**Myanmar**

**PEF Targeted Country Assistance (TCA) Narrative**

**for 2022-2025 Multi-Year Planning**

Use this template to create a narrative that contextualises your TCA plan for the planned duration and how the support that you are requesting from Gavi will help you reach your immunisation goals.

*(Populated by Gavi)*

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| **Total Envelope** | **Indicative allocation per 2022-2025** | | **%** |
| $2,181,185.68 | **2022** | $1,075,875.34 | 49.3% |
| **2023** | $1,105,310.34 | 50.7% |

1. **Key objectives for the EPI program and known gaps/bottlenecks (0.5 page)**

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| * 1. ***Please note any country context that is significant to understanding the country's vision and request for Gavi TCA support. What specific effects do these factors have on the national immunisation programme?*** |
| The COVID-19 outbreak disrupted immunization services significantly partly due to mobilizing essential health professionals working at township and sub-township levels for COVID-19 surveillance and response activities and strict restrictions on mass gathering to prevent COVID-19 transmission. With the COVID-19 pandemic, immunization coverage could be maintained at around 90% in 2020. However, the people of Myanmar have faced multiple challenges since February 2021 following the military takeover, causing an unprecedented health crisis, including the immunization service provision has deteriorated significantly. The collapse of Myanmar's public health care system and the many people refraining from seeking healthcare is taking a significant toll on the population; the COVID-19 pandemic further compounds this.  In addition to the different waves of the COVID-19 outbreak, the country's military takeover further impacted the immunization services, resulting in decreased uptake and availability of the services. While a part of this could be caused by negative impacts on accessibility caused by several factors, including COVID-19 and security issues, the low utilization also signals a change in care-seeking behavior and trust in public health facilities among the population, with more individuals either forgoing vaccination or seeking services at facilities not run by or linked to the De Facto Authorities (DFA). There is also a significant reduction in service providers following the Civil Disobedient Movement (CDM). As a result of the decreased workforce in the immunization service, there has been limited availability of either the staff or the vaccines in many parts of Myanmar. Therefore, the national Penta3 coverage for 2021 was 34%, significantly lower than that of 2019 & 2020 coverage. The below table illustrates some of the critical challenges imposed by the COVID-19 pandemic and the political instability.   |  |  | | --- | --- | | Challenges before the COVID-19 pandemic and political instability | Challenges posed due to political change | | 1. There are gaps in immunization coverage (<90%) in areas affected by conflicts, geographically hard-to-reach areas, peri-urban populations, and self-administered regions. 2. Sporadic outbreaks (measles, diphtheria) due to inadequate coverage in hard-to-reach areas. 3. Limited access for implementation in Ethnic Health Organizations (EHO) areas due to security and geographical constraints. 4. HR shortage within the MoH (cold chain technicians, Midwives shortage in hard-to-reach areas and Ethnic areas (Shan and Naga). 5. Weak financial management capacity of MoH at the National and Sub-national levels | 1. The suspension of immunization services in most states and regions is due to the health staff joining the Civil Disobedience Movement (CDM), including immunization focal persons. 2. The limited engagement of the UN with present authorities (UNCT principles of engagement) 3. Obtaining approvals for the importation of vaccines and syringes, e.g., Tax Exemption Certificate for custom clearance from FERD and MoH 4. Armed clashes among the military and Ethnic Armed Organizations (EAOs) and Local/ People Defence Forces (LDF/ PDF) 5. Geographical remoteness and transportation difficulties 6. Recent Ethnic Arm Organization's restriction in coordination with government and in-country international agencies for health service delivery 7. Unavailability of reliable information, including the health statistics |   The key objectives for the EPI program in the current context are to:   1. revitalize routine immunization services based on gaps and needs across the country with a particular emphasis on the hard-to-reach areas, underserved areas, and conflict-affected areas, 2. enhance vaccine-preventable disease surveillance and preposition the outbreak response immunization if required, 3. develop tailored communication strategies to increase the acceptance of vaccines and the services by the communities and demand for vaccines, 4. strengthen the quality of immunization services and effective vaccine management 5. facilitate the coordination within the de-facto authorities and with UN agencies and partners, including private sectors, NGOs, and EHOs, to increase immunization services, including COVID-19 vaccination, and 6. reactive the information management system, including the supply chain information system. |

1. **Current TA needs of your immunization system (1-2 pages)**

***Please provide the planned allocation of PEF TCA towards investment areas and high-level objectives. Gavi-supported investment areas and a menu of objectives are available for reference in Gavi's*** [***Programme Funding Guidelines***](https://www.gavi.org/news/document-library/gavi-programme-funding-guidelines)***. The country can plan for the remaining duration of their current HSS grant.***

*(Please feel free to add lines as needed)*

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| **High-level Plan** | | **Budget (USD)** | **%** |
| **2022** | |  |  |
| Service Delivery | * Revitalization of Routine Immunization (RI), including catch-up vaccination to reach zero-dose, under-immunized children and missed communities * Establish and/or continue partnerships with CSO, NGOs, and for-profit private sector actors, including professional associations, to reach zero-dose, under-immunized children and missed communities | $322,763 | 30% |
| Human resources for health | * Assess the capacity and functionality of health facilities and health workers and develop appropriate human resource deployment and development plans across the country, including hard-to-reach areas | $107,588 | 10% |
| Supply chain | * Design of the immunization supply chain (iSC) system to improve efficiency and vaccine availability, especially in the last mile * Support the roll-out of electronic logistics and information management system for vaccines and public health commodities to strengthen the vaccines stock management system * Support the roll-out of remote temperature monitoring devices from the central cold room and up to township level cold stores for efficient vaccines management * A concept notes on logistics management information system, including the capacity and quality of vaccine storage and distribution to improve vaccine availability, especially in the last mile | $107,588 | 10% |
| Health information systems and monitoring and learning | * Assess the health facility readiness and monitor the progress through periodic surveys * Conceptualize the DHIS2 roll-out plan by ensuring interoperability with other information systems | $107,588 | 10% |
| VPD Surveillance | * Increase the timely detection of and   response to vaccine-preventable disease outbreaks | $215,175 | 20% |
| Demand generation and community engagement | * Assess the perceptions and understand the knowledge, attitude, and practices of parents and caregivers on vaccine and immunization services and develop tailored communication strategies based on the local contexts and needs. * Introduce the human-centered design (HCD) approach as a pilot in key prioritized areas as one of the core behavior change approaches. * Establish and manage partnerships with I/NGOs and CSOs, to enhance community mobilization and promote demand for immunization in hard-to-reach townships. | $107,588 | 10% |
| Government, policy, strategic planning, and program management | * Advocacy and coordination at national and sub-national levels to resume and revitalize the routine immunization services across the countries. * Revitalization of national level technical bodies and committees: (NITAG, NCCPE, NMVC, AEFI, TWG) to guide the decisions by policymakers and to monitor the progress of immunization activities | $53,794 | 5% |
| Health financing | * Support the budgeting and targeting of domestic resources for immunization and primary healthcare (PHC) based on equity considerations * Advocacy for earmarking the budget for cold chain maintenance * Ensure for earmarking of the budget for vaccines procurement | $53,794 | 5% |
| **2023** | |  |  |
| Service Delivery | * Extend immunization services to reach zero-dose, under-immunized children and missed communities * Establish and continue partnerships with CSO, NGOs, and for-profit private sector actors, including professional associations, to reach zero-dose, under-immunized children and missed communities | $331,593 | 30% |
| Human resources for health | * Support execution of human resource deployment and development plans across the country, including hard-to-reach areas | $110,531 | 10% |
| Supply chain | * Support the scaling up of the eLMIS and remote temperature monitoring devices * Improve the design of the immunization supply chain (iSC) system to improve efficiency and vaccine availability, especially in the last mile * Increase the capacity and quality of vaccine storage and distribution to enhance vaccine availability, especially in the last mile * Strengthen logistics management information systems to ensure real-time monitoring at all immunization supply chain levels | $110,531 | 10% |
| Health information systems and monitoring and learning | * Assess the health facility readiness and monitor the progress through periodic survey * Support the roll-out of DHIS2 and ensure interoperability with other information systems | $110,531 | 10% |
| VPD Surveillance | * Sustainably integrate vaccine-preventable disease (VPD) surveillance, which meets immunization program needs, into a resilient national disease surveillance system | $221,062 | 20% |
| Demand generation and community engagement | * Implement and monitor tailored communication strategies and enhance community feedback to align local needs. * Expanding the human-centered design (HCD) approach in key prioritized areas to promote acceptance of vaccines and the services. * Strengthening partnerships and building capacities of I/NGOs and CSOs, for community engagement and feedback to promote demand for immunization in prioritized townships. | $110,531 | 10% |
| Government, policy, strategic planning, and program management | * Advocacy and coordination at national and sub-national levels to resume and revitalize the routine immunization services across the countries. * Revitalization of Interagency Coordination Committee (ICC) to coordinate among the agencies, donors, and implementing partners. | $55,266 | 5% |
| Health financing | * Support the budgeting and targeting of domestic resources for immunization and primary healthcare (PHC) based on equity considerations * Advocacy for earmarking the budget for cold chain maintenance * Ensure to earmark the budget for vaccines procurement | $55,266 | 5% |

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| ***2.1 Please reflect and describe your immunization system's current TA needs as they are aligned with investments made by Government, Gavi, and bilateral/multilateral donors. Your answers shall provide the context of and rationale for the requested TCA support from Gavi.* *Please explicitly note the duration of the requested support.*** |
| |  | | --- | | **Service Delivery**  Myanmar has been providing 13 antigens following the introduction of the HPV vaccine in October 2020. The vaccination coverage steadily increased to 91% of Penta3 coverage in 2020. However, due to the COVID-19 pandemic and the current political situation in the country, immunization services have not been functioning well, with the Penta3 coverage at 34% in 2021. As of 18 March 2022, DHIS2 data showed that the total un-immunized children for Penta 3 were 622,625 in 2021. The mathematical modeling using the GVAP document and Decade of Vaccine impact study suggests that approximately 25,000 child deaths due to vaccine-preventable diseases could not be averted in 2021.  Further delay in the revitalization of the routine immunization will also lead to an inevitable loss of herd immunity. This could potentially lead to significant outbreaks with the potential to spread across the country and spill across borders. It is essential to revitalize the routine immunization services immediately to ensure the children and people of Myanmar have opportunities to access protection against VPDs. It is also required to explore the partnership opportunities with different for-profit and non-profit partners to ensure to reach zero-dose, under-immunized children and missed communities.  **VPD Surveillance**  Myanmar has a well-established surveillance system for measles, rubella, and CRS, which is a sensitive and well-performing surveillance system that was reinforced with an electronic version of data entry and data analysis tools software (Information For Action) by WHO in 2017. Case-based measles and rubella surveillance system has been implemented as part of VPD surveillance.  Due to the COVID-19 pandemic and political situation, challenges related to the shortage of human resources and the inability to carry out the specimen transportation for all states and regions were experienced. There was evidence that minimum case reporting target and surveillance indicators were not met.  Although Myanmar has WHO accredited laboratories in Yangon and Mandalay with good laboratory practice, issues like capacity, specimen transportation, shortage of lab reagents for JE, and diphtheria during the COVID-19 pandemic due to flight restrictions were encountered. Environmental Surveillance (ES) has been initiated to detect circulating vaccine-derived polioviruses (cVDPV) and support acute flaccid paralysis (AFP) surveillance. Currently, three sites regularly conduct ES (Yangon, Sittwe, and Maungdaw). There will be an expansion of surveillance sites planned for the future. Involvement of the private sector (GPs, clinicians, and private hospitals) and the Private Hospital Association, as already recommended by NVC, will further enhance the surveillance system.  **Human Resources for Health**  Myanmar is one of the countries with the lowest health worker availability in SEAR, even before the military takeover. In Myanmar, the sum of doctors, nurses, and midwives results in a density of 17.8 health workers per 10,000 population; and yet to reach the WHO recommended benchmarks. In addition, Midwives' density was lower, at 2.22 per 10,000 population nationally who are performing as immunization service providers. With these available human resources, Myanmar could perform immunization services quite well till the military takeover on 1st February 2021. After the military takeover, the Civil Disobedience Movement (CDM) involving the health care professionals severely affected routine immunization services. The depleted health workforce was overwhelmed with the primary services and the COVID-19-related work. This situation imposed a threat to routine immunization services that had already been impeded by significant barriers such as geographical and socially hard-to-reach areas and population, and sporadic civil wars between the De Facto Authorities and ethnic armed groups and between different ethnic armed groups.  **Supply chain**  The National Immunization Program has been implementing the Effective Vaccine Management (EVM) Improvement Plan (2016-2021), which was developed based on the results of and recommendations from the 2015 EVM Assessment and its recommendations. The report pointed out several significant system weaknesses hampering access to immunization services at all levels with population growth or with increased demands for new vaccine introductions. Some of the critical decisions to be addressed that linked to and determined the operational planning were as follows.   * Electronic logistics and management system for immunization program, which entails the transition from a manually collected, compiled and managed EPI immunization and vaccine stock reporting system to a real-time tool for management * Physical infrastructure expansion of vaccines and dry stock stores at the national store as well as subnational cold stores * Cold chain expansion and extension to rural health facilities and last miles sub-rural health facilities to increase equity and vaccination coverage * Remote temperature monitoring system at all levels for efficient vaccines storage and maintaining vaccines efficacy * Decommissioning obsolete and irreparable equipment   UNICEF played a critical role in this, and the progress in implementing the improvement plan has been made to some extent. However, the activities got delayed in 2020 due to the COVID-19 pandemic. This was superimposed after the military takeover, and the national program was confronted with a challenge of workforce shortfall due to the civil disobedience movement.  National vaccine procurement is under the custody of UNICEF; hence, this vaccine forecasting and its shipment plan is also an important area where UNICEF has been supporting the national program for years in terms of technical and administrative coordination with the supply division. In late 2021, in line with the minimal engagement principle of UNCT, UNICEF supported the program to resume the long holding vaccines shipment to restore the resumption of routine immunization.  UNICEF will continue supporting the national program to strengthen the supply chain management system as mentioned above. The support may not limit to the listed activities. Still, it may expand into other immunization-related supplies management, such as cold chain repair and maintenance, which UNICEF has facilitated by outsourcing cold chain services.  **Health information systems and monitoring and learning**  EPI was planning to strengthen the health information system by utilizing the HSS 2 budget: DHIS 2 expansion at the facility level and data management training to the data focal persons across the country. After the military takeover, all health systems, including health information systems, are not functioning well; accurate and timely health information data are no longer available to guide policy and program decisions. Routine immunization coverage data was very low in 2021; it may be due to many reasons – shortage of human resources as many data focal persons are on CDM, limited capacity to report in the DHIS2 system, and depletion of time to report as the remaining staff are overburdened with COVID-19 vaccination; and also may be due to internet connectivity issues.  To restore DHIS 2 for data recording and reporting and to have quality, timely and accurate data, it is necessary to revitalize the health information system. Capacity building of newly recruited data focal persons for sub-national level and providing essential equipment may be required after a quick assessment.  For data quality, data quality self-assessment was planned to be conducted in 2021, but this could not be done. It is expected to complete in 2023. With the technical support of HISP India, MOH, together with WHO is planning to conduct capacity building of new staff on overall HMIS, including the EPI teams; WHO also plans to finalize WHO EPI dashboards and Immunization analysis app implementation and Inclusion of AEFI data elements, indicators in the routine HMIS reporting; and VPD surveillance package implementation.  In addition, for VPD surveillance data, IFA software has already been upgraded, and introduction will be conducted after all necessary IT equipment at all states and regions. WHO is planning to utilize Power BI software for the data visualization, and it will be introduced soon.    **Demand generation and community engagement**  Generally, in Myanmar, before the pandemic and political changes, the knowledge level of parents and caregivers on the types of vaccines or diseases was relatively low. However, most parents and caregivers received immunization services without much reluctance and thus, reaching over 90% immunization coverage nationally. When the pandemic started, RI coverage in Myanmar dropped to 80%, and in 2021, the RI coverage declined to 30% – a significant drop compared to previous years. There is a need to understand better the factors that contributed to this decline in immunization coverage (e.g., unavailability of vaccines, inaccessibility of services, decreased acceptability from the caregivers, etc.) to inform interventions to revitalize RI services and improve vaccination coverage. To generate uptake of immunization services, consideration is needed not only for the contributing factors related to service provision but also for the community's willingness to accept the vaccine and services within the changed social-political context. Such information dynamics will inform the design and adaptation of programmatic approaches to address issues of hesitancy and trust, among other access barriers, and bolster demand generation. And within the current complex situation in Myanmar, there are many types of community groups that need to be considered and reached for RI, including communities not affected by conflict, communities hugely or partially affected by the conflicts, Internally-displaced populations, peri-urban areas, hard-to-reach areas, and non-government-controlled areas. To reach the different types of community groups, a well-structured communication strategy that considers tailored approaches for specific targeted groups of communities needs to be developed. Before the military takeover, NITAG was actively functioning in the country to provide technical oversight, direction, and guidance on communication approaches, messaging, and risk communication. However, in the current situation, such support from NITAG is no longer obtained. Thus, additional technical assistance to develop, implement, and monitor contextualized communication strategies must be in place to ensure communities are reached, informed of, and demand RI services. To meet the communities' needs, a human-centered design approach consisting of community participation and engagement in developing tailored approaches will be established with implementing partners.  **Governance, Policy, Strategic Planning, and Program Management**  All EPI governance committees, including NITAG, were functioning well until the military takeover. With the guidance of NITAG, following WHO recommendations, all immunization activities went well, and 2 new vaccines were introduced even during the COVID-19 pandemic in the country. After political changes, due to UNCT guidance, WHO and UNICEF could not be involved much in MoH activities, and vice visa MoH is also reluctant to involve UN agencies. MoH has been calling NITAG to endorse technical matters without acknowledging WHO and UNICEF for some important decisions. It is essential to revitalize or re-form NITAG following WHO recommendations for NITAG and technical decisions. In addition, other technical committees such as NCCPE, NMVC, AEFI, and TWGs are also necessary to be revitalized. Similarly, joint planning and program management could not be done correctly with the De Facto Ministry. For the higher-level guidance and to coordinate the immunization activities among the agencies, donors, and implementing partners for the efficient and effective use of resources, make technical decisions and budget allocation, and monitor expenditures from external support, interagency coordination committee (ICC) to be revitalized.  **Health financing**  Myanmar's National Health Plan (NHP) for 2017-2021 has laid out the vision of achieving Universal Health Coverage (UHC) by 2030. The NHP aims to improve the delivery of health services and financial protection for Myanmar people through substantial investments in frontline service delivery units and a range of reforms in the health system, including health financing.  Ensuring available and adequate financial resources to support immunization program activities such as supplementary immunization activities, procurement of vaccines and syringes, and technical assistance is critical. | |
| * 1. ***How will the requested TCA support advance Gavi's 5.0 mission per the country's context with a focus on:*** * ***identifying and reaching zero-dose and consistently missed children and communities;*** * ***improving stock reporting and vaccine management at the sub-national level;*** * ***enhancing strong leadership, management, and coordination, including the use of data for decision-making;*** * ***introduction and scale-up of vaccines;*** * ***programmatic sustainability.*** |
| The requested TCA support will assist the country in meeting the strategic goals of Gavi's 5.0 mission by saving lives and protecting people's health by increasing the equitable and sustainable use of vaccines. The requested TCA will include   * Revitalization of routine immunization services will be developed to provide the road map to MoH for systematic revitalization. Revitalize Routine Immunization across the country with a particular emphasis on reaching the most vulnerable children in urban and Hard-to-Reach Areas/ Conflict-affected areas. Technical assistance will be provided at national and sub-national levels to revitalize the routine immunization services. * Continuous dialogue for cross-border collaborations for both COVID-19 and routine vaccines. * Providing technical assistance to the EPI Program for the periodic EPI evaluation, to estimate the immunization coverage by data triangulation and identifying low immunization coverage areas for prioritization. * Providing technical assistance to the EPI Program for catch-up vaccination, especially in low coverage areas and underserved areas with high zero-dose and missed children, in close coordination with state/regional focal persons. * Filling the human resources gap at states/regions and central level, recruiting the seconded staff for the vacant medical officers and administrative assistants for the immunization and VPD surveillance. * Strengthening VPD surveillance by providing support for capacity building of staff working on VPD surveillance and data triangulation, including outbreaks and surveillance data, to identify and reach zero-dose and under-immunized children and missed children. Also, support for the laboratory capacity for the VPD surveillance. WHO and UNICEF will also provide support for outbreak response immunization in the areas of VPD outbreaks, as and when required. * Supporting the AEFI & AESI Surveillance for COVID-19 vaccination and AEFI case management. * Technical support for deployment of COVAX facility supplied vaccines and vaccines supplied through Humanitarian Buffer for vaccination of population in EHO areas, border areas, etc., to ensure equity~~.~~ * Ensuring intensive support to build a robust immunization supply chain system which would allow ensuring vaccine safety, available information to make informed decisions, and program performance * Support for the revitalization of NITAG and other EPI committees according to WHO recommendations and conduct regular/ad-hoc meetings for the guidance on vaccination, especially for zero-dose children, unimmunized, and missing children. * Establishing a coordination and collaboration mechanism to engage with multiple sectors, including education sectors, both profit and non-profit organizations. * Capacity building of new staff on overall HMIS, including the EPI teams, emphasizing the identification of zero-dose, under-immunized, and missing children by data triangulation, including outbreak and surveillance data; and finalizing WHO EPI dashboards and VPD surveillance package implementation. Continuous advocacy on earmarking adequate budget support immunization program activities such as supplementary immunization activities, procurement of vaccines, and syringes. Technical assistance will also be given to developing a system for cold chain maintenance. |
| ***2.3 How will you use new vaccine introductions and campaigns planned during this period to strengthen further the areas indicated under question 2.2?*** |
| As mentioned, multiple catch-up activities will be supported along with various sectors.  With the recommendation of NITAG, the national immunization program had planned to introduce IPV2 into routine immunization. As IPV second dose is recommended to give > 4 months after the first dose, it was proposed the IPV2 at nine months of age together with MR1 and JE for the earliest injection instead of 18 months. However, the current situation may not permit support for the IPV2 introduction. |
| ***2.4 Describe how the TCA support will help re-establish routine immunization services and any other COVID-19-related recovery activities.***  *Please indicate any COVID-19-related reallocation that may have occurred for previous TCA funds (if applicable); does this reallocation remain relevant for this proposal.* |
| For immediate service resumption, TCA-funded staff will work with the MoH and other non-state actors. The MoH will be assisted in developing and socializing resumption plans, different standard operating procedures (SoP), and information, education, and communication (IEC) materials. Along with that, continuous advocacy will be made for a) earmarking an adequate budget for the immunization program, including the catch-up activities during the political instability; b) ensuring sufficient human resources; d) equipping health workers with adequate PPEs as per MoH protocols, and c) undertaking innovative and contextual social mobilization approaches for regaining communities' trust in the health system.  TCA-funded staff will also provide technical assistance in devising and executing the national COVID-19 Vaccine Deployment Plan. Technical support is being provided for the deployment of COVAX facility supplied vaccines & vaccines supplied through Humanitarian Buffer for Immunization of the population in EHO areas, border areas, etc., to ensure equity.  This year, RI resumption, including catch-up immunization, will be strengthened in COVID-19 and political instability, prioritizing zero-dose children, missed children, and underserved communities. |
| ***2.5 Describe how the TCA support will identify and overcome already known gender-related or other barriers to immunization activities. Please respond to how each partner can help address this.*** |
| |  | | --- | | In Myanmar, there is no known gender-based issue, and all people, including boys and girls, get equal chances to access health care services, including immunization services. But in some areas, especially in ethnic and hard-to-reach areas, there is low uptake of immunization services due to caregivers' low literacy and health knowledge, including some socio-cultural norms. From the provider's side, the vaccinators are midwives, primarily female. Mothers are mostly the caregivers as they take care of their children and are responsible for vaccination, and most fathers are not involved in their children's vaccination process. Involving them in this process will ensure more confidence in the immunization system. | |
| ***2.6 Describe how you prioritized the interventions to be supported by Gavi under requested TCA support.*** |
| Due to the current political instability and UNCT's minimal engagement principle, consultations have been limited to key partners, including Gavi, WHO's and UNICEF's regional offices, and donor communities. A series of consultation meetings with NGOs and CSOs, including EHOs, was facilitated during the COVAX-allocated vaccine deployment plan. A brainstorming session was also facilitated with UNICEF's Field-Office based staff to understand the local challenges and explore the opportunities.  A consultation meeting was conveyed to urge the importance of the revitalization of the routine immunization along with all the heads of different relevant development partners. A bi-weekly consultation meeting among Gavi, WHO, and UNICEF has been kicked off to discuss and review the program and identify the priority interventions.  All the proposed interventions to be supported through TA are evidence-based and tailored to the local context, political situation, and risks. These interventions are aligned with the 2022 UN Health Response Contingency Framework, a comprehensive multi-year plan (cMYP), the Myanmar National Strategic Plan for Reproductive, Maternal, Newborn, Child and Adolescent Health 2021-2025 which is incorporated into the Health National Strategic Plan, 2021-2025.  The United Nations Country Team (UNCT) is highly committed to supporting and enabling health service provision for the population across the country. The UNCT has formulated a framework that leverages all delivery mechanisms - both public and non-public health service providers- towards delivering essential life-saving health, including immunization services for the most vulnerable population. In this complex and fluid environment, the UNCT takes a pragmatic, flexible, and innovative approach to strengthen the provision of services to those most in need. |

1. **Partner diversification (0.5 page)**

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| ***3.1 Describe which partners you have already mapped, including Alliance and Expanded partners (including Global Partners, Local Partners, and CSOs), to support the activities implementation? (Refer to the*** [***PEF Targeted Country Assistance (TCA) Guidance for 2022-2025 Multi-Year Planning***](https://www.gavi.org/sites/default/files/support/TCA-guidelines.pdf) ***for the type of institutions considered global versus local partners and CSOs.)*** |
| WHO and UNICEF only; no local partner has been selected for the PEF TCA. | |
| ***3.2 Please indicate how exactly you plan to collaborate with Local Partners.*** | |
| The following strategic partnership (non-funding partnership) will be established/continued based on their comparative advantage:   * In the urban areas: Private sectors, both for-profit and non-profit; * Rural and the hard-to-reach regions including conflicted affected communities: NGOs, EHOs, CSOs; * Nationwide: Clinton Health Access Initiative (CHAI) for the rolling out of e-LMIS and PATH * Global: US CDC, Zero dose analysis- Jhpiego and P4H for health financing * Third-party for different contractual arrangements. |
| ***3.3 Please note the allocation of TCA to Local Partners (only) and describe the approach you will use to comply with the recommendation of allocating 30% of TCA to Local Partners throughout 2022-25.*** *Please refer to section 2.3 (3. Partner Mapping) of the PEF TCA Planning Guidelines for more information.* | |
| In the current political situation, it's not feasible to allocate funds through any local partners. However, the recent partnership with different NGOs and CSO will be further explored. The scope of work for the partners mentioned above for other thematic areas will be developed if the situation permits. | |
| ***3.4 Please note the allocation of TCA to CSOs only (either Global or Local Expanded Partners) and describe the approach you will use to comply with the requirement of allocating 10% of combined TCA, EAF, and HSS ceilings for CSO implementation (e.g., if less than 10% of TCA funding is allocated to CSOs, please indicate how this will be compensated through the allocation of HSS and EAF funding to CSOs).*** *Please refer to section 2.3 (3. Partner Mapping) of the PEF TCA Planning Guidelines for more information.* | |
| As mentioned, it will be explored later | |

1. **Lessons learnt from past TA experience (0.5 page)**

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| ***4.1 Please explain how the TCA plan will build on previous performance, lessons learned, and best practices of TCA activities from your previous TCA plan, including contributions to the national programme and knowledge/skill building, and how this has been taken into account in this TCA planning and prioritisation.*** |
| The technical assistance through TCA 2021 contributed to the successful implementation of UN-led vaccines to all staff and family members of UN agencies, INGOs, and NGOs in the country. With the collaborative efforts of WHO and UNICEF, the request for Humanitarian Buffer has been approved by Gavi and is presently under advanced discussion for the shipment and deployment of vaccines. For the COVAX facility vaccine, the first tranche of 2.2 million doses of SINOVAC has already arrived in Myanmar. Discussion and negotiation between MOH and partners (WHO, UNICEF, ICRC, and EHOs) are being conducted to deploy COVAX facility-supplied vaccines to EHO and border areas. Training modules on COVID-19 vaccination, microplanning formats, recording and reporting forms, and monitoring checklists were developed to train ethnic health workers. According to UNCT engagement guidelines and the conservative nature of the current MOH, coordination between MOH and WHO/UNICEF is less and needs to be strengthened.  The lessons learned and best practices of 2021 TCA shape the 2022 TCA support. Technical assistance is required to support the revitalization of routine immunization, including catch-up immunization in the low-performing and hard-to-reach areas, to vaccinate zero-dose and under-immunized children. Continuous technical assistance is required to support the data management, implementation of eLMIS, post-introduction evaluation of HPV and Rota & intussusception surveillance, laboratory capacity building for quality assurance in VPD surveillance, and cold chain extension and expansion to rural health facilities. Continuation of Coverage Evaluation Survey and Data Quality Assessment and EVM assessment will also support the WHO and UNICEF TCA funded staff. |

1. **Alignment of the One TCA plan with future Gavi planned investments (0.5 page)**

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| ***5.1 Please list all planned upcoming Gavi investments (e.g. new vaccine support, CCEOP) that would require TA support within the planned period, including Full Portfolio Planning process and describe how the TCA plan will be aligned with the ongoing and/or planned investments made by Gavi.*** |
| The plan of strengthening routine immunization services in peri-urban, slum, migrant, and conflict areas and strengthening catch-up immunization for zero-dose and missed children is in line with Gavi's ongoing activities. Ministry of Health, Myanmar, with the support of WHO, UNICEF, Gavi, and other developmental partners, will continue its effort to improve immunization coverage in Myanmar.  It will be in line with reprogramming activities of the Gavi HSS 2 budget which will include special catch up/crash activities in inaccessible areas, capacity building of immunization staff at all levels, expansion of cold chain up to Rural Health Center (RHC) levels, strengthening of the immunization supply chain, demand generation, supervision, monitoring and use of data for appropriate actions. TCA 2022 will continue emphasizing those critical interventions through various activities covered under Gavi HSS-2, TCA, and CCEOP grants. |

1. **TCA Monitoring (1 page)**

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| ***6.1 Please provide an outline of the TCA in-country mechanism to jointly monitor and track implementation progress and generation of results of the TCA plan as a whole. How will that information be used to adjust and improve programme implementation? How frequently are data reviewed and used and who will be responsible to ensure that review and learning occurs?*** |
| Considering the limited engagement with the De Facto Authority's Ministry of Health, the alternative mechanisms for the program implementation, monitoring, and tracking of the program performance will be established. This includes exploring the partnership arrangements and involvement of NGOs, private providers, EHOs, and CSOs in the provision of immunization services, especially where the areas are controlled by EAOs/ or mixed ones to ensure equity.   * Monthly catch-up meeting with Gavi and WHO and UNICEF's regional offices. Relevant development partners and CSOs could be invited based on the agenda and needs. * Coordination meetings with in-country donors and development partners to update on the progress, obtain advice on the operations and discuss challenges to find solutions. * Maintain regular coordination and discussions with NGOs, CSOs, and EHOs to exchange the progress of immunization services deliveries in hard-to-reach areas and explore the partnership opportunities for both RI and COVID-19 vaccinations. * If DFA approves, data from the proposed quarterly pulse survey will be shared and discussed. * If DFA approves, a periodic EPI review will be conducted along with MoH and all states/regional health departments and partners to:   + provide a snapshot to public health program directors and public health policymakers on the status of the EPI and VPD surveillance;   + assess progress in meeting key national goals; and   + provide an opportunity to share lessons learned * An annual multi-stakeholder dialogue exercise will be tailored to the country's context, taking into account current constraints in terms of securing visas, political instability, travel, meetings, and workload. The process will involve preparatory work on data for the review, potentially multiple exchanges with at least one event for live discussion (likely a virtual meeting), concluding with the finalization of a report and relevant additional documents (e.g., work plan and budget for short-term response/recovery activities, the roadmap for further planning). The process should be inclusive and transparent, with meaningful engagement of partners and civil society organizations. * Submission of the bi-annual progress report, including financial report |