Application Form for: Myanmar Final February 29 2008

GAVI Alliance Health System Strengthening (HSS) Applications

March 2008

An electronic version of this document is available on the GAVI Alliance website (www.gavialliance.org) and provided on CD. Email submissions are highly recommended, including scanned documents containing the required signatures. Please send the completed application to:

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Abbreviations and Acronyms

ADB	Asia Development Bank
AMW	Auxiliary Midwife
BHS	Basic Health Staff
CHW	Community Health Worker
CMSD	Central Medical Store Depot
DOH	Department of Health
EPI	Expanded program of Immunization
NHSC	National Health Sector Coordination Committee
HSS	Health System Strengthening
LHV	Lady Health Visitor
MCH	Maternal and Child Health
MEP	Management Effectiveness Programme
MOH	Ministry of Health
NHSC	National Health Sector Coordinating Body for Health Systems Strengthening (NHSC)
NHP	National Health Plan
PHS 2	Public Health Supervisor 2
RHC	Rural Health Centre
Sub RHC	Sub Rural Health Centre
SBA	Skilled Birth Attendant
TMO	Township Medical Officer
TWP	Technical Working Paper for HSS: Health Systems Barriers to Improving Immunization and MCH coverage in Myanmar
TWG	Technical Working Group HSS
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive Summary

Country Background

Myanmar (population 57 million) is a Union of 17 States and Divisions,[1] and a country of significant geographic and ethnic diversity, made up of 135 national groups speaking over 100 languages and dialects (c-MYP p. 8). Myanmar's Fourth Short-Term Five-Year Plan has set out the nation's main development objectives, one of which is to extend education and health sectors for human resource development. Myanmar is networked by 1473 Rural Health Centres and 6599 Sub Rural Health Centres under the administration of the Township Medical Officer (TMO) and Township Health Team.

Townships (n = 325) have a catchment area of 100,000 – 200,000, and are responsible for management of all secondary and primary care services, which includes within its jurisdiction 1-2 station hospitals, and 4-7 rural health centres.[2] Each RHC has 4 sub-centres covered by a midwife and public health supervisor grade 2 (PHS 2) at the village level. In addition there are voluntary health workers (community health workers and auxiliary midwives) in outreach villages providing Primary Health Care to the community (c-MYP p. 13).

Although some progress has been made in recent years, Myanmar is still beset with significant communicable disease and health system access problems, particularly as effecting mothers and children in hard to reach areas. Under-5 mortality rate is 66.1 per 1000 live births (Cause Specific U5 Mortality Survey 2003), with very high variations between urban and rural rates. ARI, prematurity/ LBW and diarrhoea are the leading causes of death of children under 5, and 73% of deaths are occurring in infancy (0-11 months). In terms of immunization coverage, although overall rates are approaching 80% for most antigens, there are wide variations in rates across the country, with 20% of Townships recording immunization coverage for measles at less than 50% (c-MYP p. 18).

Health System Barriers

There are three main clusters of health system barriers identified by health planners and managers in Myanmar, although taking into account that these barriers and their impact on health system performance are very interrelated.

1. Service delivery barriers present in a range of ways depending on the location. Barriers may relate to geographical terrain, cultural diversity, remoteness or insecurity. This diversity presents significant challenges in terms of staffing and infrastructure including logistics (cold chain, essential drugs), communication and transport. The diversity of service delivery barriers relates in many ways to the geographic and cultural diversity of Myanmar, and has resulted in the classification of areas in Myanmar as "hard to reach."

Currently, the National EPI program has classified over 100 Townships as hard to reach, with these Townships being reached through an implementation strategy known as "Crash". Crash is an immunization program "catch up" strategy that targets areas of low coverage for DPT3, usually in areas that are difficult to reach for geographic or security reasons.[3] Given the scarcity of resources and challenges of geography, cultural diversity and security, there is growing pressure on the most peripheral level of the health system to focus on a targeted or essential group of MCH

[1] The terms State and Division are administrative classifications of the Union of Myanmar. In effect, they are the same functional levels of the health system.

[2] A note on health system structure in Myanmar - although there is a District Level to the health system, it is for administrative purposes only. All technical programming functions through States and Divisions (both at the same level) and through Townshi23 s(ocut 1 .truct1 .trc .tru00 TD(P)Tj388.86 204.5603 Tm0 Tc0 Twm(2)Tu)-5.3(g)0./TT14 1 Tf6.48 0 0 6.

interventions, and not only immunization, in order that minimum standards of MCH services can be provided in these areas (See Annex 3 of the Technical Working paper for HSS (TWP) for details of the essential components of PHC). In addition to this supply side strategy, there is also an increasing requirement to focus on community based demand side strategies to stimulate greater utilization of health services where they are functioning in harder to reach areas.

2. Management and organizational barriers usually present in the form of inability to manage at Township level and below a complex system of vertical programs and projects that are in many cases planned, managed and reported on independently from each other. This is leading to fragmentations and inefficiencies in delivery and management at State/Division and Township levels and distortions in service delivery (midwives find that their most burdensome task is report writing and trainings/meetings (see TWP page 14). Myanmar health expenditures are now 70 to 80% privately funded (see Annexes 3 & 6). At the Township Level, this is leading to an over-emphasis on income generating curative care, and less focus on prevention. And for families, this means higher personal investments in securing health care provision, especially for catastrophic health events. At this point in time, Township Medical Officers and Health Teams are not yet adequately equipped organizationally and managerially to meet the challenge of fragmentation of organization, planning and financing of maternal and child health care in their jurisdictions.

3. Human Resource barriers are most obvious in relation to the numbers, distribution, and mix of health staff at the most peripheral level of the health system (i.e. midwife and Public Health Supervisor 2 (PHS 2) at the sub rural health centre). This is the most significant resource challenge described in the National Health Plan (NHP) 2006-2011 and also in the TWP. Since 1988, the number of medical graduates has doubled, but in the same time the absolute numbers of midwives have increased by only 10% (See TWP p. 13). Analysis of the workload of midwives (see conclusion of Annex 4) indicates lack of clarity of function for the midwife, overload with administration and role confusion and conflict with PHS 2. In more remote, insecure and culturally diverse regions, midwives are difficult to motivate and retain, resulting in significant numbers of unfilled posts and consequent lack of service access for these populations.

Goal, Objectives, Main Activities, and Expected Outcomes

The Goal of the Health System Strengthening Program in Myanmar is to achieve improved service coverage for essential PHC components of immunization and maternal and child health in support of 2/3 reduction in under 5 child mortality between 1990 and 2015, through strengthening programme coordination, improving health planning systems and strengthening of human resources management.
This goal directly addresses the 3 main health system barriers outlined above, and responds to *National Health Policy* of Myanmar, whose main goals include health for all using a primary health care approach, production of sufficient as well as efficient human resources for health, and the expansion of health services to rural and to border areas so as to meet overall health needs of the population. (NHP Annex 3)

The expected outcomes of the program include increases in DPT3 coverage from 70% to 90% (Nationally) and increases in deliveries by trained health staff from 67.5% to 80% (in HSS targeted Townships) between 2007 and 2011. These outcomes will be achieved through management strengthening, and resourcing, implementation and monitoring of 180 Township Coordinated Health Plans, (55% of all Townships), and the staffing of Rural Health Centres in 90 Townships (28% of all Townships) to national standards. Coordinated Township Health Planning will focus on the delivery of essential and targeted components of PHC (namely MCH, immunization, nutrition and environmental health services (see Annex 2 of the TWP for detail) with a focus on hard to reach areas. In addition to these investments in systems capacity building and service planning and implementation, it is proposed that by 2011 there will be 540 Rural Health centres renovated and 324 Sub Rural Health centres constructed across the country in the same hard to reach areas. Additionally, these targeted facilities will be adequately provided with staff, transport logistics and life saving drugs and equipment. It is proposed that by 2011, on the basis of findings of programs

of operational research and health services evaluation that National Frameworks and Systems for Human Resource Development, Health Planning and Health Financing will be in place for national scale up in the next strategic health planning cycle between 2012 and 2015.

> ***Objective 1 Service Delivery Strengthening: By 2011, 180 selected townships[4] 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%[5].***

The attainment of the HSS objective and goal will be facilitated by the targeting of "essential components" of primary health care (inclusive of immunization, MCH, nutrition and environmental health), with a focus for delivery of care at the sub rural health centre level (midwife and PHS 2). This objective incorporates activities associated with Infrastructure developments (RHC construction or renovation), logistics supply (transport, life saving drugs)[6], the financing of operational costs for the implementation of Township Coordinated Health Plans, and building capacity and partnerships with Community Health Workers and NGOs to assist service delivery coverage across the 60,000 villages of Myanmar. This objective links closely to objective 2, in so far as service delivery needs will be annually identified through the development of Coordinated Township Health Plans.

> ***Objective 2: Improved program Coordination and Capacity Building: By the end of 2011, 180 selected townships with identified hard to reach areas will have developed and implemented Coordinated Township Health Plans***

This objective will assist to achieve the goal of the HSS program and NHP through coordinated resourcing and programming of service delivery that is needs based and focused on hard to reach areas in Townships. Initial stages will focus on research and development of annual planning, costing and supervision guidelines, commencing with 20 Townships in 2008, leading to a gradual scale up to 180 Townships by 2011.Planning system development will also be linked closely to strengthening of supervision, health information systems and health financing schemes, and the implementation of a management effectiveness program. Although planning will focus mainly on the Township level and below, it is proposed to link Township planning to State/Division Planning, and later in the program cycle, to improvements to National Strategic Planning processes. Annex 3 of the TWP outlines a conceptual framework for planning system development. Health Planning will identify service delivery investments (infrastructure, logistics, transport etc) and human resource requirements, particularly as relating to hard to reach areas, and will therefore link closely to Objective 1 (strengthening of health service delivery) and Objective 3 (Human resource management). The development of health financing schemes will be integrated within the health planning system. Following trial and evaluation, it is proposed that by 2011, a minimum of 50 Townships will have functioning health finance schemes that conform to newly-developed national standards and guidelines. The financing of Coordinated Township Plans will include an equitable balance between supply and demand side strategies for health system strengthening, particularly through the agency of village health committees, community health workers and community participation in the development and functioning of health financing schemes.

[4] Please note – "selected" refers to Townships corresponding to low DPT3, low SBA and low HR numbers. Refer to Annex 9 for details.

[5] For measurable indicators in the MCH package, please refer to section 6.

[6] Please refer to Annex 10 for list of life saving drugs and supplies (includes essential drug lists for MCH, Rural Health Centre Kits and Clean Delivery Kits for midwives and Voluntary Health Workers ie. Auxiliary Midwives at village level)
(source UNICEF Yangon)

Objective 3 Human Resource Management*: *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.[7]

The HSS program, in line with the National Health Plan (NHP), will support a range of activities to improve distribution, mix, numbers and motivation of the rural health workforce, with a particular focus on the midwife and the PHS 2 in 'hard to reach' areas. This will include research and development of a Human Resource Medium Term Plan and the development of a proposal to the MOH for making fully functional all posts in 'hard to reach' areas in 90 Townships by 2011. [8]. This proposal will incorporate the description of a retention strategy for rural midwives and PHS 2 in hard to reach areas as well as potentially a local recruitment strategy for midwives from rural and remote areas. As a first step, a trial financial allowance scheme will be introduced in the first 20 Townships for midwives and PHS 2. Research and evaluation evidence from this trial will allow a gradual scale up of the retention scheme to all HSS Targeted Townships by 2011 (55% of the country). Other activities complementing achievement of this objective will include continuing education training programs and the implementation of a management effectiveness program (see TWP Page 18). Retention strategies will be complemented by programs of coordinated planning and supportive supervision (HSS Obj 2) and provision of adequate logistical, infrastructure and operational costs for the work environment (HSS Obj 1). This objective is critical to the attainment of NHP and HSS goals to improve access to MCH and other services to populations resident in 'hard to reach' or 'un reached' areas within Townships.

Main Approach

The main approach of the HSS program in Myanmar is the interlinking of objectives and activities, with the focal point for integration being the Township Coordinated Health Plan and Health Team, led by the Township Medical Officer (TMO). It is the development of coordinated management and planning at the Township (including programs of supportive supervision) that will provide the focus for most infrastructure, logistics, system development and other HSS investments. The State/Divisions will provide the system linkages to the Department of Health (DOH) through strengthening of State/Division planning and supervision systems. The DOH, through the Division of Planning and National Programs (including EPI), and the Department of Health Planning, will provide the lead role in research and development of systems (planning, financing, HR proposals), and in program administration funds management, reporting and evaluation.

The HSS program will adopt a phased approach to implementation, with scale up being guided by the National Health Sector Coordinating (NHSC) Body for Health Systems Strengthening.[9] The NHSC will review annual planning, evaluation activities and programs of operational research (HR, finance, management – see section 6). Baseline Township health system rapid assessments in support of development of Coordinated Township Health Plans will complement routine HMIS systems in monitoring progress. 20 Townships in 2008 will be trialled for planning development and implementation, with scale up to 180 Townships by 2011, which is 55% % of national Township coverage. Initial Townships will be selected based on criteria relating to the classifications within their catchments of areas that are "hard to reach" or "un reached" (see Annex 9 List of Townships).

Programs of operational research will also commence in the short term, with medium to longer term gains expected in terms of development of national planning, human resource and health finance systems (Objectives 2 and 3), and programs of annual review at Township, State and

[7] In one RHC, 5 midwives in one RHC and 4 PHS 2, 1 Lady Health Visitor and 1 Health Assistance. Each rural sub centre should have one midwife and 1 PHS2.

[8] Currently, there is a very large shortage of PHS 2 in rural areas, and it is expected that this shortfall could not be addressed in all targeted HSS Townships (180) by 2011. This is the rationale for the selection of 90 Townships in this objective.

[9] Refer to maps at the end of this executive summary which provides an overview of the HSS scale up. Annex 9 provides a more detailed list of HSS Townships and criteria for selection.

Central Level (see NHP Annex 3 Pg 28). Although Myanmar is maintaining a comprehensive rather than a selective primary health care approach as part of its National Health Policy, it remains the case that GAVI HSS investments will be targeted to essential MCH components and functions of PHC, as provided to the population by the midwife and PHS 2 at the sub rural health centre This is in support of the overall MOH and international goal of 2/3 reduction in child mortality between 1990 and 2015.

Implementation Arrangements

The focal point for management and implementation will be the *Township Medical Officer and Township Health Team*, who will develop and oversee implementation of the Coordinated Township Health Plan.

At the State/Division level, the HSS program of support will be monitored by the State/Division Health Director and management team. Principal mechanisms for monitoring and management support for Townships will be technical support for Co-ordinated Township Planning, and programs of supportive supervision from the State and Division Level. Monitoring and evaluation will be implemented by States and Divisions through (a) participation in HR and health financing research led by the Department of Health, (b) HMIS data collection, analysis and use for annual coordinated planning, and finally through (c) programs of annual review at Township, State Division and Central Levels.

At the central level, the focal point for HSS program development and implementation will be the Division of Planning in the Department of Health.[10] The DOH will be technically advised by a Technical Working Group for HSS and a national and international team of technical advisers, which will report directly to the NHSC. In turn, the NHSC is directly accountable to the Director General for Health and to the Minister for Health.

In the initial stages of the HSS program, it is at the request of the Minister for Health that program funds be channelled through WHO financial management mechanisms, which will allow direct transfer of funds from central level government account to the Townships. In the medium term, a program of financial management institutional strengthening will take place in the DOH and Department of Health Planning, with a view to transitioning to direct annual grants from GAVI to the DOH later in the HSS program cycle (2010).

Sustainability and Complementarity

In terms of *technical sustainability*, the principal strategy is Township, State/Division and Central DOH Management team building. This team building will take place through several mechanisms. These include the development of a Coordinated Township Planning System, linked in the longer term to State and Division Coordinated Planning and National Strategic Health Planning. These planning systems will be complemented by the strengthening of programs of supportive supervision and the implementation of a management effectiveness training program.

The proposal has a strong focus on building health systems research capacity in Myanmar. Two innovations proposed include the establishment of a *Health System Research Fund* at the DOH, which will assist to build and sustain research capacity in Myanmar, through provision of resource and technical support to national institutes and sub national health managers for health systems research. The second innovation proposed is the establishment of a *Health Systems Leadership Development Program*, which will involve mentoring by the DOH and international technical

[10] A note on structure - The Department of Health is the largest Department in the Ministry of Health, and is responsible for service delivery support for public health services across Myanmar. ***The Division of Planning*** in the Department of Health is responsible for research and development of health system policy and strategy. The collaborating agency for HSS is the ***Department of Health Planning***, which is responsible for the development of National Health Plan, HMIS system, financial management and health financing. The HSS focal point is in the Division of Planning, DOH.

agencies of work placements at the Central DOH for a 2 year period, in order to participate and lead in the pending health systems research and development program through GAVI and other partners (see section 5.1 for details).

Financial sustainability will be promoted through a range of strategies that are embedded in the design of this HSS program. Once again, Coordinated Township Planning provides the focus for strengthening financial sustainability, through the linking of complementary investments (UN, NGO & Government) within a single annual operational Township Health Plan. In addition to opportunities for co financing through this approach, there are also additional opportunities for significant efficiency gains through coordination of investments of multiple vertical programs. Finally, the extension of health financing schemes to 50 of the targeted HSS Townships by 2011 will provide a stronger research and evaluation platform for the scale up of health financing systems in Myanmar between 2012 and 2015 (following establishment of a national health financing framework at the end of this national planning cycle in 2011).

The key to the sustainability strategy are the complementarities of planning and investment between the Government, UN, international NGOs and the community through National NGOs and Village Health Committees. These complementarities will be evident in the development and implementation of Coordinated Township Health Plans, and is a direct measurable output of this HSS program (refer to Indicator Activity 1.5). Additionally, the consensus reached at the NGO Consultation meeting in January 2008 to identify Agreements of Work between the DOH and NGOs for HSS targeted Townships in hard to reach areas will also enhance sustainability of the HSS program, by extending the reach of complementary investments in HSS across the States and Divisions. WHO on going collaboration with MOH will complement HSS activities through training, monitoring and evaluation of basic health staff in a range of areas including management and leadership, nursing skills, essential new born care, water and sanitation, EPI, health of women and children, hospital care and health promotion. UNICEF will complement GAVI HSS investments in the areas of water and sanitation,[11] through child survival training, and essential dugs and medicine supplies to 125 Townships. JICA will complement the human resource component of the HSS program through the proposed training program for Basic Health Staff. Programs of support through WHO and UNICEF for immunization (including existing GAVI support for vaccines and immunization program strengthening) will also be reflected in the Coordinated Township Plans financed by Government and the GAVI HSS program. The international program of support through the 3 Diseases Fund (TB, Malaria and HIV) will assist to provide a balance in investments between communicable disease control and the maternal and child health focus of the GAVI HSS investment.

Process of Proposal Development

This proposal has been one year in the making, and the process has been quite inclusive with a wide range of stakeholders providing inputs into development of the HSS proposal. After initial feedback on a first submission in February 2007, the MOH, in collaboration with GAVI partners, undertook a longer term health system analysis, culminating in the publication of a TWP. The TWP developed an HSS agenda based on a health system gap analysis, and devised a HSS framework fully aligned with National Health Policy and Planning objectives (see figure below). The HSS agenda and framework was then presented and discussed at consultative meetings with health leaders in Mandalay in 2007, NGO representatives in Nay Pyi Taw in January 15, 2008, and was subjected to country and regional peer review processes in January 2008. The timing of the HSS program is in line with the National Health Planning Cycle (2007 – 2011) and is valued at 32.78 Million US $ based on the Asian Development Bank figure for Myanmar's GNI (published 2007)[12].

[11] In the GAVI HSS proposal, environmental health activities are not being funded directly by GAVI. It is expected that these activities will be co financed by UNICEF nationally in sanitation programs, and also through the WHO program for development of Water Safety Plans in 5 Townships.
[12] World Bank data on GNI for Myanmar is not available at the time of writing.

Figure 1 Summary: HSS Framework for Myanmar

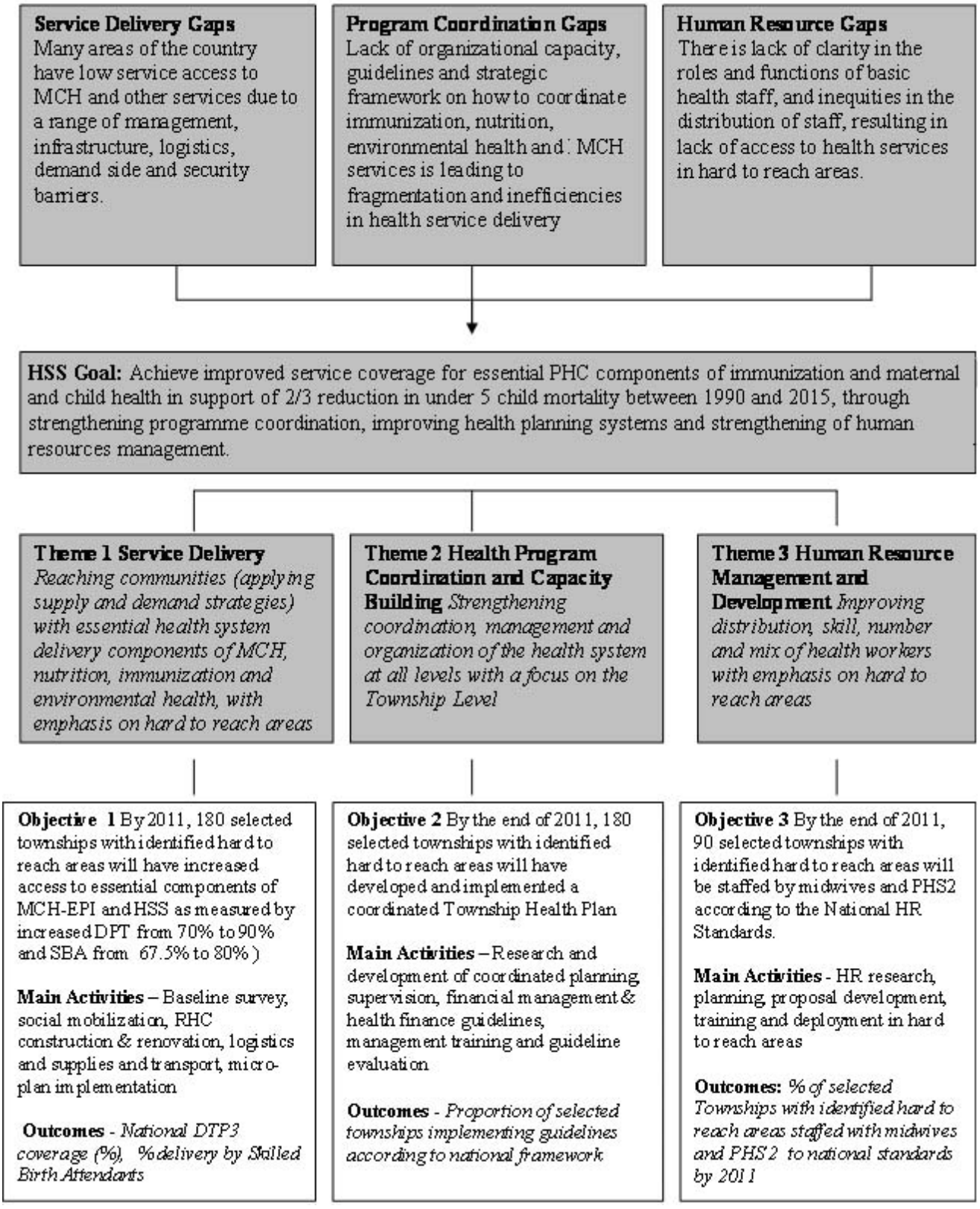
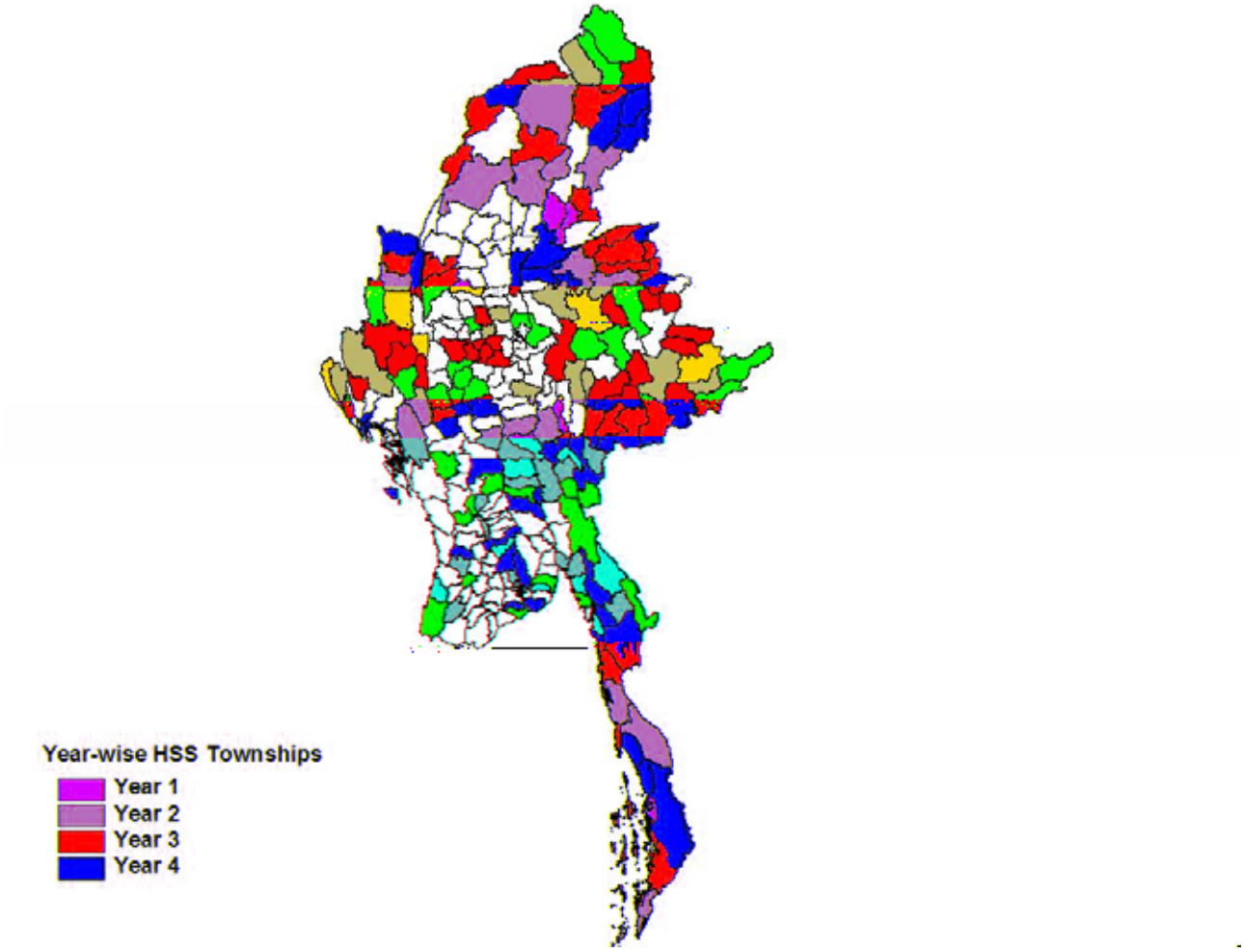


Figure 2 Maps of 180 Selected Townships by Year for Scale up of HSS Program 2008 – 2011 [13]



[13] Refer to Annex 9 for detailed list of Townships by Year. Base list was 103 "Crash Townships" of EPI program.

Section 1: Application Development Process

1.1: The HSCC (or country equivalent)

Name of HSCC (or equivalent):

National Health Sector Coordinating (NHSC) Body for Health Systems Strengthening

HSCC operational since:

The NHSC has been operational since the beginning of 2007.

Organisational structure:

The **NHSC** is chaired by the Director General of the Department of Health (DOH). Two Deputy Director Generals one for Disease Control and one for Public Health are Vice-chairs of the NHSC. Other DOH members include the Director of Planning, Director of Public Health, Director of Disease Control, Director Epidemiology, EPI Program Manager and Deputy Director of Budgeting. The NHSC is supported by a secretariat staffed by the Division of Planning and by the EPI program. The NHSC is also represented by interdepartmental representatives from Ministry of Health, other Ministries, UN, professional associations, and by a cross section of national and international NGOs. A Technical Working Group was formed to develop the proposal under the guidance of the NHSC.

It should be noted that the *National Health Committee (NHC)*, which oversaw the development of the National Health Plan, is a high level inter ministerial and policy making body. The composition of the NHC includes 9 Senior Ministers[14]. The NHC is not a technical committee. For this reason, it was considered appropriate by the MOH to convene the NHSC to support GAVI HSS proposal development and implementation. The NHSC's membership is sufficiently operational and health system specific in function to oversee development and implementation of HSS strategy. The NHSC will however report to the NHC through the Minister for Health, specifically in relation to decision making on health system policy matters.

The NHSC will also be the coordinating body for other, future health system strengthening strategy development and resourcing, and so therefore is not a stand alone committee for GAVI purposes only.

Frequency of meetings:[15]

In 2007, the NHSC has been meeting to oversee the development of GAVI health system strengthening strategy, and in particular, has undertaken to oversee special studies commissioned in support of GAVI HSS proposal development. The NHSC also convened and facilitated special workshops in Mandalay in November and an NGO consultation meeting in January in Nay Pyi Taw.

The NHSC will meet during the period of HSS funding and beyond, since it is charged with stimulating coordination amongst all Agencies for HSS development. The NHSC meets at least twice a year, and can be convened as needed. The NHSC HSS Technical Working Group has been meeting more frequently, averaging almost once a month during the HSS proposal

[14] Ministries of Health, National Planning and Economic Development, Home Affairs, Progress of Border Areas and National Races and Development Affairs, Social Welfare, Relief and Resettlement, Science and Technology, Education, Sports, Immigration and Population.
[15] Refer to Annex 5 to NHSC minutes and all related HSS records of meetings.

development process (please refer to Annex 5 for TOR of NHSC and Technical Working Group for HSS).

Overall role and function of the NHSC:

The Latest TOR for the NHSC is outlined below, was passed on (26-9-2007) by the Director General, Department of Health (see Annex 5).

1. Oversee development and implementation of national health system strengthening strategies including GAVI HSS, and ensure alignment with the "national health plan 2006-2011" and subsequent National Health Plans.
2. Coordinate inputs from central level departments and a broad range of stakeholders into development of HSS strategy
3. Oversee the conducting of special studies and reviews of health system performance
4. Provide inputs on experiences with health system strengthening to help guide development of national health plans and budgets
5. Explore the increasing and the appropriate involvement of the private sector and other non-government partners into HSS.
6. Encourage alignment with the National Health Plan and coordination of other health system strengthening efforts and activities, such as those supported by International Development partners, the Three Disease Fund, INGOs and CSOs.
7. Discuss ways to coordinate budgets and external aid going to the various health programmes into a more holistic approach to financing the health system strengthening mechanisms.
8. Monitor evolving financial, human resource and technical support needs for health system strengthening, and determine how to ensure sustainability of resources needed.
9. The NHSC will systematically overview health system strengthening implementation, and use the information to develop the Annual Progress Reports to donors (e.g. GAVI, 3-D fund, etc) and the government, and revise annual HSS plans as needed.

1.2: Overview of application development process

Who coordinated and provided oversight to the application development process?

Coordination and oversight of the HSS application development process, including special studies conducted in support of this application, was by the Technical Working Group (led by the Planning Division of Department of Health), GAVI partners, International NGOs, UN specialised agencies

3. To facilitate coordination between national departments in support of integrated health system planning, resourcing and evaluation.
4. To collect data for preparation of the GAVI HSS proposal.
5. To facilitate coordination with UNICEF, WHO, the Ministry of Health and Ministry of Finance in support of health system strengthening proposal development, implementation and monitoring and evaluation.
6. To complete GAVI HSS proposal on time for approval of NHSC and Ministers.
7. To use the resources available for proposal and strategy writing in a systematic way.
8. To collaborate with other linked departments in writing of the GAVI HSS proposal.

The Division of Planning in the DOH conducted a range of special studies (see below) to support the development of the health system working paper. The rationale for undertaking this approach was the scarcity of recent health system assessments and the need therefore to conduct an analysis to identify gaps and existing strengths and weaknesses in the system. Through GAVI HSS funding, international technical assistance was obtained for the purpose of finalizing the health system working paper and application drafting. WHO also provided in country and regional technical support for the application development including workshop facilitation.

Give a brief time line of activities, meetings and reviews that led to the proposal submission.

1. In January 2007, Myanmar Department of Health (DOH) submitted an early GAVI HSS application to the UNICEF for review. Feed back was provided by UNICEF to the Health Ministry, which indicated the following action points: (a) Identify a body/committee overseeing health sector coordination or similar function to take the lead in HSS proposal development. If such a committee does not exist, one would have to be constituted; (b) There is a need to conduct a comprehensive review of the current health system looking at all aspects of health service delivery; (c) Develop a consensus of partners on the areas for which GAVI HSS support should be requested, using the newly formed HSCC or equivalent.
2. Following this feedback from UNICEF, it was decided that 12 months would be required in which to conduct a range of health system studies and to reach consensus on health system strengthening strategy. A discussion between UNICEF and WHO representatives highlighted the need to consider the possibility of undertaking a broad assessment of the health sector as a way of updating available information.
3. Drafting of the application process was under the supervision of the newly formed National Health Sector Coordinating (NHSC) Body. A smaller HSS working group was also formed at this time to oversee the health system analysis and GAVI proposal application development. Dr Nilar Tin, Director of Division of Planning for the DOH was appointed as focal point for the preparation of the GAVI HSS proposal.
4. Actual proposal development was assigned to the HSS Technical Working Group, with additional technical assistance provided by the Planning Division and Public Health Division of the Dept. of Health, with input from other departments (including the EPI program) and State and Division Directors. The Dept. of Health, Planning Division conducted a range of special studies in collaboration with the Department of Medical Research (Lower Myanmar) and Department of Health Planning (see below) to support the development of the health system TWP.
5. The NHSC was constituted in early 2007. The NHSC had been regularly meeting to guide the proposal development process from September 2007.
6. Between 6 – 24th August 2007, in Nay Pyi Taw (capital city), a GAVI HSS funded health system consultant conducted a desk review as well as a series of interviews with the members of the Technical Working Group. The Technical Working Group identified 6 areas for strengthening of the PHC system, as well as cross cutting themes effecting Township level management and delivery of services. Barriers to improving immunization and MCH services were identified, and were incorporated into a health system draft working paper.

7. During the courtesy call to the Minister for Health by the consultant and focal point of the Technical Working Group on August 17, it was agreed to (a) focus on a minimum package of essential care to be provided by the midwife and (b) include additional stakeholders in the NHSC and (c) approve a deadline for a March 2008 proposal submission.
8. A work plan was constructed for completion of the proposal, commencing with establishing mechanisms and a time frame for developing the proposal and identification of bottlenecks or barriers for improving coverage. The plan also endorsed the development of a range of "special studies" and "desk reviews" to strengthen the health system analysis.
9. From 29 to 31 August 2007, members of the HSS Technical Working Group together with technical officers from UNICEF and WHO in Myanmar attended a regional HSS forum sponsored by WHO SEARO in Sri Lanka. The objective was to share experiences on the GAVI HSS proposal development process, have a peer review of the evidence base used to define health system gaps, and to outline a process for completion of the health system analysis and the HSS proposal.
10. The proposed HSS objectives, activities and HSS implementation strategy outlined at the WHO/SEARO HSS proposal development workshop was presented to the NHSC at its 26 September meeting, with feedback received.
11. Between August and November 2007, a range of studies and desk reviews were conducted in support of development of the HSS strategy. These included:

    a. *Midwifery Study-"*Are we overburdened in rural areas? Voices of midwives"
    b. Study on Community Perceptions of Health "*Perceptions of people in the community towards health and existing health services in rural areas of selected townships"*
    c. *A Review of Management Effectiveness Program* "Review of experiences and lessons learned from Management Effectiveness Program in Myanmar"
    d. EPI Desk Review
    e. Developing mapping of NGO activity in supporting health services in Myanmar.

12. For 5 days in November 2007, a workshop was convened by the HSS Technical Working Group in Mandalay and with the participation of Township Medical Officers, State and Division Directors, WHO SEARO and UNICEF external consultant, and national advisers. The objectives of this workshop were (a) to present recent findings on HSS assessment, barriers and surveys, (b) to develop an HSS goal in line with the NHP and GAVI requirements (framework), (c) to draft initial objectives and indicators and (d) to reach final consensus on a way forward to finalize the GAVI HSS application.
13. In early December, the findings of the studies and the outcomes of the workshop gap analysis and HSS framework development were written into the next draft of the HSS application. Outcomes were (1) Revised health system working paper (2) Draft 1 of GAVI Application.
14. On January 15 2008, the HSS Technical Working Group convened a 1 day meeting with International NGOs to gain their further input into the development of the proposal, particularly in relation to selection of main theme areas and coordination mechanisms.
15. In early January, the HSS working group and a UNICEF consultant reviewed and revised the application based on feedback from working group membership and SEARO region.

Who was involved in reviewing the application, and what was the process that was adopted?

1. Review processes were included throughout the proposal development process, including in the very early stages in early 2007. UNICEF and WHO representatives advised the DOH to adopter a longer term view to proposal development, in particular focussing on more in depth health system analysis and stakeholder participation.
2. The Minister for Health reviewed the process mid 2007, and requested a maternal and child health service delivery focus at the periphery (focussing on the midwife role). SEARO HSS

advisers were closely involved with guiding processes through regional information sharing and in country technical support.
3. International NGOs were invited to a meeting in January 2008 in order to comment on the initial framework drafted by the HSS working group.
4. In mid January, the peer review process commenced. A questionnaire was drafted in order to focus reviewer's comments on the key issues of proposal ownership, logic and relevance to national health needs and strategies. The drafted application was circulated to key stakeholders.
5. In early February, comments from the peer review were included into the revised proposal.

Who approved and endorsed the application before submission to the GAVI Secretariat?

The application was approved and endorsed by the NHSC at the meeting on 15th February 2008, and then sent for final approval by the Minister of Health and Minister of Finance and Revenue.

1.3: Roles and responsibilities of key partners (HSCC members and others)

Title / Post	Organisation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS application development
1.Dr Tin Win Maung Director General	Department of Health	Yes	Overall responsibility for GAVI Health System Strategy, Chair of NHSC
2. Dr. Kyaw Nyunt Sein Deputy Director General (Disease Control)	DOH	Yes	Vice-Chair of NHSC. Provided input on disease control matters (including EPI) into the GAVI HSS proposal development. Also facilitated negotiations with international NGOs and 3- Diseases Fund
3. Dr. San Shway Wynn Deputy Director General (Public Health)	DOH	Yes	Vice-Chair of NHSC. Provided input on public health matters into the GAVI HSS proposal development. Also facilitated negotiations with internationals NGOs.
4. Dr Saw Lwin Director (Disease Control)	DOH	Yes	Chair of HSS Technical Working Group. Facilitated the health system strengthening workshop in Mandalay in November 2007.
5. Dr. Nilar Tin Director (Planning)	DOH	Yes	MOH Focal point for GAVI HSS proposal development. Oversight of the HSS proposal development over a 12 month period, including the development of the TWP and also led specific research programs in support of the HSS proposal development.
6. Dr. Thein Thein Htay Director (Public Health)	DOH	Yes	Member of Technical Working Group that participated in workshops and consultations for HSS strategy development.
7. Dr. Phone Myint Director (Planning)	Dept of Health Planning	Yes	Attendance at NHSC Meetings. Provided inputs for health financing and revitalization of village health committees.
8. Dr. Hla Hla Aye Director (International Health)	Ministry of Health	Yes	Attendance at NHSC Meetings
9. Daw San San Yee Director	Ministry of Finance and Revenue	Yes	Attendance at NHSC Meetings. Provided inputs for financing mechanisms.
10. Daw Than Than Lin Director	Foreign Economic Relations Department, Ministry	Yes	Attendance at NHSC Meetings.

	of National Planning and Economic Development		
11. U Kyaw Wiin Director	Office of Auditor General	Yes	Attendance at NHSC Meetings.
12. U Win Maung Director	Ministry of Progress of Border Areas and National Races & Development Affairs	Yes	Help develop public health criteria for selecting HSS-targeted Townships
13.Dr Wai Wai Thar Secretary	Myanmar Maternal and Child Welfare Association	Yes	Provides feedback on social mobilization strategy.
14. Dr. Thet Thet Zin Secretary	Myanmar Women's Affairs Federation	Yes	Provides feedback on social mobilization strategy.
15..Dr. Sein Win Joint Treasury	Myanmar Medical Association	Yes	Provides input on medical services; e.g. TMO roles and barriers to effective performance of work
16. Dr. Saw Ni Tun Representative	Myanmar Red Cross Association	Yes	Provides perspective of NGO on HSS
17. Daw Nwe Nwe Khin Representative	Myanmar Nurses Association	Yes	Gives feedback on issues with nursing, midwives and PHS 1 & 2
18. U Aung Khin Chairperson	Myanmar Health Assistant Association	Yes	Gives feedback on township workforce and health assistants
19. U Zaw Win Myint Representative	USDA	Yes	Member
20. Dr Osamu Kunuii Chief, Health and Nutrition Section	UNICEF	Yes	Focal Point GAVI HSS UNICEF. Facilitates technical support through UNICEF, and provided peer review support.
20. Dr Siddharth Nirupam Child Survival Specialist	UNICEF	No	Provides inputs to proposal development in the areas of child survival and drugs and supply systems.
21. Ms Margareta Skold Public Health Administrator	WHO	Yes	Focal Point GAVI HSS WHO Facilitates and provides technical support and provided peer review support.
22. Ms Yoshika Umabe Project Formulation Advisor	JICA	Yes	Focal Point GAVI HSS JICA. Provided comments on design and suggested an approach for complementarities of activities for continuing training for basic health staff.
23.Dr. Than Zaw Myint Director	Department of Medical Sciences	Yes	Provides input on human resource development.
24. Dr. Than Htein Win Assistant Director EPI	DOH	Yes	Secretariat of NHSC National EPI Manager: coordination of HSS with immunization system strengthening efforts, ICC member
25.Dr. Nyo Nyo Kyaing Deputy Director (Planning)	DOH	No	Technical Working Group
26. Dr. Than Lwin Deputy Director BHS	DOH	No	Technical Working Group
27.Dr. Myint Myint Zin Deputy Director	DOH	No	Technical Working Group

Nutrition			
28. Dr. Theingi Myint Deputy Director MCH	DOH	No	Technical Working Group
29. Dr. San San Aye Deputy Director	Dept. of Health Planning	No	Technical Working Group Assist in identifying linkages between HSS and other Health Sector Development strategies, programmes and policies.
30. Dr. Soe Lwin Nyein Director (Epidemiology)	DOH	Yes	Technical Working Group
31. Dr. Phone Yaung Deputy Director (Environmental Health)	DOH	No	Technical Working Group
32.Dr. Than Tun Aung Assistant Director EPI	DOH	No	Technical Working Group Member of 'National Committee of Immunization Practices" Focal Point for Immunization campaigns ICC member
33.Dr. Myint Myint Wai Medical Officer Planning	DOH	No	Technical Working Group Assist in identifying linkages between HSS and other Health Sector Development programmes.
34. Dr Khaymar Mya Assistant Director EPI	DOH	No	Member of National Committee of Immunization Practices Focal Point for training, Cold Chain Management and Crash Programme ICC member, Technical Working Group
35. Mr Thomas O'Connell Consultant	WHO/SEARO	No	Focal Point GAVI HSS WHO SEARO: Technical Support on drafting and Proposal Review
36. Dr George L Dorros Consultant	WHO	No	Consultant Health System Analysis
37. Mr John Grundy Consultant	University of Melbourne	No	Consultant Health System Analysis and Application Drafting
38. Dr. Nihal Singh Medical Officer (EPI)	WHO	No	Coordinated the EPI Desk Review and provides input on EPI to the proposal

1.4: Additional comments on the GAVI HSS application development process

1.4.1 Proposal Process

After an initial attempt at development of a GAVI HSS application in early 2007, it was recognized by all concerned that more detailed health system analysis would be required in order to develop a more evidence based and strategic proposal with broader stakeholder involvement in its development. Limitations in the proposal development process are still recognized (1) Strengthened operational health services research programs are in early stages of development (2) NGO and planning coordination mechanisms are limited in scope and level of development.

Notwithstanding these limitations, every effort has been made in the proposal development process over the last 12 months to strengthen the evidence base for the proposal development through (a) wide stakeholder participation through inclusive proposal development and peer review and (b) the conducting of specific research studies designed to assist with identification of health system gaps. This process will be continued in HSS strategy implementation, with NGO coordination (see Activity 1.5) and strengthening of operational research (see Activities 2.1 – 2.3) being main activities in support of program objectives.

1.4.2 NGO Participation

NGOs will be involved directly in HSS program implementation through coordination of activities within the Coordinated Township Health Planning System. The type and level of implementation will depend on the characteristics of the Township Health Plan and the functions and expertise of the international or national NGO.

At the DOH-NGO information forum conducted in Nay Pyi Taw on January 15 2008, the following consensus was reached between the HSS Working Group and international NGOs:

- That the concept of a Coordinated Township Health Plan will assist NGOs to collaborate with the government for HSS and PHC service delivery.

- More consideration is required in the proposal for demand side initiatives, particularly in relation to (a) support for village health committee to raise awareness on prevention of disease and accessibility as well as quality of health services (b) participation in health financing schemes (identification of the poor by village health committees with support from NGO for financing)

- That there are opportunities for co financing of Township health plans , and that these areas include the following: construction/ renovation, training, social mobilization, national programs support for AIDS, TB and Malaria, volunteer training, provision of equipment and supplies, support for health financing schemes..

- Agreements of Work will be negotiated between the DOH and NGOs to shift support to HSS targeted hard to reach Townships in order to complement HSS investment (in State Areas).

- Reactivation of health committees [16] is required in the HSS proposal in order to strengthen demand for health services.

- Health Finance costs should cover both RHC drug revolving funds as well as hospital costs for catastrophic health events. Research is required as a first step to decide on the priority approach for health financing.

[16] At each level of the health system there is a Health Committee chaired by the Local Authority with membership of health officials.

- Inclusion of two international NGOs into the National Health Sector Coordinating Body for HSS

The *Private Sector* has not been directly involved in the development of this proposal. The private sector is mostly focussed in the cities and towns of Myanmar, whereas the focus of the HSS program is in rural areas.

Section 2: Country Background Information

2.1: Current socio-demographic and economic country information[17]

Information	Value	Information	Value
Population [1]	57,793,004	GNI per capita [5]	$US 270
Annual Birth Cohort [2]	1,556,615	Under five mortality rate [6]	66.1 / 1000
Surviving Infants [3]	1,479,251	Infant mortality rate [7]	49.7 / 1000
Percentage of GNI allocated to Health [4]	2.8%	Percentage of Government expenditure on Health [8]	3.87 % (2005)

1. Statistical Year Book 2005 (projection for 2007 based on 2.02 percent Growth Rate)
2. Statistical Year Book 2005 (projection for 2007 based on 2.02 percent Growth Rate)
3. GAVI-ISS Annual Progress Report 2006;
4. World Health Report 2006
5. Source: Asian Development Bank, Myanmar 2007 Fact Sheet, www.adb.org./myanmar NOTE: No World Bank GNI data available.
6. Cause specific Under 5 Mortality Survey 2003
7. Cause specific Under 5 Mortality Survey 2003
8. State Budget Law 2005

2.2: Overview of the National Health Sector Strategic Plan

The situation analysis of the National Health Plan (NHP) identifies the following overall weaknesses and constraints to health system performance.

In terms of disease burden, the national plan observes that progress in *reducing maternal and child mortality* is "sluggish" and requires higher priority status in order to reach the millennium development goals (Page 11). Communicable diseases are still highly prevalent due to poor environmental conditions, health knowledge and living conditions (Page 10).

In terms of *rural health care and coverage,* expansion of health facilities was found to be more focused on hospital rather than rural health centre development, with greater concentration of skilled health staff in rural areas (Page 10).

In terms of *health financing*, it is observed that the proportion of out of pocket payments by households is high and that consequently, one of the policy objectives of the country is to explore alternative health financing mechanisms (Page 11).

One of the reasons cited in the situation analysis for failing to reach service delivery targets is the incorrect mix, numbers and distribution of the *health workforce*, that there is excessive work burden for some, lack of clarity on roles and functions, and limitations in skills training and the quality of supervision systems (Page 11).

In terms of *organization and management of health services*, the situation analysis indicates that there are weaknesses in inter sectoral collaboration and service integration, with stronger partnerships required between public and private sectors (Page 11). The Plan also observes that there is underutilization of *health research*, and that availability of *quality data* that is timely, complete and relevant is still lacking.

[17] If the application identifies activities that are to be undertaken at a sub-national level, sub-national data will need to be provided where it is available. This will be in addition to the national data requested.

SOCIAL OBJECTIVES AND HEALTH POLICY OF THE STATE

The Social Objectives of the State: The National Health Plan 2006 – 2011 relates directly to the 4th of the four *social objectives* of the State, which aims for the "uplift of health, fitness and education standards of the whole nation." (NHP Annex 1)

A *National Health Policy* was promulgated in 1993, of which the main objectives include the following: (see NHP Annex 2)

(1) To raise the level of health of the country and promote physical and mental well being of the people with the objective of achieving "health for all" goal, using *primary health care approach*.

(2) To produce sufficient as well as efficient *human resources for health* locally in the context of the broad framework of long term health development planning.

(3) To augment the role of co-operative joint features, private sectors and *non government organizations* in delivery of health care in view of the changing economic system.

(4) To expand health services not only to rural but also to border areas so as to meet overall health needs of the country.

OBJECTIVES OF THE NATIONAL HEALTH PLAN 2006 - 2011

The National Health Plan developed more specific objectives for 2006 – 2011 periods addressing most of the health objectives outlined in the National Health Policy above, but also including the following:

Health Services Strengthening

(1) To improve the health status of entire community by providing quality health care services for mother, newborn and under 5 children (Objective 3.1 National Health Plan Pg 59)

(2) To reduce morbidity and mortality of vaccine preventable diseases for achieving eradicating or eliminating from public health problems (Objective 3.1 National Health Plan Pg 79)

Health Organization & Coordination

(3) To accelerate the health development activities with stronger linkage among health and health related sectors and National and International NGOs. (Objective 2.6 National Health Plan Pg 23)

(4) To make optimal level integration in collaboration with other departments for providing health services (Objective 3.1.5 National Health Plan Pg 26). To provide health services through an integrated approach. (Objective 3.1.4 National Health Plan Pg 26)

Health Financing

(5) To develop an appropriate alternative health care financing system in the context of Myanmar's socio-economic system basing upon the experience gained from community cost sharing system. (Objective 3.1.6 National Health Plan Pg 26)

(6) To promote utilization of health systems research to improve health systems performance by enhancing research culture among decision makers at all levels (Objective 2.1 National Health Plan Pg 205)

Health Information

(7) To produce information for taking action in the health sector for all round development of health of the people by means of improving the timeliness, quality, access and use of management information (Objective 2.1 National Health Plan Pg 235)

Human Resource Management & Development

(8) To recruit new community health workers in all states and divisions to have full primary health care coverage (Objective 3.1.3 National Health Plan Pg 26)

(9) To deploy basic health personnel to newly established rural health centres so as to provide primary medical care and preventive services. (Objective 3.2.3 National Health Plan Pg 26)

(10) To review the responsibility and duty of basic health staff, especially HA, LHV, MW and PHS-2. (Objective 3.2.4 National Health Plan Pg 26)

(11) To produce different categories of human resources for health in accordance with the National Health Plan which is in line with the National Health Policy. (Objective 2.1 National Health Plan Pg 251)

Health Research

(12) Promoting operational researchers, monitoring and supervision and evaluation of primary Health care Services. (Objective 5.7 National Health Plan Pg 28)

Chapter 3 of the plan outlines the monitoring and evaluation strategy, with a specific committee established to monitor plan implementation nationally, with sub national monitoring taking place through townships, state and division reporting and supervision. What information is not obtainable through routine HMIS should be sought through health research. There is also a mid term and end of plan period evaluation proposed.

Most of the National Plan 2006 – 2011 is planning by programs and projects, and these are listed in detail on Pages 19 and 20 (a Total of 12)

(1) Community Health Care Program
(2) Disease Control Program
(3) Hospital Care Program
(4) Environmental Health Program
(5) Health System Development Program
(6) Health Promotion Program
(7) Health Management Information System Program
(8) Development of Human Resources for Health Program
(9) Health Research Program
(10) Laboratory Services and Blood Safety Program
(11) Food and Drug Administration Program
(12) Development of Myanmar Traditional Medicine Program

MAIN STRENGTHS AND WEAKNESSES, and PRIORITY DEVELOPMENT AREAS

The National Health Plan **(see Annex 1) indicates that significant progress has been made in recent years in hospital expansion (Page 4), curative care, technology introduction and**

private sector expansion (Page 2). However, there are persisting high rates of communicable disease and persisting high infant and maternal mortality rates. This is attributed to fundamental weaknesses in the health care system, particularly in rural areas. In the last planning cycle, there was inability to expand the number of rural health centres as planned and provide essential drugs and equipments to facilities (Page 3). This situation is exacerbated by high rural health staff turnover or insufficient staff numbers (Page 3), financial limitations (Page 3), and high out of pocket expenditures on health by the population.

This being the case, the NHP proposes that "priority be given to border areas where development has been lagging behind, in addition to the rural areas, to ensure universal access to health services based on Primary Health Care." (Page 2)

The TWP **(see Annex 3) indicates that "the elements and potential for an effective Basic Health Service which supports a PHC approach in providing essential care and provides universal coverage exists in Myanmar. Developing this potential can be most effectively undertaken only if the identified health systems barriers related to attaining improved coverage and sustainable routine immunization of children is understood within the institutional leadership and managerial context which they exist" (Page 25). Main weaknesses are summarised as follows:**

The vertical programmes promote and provide incentives for implementers to adopt a project oriented approach and discourage the emergence and implementation of integrated work plans at the BHS level. The TWP indicates that there are very strong linkages between managerial practices in the health system and the barriers to improving effective coverage and routine immunization. This is leading to overburdening of work of primary care providers (in particular midwives) with documentation and vertical programming, distracting them from their core midwifery functions.

The TWP highlights fundamental weaknesses also in terms if limitations of finance, essential drugs, supplies, transport and infrastructure in rural areas.

In terms of health system strengthening, it is recommended in the TWP that any HSS strategy must be an integral part of the institutional and managerial process at all levels of the health system, and that high priority be given to development of coordinated planning systems. (Page 26) **"The purpose of developing coordinated planning and supervision guidelines, reinforced by management capacity building, is therefore to reorient health service delivery towards more coordinated management and delivery patterns." (Page 32)**

Section 3: Situation Analysis / Needs Assessment

3.1: Recent health system assessments[18]

Title of the assessment	Participating agencies	Areas / themes covered	Dates	Main Findings
1. National Health Plan Situation Analysis	Ministry of Health	Barriers to Health System performance	2005	• Development of rural areas lagging behind rest of country • Examine need to expand private sector, social society and NGO involvement in health sector development • Establish an equitable system for health financing that ensures universal access and prevents financial burden on households due to illness • Meet challenges of rising burden of non communicable disease • Capacity building of Health Management Information System (HMIS) needed • HR development, training and capacity building required • Need management training for Township Medical Officers, to support universal coverage with basic essential medicines and health interventions • All disease control programmes to increase collaboration with each other • Need to increase sectoral collaboration at all levels
2. HSS TWP	Department of Health Department of Medical Science Department of Health Planning WHO UNICEF	Barriers and bottlenecks to health system performance	2007	The following systemic barriers to immunization and MCH performance were identified: • Between 1988 and 2007, there was a 31.8% increase in the number of hospitals and only a 10.2% in the number of Rural Health Centres (Page 10) • There are strong weaknesses in program integration and coordination, with managerial practices focussed on vertical programming.(Page 25-27) • Between 1988 and 2007, the number of doctors doubled, whereas the numbers of midwives increased by only 11%.(Page 12) • There are low staff population ratios in many areas, and pockets of very low coverage of delivery by

[18] Within the last 3 years.

				trained staff. (Page 13) • Basic Health Staff (BHS) currently spend 35% of their time on trainings, and the effectiveness of these training has not been evaluated. (Page 14) • Little incentives for BHS staff to provide services in remote areas • Private households invest 73% of all national health expenditures according to the National Health Accounts. • International Aid Flows to Myanmar are the lowest per capita in the region according to OECD figures (Page 15) • Government health expenditure for curative care is 29.57% versus 9.45% for prevention and public health • The medical supply system is not functioning effectively, with undersupply of medicines and equipments in some areas – there is no monitoring of user needs. (Page 17) • Planning at all levels has become “projectized” along vertical lines. Costing often does not match activities planned (page 18,19) • In terms of supervision, there is very low level of analytical and problem solving analysis which results in a perpetuation of managerial problems.(Page 21) • Better communication is required with NGOs and local authorities to ensure more coordinated planning and health partnerships (Page 22) Three main areas need strengthening 1. Service delivery 2. Programme coordination (planning, management & financing) 3. Human Resource management and development
3. MOH Myanmar 2007 Nilar Tin et al "Are we overburdened in rural areas? The Voices of Rural Midwives"	Dept. of Health & Dept. of Medical Research	Barriers to health system performance at the primary level of care (sub rural health centre)	2007	• Majority of midwives interviewed said they were overburdened with recording and reporting, disease control, environmental health and nutrition. This is affecting their main duties in relation to midwifery function. • Collaboration between midwives and Public Health Staff 2 (PHS 2s) was rated to be low due to same pay scales and professional competition • Job descriptions and deployment patterns of midwives and PHS 2 should be reviewed so as to make the mix and distribution of staff optimal
4. Situation Analysis c-MYP and Desk Review EPI	Dept. of Health WHO UNICEF	Health system barriers to immunization performance.	2006 and 2007	• Accessibility to services is variable across the country, and is related to mobility of population, geographic access and security • Health infrastructure is limited in some townships, particularly in relation to transport services and logistics systems • Health workforce motivation is limited at times due to lack of transport, operational costs, incentives and workload • Integration of the health system occurs at the delivery level, but more opportunities exist for improving other health interventions in partnership with immunization

5."Functional Analysis of Basic Health Staff in 3 Different Townships of 3 different zones of Myanmar."	Nilar Tin, San Shwe Win, Nyo Nyo Kyaing, Kyaw Khine, Thidar Kyu, Mya Win Mon.	Research paper presented at Dept. Medical Research (DMR) conference 2004.	DEC 2004	• Improvement in health manpower management as increasing recruitment and deployment of midwives according to native lands. • Remapping of townships with the increase in population and increase in BHS to fulfil the standard ratio of BHS : Population • Job description of BHS should be reviewed and revised sharing some workload of midwife to PHS 2 • Increasing recruitment of voluntary health workers to obtain one health volunteer/ village • Improving continuing medical education by conducting Training of Trainers to Township Medical Officers on management science, epidemiology and educational science (by Central & State/Divisional Training Teams)
6. Mapping of NGO presence and contributions to health		Dept. Health Planning	2007	• NGOs are active in 41% of Townships and are providing a range of PHC services including MCH, HIV AIDS, and nutrition. Although NGOs are active in all these Townships, it is estimated that they may only be active within certain parts of Townships.
7. "Perceptions of people in the community towards health and existing health services in the rural areas of selected townships"	Dr. Nilar Tin	Director Division of Planning DOH	2007	• Communities identify financial factors as being major access barrier to basic health service. • Women acquiring more information and understand more on preventive and promotive measures than men (which could be due to having more contact with health post and health personal as they have to attend those places for pregnancy, child birth and child health) • Whenever the needs were mentioned it was to have a midwife or health post in their community. Women would prefer to deliver by skilled birth attendant rather than untrained birth attendant.

3.2: Major barriers to improving immunisation coverage identified in recent assessments

This barrier analysis is based on findings from the following five major sources/studies:

1. National Health Plan Situation Analysis: In the situation analysis of the National Health Plan 2006 – 2011, cross cutting health system barriers to improved performance are identified, all of which are likely to impact on delivery programmes such as immunization. Chapter 2 of the National Health Plan describes the organization and consultative process of plan development (Page 9 National Health Plan).

2. Health System Strengthening Technical Working Paper Barrier Analysis: This paper and analysis, especially commissioned for the HSS development program, incorporates analyses from 5 research papers and 3 weeks of interviews, working sessions and workshop analysis (see section 1.2 for description of process).

3. Immunization Desk Review and C-MYP: As part of the development of the *c-MYP* in 2007, a 5 day consultative meeting was conducted with participation of the National Immunization program, Division of Planning and international advisers from WHO and UNICEF. In the c-MYP, the most important challenge noted for the national immunization program is to reach the un-reached. Limitations to accessibility, health infrastructure and health worker motivation have been identified as major health system constraints in the c-MYP. As part of HSS strategy development in Myanmar, an EPI desk review was undertaken in late 2007. In the *EPI Desk Review*, the following systemic barriers to immunization performance were identified (Page 9 Desk Review): (a) Accessibility to services is variable across the country, and is related to mobility of the population, geographic access and security; (b) Health infrastructure is limited in some townships, particularly in relation to transport and logistics. (c) Health workforce motivation is limited at times due to lack of transport, operational costs, incentives and workload. (d) Integration of immunization occurs at the delivery level, but more opportunities exist for improving other health interventions in partnership with immunization.

5. The midwifery study, titled "Are we overburdened in rural areas? The Voices of Rural Midwives" (MOH Nilar et al Myanmar 2007) was commissioned specifically for the HSS program development. This was a cross sectional study, incorporating both quantitative and qualitative research methods. Two townships in Yangon division with rural characteristics were selected for the study. Interviews with (61) midwives and two focus group discussion were conducted. The general objective was to obtain information on how to further improve health services by rural midwives, with the specific objective to elicit priority problems impinging on their work performance (see Discussion & Conclusions in Nilar et al Page 26)

6. *"Perceptions of people in the community towards health and existing health services in the rural areas of selected townships"* (Principle Investigator: Dr. Nilar Tin). This study analyzes community perceptions of health and health services access. This was an in depth study of community perceptions in 4 Townships using participatory rural appraisal methods.

Findings from these five studies (as well as others reported in the Technical Working Paper) are summarized below according to health system barrier headings.

INFRASTRUCTURE and LOGISTICAL BARRIERS

The National Health Plan identifies major drawbacks in implementing health plans as relating to infrastructure issues (inability to expand rural health centres according to planned targets). These same factors are affecting the performance of the environmental health program. In terms of rural health care and coverage, expansion of health facilities was found to be more focused on hospital rather than rural health centre development, with greater concentration of skilled health staff in rural areas (Page 10, Para 3). As of April 2006, there were 1456 rural health centres, with a proposal to expand by 60 per year up to 2011. There are 5824 sub rural health centres, with a proposal to expand 300 per year up to the year 2011. (Page 253 – 254 National Health Plan).
Between 1988 and 2007, there was a 31.8% increase in the number of hospitals (from 617 to 813) but only a 10.2% increase in the number of rural health centres (Page 10).

In terms of supply systems, they are often perceived as “stand alone” or quasi independent system by the users, who report untimely or late delivery of supplies, distribution which does not match the needs of the services resulting in oversupplies or undersupplies of medicines, high transportation costs (Page 17 TWP).

Limited electric power, low rate of urbanization, staff vacancies at all levels, and difficult access means it is not possible to immunize infants using routine immunization strategies in some locations (c-MYP Page 16). According to the 2005 Joint Report form, there were 65 townships with coverage less than 50% (out of Total of 325). In some townships such as Gongyan, Chin Shwe Haw, others in northern and eastern Shan, and Wa regions bordering to China, the coverage is very low due to poor public health infrastructure and difficult terrain (c-MYP Page 18).

In terms of logistics, vaccines are distributed in cold boxes from 3 central vaccine depots and/or/to 20 sub-depots located in Yangon, Mandalay, Magway and in major cities to township level 1-3 monthly and it takes up to 4 days by road. Beyond township level, a few station hospitals and RHCs have solar refrigerators. But, the majority relies upon vaccine carriers with ice-packs (c-MYP). Transport limitations were often cited as a constraint for reaching more inaccessible areas (see Page 4 c-MYP), and also for effective functioning of cold chain systems and referral systems.

HUMAN RESOURCE BARRIERS

The situation analysis makes frequent reference to human resource barriers to health program performance, mostly in terms of lack of human resour

The c-MYP analysis indicates that health workers are sometimes not sufficiently motivated due to inadequate support on transport, training and operational costs. (Page 4 Executive Summary c-MYP) Now the ratio of midwifery skilled providers (including AMWs) to village is 1:2 while the national target is at least one midwifery skilled person to every village (Page 10 c-MYP). [19] A sense of pride and professionalism among health staff, especially the midwives, is the major reason for the success of immunization program. But health workers from RHCs have to undertake a series of time consuming activities like vaccine collection, transport, and delivery processes, often at their own expenses to reach the children in villages supposed to be visited monthly (Page 21 c MYP).

MANAGEMENT & ORGANIZATIONAL BARRIERS

Disease control programs are limited by reporting delays, and weaknesses in analysis of surveillance information and response. This has led to a delay in reporting of epidemics (NHP Para 1 Page 4). Lack of availability of quality data which is timely, complete and relevant is also noted in relation to development of the health management information system. (NHP Page 12 Para 2).

The effectiveness of health system development is limited by financial constraints (NHP Page 11 Para 2), lack of access to information to develop alternative health financing mechanisms, and weaknesses in health partnership development (see NHP Page 4 Para 4) Poor integration of management and service delivery is also noted as a major weakness in health system organization (NHP Page 11, Para 4).

The technical working paper devotes a larger section to organizational constraints to health program performance (see TWP Section 6 Cross Cutting Issues). The main problem is described in terms of the development of the health system in to a series of health system vertical projects, many of which do not relate to each other, leading to distortions and inefficiencies in service delivery. Managerial culture in the MOH values hierarchical structures resulting in a top down approach to planning and implementation of public health programs such as immunization. There are strong linkages between leadership and managerial practices in the health system and barriers to improving effective coverage. There is no effective coordinated planning system at State / Division or Township level, and much of the burden of program planning and implementation is taken up by the midwives at the lowest level of the system. There are leadership and management gaps at the Township level, leading to inefficiencies in financial management and functioning of supply systems. There are very low levels of analytic and problem solving techniques in relation to supervision systems. Coordination mechanisms with NGOs are also not strong in many instances (see TWP ages 14 – 25 "Cross Cutting Issues").

DEMAND SIDE BARRIERS (GEOGRAPHIC, CULTURAL AND COMMUNICATION BARRIERS TO SERVICE ACCESS)

More policy guidance is required in relation to public health and reproductive health in terms of involving government departments, social organizations, and the community in order to create and enabling environment for behaviour change (NHP Page 4 Para 5). The National Plan makes frequent references for the need to strengthen partnership programs.

There are a range of service delivery access factors identified in the TWP. "Hard to Reach" includes geographically inaccessible areas, the urban poor, populations living in conflict areas, and other socially or economically marginalised populations. Language and cultural barriers are also cited in the assessment as being influential in restricting access. These populations are identified

[19] Please note – the Auxiliary Midwife is a health volunteer, and is hence not included in the definition of skilled birth attendant. AMWs are not authorized to give injections or vaccination and not salaried (page 12 cMYP)

on Page 8 – 9. There is also a category referred to as "un-reached", which can relate to cultural, remoteness or security issues (TWP Page 9 Para 2).

There are also wide regional and state variations with the highest mortality in the “Hilly Areas” and “Central Plains” (Under 5 mortality survey, 2002-2003, DOH). For children who die between months 2 and 5, the leading causes of deaths are acute respiratory infection (ARI), septicaemia, brain infection, beriberi, diarrhea and malaria. For children ages 6-11 months, the leading cause of death is also due to ARI followed by diarrhea. (Under 5 mortality survey, 2002-2003, DOH) (Page 9 c-MYP) The EPI program now reaches all townships (Page 10), but the problem rests with inaccessible areas within townships.

The inaccessibility is not only geographic. There are many cultural barriers in Myanmar that are related to administrative and cultural diversity. Administratively, the country is divided into 14 States and Divisions and consists of 65 districts, 325 townships and 64,976 villages. The Union of Myanmar is made up of 135 national groups speaking over 100 languages and dialects. The major ethnic groups are Kachin, Kayah, Kayin, Chin, Mon, Bamar, Rakhine and Shan (Page 8 c-MYP).

The NHSC NGO consultation meeting (see Annex 5) highlighted the need for more community mobilization in support of health program activities including the organization of health financing schemes (poverty identification systems in order to identify populations that would be exempted from user fees). Both Government and non government representatives at this consultation highlighted the need to reactivate the health committee systems at Township and Village Level.

FINANCIAL BARRIERS TO ACCESS

There are indications in the TWP, as in the National Health Plan, that there may be community service access problems relating to *payment for services* for catastrophic health events. At the very least, if the population has access to health services, property may need to be sold in some cases (TWP Page 16 Para 1 & 3). A stronger health financing system would reduce the costs of out of pocket expenses. Up to 80% of health service expenditures are privately funded in Myanmar, and there are comparatively speaking very low rates of international aid flows (TWP Page15). There are also financial management barriers in terms of the Township's capacity to manage health financing schemes (TWP Page 16-17). The income generating nature of curative care means that preventive programs receive less attention.

The study on community perceptions of health indicated that communities consider financial factors as being critical in determining their accessibility to health services (see Annex 13).

SUMMARY AND CONCLUSIONS ON HEALTH SYSTEM BARRIERS IN MYANMAR

At the Mandalay Workshop in November 2007, all the above evidence was reviewed and debated, and health system barriers were clustered into three main groupings or "themes".

SERVICE DELIVERY BARRIERS: On the demand side, service delivery barriers to immunization and maternal child health services in Myanmar are varied and in many instances locally defined by cultural, geographic and security factors. Financial barriers to access are cited in most assessments. On the supply side, there are some common themes, including limitations in infrastructure, logistics, and transport and supply systems. There is insufficient focus on the basics of MCH for hard to reach populations.

ORGANIZATIONAL, MANAGEMENT AND COORDINATION BARRIERS: There is frequent reference in studies and analyses to fragmentation of health organization along vertical program lines and underperformance in the area of health management, which is resulting in inefficiencies and inequities in health services provision. Planning, supervision, management and information systems at State/Division and Township level are very limited in quality and effectiveness, which is

reported to negatively impact on health service performance, particularly in terms of the overburdening of work and insufficient support for midwives at the peripheral level (sub rural health centre). There is also management underperformance in the areas of financing and financial management, integrated Township and State/Division planning and NGO coordination.

HUMAN RESOURCE BARRIERS: This was an often cited barrier in all assessments. Inequities in distribution, numbers, mix and motivational factors of the health workforce, particularly at the most peripheral level of the system, is the major identified constraint on reaching the hard to reach or un-reached populations.

One of the notable findings from the health system barrier analysis is the variability of barriers to service access, based on local area conditions of culture, geography, security, population density and remoteness. Nationally, priorities have been set in terms of human resource management and program coordination, precisely so as to facilitate at Township level local area barrier analysis, priority setting and planning implementation in order to reach the hardest to reach populations within the Townships.

3.3: Barriers that are being adequately addressed with existing resources

In terms of overall health system barriers in Myanmar, there are no single set of barriers that are being adequately addressed with existing resources. However, in many cases, aspects of each barrier are being adequately addressed.

(1) Service Delivery Barriers (Infrastructure, Supply, Logistics)

There is a substantial network of hospitals, rural health centres and sub rural health centres across the country, and up to 50,000 employees. It is in rural and remote areas, particularly in border regions, that infrastructure is the most limited. As the NHP observes hospital expansion and development has been funded by government in recent years, (31% increase since 1988), but the rural health centre development has been much slower (increase of 10%). (NHP Page 10 TWP). For the immunization program specifically, although the program is strongly dependent on international finance, there are sufficient availability of vaccines and injection equipment. It is transport and cold chain below the Township level that presents the biggest infrastructure and logistics barrier for EPI.

(2) Demand Side Barriers

Myanmar has a significant organizational network for social mobilization in the health system. The system of community health volunteers and auxiliary midwives (volunteers with limited training at village), back up by a system of health committees at each administrative level provides a sound basis on which to strengthen social mobilization activities in support of preventive health programs. Although the “structure” and “system” for addressing demand side barriers is in place, the functions need to be revitalized (see below).

(3) Organisational and Management Barriers

In terms of program management, Myanmar has been successful in achieving relatively high immunization coverage, and access to specific national program strategies including nutrition, TB and malaria Control, and aspects of reproductive health and Environmental sanitation. The organisational issue is not so much programmatic, but systematic, in terms of strengthening planning, financing and supervision links for more coordinated service delivery, particularly in hard to reach areas where language, culture, geography or security presents region specific barriers.

In terms of health information, although there is sufficient data collected (i.e. midwives consider report filling their most burdensome task), there is insufficient attention to data analysis, problem solving and team building.

Although financing of the health system is on the increase, there are still 70% to 80% private expenditures on health. Not enough data is available on the distribution of wealth in Myanmar. However, it can be assumed for the upper socio economic groupings resident in towns and cities, there may be limited barriers to financial access. This is not the case for rural and remote populations in the lower poverty quintiles, particularly in relation to financing of catastrophic health events.

Program managers state that most of the focus on equipment (including transport) and essential drug supply is on the Township and not on the Rural Health centre or sub centre. For this reason, there are often low levels of reported drug supply access at these peripheral facilities.

(4) Human Resource Barriers

In terms of human resources development, there are adequate training funds for technical programming, as evidenced by the fact that 35% of BHS time is devoted to trainings and meetings. In terms of HR development, the barrier issue is not training resourcing so much as training coordination.

3.4: Barriers not being adequately addressed that require additional support from GAVI HSS

The following barriers have been summarized and prioritized according to the following criteria:

(1) A focus on the Township level and below
(2) A focus on hard to reach and un reached areas
(3) Impact on NHP goal of reductions in maternal, and in particular, child mortality
(4) Sustainability of inputs beyond the period of GAVI support

(1) Service Delivery Barriers

As outlined in the NHP, TWP and c-MYP, there is significant inequity in mortality rates, program coverage and infrastructure development across the country. The particular geographic areas most affected include border regions, geographically remote, insecure regions and regions characterized by language and cultural difference. Lack of facility, logistics systems, equipment, life saving drugs and transport in these targeted areas is a contributing factor to inequity in health service coverage and access. Additional support is needed to identify hard to reach and never reached areas at the micro level (i.e. within townships), and effectively identify logistics, communication, transport and infrastructure barriers that are impeding service access. Given the scope of work of the most peripheral level health staff (midwife and PHS 2), and the resource scarcity pressures that they are currently under, additional assistance is required to more clearly define and equip staff and facilities for delivery of essential components of PHC (MCH, Nutrition, and reproductive and environmental health – see Annex 4 of the TWP).

(2) Demand Side Barriers

As outlined in the NHP, it is observed that coverage of PHC could be improved through training and deployment of community health workers (Page 3). Delays in disease reporting and outbreak response are also occurring due to lack of full collaboration of the community (Page 4). The presence of “floating populations” in Myanmar is cited in the NHP as a constraint for expansion of environmental health programs (Page 4). The NHP recommends “increasing the accessibility of

health care services through selection and training of new VHWs and refresher training of old VHWs." (Page 23) The requirement to "reactivate" health committees at Township and Village level is a consistent barrier to social mobilization highlighted in assessments and consultations. The lack of expansion of health financing schemes (for primary and hospital care), and the absence of a national framework on health financing are both significant gaps in the Myanmar Health System that are effecting demand for, and accessibility to, basic health services.

(3) Organizational Barriers

The analysis in the NHP and TWP and HR studies highlights the significant problems associated with overemphasis on vertical programming and project management, leading to the development of parallel systems of planning, reporting and implementation. This is affecting health system efficiency and delivery, as judged by % time of midwives completing reports and % time attending training and meetings, and, most importantly, by inequities in health service access, coverage and health outcomes across the country. There therefore remain significant unresolved organizational barriers to health system performance extending from State to Township to the delivery system level. More assistance is required to develop coordinated management, planning, financial and supervision systems, in order to assist with improved coordination and targeted delivery of health services to the hardest to reach populations. The particular focus of this organizational support should be the Township level, as it is the basic management unit for primary and secondary care services in Myanmar. This is especially important when considering the regional diversity of Myanmar, and the region specific characteristics of culture, geography, demography and security. This provides a strong rationale for strengthening of decentralized planning and organizational management, so that Township Medical Officers and Health Teams, and Local Authorities and NGOs are best equipped to coordinate Township specific responses to Township specific problems.

(4) Human Resource Barriers

Aside from issues of service delivery access and coordination outlined above, the fundamental problem impeding population access to health services is the performance and accessibility of the most peripheral level of care – the sub rural health centre staffed by a midwife and PHS 2. What the NHP and TWP and supporting studies clearly describe and highlight are inequities in distribution of staff, numbers of staff, mix of function and staff motivation. More support is required to strengthen national HR research, planning, and strategy development to develop effective national responses to this problem. More support is required organisationally at State and Township level, in order to put in place sufficient development and support systems to retain quality staff in more geographically remote or less secure regions. These support systems include coordinated supervision, planning, professional development opportunity, and strengthening of local area coordination and support from local authorities, CHWs and NGOs.

SUMMARY OF BARRIERS THAT REQUIRE ADDRESSING

In summary, service delivery barriers, limits to organizational coordination, (particularly at the Township level) and inequities in human resource numbers, distribution and mix at the primary level of care are the three main barriers to health system performance in hard to reach areas of Myanmar. Health service barriers are represented by supply side factors, (infrastructure, logistics, transport, supplies) and demand side issues (in particular limits to financial access, geographic, cultural and security issues).The barriers are overlapping, in so far as improvements to infrastructure will not yield results in the presence of HR inequities. In a similar way, improvements in human resource placement will not lead to improvements in quality and access in the absence of coordinated organizational support from the Township and RHC level, and increased accessibility to services for the population through social mobilization and health financing strategy implementation.

Given the interlinking nature of these health system barriers, more assistance is required to develop coordinated management and planning processes at the Township level, in order to address in a systematic way the multiple determinants of poor health access for ‘hard to reach’ and ‘un-reached’ populations within Townships.

Section 4: Goals and Objectives of GAVI HSS Support

4.1: Goals of GAVI HSS support

HSS Goal: *The Goal of the Health System Strengthening Program in Myanmar* is to achieve improved service coverage for essential PHC components of immunization and maternal and child health in support of 2/3 reduction in under 5 child mortality between 1990 and 2015, through strengthening programme coordination, improving health planning systems and strengthening of human resources management.

National Planning Links: This goal links to the fourth of the four social objectives of the State, which aims for "uplift of health, fitness and education standards of the whole nation." (Annex 1 NHP). It is consistent with, and supportive of, the National Health Policy of Myanmar, whose main goals include health for all using a primary health care approach, production of sufficient and well as efficient human resources for health, and the expansion of health services not only to rural but also to border areas so as to meet overall health needs of the population.(NHP Annex 3) Finally, the goal is supportive of National Health Plan 2006 – 2011 specific objectives on provision of quality health services for mother, newborn and under 5 children (NHP Obj. 3.1 Pg 59), reductions in U5 MR by one third of existing rate by 2011 (NHP Obj 3.1 Pg 79) and provision of health services through an integrated approach (NHP Objective 3.1.4 Pg 26).

Expected Outcomes: The expected outcomes for the program of support are reductions in child mortality and improved access to maternal and child health care services. This will be measured by improved attendance of skilled personnel at births, improved immunization coverage and improved coverage of appropriate management of child illness (diarrhoea case management). Given the scope of the health system strengthening program, national impact is expected by 2011.

Rationale: Three theme areas have been identified that relate directly to the described goal above and to the health system barriers (service delivery, organization and human resource development) outlined in section 3.4

Theme 1 Service Delivery Strengthening: *Reaching communities (applying supply and demand side strategies) with essential health system delivery components of MCH, nutrition, immunization and environmental health, with emphasis on hard to reach areas*
Theme 2 Health Program Coordination and Capacity Building: Strengthening coordination, management & organization of the health system at all levels with a focus on the Township Level
Theme 3 Human Resource Management and Development: Improving distribution, skill, number and mix of health workers with emphasis on hard to reach areas

These three themes relate directly to the gaps summarized and prioritized in section 3.2. That is, lack of service delivery focus and resourcing, poor organization and programming coordination at Township and State/Division level, and inequities in human resource mix, distribution and numbers (particularly at the most peripheral level) are the fundamental barriers to health system performance that will be addressed by the HSS program in Myanmar. Objectives are as follows:

Objective 1: Communities from 180 selected townships with identified hard to reach areas will have increased access to essential components of MCH-EPI and EH and Nutrition by 2011, as measured by increased DPT from 70% to 90% and SBA from 67.5% to 80%
Objective 2: By the end of 2011, 180 selected townships with identified hard to reach areas will have developed and implemented coordinated township health plans.
Objective 3: By the end of 2011, 90 selected townships with identified hard to reach areas will be staffed by midwives and PHS2 according to National HR Standards.

4.2: Objectives of GAVI HSS Support

Objectives & Activities	Expected Outcomes	Linkages	Rationale & Discussion	Responsible
Objective 1 Communities from 180 selected [20] townships with identified hard to reach areas will have increased access to essential components of MCH-EPI and EH and Nutrition by 2011, as measured by increased DPT from 70% to 90% and SBA from 67.5% to 80%	**Indicators and Targets:** 1. National DTP3 coverage (%) increased from a baseline of 70% to a target of 90% by 2011 2. Delivery by Skilled Birth Attendants from a baseline of 67.5% to a target of 80% by 2011	This objective relates to the Social Objectives of the State and the National Health Policy (Annex 1, 2 of NHP), as well as to specific objectives of the NHP, which aim at improving quality of care for women and children (Obj. 3.1 Pgs 59 & 79). The National Health Policy (Annex 2 of NHP) specifically proposes to expand services to rural and border areas.	The National Health Plan, c-MYP and the TWP all clearly articulate the inequities in health services coverage in some rural and border areas. Inequities in access are related to service delivery barriers (theme 1), organization barriers (theme 2) and human resource barriers (theme 3). It is proposed that in collaboration with the other 2 themes areas, activities under this objective will support the attainment of the HSS goal through resourcing and implementation of coordinated and needs based Township coordinated health plans. The attainment of the HSS objective and goal will be facilitated by the targeting of "essential components" of primary health care (inclusive of immunization, MCH and environmental health), [21] with focus for delivery of care at the sub rural health centre level (midwife and PHS 2). Infrastructure, logistics, transport, human resource and operational activities and costs will be identified in sub RHC micro-plans, and consolidated into a Township Micro-Plan. In the short term, coordinated Township health planning guidelines will be developed through Obj. 2 and trialled in 20 Townships in 2008. In the long term, following evaluation, the Township planning system will scaled up to 60 Townships in 2009, reaching 180 Townships or 55 % of the country by 2011. Additional expected outcomes of this objective include (a) an increase in the number of districts achieving ≥80% DTP3 coverage from 75 townships in 2007 to 325 townships in 2011 (b) reductions in under five mortality rate (per 1000) from a baseline of 66.1 to a target of 38.5 by 2011, (c) increase in the proportion of children (0-59 months) who had diarrhoea episode in the last month who had Oral Rehydration Solution (ORS) from a baseline of 53% to a target of 80% by 2011 and (d) increase in the % of 6-59 months children having Vitamin A during past 6 months from a baseline of 80% to a target of 90% by 2011(e) 100% of renovated health facilities have access to safe water source	National Health Sector Coordination Body for HSS

[20] Please note – "selected" refers to Townships corresponding to low DPT3, low SBA and low HR numbers. Refer to Annex 9 for details.
[21] See TWP for description of Essential Components of PHC Care Annex 4

Objectives & Activities	Expected Outcomes	Linkages	Rationale & Discussion	Responsible
Activity 1.1 SURVEY Conduct baseline health systems rapid assessment to establish base line indicators & outcome, impact and research for operations (including mapping in selected townships) [22].	**Indicator and Targets**: Complete Township rapid assessments of health service access, with identified and mapped hard to reach and un-reached areas; 20 townships assessed in 2008, 40 in 2009, 60 in 2010 and 60 in 2011 (total 180)	Refer to NHP Pg 273 which outlines need for development of health systems research capability, identification of factors effecting national health, and translation of research findings into practice. See also NHP Objective 2.1 Page 205, Objective 5.7 Pg 28	Due to weaknesses in the current HMIS, and the need to build research capacity in Myanmar, as well as for the purpose of strengthening baseline assessments, it is proposed that each Township be supported to develop a rapid assessment of health systems and essential PHC care provision, with a particular focus on mapping of hard to reach and un reached areas. This will also provide input into development of health planning guidelines and health finance systems (Theme 2) and strategies to improve HR distribution, mix and motivation (Theme 3)	Dept of Health Dept of Health Planning, Dept of Medical Research (UM,MM,LM), WHO National Programs, State/Division Directors, TMOs

[22] The methodology of the HSS rapid assessment will be identified and adapted to Myanmar conditions in the first month of the program. The rapid assessment is likely to assess health service coverage, as well as Township gap analysis of health systems components – planning, HR, HMIS, financial management, health financing, community participation, infrastructure and supplies. Townships for mapping would be selected to identify hard to reach pockets in relatively good coverage areas.

Objectives & Activities	Expected Outcomes	Linkages	Rationale & Discussion	Responsible
Activity 1.2 SUPPLIES Purchase Essential Supplies and equipment based on needs identified in coordinated Township health plans.	**Indicator:** Proportion of Rural Health Centres (RHCs) in HSS-targeted townships, with no stock out of essential supplies (commodities availability, service access, utilization, quality) in the last 6 months.	c-MYP Pgs 44-46 Strategies 7 & 8.	The TWP (page 17) makes reference to overly vertical supply systems, and lack of timeliness and poor distribution of supply systems. The c-MYP points out that immunization services are impeded by the fact that, below township level Pop.100-200,000), the cold chain system is dependent on vaccine carriers with ice packs (c-MYP Page 20). Under this activity, Township and below Health Plans will identify supplies and logistics needs, and resource these needs according to MOH standards and guidelines for equipment and supplies. This will support the objective through increasing the accessibility of services to populations, particularly in hard to reach or never reached areas. Under this activity, investment will be undertaken to improve the supply management system by introducing a demand based supply system. The health information system will be improved by introducing "stock out" monitoring of rural health centre life saving drug supplies. Please refer to Annex 10 for list of life saving drugs and supplies (includes essential drug lists for MCH, Rural Health Centre Kits and Clean Delivery Kits for midwives and Community Health Workers (ie Auxiliary Midwives at village level) This activity will be complemented by investment by UNICEF in Women and Child Health Development Project.	Township Health Teams State and Division Directors Dept. of Health UNICEF
Activity 1.3 INFRASTRUCTURE 540 RHCs and 324 sub-RHCs in HSS-targeted Townships will be renovated including construction of sanitary latrines and improving access to safe water source by 2011, based on needs identified in coordinated township health plans.	**Indicators & targets** 540 RHC (3/township) with delivery rooms, sanitary latrines and safe water sources renovated by 2011 324 sub-RHCs are constructed by 2011	Pg 253 – 254 of NHP outlines MOH plan to expand development of RHCs and sub RHCs.	The NHP points out that some of the main reasons for inability to expand services and access to rural and border areas is a focus on hospital development, and less focus on the development of rural health centres and sub rural health centres (NHP Page 10). Under this activity, Coordinated Township Health-Plans will identify infrastructure needs, and resource these needs according to MOH standards and guidelines (Refer to Annex 11 for MOH standards for construction). This will support the objective through increasing the accessibility of health interventions to populations, particularly in hard to reach or never reached areas.	Dept. of Health Township Medical Officer State / Division Health Directors

Objectives & Activities	Expected Outcomes	Linkages	Rationale & Discussion	Responsible
Activity 1.4 TRANSPORT Provision of essential transport for township and BHS to reach hard-to-reach areas, based on analysis in Coordinated Township Health Plan	**Indicator:** Number of transport vehicles distributed to hard-to-reach areas in HSS-targeted townships annually. **Other expected results**: Number of bicycles provided to PHS 2 and midwives annually Number of trolley jeeps provide to RHCs at hard to reach areas annually	See c-MYP Page 25, which plans to include transport plans in all micro-plans at District level (service Delivery Point 4) See C-MYP Transport costs Page 83	Many of the situation analyses point out that one of the main barriers to access is geographical (distance and terrain). During the micro-planning process, mobility needs of staff at the sub RHC and RHC needs will be assessed, with the focus on enabling health staff (in particular midwives and PHS 2) more capacity to reach out to the hardest to reach.	Dept of Health Township Medical Officer State / Division Health Directors
Activity 1.5 PARTICIPATION Organizing a township level planning and review team composed of NGOs, local authorities, Community Health Workers and selected community representatives to develop and implement coordinated township Health plans in 100% of HSS-targeted townships by 2011.	**Indicator:** All HSS-targeted townships have coordinated health plans that include the activities of local NGOs, I-NGOS, CHWs and local authorities.	This activity supports the NHP Obj. 2.6 Pg 23 which aims for stronger linkages between health related sectors and national and international NGOs.	As outlined in the TWP, International NGOs are active in 41% of Townships, with services expected to cover 10-20% of the population. National NGOs are active across the country. According to a DOH study, of the original 40,000 community health workers trained, 50% are still active, and provide a vital link in the referral and health promotion chain, particularly in remote areas (TWP, Pages 22- 24). However, coordination mechanisms with Township Health Teams, Local Authorities, NGOs and CHWs are often not strong. CHWs can assist midwives and PHS 2 to cover the population in the hardest to reach areas. This activity will assist to obtain the objective to increased access for MCH services for the population through strengthening Township level NGO coordination mechanisms, CHW support and training, and involvement of NGOs and local authorities in micro-planning. This includes advocacy to local authorities and stakeholders on HSS at township level. Investment will also be made in reactivating health committees at Township and Village level.	Dept of Health Township Health Teams State & Division Directors Local Authorities NGOs Health Committees.

Objectives & Activities	Expected Outcomes	Linkages	Rationale & Discussion	Responsible
Objective 2 By the end of 2011, 180 selected townships with identified hard to reach areas will have developed and implemented coordinated township health plans.	**Indicator and Targets** By 2011, 180 Townships with identified hard to reach areas have developed and implemented coordinated health plans (annual milestones 20 by 2008, 60 by 2009, 120 by 2010, 180 by 2011)	Refer to National Health Policy on PHC (NHP Annex 2 Point 1 and Point 4) See NHP (Objective 3.1.5 Page 26 and 3.1.4 Page 26) See c-MYP Page 75 Objective 8 on linkages of EPI with other interventions. See Page 37 regarding integration of other services with RED strategy	As outlined in the situation analysis, one of the major barriers to health system performance is the verticalization of the health system, which is leading to inefficiencies in health services management and delivery (as evidenced by burden of work of midwives, inequities in health coverage and TMO focus on funded projects and curative care). Consensus has been reached by health leaders following gap analysis that the primary management strategy for improving health service delivery is strengthening the coordination of management, supervision and planning of the health system, with a focus on coordinated planning at the Township level and below (pop. 100 – 200,000). This objective will assist to achieve the goal of the HSS program and National Health Plan through coordinated resourcing and programming of service delivery that is needs based and focused on hard to reach areas in Townships. Initial stages of the HSS program will focus on research and development of coordinated health planning and supervision guidelines, leading to a gradual scale up to 180 Townships by 2011.Planning system development will also be linked closely to strengthening of supervision, health information systems and health financing schemes, and the implementation of a management effectiveness program (see activities below). Although planning will focus mainly on the Township level and below, it is proposed to link Township planning to State/Division Planning, and later in the program cycle, to improvements to National Strategic Planning processes. Annex 3 of the TWP outlines a conceptual framework for planning system development. The Coordinated Health Plans will identify service delivery investments (infrastructure, logistics and transport etc), social mobilization strategies and human resource requirements, and therefore these plans provide the main links for the 3 objectives of HSS strategy.	Township Health Teams State & Division Directors DOH in collaboration with Dept. of Health Planning

Objectives & Activities	Expected Outcomes	Linkages	Rationale & Discussion	Responsible
Activity 2.1 GUIDELINES DEVELOPMENT Develop national guidelines for coordinated township health planning (including financial management and health financing) & supervision at all levels (including checklists)	**Indicator & Targets** 100% of HSS-targeted townships, and all their RHCs and sub-RHCs and station hospitals, receive the new nationally approved guidelines for coordinated health planning and supervision annually	Links with integration Objectives in NHP (Objective 3.1.5 Page 26 and 3.1.4 Page 26) and also with c-MYP Objective 8 on links of immunization with other interventions. Page 76	In the first 3 months of the HSS program, its is proposed that the Division of Planning in partnership with technical partners will research and develop the following (a) Micro-planning, costing and supervision guidelines for Township Level and below (b) State and Division Planning, costing and supervision guidelines. Annex 3 in the TWP outlines in more detail the conceptual framework for guideline development (incorporating planning, supervision, costing). This activity is central to achieving the overall HSS goal of increased access to MCH services through more coordinated management and service delivery. This activity is specific to attainment of the national HSS objective of reaching hard to reach areas with coordinated micro-plans. Later in the HSS program development, investment will be undertaken to link Township to State/Division Planning and to National Strategic Health Planning.	Dept. Health in collaboration with Dept. of Health Planning Dept. of Medical Research (Upper Myanmar) Dept. of Medical Research (Central Myanmar) Dept. of Medical Research (Lower Myanmar)
Activity 2.2 HEALTH FINANCING RESEARCH Complete a research program on financial management capacity and feasibility and effectiveness of health financing schemes in all HSS targeted townships by 2012.	**Indicator & Targets** Baseline research papers produced annually on experiences in selected HSS-targeted townships with financial management and health financing, which will lead to a final report in 2012 recommending financial management and health financing guidelines.	See Objective 3.1 of NHP (Page 212) regarding development of health financing system.	As indicated in the TWP and in the National Health Accounts, between 70 and 80% of health expenditures in Myanmar are privately funded. In response to this situation, Myanmar has been conducting trials of community based schemes such as revolving drug fund and community cost sharing schemes. This activity will evaluate the effectiveness of these schemes in the shorter term, and in the longer term lead to the development of national guidelines for management of health financing schemes. It is proposed that in the longer term these finance guidelines could be incorporated within the planning guidelines for Township level and below. As funding of final townships occurs in 2011, it will take until 2012 to fully assess experiences of all 180 HSS-targeted townships in health financing and financial management.	Dept. Health Planning, in collaboration with Division. of Planning Dept of Health Dept. of Medical Research (Upper Myanmar) Dept. of Medical Research (Central Myanmar) Dept. of Medical Research (Lower Myanmar)

Objectives & Activities	Expected Outcomes	Linkages	Rationale & Discussion	Responsible
Activity 2.3 HEALTH FINANCING SCHEMES: Pilot health financing schemes, according to national guidelines in 50 townships by 2011	**Indicator & Targets** Starting in 2009, 15-20 townships per year commence pilot study in health financing scheme, to total of 50 townships by 2011.	See Objective 3.1 of NHP (Page 212) regarding development of health financing system	Training programs will be targeted to the scale up of the financed Coordinated Township Health Plans nationally between 2008 and 2011. This activity will assist attainment of objectives 1 & 2, through promotion & capacity building of coordinated financing and resources management to ensure service delivery at the most peripheral levels of system. It is expected that trial investment in revolving drug funds and community cost sharing in at least 50 Townships by 2011 (with possible inclusion of hospital based schemes) will guide the development of a longer term health financing strategy for Myanmar between 2012 and 2015. This activity will be supplemented by selected fellowships and study tours on health financing in the wider region, and international technical assistance (WHO)	Dept. Health Planning DOH Dept. of Medical Research (Upper Myanmar) Dept. of Medical Research (Central Myanmar) Dept. of Medical Research (Lower Myanmar)
Activity 2.4 TRAINING Implement the training program on coordinated management through the modified MEP, which includes health planning and supervision, in HSS-targeted townships by 2011.	**Indicator & Targets** Number of TMOs and BHS trained for MEP annually in HSS-targeted townships. **Other outcomes:** Number of State/Divisional level trainers that have been have been provided MEP training on an annual basis	Page 11 of the NHP (section f) describes the need for building of Township Health Teams and collaboration with other sectors). Also NHP Activity 11 Pg 27 (TMO Management Training)	The situation analysis indicates there are significant barriers to continuing training that include the following: (1) Training programs are too vertical (2) High % of time spent by BHS on trainings and meetings (35%) (3) Lack of management capacity and opportunity for management training (4) lack of links between continuing training and pre service training. In the short term, a continuing training strategy will be developed to address these barriers, focusing on development of coordinated management effectiveness (see TWP section on cross cutting issues) and MCH training programs with links strengthened between continuing training and pre service curriculum. WHO is supporting training activities for Township Medical Officers (TMOs) in programme planning, management, leadership, budgeting and monitoring and supervision, under the *Management Effectiveness Programme (MEP).* This activity will assist attainment of objectives 1 & 2, through promotion & capacity building of coordinated management and quality service delivery at the most peripheral levels of system. Complementarities with other training investments (through Govt., UN and NGOs) will be identified in coordinated Township Health Plans, in order to develop more efficient approaches to continuing training.	Central MEP Training Hub Dept. of Health State and Division learning centres MEP University of Medical Science

Objectives & Activities	Expected Outcomes	Linkages	Rationale & Discussion	Responsible
Activity 2.5 PLAN DEVELOPMENT Develop and monitor coordinated health planning of HSS-targeted townships according to new national planning guidelines (activity 2.1) and framework at all levels	**Indicator:** Annual proportion of HSS-targeted townships implementing the coordinated health planning and supervision guidelines according to national framework, with target of 100% by 2011.	Page 11 of the NHP describes the need for building of Township Health Teams and collaboration with other sectors). Also NHP Activity 11 Pg 27 (TMO Management Training)	Following development of the guidelines, in the short term (2008), it is proposed that the Division of Planning and State/Division Directors assist facilitation of Coordinated Township Health Plans (see Annex 3 TWP). This will result in the development of costed plans for the last 6 months of 2008, and supervision plans to support implementation. This activity is the most specific to attainment of objective 2, and will be essential for the attainment of the HSS goal by providing the focal point for HR, logistics; infrastructure and operational investments in support of improved MCH access in hard to reach areas. Later in the HSS program development, investment will be undertaken to link Township to State/Division Planning and to National Strategic Health Planning.	Dept. of Health Planners at State Division Level Township Planners RHC and Sub RHC Staff Health Committees State/Division, Township Levels

Objectives & Activities	Expected Outcomes	Linkages	Rationale & Discussion	Responsible
Activity 2.6 RESEARCH & EVALUATION Build research capacity for health systems development in Myanmar, and in particular on assessing process and impact of coordinated State & Township coordinated health planning	Annual Evaluation completed on process and impact of coordinated health planning and supervision system Selected research and evaluations studies on health systems and PHC	Activities 17 – 19, Pg 28 NHP on Township, State, Central Planning Evaluation	In order to guide scale of the HSS program from 2009, the Dept. of Health & Dept. of Medical Research will conduct an evaluation of process and impact of the coordinated planning and supervision system, with a view to guiding the scale up of the program nationally from 2009 (60 Townships 2009, 120Townships 2010, 180 Townships 2011). Subsequently, annual reviews will be built into the planning process to support implementation. A *Health Systems Research Fund* will be managed by the Director General of the DOH and the Working Group for HSS, with the aim being to call for expressions of interest from central, states and divisions and Townships for research on health systems development A *Health Systems Leadership Development Program*, which will involve mentoring by the DOH and international technical agencies of work placements at the Central DOH for a 2 year period. This will facilitate participation and leadership by State / Division and Township Managers in the pending health systems research and development program through GAVI and other partners (see section 5.1 for details).	Director General DOH DOH in collaboration with research institutes. State and Division Managers and Township Medical Officers.

Objectives & Activities	Expected Outcomes	Linkages	Rationale & Discussion	Responsible
Objective 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.	Percent of HSS-targeted townships staffed by midwives and PHS2 according to the national HR standards, with 90 of 180 HSS townships fully staffed by 2011. (Given high levels of undersupply of PHS 2 in rural areas, 90 out of 180 HSS targeted Townships were judged to be the most realistic target for 2011 by the Technical Working Group for HSS).	See Objective 2.6 NHP Page 23	This is the most critical objective towards attainment of HSS and NHP goals. As the situation analysis has demonstrated, the major constraint to health system performance in Myanmar is the inequity of distribution, mix and numbers of health staff, particularly at the primary level of care (sub – RHC with midwife and PHS 2). Much of this inequity is attributable to lack of HR and Township level coordinated management and planning and supervision, and problems of motivation, associated with levels of support or distance, security or cultural barriers. In order to address this problem, the HSS program, in line with the NHP, will support a range of activities to improve distribution, mix, numbers and motivation of the rural health workforce, with a particular focus on the midwife and the PHS 2 in hard to reach areas. This objective is critical to the attainment of NHP and HSS goals to improve access to MCH and other services to populations resident in hard to reach or never reached areas. Appropriate deployment will be promoted through the research, planning and proposal strategies outlined below. (1) Skill-building of staff through continuing education programs (see Activity 3.4) (2) Strengthening of supportive supervision programs through the MEP program (see Activity 2.3). (3) Adequate resourcing of Coordinated Township Health Plans (see Objective 1 and activities) (4) Strengthening of local authority and NGO coordination and support for primary health care (see Activity 1.5) (5) Development of a medium term HR plan and proposal, outlining strategies for local recruitment and retention (see Activity 3.2 and 3.3) and (6) Development of a scheme of financial allowances for remote health staff. Consideration was given to application of "performance based" strategies for HR management in this proposal development. Given this would be a completely new strategy for Myanmar, attention will be given in the HSS program to research and development of performance based strategies and other motivational factors for improvements to Township health system performance.	Division of Planning in collaboration with Dept. of Medical Sciences

Objectives & Activities	Expected Outcomes	Linkages	Rationale & Discussion	Responsible
Activity 3.1 RESEARCH Conduct Research program for HR planning focusing on distribution mix function and motivation and management capacity (including financing), by 2010.	Completed research program will provide the evidence base for appropriate mix, distribution and function of health workforce to be included (a) HR proposal for improving rural health retention (b) Interim HR strategy (updated each year) and (c) final national HR strategy (2011)	See research Links above. See Asia-Pacific Action Alliance on Human Resources for Health)	A research agenda has been prepared to support this program and is described in detail in section 6.5. Specifically in relation to HR management, in the short term, the mapping of resource needs in Townships as part of the micro-planning process will help to identify hard to reach areas and human resource requirements. In the longer term, functional analysis of the roles of midwife and PHS 2 will be further reviewed, in order to identify job descriptions matched to population needs and the capacities of the health staff. At the Township level, functional analysis will also be conducted of public health management roles of the Township Health Team, in order to more clearly articulate management roles and job descriptions, and capacity development needs (also in relation to financial management capacity). Research will also be conducted into the feasibility of performance based management strategies for staff in Myanmar, as well as a deeper analysis of the motivational issues of Township Health Management. These research studies will provide input into the development at the National level of a medium term Human Resource Plan as well as for proposals to place new staff or to develop new local recruitment strategies. It is proposed that these research and planning efforts will contribute to the attainment of the objective of improved placement and retention of health staff in hard to reach areas. HR Research programs will function in close collaboration with existing research effort through the Asia Pacific Alliance for Human Resources.	Division of Planning Dept of Medical Sciences, DMRs

Objectives & Activities	Expected Outcomes	Linkages	Rationale & Discussion	Responsible
Activity 3.2 HR PLAN Develop HR Plan recommending strategies for retention and deployment of staff in hard-to-reach areas, based in part on research from activity 3.1	HR plan drafted by 2009, revised annually based on research (e.g. activity 3.1) and finalized by 2011, which recommends strategies for retention and deployment of staff in hard to reach areas.	Objective 3.1.3 NHP Pg 26 Objective 2.6 NHP Pg 23 Both relates to deployment of CHWs and BHS in hard to reach areas.	As described above, the Dept. of Medical Sciences is currently in the process of developing a medium term HR plan 2008 – 2011. The HSS program will support this national approach to HR planning, through research and development of HR management, planning and development strategies such as: Midwife pooling, local recruitment strategy, review of selection criteria, improve medical education of training teams at central, S/D levels, Review of deployment policy & pattern, financial allowances for rural staff, performance based strategies). It is expected that as an outcome to the development of this medium term HR Plan, the MOH/DOH will have improved clarity on existing deployment pattern of staff, as well as have in place the funded strategies (both local and national) develop, place and retain midwives and PHS 2 in hard to reach and un-reached areas.	Division of Planning in collaboration with Dept. Medical Sciences
Activity 3.3 HR PROPOSAL Development of Proposal to MOH recommending appropriate deployment number and pattern of MW and PHS2 in hard-to-reach areas, assessing retentions scheme options that include financial incentives.	National HR proposal drafted by 2008, and implemented nationally by 2011 in 180 HSS-targeted townships, providing retention schemes that target midwives and PHS2 in hard to reach areas.	As Above.	In the medium term (by 2009), based on research studies conducted (Activity 3.1), HR Plan developed (Activity 3.2) and Coordinated Township Health Plans developed in the initial 20 Townships (Activity 2.2), a proposal will be prepared for the MOH with short and longer term recommendations for appropriate functional description, distribution and deployment of rural health staff (midwife and PHS 2) in hard to reach and un-reached areas. This will be updated annually based on research and evaluation findings, and then form the basis for the longer term HR strategy from 2011.	Division of Planning in collaboration with Dept. Medical Sciences

Objectives & Activities	Expected Outcomes	Linkages	Rationale & Discussion	Responsible
Activity 3.4 CONTINUING TRAINING Conduct coordinated MCH, EPI, Nutrition & EH training programs applying the principles of MEP	Numbers of staff trained annually in coordinated MCH, EPI, Nutrition & EH training in HSS targeted districts.	See Activities 8 – 16 on Page 27 of NHP	The situation analysis indicates there are significant barriers to continuing training that include the following: (1) Training programs are too vertical (2) High % of time spent by BHS on trainings and meetings (35%) (3) Lack of management capacity and opportunity for management training (4) lack of links between continuing training and pre service training. In the short term, a continuing training strategy will be developed to address these barriers, focusing on development of coordinated management effectiveness and MCH training programs with links strengthened between continuing training and pre service curriculum. Training programs will then be targeted to the scale up of the financed Coordinated Township Health Plans nationally between 2008 and 2011. This activity will assist attainment of objectives 1 & 2, through promotion & capacity building of coordinated management and quality service delivery at the most peripheral levels of the health system. Complementarities in investment exist with WHO/UNICEF continuing training programs, national program training (RH and Nutrition) and the proposed Continuing training program for Basic Health Staff proposed by JICA (see Annex 5)	Division of Planning, Public Health Division, Epidemiology Division, DOH WHO

Section 5: GAVI HSS Activities and Implementation Schedule

5.1: Sustainability of GAVI HSS support

TECHNICAL SUSTAINABILITY

The scope of work of the HSS program, although focused on three key themes, is very wide in geographical reach, with the proposal to scale up to 180 Townships (55% of the country) by 2011. This being the case, technical strategies will need to concentrate on ways to strengthen and utilize technical capacity at State and Division level to support implementation across the country.

5.1.1 Training Strategy

The GAVI training investment will be complemented by the WHO on going collaboration with MOH through training, monitoring and evaluation of basic health staff in a range of areas including management and leadership, nursing skills, essential new born care, water and sanitation, EPI, health of women and children, hospital care and health promotion. In addition complementary training programmes include proposed JICA program for training of Basic Health Staff, and the UNICEF Woman and Child Health Project that is active in over 100 Townships across the country (refer to Annex 10). The proposal to develop a more integrated training plan within a Coordinated Township Health Plan is a more sustainable human resource development strategy than continuing with a vertical or project based system of training.

5.1.2 Supervision and Management Strategy

At the Township level and below, technical support and improvements will be sustained by a new focus on coordinated supervision and planning, with efforts being made in line with international trends to integrate capacity building programs with supervision (on the job training). This coordinated supervision and planning would also include forecasting the distribution and end usage of medicines and equipment supplied under HSS.
The emphasis on organizational coordination and partnership for planning, supervision and implementation (see Activities under Objective 2 particularly MEP) will assist to sustain technical support through team approaches to problem solving and through complementarities in technical support through the UN, NGOs and Government.

5.1.3 NGO Collaboration Strategy

International NGOs are active in 41% of Townships. Strengthening of collaboration links between local authorities, NGOs and TMOs will enhance the capacity of TMOs and NGOs to provide mutual technical support and to share and implement best practices that can be taken to scale in order to reach planning targets and hard to reach populations. In addition, collaboration will facilitate implementation of training programmes which are in line with national training curriculum. The recommendation by the DOH to develop Agreements of Work with NGOs in HSS targeted areas will assist with complementary financing and technical support for expanding MCH coverage.

5.1.4 National Coordination

The NHSC will be responsible overall for HSS program implementation, including oversight of research programs and international programs of technical assistance. Effective coordination of technical support will enhance capacity for sustainability, by ensuring technical support is prioritized toward the national need and is focused on national capacity building for research and evaluation.

5.1.5 National Health System Research Fund

There is a significant program of operational research being proposed to support program implementation and evaluation. Most of this research will be led by the Depts. Planning and Dept. of Medical Research (Lower, Central and Upper Myanmar), with additional research partnerships being proposed to be established with Asia-Pacific Action Alliance on Human Resources for Health (AAAH) and UN agencies. Two innovations are proposed by the MOH for sustaining health system development and research capacity building. The first is the establishment of a *Health System Research Fund* at the DOH will also assist to build and sustain research capacity in Myanmar, with annual calls for expression of interest for health systems research from national institutes, and with technical oversight and support from the HSS Technical Working Group.

5.1.6 Health Systems Leadership Development Program

The second innovation proposed is the establishment of a *Health Systems Leadership Development Program* at the Department of Health in the Ministry of Health. This will be established in order to enhance and sustain institutional capacity in the MOH, States and Divisions and Townships for health systems research, development and practice. It is proposed that 15 managers undertake work placements at the Central DOH for a 2 year period, in order to participate in and co facilitate the pending health systems research and development program through GAVI and other partners (health planning, health financing, human resource management research, logistics management, policy and practice). Following this two year period, a second rotation of 15 managers will be invited into the program, and the original 15 will return to existing management posts at State/Division and Township levels. At the end of 4 years, it is projected that 30 health managers at State/Division and Township Level will have the capacity to lead on health systems research, planning and evaluation, and conduct continuing training through the existing Management Effectiveness Program managed by the DOH and States/Divisions with the support of WHO. Detailed terms of reference, expected outcomes and criteria for selection are detailed in Annex 8.

Taking into account the strategies outlined above, there are very good prospects for sustaining the technical innovations of the HSS program through application of training, management, collaboration and research capacity building programs and partnerships.

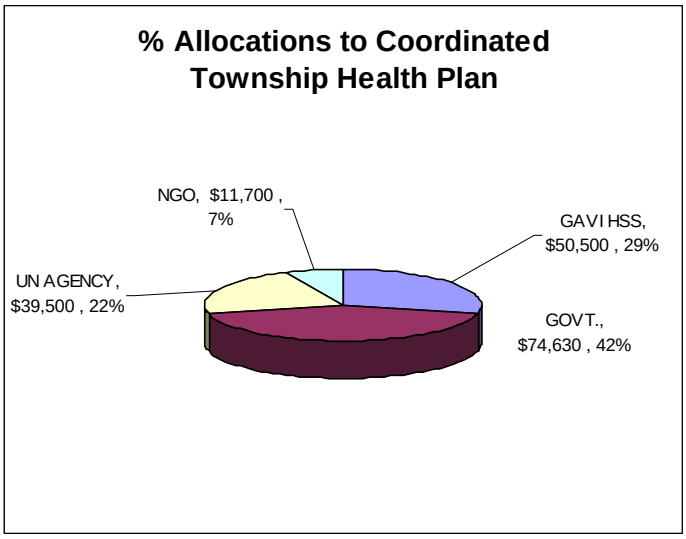
FINANCIAL SUSTAINABILITY

5.1.7 Sustaining Through Management Support

In order to maintain the gains of the HSS program after GAVI support ends (particularly in relation to HR placement and retention), it is proposed that a range of management supports will be put in place. These include coordinated planning and supportive supervision programs (see Activity 2.1), provision of appropriate operational costs for transport and service delivery functioning (see Objective 1 activities), and the scaling up of coordinated MEP and MCH continuing training programs (see Activity 2.3 & 3.4). These institutional supports are viewed as being more sustainable in the long term, given the complementarities of resourcing and technical support that are integral parts of the proposed Coordinated Township Health Planning System.

5.1.8 Research and Development of Health Financing Schemes

As outlined in the situation analysis, between 70% and 80% of health expenditures are privately funded in Myanmar. This is clearly non sustainable for families living in poverty. The HSS program will assist to sustain access of poorer families to primary care services through the research, development and scale up of health financing schemes, in line with National Health Objectives.



5.1.9 Sustaining Through Diversification of Funding Sources

Along with health financing schemes and national health budgeting, the HSS program will also provide opportunities to further diversify sources of funding through strengthening coordination mechanisms between Township Health Teams, NGOs and local authorities (see Activity 1.5). At the NGO consultation meeting with the NHSC on January 15 2008, it was recommended by the DOH that NGOs and the DOH develop Agreements of Work for NGOs to work in HSS strengthening Townships in harder to reach areas of States and Divisions. Estimates of Township Financing by the HSS Technical Working Group indicate the likely diversity and scale of funding source for Township Health Plans (see below). As indicated in the TWP (see discussion section), the sustainability strategy is based on the approach that the GAVI program functions as a support for health systems in the wider context of health planning for the Township (with its complementary funding sources), and not as a stand alone "project".

5.1.10 Increasing Government Financial Commitments

Between 2001 and 2006, current expenditures by government on health increased from 5064 million kyat to 15,376 in 2006. For capital spending the increase was from 2624 million kyat in 2001 to 8035 million kyats in 2006 (see NHP Page 6 Paragraph 2). Although expenditures are starting from a low base, there are still very positive trends in government health investment. Current expenditures by the Government on health are projected to increase by 6% in 2006 – 2007 and by 5% in 2007 – 2008 (these figures are 2% for increases in capital costs in the same two years – see Workshop on National Health Accounts Page 33). (This document also outlines proposals or approaches for institutionalizing NHA in Myanmar).

5.1.11 Strengthening of Demand Side Strategies

Research undertaken by the DOH on community perceptions of health services, and input of NGOs into this proposal both indicate strong linkages between the concept of sustainability and the application of community based or demand side approaches to improving health service access and quality. This being the case, in the Township Coordinated Planning guidelines, it is proposed to ensure that there is a package of funding for support for social mobilization activities, including support for revitalization of village health committees, and training or retraining of community health volunteers (including auxiliary midwives) as well as the development of community supported health financing schemes.

5.1.12 Increasing Financial Management Capacity of Townships and the Central MOH

The development of health financing schemes and decentralization of planning and financial management to Townships are three important health system strategies in Myanmar. Financial sustainability will be promoted through building the capacity of TMOs and Township Health Teams in the areas of financial management including the management of health financing schemes (see Objective 2). Similarly, it is proposed that in the first two years of the program grant, an international financial management specialist will work with the DOH to develop an institutional development plan to strengthen DOH capacity to manage large international health grants over the longer term.

5.2: Major Activities and Implementation Schedule (according to Implementation Year/ quarters)

Major Activities	Year 1				Year 2				Year 3				Year 4			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Objective 1 By 2011, 180 selected townships with identified hard to reach areas will have increased access to essential components of MCH-EPI and EH and Nutrition as measured by increased DPT from 70% to 90% and SBA from 67.5% to 80%				20				60				120				180
Activity 1.1: SURVEY Survey to establish base line indicators & outcome, impact and research for operation (including mapping)	X				X				X				X			
Activity 1.2: SUPPLIES Increase availability of Essential Supplies and equipment based on needs identified in coordinated Township health plans.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Activity 1.3: INFRASTRUCTURE 540 RHCs will be renovated and 324 sub-RHCs will be constructed in 180 HSS-targeted Townships by 2011, based on needs identified in coordinated township health plans.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
1.3.1 Renovation of 540 Rural Health Centres				60				120				180				180
1.3.2 Construction of 324 Sub Rural Health Centres				40				80				120				120
1.3.3. Installation of (63) Solars in hard to reach townships				X				X				X				X
Activity 1.4: TRANSPORT Provision of essential transport for township and BHS to reach hard-to-reach areas, based on analysis in Coordinated Township Health Plan:	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Activity 1.5: PARTICIPATION Involving NGOs, local authorities and Community Health Workers in developing and implementing coordinated township Health plans in 100% of HSS-targeted townships by 2011.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Major Activities	Year 1				Year 2				Year 3				Year 4			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Townships				20				60				120				18

Major Activities	Year 1				Year 2				Year 3				Year 4			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
No of Townships																
Objective 3 By the end of 2011, 90 out of 180 selected townships with identified hard to reach areas will be staffed by midwives and PHS2 according to the National HR Standards.								20				60				90
Activity 3.1: RESEARCH Conduct Research program for HR planning focusing on distribution mix function and motivation and management capacity (including financing), by 2010.				X				X				X				
Activity 3.2: HR PLAN Develop HR Plan recommending strategies for retention and deployment of staff in hard-to-reach areas, based in part on research from activity 2.1				X X												

Section 6: Monitoring, Evaluation and Operational Research

6.1: Impact and Outcome Indicators

Indicator	Data Source	Baseline Value[23]	Source[24]	Date of Baseline	Target	Date for Target
1. National DTP3 coverage (%)	HMIS: Dept of Health Planning	70%	WHO UNICEF Joint Report Form Dept. of Health	2006	90% cMYP	2011
2. Number / % of districts achieving ≥80% DTP3 coverage (National)	HMIS: Dept of Health Planning	75 Districts (Townships)/23%	WHO UNICEF Joint Report Form Dept. of Health	2006	325 Townships (100% cMYP)	2011
3. Under five mortality rate (per 1000) (national)	Survey, (HMIS data needs to be strengthen)	66.1	HMIS: Dept of Health Planning Survey DOH UNICEF	2003	38.5 MDG Target	2015
4. Delivery by Skilled Birth Attendants[25] (HSS targeted Townships)	Dept. Health (Survey)	67.5%	Union of Myanmar MDG report 2006 *Fertility Reproductive Health Survey*	2003	80% NHP (page 60)	2011
5. Rate of ORS Use of <5 children (National)	HMIS	53%	Dept. of Health Planning Public Health Statistics Annual Report 2006	2006	80%	2011
6. % of 6-59 months children having Vitamin A during past 6 months (National)	Dept. of Health Nutrition Dept.[26]	80%	Bi Annual Report of Nutrition Dept.	2007	90%	2011

[23] If baseline data is not available indicate whether baseline data collection is planned and when
[24] Important for easy accessing and cross referencing
[25] Defined as delivery by midwife (Basic Health Staff)
[26] Also available from HMIS but underreporting.

6.2: Output Indicators

Indicator	Numerator	Denominator	Data Source	Baseline Value	Source	Date of Baseline	Target	Date for Target
1. % of townships have developed and implemented coordinated plans according to national framework	No of Townships with Coordinated Plans	325 Townships	Dept. Health	0% [27]	Annual Program Review (Annual Evaluation Report)	2006	55% (180 Townships)	2011
2. Number/% of RHC visited at least 6 times in the last year using a quantified checklist	Number of RHC visited at least 6 times in the last year using a quantified check list	Total Number of RHC in HSS program areas	Dept. Health	To be determined	Base line Survey	2008	100 % in HSS investment area (180) Tsp	2011
3. Number of managers/ trainers / BHS trained for MEP at each level per year	Number of managers/ trainers / BHS trained for MEP at each level		Dept. Health	300 BHS and 50 managers and trainers for MEP	Annual Program Review	2007	9,000 BHS and 100 Managers and Trainers	2011
4. Proportion of RHCs with no stock out of essential supplies in the last 6 months (availability, service access, utilization, quality)	Proportion of RHCs with no stock out in the last 6 months	Total number of townships	Dept. Health	To be determined	Base line Survey	2008	100 % of RHCs in HSS investment area	2011

[27] In fact, all Townships have micro-plans, but they are vertical. The "0%" refers to absence of ***coordinated*** planning (integrated annual plans)

5. No of RHC and sub RHC renovated and/or constructed per year	Number of RHC and sub RHC renovated and/or constructed		Dept. Health	30 RHCs (renovated) and 90 sub RHCs (constructed)	Dept. Health	2007	540 RHC renovated and 324 sub RHC constructed in HSS investment area (180 Tsp)	2011
6. Percent of selected Townships with identified hard to reach areas staffed by midwives and PHS2 according to the National HR Standards.[28]	Number of townships that are staffed appropriately according to National standard	325 townships	Dept. Health	To be determined	Base line Survey	2008	90 Townships out of 180 Townships	2011

[28] In one RHC, 5 midwives and 5 PHS 2, 1 Lady Health Visitor and 1 Health Assistance. Each rural sub centre should have one midwife and 1 PHS2.

6.3: Data collection, analysis and use

Indicator	Data collection	Data analysis	Use of data
Impact and outcome			
1. National DTP3 coverage (%)	HMIS	Analysed according to agreed population denominators of MOH. The data is disaggregated at Township, State/Division and Central Level	(1) Measuring progress towards attainment of MDGS. (2) Measuring impact of GAVI HSS.(3) For national immunization program planning (4) For Township and State Division Health Planning (5) Measuring impact of HSS
2. Number / % of districts achieving ≥80% DTP3 coverage	HMIS	Analysed according to agreed population denominators of MOH. The data is disaggregated at Township, State/Division and Central Level	(1) Measuring progress towards attainment of MDGS. (2) Measuring impact of GAVI HSS.
3. Under five mortality rate (per 1000)	UNICEF MOH Mortality Survey (last conducted 2003)	Using population health data analysis.	(1) Measuring progress towards attainment of MDGS. (2) Measuring impact of GAVI HSS.
4. Delivery by Skilled Birth Attendants	Reproductive Health Survey UNFPA MOH last conducted 2005	Using population health data analysis.	(1) Measuring progress towards attainment of MDGS. (2) Measuring impact of GAVI HSS.
5. Proportion of children (0-59 months) who had diarrhoea episode in the last month who had Oral Rehydration Solution (ORS)	HMIS	Analysed according to agreed population denominators of MOH. The data is disaggregated at Township, State/Division and Central Level	(1) Measuring progress towards attainment of MDGS. (2) Measuring impact of GAVI HSS.(3) For child health program planning (4) For Township and State Division Health Planning (5) Measuring impact of HSS
6. % of 6-59 months children having Vitamin A during past 6 months OR Sanitary latrines (% townships with ratio of 6 people to sanitary latrine)	HMIS	Analysed according to agreed population denominators of MOH. The data is disaggregated at Township, State/Division and Central Level	(1) Measuring progress towards attainment of MDGS. (2) Measuring impact of GAVI HSS.(3) For child health program planning (4) For Township and State Division Health

			Planning (5) Measuring impact of HSS
Output			
1. By 2011, 80% of townships have developed and implemented coordinated Township Health Plans according to national framework	Annual Program Review at State/Division Level	Analysed based on proportion of Plans that meet standards identified in the national planning guidelines developed in 2008.	Measure the impact of the HSS program in establishment of coordinated health planning system.
2. Number/% of RHC visited at least 6 times in the last year using a quantified checklist	Annual Program Review at State/Division Level	Analysed as the Number of RHC visited at least 6 times in the last year using a quantified check list in proportion to the total number of RHC in HSS program areas	Measure the impact on management performance of the management effectiveness program and the coordinated supervision guidelines.
3. Number of managers/ trainers / BHS trained for MEP at each level per year	Annual Program Review at State/Division Level	The total number of managers/trainers trained at each level each year will be totalled nationally and disaggregated by level.	This will assist to measure the rate of expansion of the MEP program in support for HSS
4. Proportion of RHCs with no stock out of essential supplies (availability, service access, utilization, quality) in the last 6 months.	Annual Program Review at State/Division Level (With proposal to integrate new indicator within HMIS later in the HSS Program cycle after the design of the demand based drugs and supply system).	A demand based life saving drug supply system will be designed with support of TA in Year 1. Initially this indicator will be analysed based on rapid health system appraisal and annual program review, with integration into the HMIS at a later stage. The proportion of RHCs with no stock out refers to no stock out in the last 6 months of the drugs and equipment listed in Annex 10.	This will be used to assess population accessibility to health services. It will also assist annual operation Township Health Planning by identifying gaps in accessibility. It will also be used to assess the effectiveness of the demand based drug supply system that is proposed to be introduced in 2008 in selected HSS Townships.
5. 5. No of RHC and sub RHC renovated and/or constructed per year with sanitary latrines and access to safe water source	Annual Program Review at State / Division Level and Central Level & HMIS	Analysed according to the number of constructions and renovations in the last year within the Township. Will include constructions and renovations from all sources. Baseline	Used to assess the progress in rebuilding of health infrastructure as measured against health system baseline assessment and NHP targets for construction.

		will be established in the initial health system assessment.	
5. 6. No of Township hospital/RHC /sub RHC with solar installation. This is for other purpose of use such as electricity for sterilization, computer use for data collection and many others.	Annual Program Review at State / Division Level and Central Level	Analysed according to the number of installation of solar in the last year within the Township. Will include installation from all sources. Baseline will be established in the initial health system assessment.	Used to assess the progress in installation of solar as measured against health system baseline assessment targets for construction.
6. Percent of selected Townships with identified hard to reach areas staffed by midwives and PHS2 according to the National HR Standards.[29]	Annual Program Review at State / Division Level and Central Level & HMIS	A baseline will be provided by the health systems rapid assessment.	This will be used to assess population accessibility to health services. It will also assist annual operation Township Health Planning by identifying gaps in human resource distribution and mix. It will also be used to assess the effectiveness of the retention strategy that is proposed to be introduced in 2008 in selected HSS Townships.

6.4: Strengthening M&E system

Four methods will be applied to strengthen the public health M & E System in Myanmar.

6.4.1. Research Capacity Building

As noted in the NHP, health research capacity is limited in Myanmar. The HSS program provides an important opportunity to strengthen health system research at national and local area levels through the following:

- Working with Townships to develop baseline rapid assessments of health systems
- Working with Townships to trial and evaluate health finance schemes
- Research and development of an appropriate retention scheme for midwives and PHS2
- Research and development of a human resource development plan
- Research and development of a demand based system for supply of life saving drugs and equipment for rural health centres.

Research quality will be strengthened through the Department of Health, Department of Medical Science and Departments of Medical Research by providing opportunities for researchers to

[29] In one RHC there are 5 midwives and 5 PHS 2, 1 Lady Health Visitor and 1 Health Assistance. Each rural sub centre should have one midwife and 1 PHS2.

develop skills through the establishment of the *National Health Systems Research Fund* and the *Health Systems Leadership Development Program* (see section 5.1 for details).

6.4.2. Health Management Information System Development

The HMIS system will be utilized to monitor most of the indicators of progress for the HSS program. However, there are some key output indicators for which there are no HMIS reporting (e.g. reported stock out of essential drugs at RHC level). Opportunity will be undertaken during the HSS program to identify gaps and weaknesses in the HMIS system, with the intent of recommending to the Department of Health Planning (through the Technical Working Group for HSS) additions of changes to the HMIS system. Rapid health systems assessments for Township Health Systems will also provide an additional source of information for strengthening National HMIS M & E systems.

6.4.3. Health Planning System Development

As noted earlier, the health planning system at the Township Level is the focal point for strengthening health systems in Myanmar. In order for the planning system to be responsive to community health needs, there will need to be a close link between health information systems and health planning. The appropriate collection, analysis and use of health information, and its links to health planning, will be a core component of the health planning guidelines to be developed in Year 1 of HSS implementation. Additionally, the systematic development of programs of integrated annual program review at Township, State/Division and National level will provide an additional source of M & E information for evaluation of impact of HSS investments, as well as for providing guidance for the design of annual operational plans of Townships and States/Divisions.

6.4.4. Complementarities of Efforts to Strengthening Data Management

Complementarities of effort to strengthening data management, which will support GAVI HSS monitoring will include the 3-D program of technical support for HIV, TB and Malaria being supported through the EU and other partners.

It is also proposed that in the first year of the HSS program, training on planning and supervision (incorporating appropriate data collection and use) will assist the capacity of Township Health Teams to use health information for planning and evaluation purposes effectively.

6.5: Operational Research

Operational Research will support all three theme areas of service delivery strengthening, management and organizational coordination and human resource development. Research leaders will be based at the Division of Planning and Dept. of Medical Research (divided into three regions of Upper Myanmar, Central Myanmar and Lower Myanmar).

A research agenda for health system strengthening is outlined below.

6.5.1. Health Service Research

It is proposed that during the scale up of the HSS program, rapid assessments of health systems (health management, human resources, planning and supervision systems, health financing) will

be undertaken to establish baseline indicators for health systems functioning and MCH coverage. During this process, there will be a particular focus on mapping of hard to reach and never reached areas. This will also provide input into development of health planning guidelines and annual operational health plans (Theme 2)

6.5.2. Health Management Research and Guideline Development

In the first 3 months of the HSS program, it is proposed that the Division of Planning in partnership with technical partners will research and develop the following (a) Township planning, costing and supervision guidelines for Township Level and below (b) State and Division Planning, costing and supervision guidelines.

6.5.3. Human Resource Management Research

In relation to HR management, in the short term, the mapping of resource needs in Townships as part of the rapid assessment of health systems will help to identify hard to reach areas and human resource requirements. In the longer term, functional analysis of the roles of midwife and PHS 2 will be further reviewed, in order to identify job descriptions matched to population needs and the capacities of the health staff. At the Township level, functional analysis will also be conducted of public health management roles of the Township Health Team, in order to more clearly articulate management roles and job descriptions, and capacity development needs (also in relation to financial management capacity). Research will also be conducted into the feasibility of performance based management strategies for staff in Myanmar, as well as a deeper analysis of the motivational issues of Township Health Management. Research will also be conducted to support the development of a medium term HR Plan, focusing on distribution mix function and motivation and management capacity (including financing). The financial allowance scheme for remote health staff will also be trialled and evaluated, with the evaluation results guiding the development of a proposal to the MOH in 2008 for improving retention of health staff in rural areas. The research through GAVI HSS will be complemented through other research effort undertaken by the DOH through the technical support of the Asia Pacific Action Alliance for Human Resources (AAA H).

6.5.4. Health Financing Research

As indicated in the TWP and in the National Health Accounts, between 70 and 80% of health expenditures in Myanmar are privately funded. In response to this situation, Myanmar has been conducting trials of community based schemes such as revolving drug fund, community cost sharing schemes. This activity will evaluate the effectiveness of these schemes in the shorter term, and in the longer term lead to the development of national guidelines for management of health financing schemes. It is proposed that in the longer term these finance guidelines could be incorporated within the health planning guidelines for Township level and below.

6.5.5. Drugs and Supplies Management Systems

An international consultant will be obtained by the MOH through UNICEF to work with the Dept. of Health and the HSS Technical Working Group to design a demand based system for life saving drugs and equipment. The focus of the research will be on Rural Health Centres and Sub Centres.

6.5.6. Program Evaluation

Aside from baseline health systems rapid assessments, the HSS program is proposing annual evaluations and mid and final term evaluations in line with (1) National Health Plan proposals for annual review and (2) The conceptual approach of inclusion of systems of annual review within the planning process at State/Division Level and Township level (see TWP Annex 3). In the longer term (by 2011) it is proposed that the functioning of this system of annual review will serve to

strengthen national annual program reviews for Strategic Health Planning as part of the next cycle of national health planning (2011- 2015). Finally, an external review is proposed for the GAVI HSS program at the beginning of 2009.

6.5.7. Building and Sustaining Health Systems Research and Management Capacity in Myanmar

Establishment of a Myanmar Health Systems Research Fund

Given the scope of health systems development in this proposal, and the public policy health needs specified in the National Health Plan (particularly Human Resource Development and Health Financing) it is proposed that as part of the HSS program a Health Systems Research Fund will be set aside under the Office of the Director General at the Department of Health, technically assisted by the Division of Planning and the HSS Working Group.

The Office of the Director General will call for annual expressions of interest for design and implementation of health systems research proposals. Technical oversight for this program will be provided by the HSS Working Group in relation to the quality of research design, and by also providing recommendations on the translation of research findings into policy and practice.

Main research partners will include the following: Departments of Medical Research (Upper Myanmar, Central Myanmar and Lower Myanmar), the University of Public Health Yangon, WHO (Health Systems), UNICEF (Supply and Logistics Systems) and international health institutes (not yet specified). States and Divisions and Township Health Departments are also expected to participate and lead in research activity through the proposed “Myanmar Health System Research Fund” and the “Health Systems Leadership Development Program” of the Department of Health (see Annex 5 for details).

Section 7: Implementation Arrangements

7.1: Management of GAVI HSS support

Management mechanism	Description
Name of lead individual / unit responsible for managing GAVI HSS implementation / M&E etc.	As discussed in section 1.1, the National Health Committee is the peak decision making body on health sector policy. However, being essentially an intersectoral body, it does not have the technical depth to oversee design and implementation of health system strengthening strategy. However, in relation to health system issues, if a policy decision is required through HSS research or programming (eg planning system, health finance framework) the matter could be put up to the National Health Committee through the office of the Minister of Health. At the *Central Level* of the MOH, the focal point for GAVI HSS is Dr Nilar Tin, Head of the Planning Division of the Department of Health. The function of this Division will be research and development of health system strengthening strategy, and overseeing HSS resource allocation and activities in close coordination with the HSS Working Group (see TOR in Annex 8).This focal point and Division will coordinate closely with Epidemiology division (Dr Soe Lwin Nyein) (EPI), Division of Public Health (MCH and Nutrition) (Dr. Thein Thein Htay) and Department of Health Planning (HMIS and Health Finance, Financial Management). Technical support will be provided nationally through the Technical Working Group for HSS, the NGO consultations and membership with the NHSCC and programs of international technical support through WHO and UNICEF. In the Public Health Division of the DOH, there is a central Hub for the management effectiveness program (MEP). This hub will act as the central training team for management capacity building. Three staff members will be appointed by the MOH from within the Department of Health to focus exclusively on GAVI HSS programming over the four cycle of the health sector plan. *At the State and Division Level*, the focal point for HSS investments will be the State/Division Health Director. The State / Division Health Director will delegate technical responsibility for monitoring, supervision, training and planning to the Deputy Directors for States and Divisions. At each State and Division, there is a health information Unit (including Unit Statistician) and a Training Team that will assist Townships introduce the Coordinated Planning System. A the State and Division Level, the Divisional Health Directors and Deputy Directors (including Training Team) act as the Learning Centre for MEP (12 states and division now have MEP system). The State or Division Health Director is the secretary of the State/ Division Health Committee. At the *Township level*, the Township Medical Officer (TMO) will be responsible for planning and implementation and monitoring and evaluation, in collaboration with the Township Health Team. The TMO is the secretary of the Township Health Committee. At the rural areas, at the Rural Health Centre, the Health Assistant is supported by 12 staff members (Lady Health Visitor), 5 midwives and 5 PHS2 and 1 watchman. 4 of these midwives and 4 of these PHS2 are based at 4 sub centres. The midwife is secretary to the Village health committee, which has the primary role of supporting the midwife and PHS 2 providing health services.
Role of NHSC (or equivalent) in implementation of GAVI HSS and M&E	The Division of Planning will provide quarterly updates on HSS progress to the NHSC. The role of the NHSC will be to (1) coordinate inputs of national programs and departments, UN and NGOs into HSS implementation (2) consider results and recommendations of progress reports and take corrective action (3) ensure that HSS investments coordinate closely with the national health plan (4) review and endorse the GAVI Annual progress Report (refer to section 1.1)

Mechanism for coordinating GAVI HSS with other system activities and programs	The principal method for coordination of GAVI HSS support with other system activities and programs will be the development of the coordinated planning system. A comprehensive approach to Township planning, evaluation and resourcing will promote coordination between MCH, EPI, and Nutrition and environment health by having a common framework for objective setting, activity planning, M & E and costing. It will also enable complementarities of investment from UN and NGO sources (see TWP Annex 3) Finally, systems of annual program review at Township, State/Division and Central level will provide the main forum for coordination and reporting of HSS investments. The second method for coordination is through the NHSC. The NHSC is represented by health leaders from public health, immunization, finance and planning, and civil society (national and international), and is therefore the lead body for coordination. The HSS Technical Working Group will be the technical support mechanism for NHSC, and through its membership will assist to coordinate national program activities, training and plans within the coordinated planning system. The third method of coordination will be through the NGO – NHSC coordination mechanism (see section 1.4 for detail).

7.2: Roles and responsibilities of key partners (HSCC members and others)

Title / Post	Organisation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS implementation
Minister of Health	Ministry of Health	No	Responsible for referring matters of health system policy from the NHSC to the National Health Committee for decision making.
Dr Tin Win Maung Director General	Department of Health.	Yes	Overall Responsibility for Health System Strategy Chair of NHSC
Dr. Kyaw Nyunt Sein Deputy Director General (Disease Control)	DOH	Yes	Vice-Chair of NHSC
Dr. San Shway Wynn Deputy Director General (Public Health)	DOH	Yes	Vice-Chair of NHSC
Dr Saw Lwin Director (Disease Control)	DOH	Yes	Chair of Technical Working Group
Dr Nilar Tin Director Planning	DOH	Yes	Focal Point for HSS at the DOH
Dr. Thein Thein Htay Director (Public Health)	DOH	Yes	Integration of MCH, Nutrition and Environmental Sanitation into Township Coordinated Health Planning Systems
Dr. Phone Myint Director (Planning)	Dept of Health Planning	Yes	Development of financial management and health finance systems and revitalization of health committees at all levels
Dr. Hla Hla Aye Director (International Health)	MOH	Yes	Coordination of communications and agreements between MOH and GAVI

Dr Wai Wai Thar Secretary	Myanmar Maternal and Child Welfare Association	Yes	Provides feedback on social mobilization strategy.
Dr. Thet Thet Zin Secretary	Myanmar Women's Affairs Federation	Yes	Provides feedback on social mobilization strategy.
U Zaw Win Myint Representative	USDA	Yes	Provides feedback on social mobilization strategy
Dr. Sein Win Joint Treasury	Myanmar Medical Association	Yes	Provides input on medical services; e.g. TMO roles and barriers to effective performance of work
Dr. Saw Ni Tun Representative	Myanmar Red Cross Association	Yes	Provides perspective of INGO on HSS
Daw Nwe Nwe Khin Representative	Myanmar Nurses Association	Yes	Provided feedback on issues with nursing, midwives and PHS 1 & 2
U Aung Khin Chairperson	Myanmar Health Assistant Association	Yes	Provided feedback on township workforce and health assistants
Dr Osamu Kunuii Chief, Health and Nutrition Section	UNICEF	Yes	Focal Point GAVI HSS UNICEF
Ms Margareta Skold Public Health Administrator	WHO	Yes	Focal Point GAVI HSS WHO
Ms Yoshika Umabe Project Formulation Advisor	JICA	Yes	Focal Point GAVI HSS JICA
U Win Maung Director,	Ministry of Progress of Border Areas and National Races & Development Affairs	Yes	Member Help develop public health criteria for selecting HSS-targeted Townships
Dr. Than Htein Win Assistant Director EPI	DOH	Yes	Secretariat of NHSC National EPI Manager: coordination of HSS with immunization system strengthening efforts ICC member
Dr. Nyo Nyo Kyaing Deputy Director (Planning)	DOH	No	Technical Working Group
Dr. Than Lwin Deputy Director BHS	DOH	No	Technical Working Group
Dr. Myint Myint Zin Deputy Director Nutrition	DOH	No	Technical Working Group
Dr. Theingi Myint Deputy Director MCH	DOH	No	Technical Working Group
Dr. San San Aye Deputy Director	Dept. of Health Planning	No	Technical Working Group Assist in identifying linkages between HSS and other Health Sector Development strategies, programmes and policies. Research and development of health financing schemes.
Dr. Soe Lwin Nyein	DOH	Yes	Technical Working Group

Director (Epidemiology)			
Dr. Phone Yaung Deputy Director (Environmental Health)	DOH	No	Technical Working Group
State/ Division Health Directors	DOH	No	Planning, monitoring and supervision and training, financial management.
Deputy State/ Divisional Health Directors	DOH	No	Planning, monitoring and supervision and training
Township Medical Officer	DOH	No	Planning, monitoring and supervision and training, financial management (public health), Implementation Coordinated Township Health Plans
Station Health Officer	DOH	No	Implementation Coordinated Township Health Plans
Health Assistant	DOH	No	Implementation Coordinated Township Health Plans
Village Health Committees	Community	No	Implementation Coordinated Township Health Plans

7.3: Financial management of GAVI HSS support

Mechanism / procedure	Description

Mechanism for channelling GAVI HSS funds into the country	On request of MOH Myanmar, WHO will manage and administer the GAVI HSS funds for the first two years as an interim measure with the exception of construction and renovation costs (Activity 1.3) and supplies and equipment (Activity 1.2). Once a decision has been reached by the GAVI Board regarding funding of the Myanmar application, the relevant legal agreements will be established for the management and administration of the funds by WHO. ▪ WHO will charge 7% Programme support costs (PSC) on the overall project cost. ▪ Direct administrative cost for managing the GAVI HSS funds by WHO is included in the overall budget.

Mechanism for channelling GAVI HSS funds from central level to the periphery	*Mechanisms for Year 1 & 2 of HSS Program in Myanmar* Funds will be obligated by WHO through the WHO country office in Myanmar. Disbursements will be based on WHO mechanisms of Agreement for Performance of Work (APW) and DFC Direct Financial Cooperation (DFC) and/or other contracts currently being used in the implementation of WHO collaborative work plan with MOH. The administration of the Funds will be in accordance with WHO Financial Regulations and Financial Rules as well as its financial procedures and practices (including financial monitoring). Monitoring of Programmatic implementation will be done through WHO Activity Management System (AMS) and by monitoring officers. This will require that WHO strengthens its financial management and monitoring capacity through additional human resources at the country office to be able to administer, disburse and monitor these additional GAVI HSS funds in an accountable and transparent way. Costs for this are included in the overall budget. *Rationale:* The system described above which is the current system used for managing international health grants channelled through WHO, will be put in place for the first two years. During the same period, DOH NHSC will initiate a process of consultation between Ministry of Health and Ministry of Finance and Ministry of National Planning and Economic Development to explore options for the direct management by the Government of Myanmar of the GAVI HSS funds from 2010 onwards including feasible mechanisms for institutional strengthening. Two years will be required to research and develop these options.
Mechanism (and responsibility) for budget use and approval	At the Central level, the Director of Planning at the DOH will recommend approval of budgets to the Director General Department of Health. Budgets will be reviewed by the Head of Budget Section (U Kyaw Htay) under Admin Division (Dr. Swe Win) Director (Admin) of Dept. Health the Dept of Health. 3 signatures will be required (Director Administration DOH, Dir. Planning at DOH and Head of Budget Section DOH).

Mechanism for disbursement of GAVI HSS funds	The funds will be disbursed to the Dept. Health to the MD 56 Government Account managed by DOH Budget section. From there, funds will be disbursed directly to States and Divisions and to Townships by fax or by bank draft to Government Bank Accounts at that level. Funds will be disbursed based on costs identified in Coordinated Health Plans or specific activity plans. State and Division Health Director is the drawing officer for all government funds supported by administrative staff. At the Township level, the TMO is the drawing officer supported by administrative staff. *Discussion* The current system for financing of Township health activities is a top down supply driven funding of national program activities. There is currently no system of financial controls and procedures for needs based bottom up coordinated health planning. The development of a budgeting system linked to annual operational planning (Township and State and Division) is therefore included in the overall proposal. International technical assistance will be sought to strengthen institutional financial management mechanisms for budgeting, financing and monitoring of the Coordinated Township Health Plans including financial controls and procedures from central level for disbursement and accounting.
Auditing procedures	The Auditor General (Ministerial Level) conducts an external audit of the budgeting, finance and functions of all Ministries on an annual basis.

7.4: Procurement mechanisms

7.4.1 Life Saving Drugs, Equipment (including Transport) and Supplies

All equipments drugs and supplies will be procured through UNICEF procurement mechanisms. Please refer to Annex 10 which provides a list of essential life saving drugs and equipment that is currently utilized by the MOH and UNICEF. Drugs equipments and supplies will be distributed through routine government mechanisms. Needs of drugs, equipment and supplies will be identified in the Township Coordinated Health Plan. International technical assistance will be provided by UNICEF to transition the HMIS to a demand based system for life saving drug and equipment supply for Township level and below (focussing on RHC and sub RHC). This program will be complemented by a UNICEF program of support to the DOH to strengthen drug and supply systems across the country.

7.4.2 Construction & Renovation

All construction and renovation activities will conform to Ministry of Health standards and procedures for (1) Rural Health Centre and Sub Centre construction standards and (2) Standard procedures for procurement of services to construct or renovate. Any construction activity of the DOH needs to proceed through the Construction Committee that is located at each level of the health system. The Township construction committee is responsible for tendering process, financial management, assessment of standards and ensuring that construction/renovation work is completed within contracted timeframes. The Township Medical Officer reports progress to the State/Division Health Director. All construction activity requires the endorsement of the Director General for Health at the Department of Health. Please refer to Annex 11, which outlines the terms of reference for the construction committees that are overseeing construction and renovation.

7.5: Reporting arrangements

The reporting arrangements for the HSS program area as follows:

7.5.1 Central, State and Division and Township Level

Routine HMIS systems and reporting will be the main reporting mechanisms for HSS. Programs of annual review will supplement HMIS reporting. Information on HSS will also be reported through baseline HSS assessment, mid term review and annual plan situation analyses. There will be no parallel report systems established for GAVI supported HSS programs. Investments from other sources (Government, UN, NGO) will mean that the main reporting systems are enhanced planning and HMIS systems, backed up by programs of annual review, programs of supportive supervision, mid term evaluation and specific research studies.

Annual Program Reviews and the quarterly meetings of the NHSC and HSS Technical Working Group will provide the main opportunity for dissemination of research findings.

7.5.2 International Level

Reporting systems internationally will be through the Annual progress Report as specified by GAVI secretariat.

Regionally, information on GAVI HSS will be reported through regional HSS forums.

Internationally, reporting will take place through publication of research studies and HSS developments.

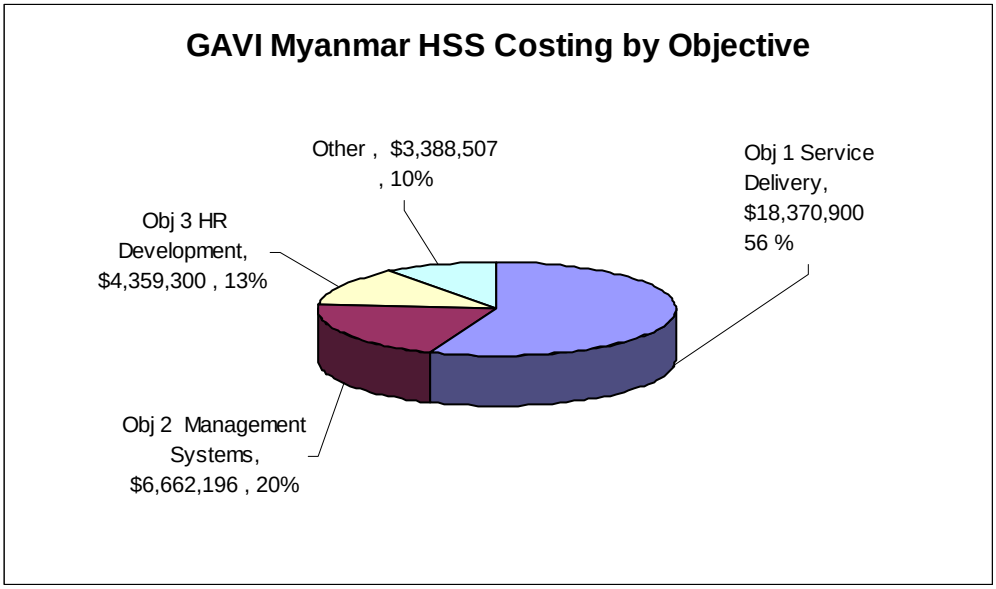
7.6: Technical assistance requirements

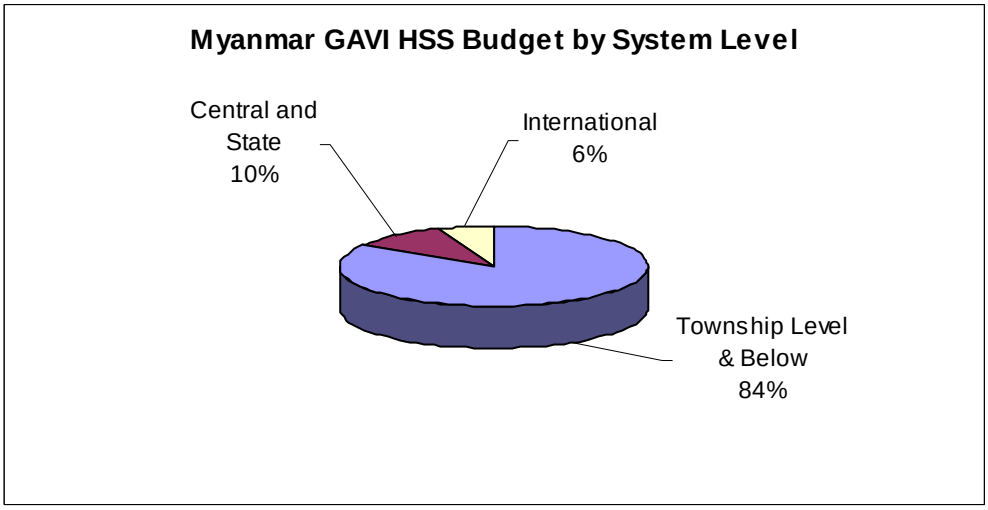
Activities requiring technical assistance	Anticipated duration	Anticipated timing (year, quarter)	Anticipated source (local, partner etc.)
1. Health System Strengthening	3 Years	Year 1, Year 2, Year 3 (0.5 Time), Year 4 (0.5 Time)	WHO/GAVI
2. Health Planning	3 months	Year 1 one month, Year 2 one month, Year 3 one month	WHO/GAVI
3. Health Financing and Financial Management	3 Months	Year 1 one month, Year 2 one month, Year 3 one month	WHO/GAVI
4. Drug Supply Information Systems	3 Months	Year 1 one month, Year 2 one month, Year 3 one month	UNICEF/GAVI
4. Human Resource Management	3 Months	Year 1 one month, Year 2 one month, Year 3 one month	AAA H (existing resources)
5. Management Effectiveness Program Support	1 Month	Year 1 one month	WHO/GAVI
6. Child Survival	Long Term Advisor	4 Years	UNICEF (existing resources)
Immunization Systems	Long Term Advisor	4 Years	WHO/UNICEF (existing resources)

Section 8: Costs and Funding for GAVI HSS

8.1: Cost of implementing GAVI HSS activities

Figure 3 Analyses of Budget Details





Budget Details

TOWNSHIP SCALE UP OF HSS	20	60	120	180	180
Activity costs	**2008**	**2009**	**2010**	**2011**	**TOTAL**
Objective 1 By 2011, 20 selected townships with identified hard to reach areas will have increased access to essential components of MCH-EPI and EH and Nutrition as measured by increased DPT from 70% to 90% and SBA from 67.5% to 80%	**USD**	**USD**	**USD**	**USD**	**USD**
Activity 1.1: SURVEY Conduct survey to establish base line indicators & outcome, impact and research for operations (including mapping)	40,000	80,000	120,000	120,000	360,000
Activity 1.2: SUPPLIES Increase availability of Essential Supplies and equipment based on needs identified in coordinated Township health plans	360,000	1,080,000	2,160,000	3,240,000	6,840,000
Activity 1.3: INFRASTRUCTURE 540 RHCs and sub-RHCs in 180 HSS-targeted Townships will be renovated including construction of sanitary latrines and improve access to safe water source by 2011, based on needs identified in coordinated township health plans.					
1.3.1 Renovation of 540 RHCs	240,000	480,000	720,000	720,000	2,160,000
1.3.2 Construction of 324 Sub Rural Health Centres	510,000	1,020,000	1,530,000	1,530,000	4,590,000
1.3.3. Installation of Solar for (63) RHCs at hard to reach townships	55,900	86,000	86,000	43,000	270,900
Activity 1.4: TRANSPORT Provision of essential transport for township and BHS to reach hard-to-reach areas					-
1.4.1 Supply of Recurrent Transport costs based on needs identified in Township Coordinated Plans.	100,000	300,000	600,000	900,000	1,900,000
1.4.2 Supply of transport capital to Townships based on needs identified in Township Coordinated Health Plan	50,000	100,000	150,000	150,000	450,000

Activity 1.5: SOCIAL MOBILIZATION: Involving NGOs, local authorities and Community Health Workers in developing and implementing coordinated township Health plans in 100% of HSS-targeted townships by 2011)	200,000	400,000	600,000	600,000	1,800,000
Objective 2: By the end of 2011, 180 selected townships with identified hard to reach areas will have developed and implemented coordinated township micro-plans					
Activity 2.1: GUIDELINES DEVELOPMENT Develop national guidelines for coordinated township health planning (including financial management and health financing) & supervision at all levels (including checklists)	40,000	20,000	20,000	20,000	100,000
Activity 2.2: HEALTH FINANCING RESEARCH Complete a research program on financial management capacity and feasibility and effectiveness of health financing schemes in all HSS targeted townships by 2012.	30,000	40,000			70,000
Activity 2.3: HR FINANCING Training and Piloting of health financing schemes, according to national guidelines in 50 townships by 2011		300,000	600,000	900,000	1,800,000
Activity 2.4: TRAINING Implement the training program on coordinated management through the modified MEP program (includes health planning and supervision) in HSS-targeted townships by 2011.	30,000	60,000	90,000	90,000	270,000
Activity 2.5: PLAN DEVELOPMENT Develop and monitor coordinated health planning of HSS-targeted townships according to new national planning guidelines (activity 2.1) and framework at all levels					

2.5.1 Management Support (from Township Coordinated Plans) Includes supervision and planning activities ($10,000 per Township per annum scaling up to 180 Townships by 2011))	200,000	600,000	1,200,000	1,800,000	3,800,000
Activity 2.6: RESEARCH & EVALUATION Assess process and impact of coordinated State & Township coordinated health planning, and then disseminate findings					
2.6.1 Annual Program Review Central Level	20,000	20,000	20,000	20,000	80,000
2.6.2 Annual Program Review State and Division Level	51,000	51,000	51,000	51,000	204,000
2.6.3 External Review of progress of HSS			50,000		50,000
2.6.4 Establish Health Systems Research Fund	72,049	72,049	72,049	72,049	288,196
Objective 3 By the end of 2011, 20 selected townships with identified hard to reach areas will be staffed by midwives and PHS2 according to the National HR Standards.					
Activity 3.1: RESEARCH Conduct Research program for HR planning focusing on distribution mix function and motivation and management capacity (including financing), by 2010.(complementary Funding through AAAH, but with specific research studies funded by GAVI - evaluation of financial allowances, research on performance based systems and motivational factors of rural health workforce)	20,000	10,000	10,000	10,000	50,000
Activity 3.2: HR PLAN Develop HR Plan recommending strategies for retention and deployment of staff in hard-to-reach areas, based in part on research from activity 3.1 (complementary Funding through AAAH, but with National HR Conference funded through GAVI))	30,000			30,000	60,000

Activity 3.3: HR PROPOSAL Development of Proposal to MOH recommending appropriate deployment number and pattern of MW and PHS2 in hard-to-reach areas, assessing retentions scheme options that include financial incentives.(complementary Funding through AAAH)	20,000	10,000		10,000	40,000
3.3.1 HR costs (HR Finance incentive scheme for health staff in remote areas - identified in Township Coordinated Plans) ($5,500 per Township per Year)	115,500	346,500	693,000	1,039,500	2,194,500
Activity 3.4: CONTINUING TRAINING Conduct coordinated MCH, EPI, Nutrition & EH training programs applying the principles of MEP (Capacity Building (from Township Coordinated Plans)					

M&E support costs (see Activity 2.5.1 and Activity 2.6.1 and 2.6.2 for details on M & E)					
International Technical Assistance					
Health Systems Advisor (WHO)	198,000	198,000	99,000	99,000	594,000
Financial Management Consultancies	15,000	15,000		15,000	45,000
Planning Consultancies	15,000	15,000		15,000	45,000
Management Effectiveness Programme	15,000	15,000			30,000
Operational Health Systems Research		15,000	15,000		30,000
Drugs Supply System	15,000	15,000		15,000	45,000
Sub Total	3,443,849	6,286,249	9,667,249	12,270,749	31,668,096
Programme Support Costs WHO 7%	163,369	259,437			422,806
UNICEF 10% procurement cost	42,000	108,000	216,000	324,000	690,000
TOTAL COSTS	**3,649,218**	**6,653,686**	**9,883,249**	**12,594,749**	**32,780,902**

8.2: Calculation of GAVI HSS country allocation

GAVI HSS Allocation	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	Year 4 of implementation	**TOTAL FUNDS**
	2007	2008	2009	2010	2011	
Birth cohort	1556615	1588059	1620137	1655780	1692207	
Allocation per newborn	$5	$5	$5	$5	$5	
Annual allocation		**$7,940,295**	**$8,100,685**	**$8,278,900**	**$8,461,036**	**$32,780,916**

Source and date of GNI and birth cohort information:

GNI: $217 Source ADB Fact Sheet 2007 (see Annex 7) [30] .....

Birth cohort: GAVI ISS Annual Progress Report 2006 .....

Total Other: .....

[30] Please Note – there is no published World Bank Figure

Section 9: Endorsement of the Application

9.1: Government endorsement

Endorsement of the Application

Government endorsement

The Government of the Union of Myanmar commits itself to providing immunisation and other child and maternal health services on a sustainable basis. Performance on strengthening health systems will be reviewed annually through a transparent monitoring system. The Government requests that the GAVI Alliance funding partners contribute financial assistance to support the strengthening of health systems as outlined in this application.

Name: Professor Kyaw Myint	Name: **Major General Hla Tun**
Title / Post: Minister of Health	**Title / Post: Minister of Finance and Revenue**
Signature:	Signature:
Date: 28-2-2008	Date: 28-2-2008

9.2: Endorsement by Health Sector Coordination Committee (HSCC) or country equivalent

Members of the Health Sector Coordination Committee or equivalent endorsed this application at a meeting on 15-02-2008. The signed minutes are attached as Annex 1.

Endorsement by National Health Sector Coordination Body for Health system Strengthening (NHSC)

Members of the National Health Sector Coordination Body for Health System Strengthening endorsed this application at a meeting on 15-02-2008.
The signed minutes are attached as Annex 5.

Chair of NHSC :	
Name: Dr. Tin Win Maung	**Post / Organisation:** Director General Department of Health Ministry of Health
Signature:	**Date**: 15-02-2008

9.3: Person to contact in case of enquiries:

Name: Dr. Nilar Tin

Title: Director (Planning) Department of Health

Tel No: 95-67-411384

Address: Ministry of Health, Building 4,
Nay Pyi Taw, Myanmar

Fax No.95-67-411022

Email: nittin@mptmail.net.mm

ANNEX 1 Documents Submitted in Support of the GAVI HSS Application

Document (with equivalent name used in-country)	Available (Yes/No)	Duration	Attachment Number
National Health Plan	Yes	2006 - 2011	**1**
cMYP[31]	Yes	2007 - 2011	**2**
MTEF[32]	No		**-**
PRSP[8]	No		**-**
Recent Health Sector Assessment documents (1) Technical Working Paper on Health System Barriers to Immunization and MCH Performance (2) Are we Overburdened in Rural Area? The Voices of Rural Midwives	Yes Yes		**3** **4**
NHSC minutes, signed by Chair of NHSC endorsing the proposal and associated minutes of meetings in support of HSS proposal development.	Yes		**5**
Report of the Workshop on National Health Accounts	Yes	2007	**6**
ADB Fact Sheet 2007 (Source of GNI) World Bank Statement on Myanmar	Yes	2007	**7**
Terms of Reference NHSC, Technical Working Group HSS, Consultants and Advisors	Yes	2007 - 2011	**8**
List of HSS Townships and Mapping	Yes	2007 - 2011	**9**
List of Life Saving Drugs and Equipment Lists	Yes	2007 - 2011	**10**
Building Standards & Procurement Guidelines DOH	Yes	2007 - 2011	**11**
Ministry of Health Structures (Power point)	Yes		**12**
"Perceptions of people in the community towards health and existing health services in the rural areas of selected townships"	Yes	2007	**13**
Questionnaire for Peer Review	Yes		**14**
Updated budget in Excel	Yes		**15**
Peer review comments by UNICEF	Yes		**16**
Peer review comments by WHO	Yes		**17**
Peer review comments by Save the Children US	Yes		**18**
Peer review comments by ACF	Yes		**19**
EPI Desk Review	Yes		**20**

[31] If available – and if not, the National Immunization Plan plus Financial Sustainability Plan
[32] if available please forward the pages relevant to Health Systems Strengthening and this GAVI HSS application

ANNEX 2 Banking Form

GLOBAL ALLIANCE FOR VACCINES AND IMMUNISATION	**Banking Form**

SECTION 1 ***(To be completed by payee)***

In accordance with the decision on financial support made by the Global Alliance for Vaccines and Immunisation dated . . . . . , the Government of . . . . . hereby requests that a payment be made, via electronic bank transfer, as detailed below:

Name of Institution: ***(Account Holder)***	----------

Address:	----------

City – Country:	

SECTION 2 ***(To be completed by the Bank)***

FINANCIAL INSTITUTION	**CORRESPONDENT BANK (*In the United States)***
Bank Name:	
Branch Name:	
Address:	
City – Country:	
Swift code:	
Sort code:	
ABA No.:	
Telephone No.:	
Fax No.:	

I certify that the account No. . . . . Is held by (*Institution name)* . . . . . .at this banking institution.

The account is to be signed jointly by at least …… *(number of signatories)* of the following authorized signatories: **1** **Name:** **Title:** **2** **Name:** **Title:** **3** **Name:** **Title:** **4** **Name:** **Title:**	**Name of bank's authorizing official:** **Signature :** **Date:** **Seal:**

COVERING LETTER

(To be completed by UNICEF representative on letter-headed paper)

TO: GAVI – Secretariat
Att. Dr Julian Lob-Levyt
Executive Secretary
C/o UNICEF
Palais de Nations
CH 1211 Geneva 10
Switzerland

On the …… I received the original of the BANKING DETAILS form, which is attached.

I certify that the form does bear the signatures of the following officials:

	Name	Title
Government's authorizing official	.....	.....
Bank's authorizing official	.....	.....

Signature of UNICEF Representative:

Name .....

Signature .....

Date .....