funds. A recently published sector report suggests the main corrective action would be improved policy and planning development to support more comprehensive planning, budgeting and M& E systems (Township Planning Review, 2015), as well as expediting placement of technical support at township level through the HSS Officer role.
- **Difficulty with clarifying population denominators**: The PIE evaluation from 2014 indicated that head counts are not often reliable, and are conducted differently using different formulas (MoH, 2014). Populations projections of infant cohorts are significantly different to head count data (refer to APR, which indicates according to a headcount of the population, the surviving infant cohort in 2014 is 928960, which is widely different from the estimated or projected total of around 1,400,000 in 2013). The cohort is likely to be reassessed after official publication of the census data.
- **Cold Chain and Vaccine Management Bottlenecks**: Monitoring of the implementation of a cold chain improvement plan indicates progress in many areas (an assessment in 2014 indicated improvement from 4 scores showing the target of 80% at the previous EVM in 2011 to 16 scores at or over 80% in 2014).However, substantial areas are identified which require further action (arrival procedures, cold chain storage space for upcoming vaccine introductions, temperature monitoring, maintenance and inventories) (EVMA Status Report 2014).

3.1.2. NVS renewal request / Future plans and priorities

Vaccine Targets
Head count data was used for 2014 and projections based on this have been calculated for subsequent years. It is reported in 2014 that 813,390 were vaccinated. The target for 2016 is 95% or 1,393,190. This represents a 7% increase from the 2014 result which is a reasonable target, particularly given the planned implementation of a reaching every community strategy. In addition to pentavalent vaccine. It is also proposed to introduce PCV vaccine in January 2016. A reduced target of 946,610 for PCV1 is proposed (compared to 1.4 million for pentavalent 1), reflecting the expected updated population target from the soon to be published census results.

Future Priorities
Service Delivery Strategy: Both the cMYP and APR (reinforced by findings of post introduction evaluation of pentavalent vaccine introduction in 2014), indicate that a top program priority is strengthening routine immunization in urban areas, in rural and remote hard to reach and border areas, principally through implementation of a Reaching Every Community (REC) strategy.

New Vaccines: In addition to service delivery strategy, the country is proposing introduction of new vaccines. It is proposed to introduce PCV 10 into the routine immunization schedule in 2016, and to assist to maintain the polio free status through introduction of Inactivated Polio vaccine into routine immunization schedule in 2015.

Program Management and Surveillance: The APR points out the need to strengthen measles elimination and rubella control activities and establish sentinel hospital surveillance of congenital rubella syndrome. This will also include the introduction of the measles rubella vaccine in to routine immunization schedule at 9 months.

Cold Chain Expansion: Updated assessments in 2014 plan the implementation of the cold chain replacement and expansion plan in preparation for PCV-10 introduction and other new vaccines (IPV and MR in 2015, and potentially rotavirus, JE in subsequent years see cMYP page 38). The cold chain expansion and replacement has already secured funding from 3 MDG and managed through UNICEF. About US$ 8 million will be invested in the cold chain system strengthening including procurement, distribution and capacity building on cold chain and vaccine management in 2015 and 2016.Given the expansion of the immunisation schedule, it will be a priority in 2015-2016 to conduct an effective vaccine management assessment, develop a comprehensive EVM improvement plan (to be completed in 2015) and then accelerate monitoring and implementation activities.

Human Resource Development: The MoH has agreed to assign Public Health Supervisors to strengthen the immunization work force. The EPI program plans to conduct training for the PHS in August 2015 (immunization In Practice).

Additional priorities include developing and implementing a communication strategy for routine immunization to create demand and uptake of immunization services, and improving monitoring, particularly in areas with low immunization coverage (APR, 2014).

3.2. Health systems strengthening (HSS) support

3.2.1. Grant performance and challenges

Achievement of Results
Coverage was 70% for DPT3 baseline and was 73% according to WHO UNICEF estimates in 2013, and 88% according to official estimates in 2014. Pending clarification of WHO UNICEF estimates, the 88% coverage rate for 2014 is a substantial improvement on the 73% result from

2013. The number of districts achieving greater than 80% has also increased substantially from a figure of 155 in the APR (147 in JRF figures) to 273 in 2014 (JRF figure on WHO Website 2015). Output indicators in the M & E framework describe steady improvements in such system outputs as coordinated plans, reduced essential medicine stock out, facilities constructed. These results are consistent with findings of an independent evaluation of HSS conducted in 2014 ((MOH, WHO, IHPP Thailand, 2014).) in 20 Townships, which found the HSS design was fit for purpose in terms of expanding PHC services for hard to reach or unreached populations. "After two full years of the program, these outreach services contributed to increased coverage of key indicators such as ANC, TT2, SBA, DTP3 and BCG implementation. " (MOH, WHO, IHPP Thailand, 2014 Executive Summary). A similar finding was established during the recent township Health Planning Review in terms of the capacity of coordinated planning at Township level to expand access to unreached or hard to reach populations (MoH, 2015).

Implementation Progress

The APR (2014) details implementation progress. In 2014, 120 townships implemented Coordinated township Health Plans and delivered a package of primary health care services (EPI, MCH, Nutrition and environment health) in hard to reach areas. More detailed data from 76 Townships illustrates that a total of 541 zero dose children were immunized through outreach program in hard to reach areas, and there were 25, 991 under 1 immunization contacts in 2014. National Service Availability and Readiness Assessment (SARA) were conducted and preliminary results disseminated. Final report on SARA will be launched in August 2015). There was an expansion of hospital equity funds (10,452 beneficiaries) and as well as of the MCH voucher scheme to 2 Townships, training and recruitment of auxiliary midwives (1334) and community health workers (900), essential medicine supply and equipment to 120 Townships (UNICEF Report 2014), construction of sub rural health centers (75% completion of construction of 30 sub centers, Myanmar Red Cross Report 2014), conducting of a joint review on Township Health Planning (MoH 2015) and finally, implementation of a management training program for Townships and Basic Health Staff (60 Townships) (APR, 2014).

Bottlenecks and Proposed Corrective Action

Decreased HSS program Quality: Concerns have been expressed in the APR that the quality of HSS programming has declined as the program has scaled up. This is attributed to the variable capacity of Township health management systems (planning, management, financial management) to oversee and implement HSS strategy. Program quality has also been challenged by the inability to recruit and appoint technical support at Township level through the HSS Officer role. Finally, a recent Township Health Planning Review has found that, in many locations, there are multiple planning models with a diverse set of planning, budgeting and management systems, which is presenting major coordination challenges for all stakeholders concerned. A number of corrective actions have been considered by the NHSC are being taken here.

Firstly, a no cost extension was approved for a 1 year period in order to provide management the required time to prepare Townships to manage the grants and introduce systems.

Secondly, negotiations are taking place with the MoH to remove policy obstacles preventing the location of the required TA (HSS Officers) in the Townships.

Thirdly, the findings of the Township Health Planning Review (MoH, 2014), recommended to develop a streamlined technical cooperation strategy and planning system in order to move towards a system of One Plan, One Budget and One M & E in Myanmar. In relation to the more immunisation specific bottlenecks and challenges, the no cost extension period will see increased investment in cold chain and logistics procurement (and training of Public Health supervisors for EPI work ($350,000 allocation), in order to lay the groundwork for ongoing vaccine introductions and coverage improvement as outlined earlier. In terms of equity challenges, the HSS program will seek to align more closely the RHC planning strategy of HSS (with a focus on the hard to reach/unreached populations) with the REC strategy of EPI, in

order to consolidate and expand coverage improvements for high risk populations in urban, remote and border areas.

3.2.2. Strategic focus of HSS grant

The initial strategic focus of HSS was on provision of a PHC package of services for hard to reach or unreached populations, using a coordinated planning system strategy at township level and below. Although the general strategic focus remains unchanged, in the last two years, given the scale up of the EPI program and GAVI Board pressures for more immunisation specific focus, there has been a reprogramming of funds towards cold chain and logistics support, and more emphasis on preparing Public Health Supervisors for the role of EPI (in order to contribute in scaling up immunization services delivery in areas with low coverage and hard to reach areas). This is to support an EPI initiative over the last two years to retrain public health supervisors for EPI work. The strategic intent to deliver immunisation within the context of the integrated PHC delivery system of Myanmar remains unchanged, and has been reinforced by the findings of the recent Township Health Planning Review, where stakeholders, including Township Medical Officers, highlights the challenges of management of multiple vertically directed and externally funded projects and programs. A potential for further strategic alignment is with the hard to reach/unreached planning strategy of HSS with Reaching Every Community Strategy of EPI, in order to ensure a coordinated and non-fragmented approach to improving immunisation /PHC equity.

3.2.3. Request for a new tranche, no-cost extension, re-allocation or reprogramming of HSS funding / Future HSS application plans

The country requested a no cost extension of the HSS grant for a period of 1 year, up until the end of 2016. The no cost extension, (and reallocated funding arrangements) was endorsed at the 8th and 9th meetings of the National Health Sector Steering Committee. The specific request, as described in the APR, was for reallocation for funds include procurement of cold chain and logistics equipment (330 ILR), and training (new and refresher training) of Public Health Supervisors in EPI service delivery, and updating the roles of Public Health Supervisors in EPI/PHC. This reallocation of funds addresses key bottlenecks in terms of vaccine management and cold chain capacity, and quantities and mix of PHC staff with EPI skills. The total budget plan for 2016 is for $5,420,749.

3.3. Graduation plan implementation*(if relevant)*

Although the country is not near graduation status yet, early attention may need to be given by the Gavi Alliance and MoH for the longer term strategy to support government financing of traditional vaccines. This may be the first step towards developing the ground work for graduation, before undertaking more detailed graduation planning in subsequent years.

3.4. Financial management of all cash grants

There are a number of implementing partners from the HSS grant. These include the Ministry of Health, WHO, UNICEF, and Myanmar Red Cross Society.
HSS: For HSS, financial statements are provided from the Ministry of Health and WHO for the HSS Grant. UNICEF has published a detailed progress report which outlines the distribution of essential medicines and equipment, and includes an overall statement of expenditures. MRCS provides a detailed financial statement for the period June 2014 to April 2015 for expenditures on construction of 30 health centers. Total budget approved by the IRC is US$ 1,137,570, of which 60% was disbursed on signing the Grant Agreement in 2014, a further 30% (US$ 341,271) will be disbursed once a Q3 2015 Gavi audit confirms that 80% of the construction has been completed, with the remaining 10% paid to MRCS on completion of the project. The Government audit is completed, but MOH is waiting for report from Auditor General's office.
Introduction Grants: An expenditure of $781,030 was reported in the APR in 2014, with a balance of $2,446,955 (funds were received from GAVI in 2014). No information is provided of expenditures, or what the balance of funds will be utilized for. An audit is pending (as above)

Recommended actions

Actions	Responsibility (government, WHO, UNICEF, civil society organisations, other partners, Gavi Secretariat)	Timeline	Potential financial resources needed and source(s) of funding
COLD CHAIN: Conduct EVM and closely monitor implementation of improvement plan	MoH, National EPI, UNICEF	2015/16	UNICEF (100,000 for assessment) and 200,000 for Improvement plan
COLD CHAIN: Accelerate implementation of cold chain expansion and replacement plan in preparation for vaccine introduction	MOH, National EPI, UNICEF	2015/16	3 MDG Funds (8.5 million USD)
COMMUNICATION AND SOCIAL MOBILISATION: Develop routine immunization communication strategy/plan of action and roll out implementation	MOH, National EPI, UNICEF, WHO	2015/16	UNICEF
DATA QUALITY: Plan Coverage Survey and implement data quality improvement activities	MoH, National EPI, WHO and UNICEF	2016	Not identified
DATA QUALITY: Update target populations based on newly published census data	MoH, EPI program	2015	Not required
HSS: Appoint HSS Officers to assist scale up of HSS & Plan for evaluation of HSS 1	MoH, GAVI HSS	2015/16	GAVI HSS
EQUITY/HSS: Implement REC/planning approach for hard to reach populations and urban migrant populations as indicated in the EPI improvement plan	MoH, National EPI, NHSC, Partners, UNICEF and WHO	2015/16	GAVI HSS, UNICEF, WHO and other partners
TRAINING: Conduct Training of Public Health Supervisors contribute in the immunization service provision especially in hard to reach areas	MoH, national EPI	2015/16	GAVI HSS
FINANCIAL MANAGEMENT: Need for follow up by GAVI Secretariat of Financial Management requirements (external audits HSS and new vaccine introduction grants)	GAVI Secretariat with implementing partners	2015	Not required

4. TECHNICAL ASSISTANCE

4.1 Current areas of activities and agency responsibilities

HSS Officers and the long term Health Sector adviser provide technical support through WHO. Administration of the HSS grant is also facilitated through the WHO Office. An EPI adviser

and NPOs at WHO also technically support wider program implementation for most of the component areas of the immunisation program.

UNICEF also provides national and international technical support, particularly for cold chain and logistics, procurement of vaccines, essential medicines and equipment (UNICEF Progress Report, 2015), communication, and service delivery strategy (REC), as well as other aspects of the immunisation system

The Myanmar Red Cross Society has been sub contracted to facilitate the construction of health facilities through the HSS program. Various NGOs across the country provides a wide range of technical support for health system development and program implementation (MCH/EPI), principally through the multi donor MDG Fund. The World Bank is also commencing implementation of a long term health system development program, with a broad range of health system technical support proposed, particularly for planning and financial management. The Global Fund administers the largest grant in donor terms for TB, Malaria and HIV programs, and also has long and short term programs of technical assistance.

4.2 Future needs

Health Sector TA: The Township Health Planning Review identified technical assistance needs in the area of health system planning and management at all levels of the system. Given the complexity and diversity of Myanmar outlined in the contextual analysis, and taking into account the sharply increased aid flows and government investment in health in Myanmar, then this area of technical cooperation will be a high priority need at central, regional and Township levels for the next 5 years.

Immunisation TA: The immunisation program is expanding in terms of vaccine introductions, coverage scale up, and logistical needs. Particular areas of technical cooperation that will be required in subsequent years include the following:

- Vaccine Management assessment and monitoring of improvement plans
- Strengthening immunization supply chain systems and establishment of electronic logistics information management systems.
- Implementation, monitoring and evaluation of reaching every community strategy
- Surveillance and AEFI systems development to monitor impacts and promote safety
- Technical support for implementation of coverage surveys and data quality improvement activities

5. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT& ADDITIONAL COMMENTS

The contents and main decisions of this Joint appraisal were discussed at the 8th and 9th NHSC meetings, and ICC meeting of June 20115, at which HSS and immunization progress was assessed and the APR reviewed. This Joint Appraisal reflects the main points from these discussions at the two NHSC meetings and the ICC Meeting of June 2015, which also endorsed the APR, approved reallocation of funds and no cost extension, and discussed immunization strategy.

The main issues raised by the NHSC (8th and 9th meetings) and ICC June 2015 were as follows:

- The “catalytic” role of HSS in stimulating sector reform and social protection initiatives, including coordinated pro equity health planning strategies (see 8th NHSC meeting)

- Reallocation of funding to cold chain and logistics and training of Public health Supervisors to accelerate immunisation improvement in the final year of HSS (8thNHSC)
- An outline of the challenges and barriers to implementation outlined elsewhere in this joint appraisal (8th NHSC meeting)
- Recommendations for reallocation of funds to enable the 120 Townships to absorb funds, develop systems and implement programs.
- Identification of specific cold chain strengthening procurement and activities in 2015 and 2016 (9th NHSC meeting) (with activities technically supported by UNICEF and with additional funding through 3MDG Fund)
- Endorsement of the APR at the 9th NHSC meeting and the ICC meeting of June 2015
- The importance of communication strategy for improving utilization of immunization services by hard to reach and migrant populations (ICC June 2015)
- The ICC in June 2015 endorsed the planned "EPI Improvement Plan" which will aim to accelerate immunization coverage nationally, but particularly in hard to reach and border areas

6. ANNEXES

- **Annex A. Key data** (this will be provided by the Gavi Secretariat)

- **Annex B. Status of implementation of the key actions from the last joint appraisal and any additional High Level Review Panel (HLRP) recommendations**

Key actions from the last appraisal or additional HLRP recommendations	Current status of implementation
Myanmar is recommended to start progressively increasing its government funding of traditional vaccines.	For the 2014 year, it still remains the case that the Government of Myanmar does not finance traditional vaccines as yet. However, the APR data indicates government financing of $2.7 million for the EPI program (of which $948,226 was for co-financing of GAVI funded vaccines)
Once the 2014 census results are disseminated, population figures and targets should be adjusted accordingly.	The census, although completed, has not officially reported results. When results are reported, the targets will be adjusted. For the time being, head counts with population projections are being used.

- **Annex C. Description of joint appraisal process**

An external consultant was contracted to review all documentation related to the program including the APR, previous appraisals, vaccine management evaluations, the cMYP, HSS evaluations, sector reviews, and immunisation data. The National Health Sector 8th and 9th Committee meetings (attached to APR) document the internal dialogue regarding the strategic directions of the program. The draft JA was then circulated to Country partners for their review and inputs and revision.

- **Annex D. HSS grant overview**

General information on the HSS grant							
1.1 HSS grant approval date			2008				
1.2 Date of reprogramming approved by IRC, if any			Implementation only commenced in 2011 due to delays in commencing the grant Funds have been historically reprogrammed for cold chain and logistics. The number of Townships for HSS investment has been reduced from 180 to 120 in order to have a more focused and manageable investment				
1.3 Total grant amount (US$)			$32,770,639				
1.4 Grant duration			2008-2013				
1.5 Implementation year			2014				
(US$ in million)	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
1.6 Grant approved as per Decision Letter				2,833,405	7,459,236	8,353,249	14,124,749
1.7 Disbursement of tranches				2,188,805	4,303,428	3,648,25	20,736,197
1.8 Annual expenditure				601,380	1,213,471	3,444,900	6,527,855
1.9 Delays in implementation (yes/no), with reasons Yes			There were delays with HSS start up due to need to negotiate agreements with partners (WHO & UNICEF) to channel funds to the country. The recent delays requiring no cost extension at this time relate to (a) absorptive capacity of Townships to manage funds (b) policy and HR constraints which have resulted in delayed appointment of HSS Officers to township to facilitate development and implementation of costed Township Health Plans				
1.10 Previous HSS grants			Nil				
1.11 List HSS grant objectives 1. By 2011, 180 selected with identified hard to reach areas will have increased access to essential components of MCH-EPI and EH and Nutrition as measured by increased DTP from 70% to 90% and increased delivery by Skilled Birth Attendant (SBA) from 67.5% to 80%TP 2. By the end of 2011, 180 selected townships with identified hard to reach areas will have developed and implemented Coordinated Township Health Plans ***3.*** By the end of 2011, 90 selected townships with identified hard to reach areas will be staffed by midwives and PHS2 according to the National HR Standards							
a. Amount and scope of reprogramming (if relevant) Reallocation for the 2016 calendar year, for priority activities such as procurement of ice lined refrigerators, revision of guideline on roles and responsibilities of Basic health staff and training of these staff on EPI. The no cost extension and change of activities were discussed and approved in the 8th and 9th NHSC meetings (refer to minutes attached to the APR).							

- **Annex E. Best practices**

Both an independent external evaluation ((MOH, WHO, IHPP Thailand, 2014) and an internal Township Planning Review (2015) have indicated that the HSS initiative has been a catalyst for broader health sector efforts towards development of coordinated planning, budgeting and M &E systems, as well as contributing towards improved equity in health care access. The Myanmar case may illustrate the capacity for the originally stated aims of HSS to be a catalyst for health sector reforms. The impact of HSS on immunization would need more detailed evaluation, which

is planned as part of the upcoming review of development of the next Health Sector Strategic Plan (APR 2014).

- **Annex F. Coverage and Denominator Discussion**

Email exchange between Andrew Thomson, SCM, John Grundy, JA Consultant and Daniel Ngemera, UNICEF Country Office, regarding large coverage changes in Myanmar 2012-2014.

Hi John,

……By the way, the DTP3 coverage figures 2012 84%, 2013 75% and now 2014 88%. Could the increase in dropout rate from 3% to 17% between 2012 and 2013, which was responsible for the coverage drop from 84 to 75% have been an artefact?

Or do you have the impression that coverage did in fact increase by 13% from 2013 to 2014?

Thanks a lot
Andrew

Hi Andrew

I followed up with UNICEF about this (Daniel)

His response is as at the bottom of this message. In particular note point about less numbers immunized in 2014, though this would be nice to confirm with WHO

In the APR they seem to use population projections, new census data and head counts at different times. The PCV request is different again because I believe they are basing this on new census projections which are not published yet. This is why proposed actions in the JA are emphasizing data quality work, including coverage surveys.

So I think it's all lack of clarity on denominators. It may be the case though that GAVI HSS, 3MDG Fund and UNICEF and other programs are accelerating coverage in focus areas.

Let me know if you want me to follow up more on this

John

Dear John,

….. Revision of the target population: actually to me I am seeing as the main reason for the jump. In 2014, the head counts provided an estimated number (denominator) was around 928,000 compared to nearly 1.4 million used in 2013. In addition the number of children immunized in 2014 were around 814,000, while in 2013 the number of vaccinations reported were about 1,065,000 against the estimated target of 1,400,000. Therefore based on this I could confidently say that the jump is mainly contributed by the changes in the numbers (denominator). Best regards, Daniel