Ministry of Health and Sports

The Republic of the Union of Myanmar

MYANMAR NATIONAL HEALTH PLAN

2017 - 2021

December 2016

ACKNOWLEDGEMENTS

The team responsible for the formulation of the National Health Plan 2017-2021 would like to thank HE Dr. Myint Htwe, Union Minister of Health and Sports (MoHS), for initiating and guiding the process of developing this Plan. The team's sincere gratitude goes to all the participants who attended the different workshops and meetings for sharing thoughts, generating ideas and contributing to the development of the Plan. These include representatives from MoHS's various Departments and Programs, from health authorities at State/Region and Township levels, from the NLD Health Network, from Ethnic Health Organizations, from the various Councils and Professional Associations, from civil society, from private sector, from development partners, as well as independent experts and academics. The team's gratitude also goes to representatives from other Ministries who provided valuable inputs. In addition, the team would like to thank the different agencies and individuals that were consulted while preparing this report for the information they shared. Last but not least, the team would like to express its utmost appreciations to the development partners that provided the financial support, which made this inclusive and participatory exercise possible.

Mothers and children receive post-natal care in Kone Thar village, Ngape Township, Magway Region.

National Health Plan (2017-2021) Executive Summary dissemination in Nay Pyi Taw, December 2016.

A mother and her child receive vaccinations at Hsihseng township, Shan State.

FOREWORD

Myanmar has reached a critical junction in its history. With ongoing political, social and economic transition, there is a real opportunity for the country to live up to its full potential.

Investing in health could not only contribute to improving the overall health status of the population but also stimulate economic growth of the country. Rendering quality essential health services together with improving access is critical to sustainable development of the country.

The health care delivery system of the country has not been accorded enough attention over the years. It has led to weak health infrastructure, insufficient number of adequately skilled human resources, and high out-of-pocket spending, coupled with questionable quality of health care services. For a long time, specialized or tertiary care has been prioritized, mainly in urban areas at the expense of basic essential care for the majority of the population. This is reflected in some of the key health indicators and compared poorly with those in other countries of the region. Those indicators also show considerable in-country inequities across geographical areas and socio-economic groups.

Today, we have the chance to reverse this scenario. The formulation of the National Health Plan 2017-2021 presents a unique opportunity to outline a new path for the health system that will help the country move towards Universal Health Coverage in an equitable, effective and efficient manner.

This Plan differs from previous National Health Plans in both its formulation process and scope. In the formulation process, a wide range of stakeholders, like-minded organizations and development partners were actively involved. Features of the Plan that are noteworthy include: its focus on ensuring access to essential health services for the entire population; its emphasis on primary health care delivered at township level and below; its consideration for involvement of healthcare providers outside Ministry of Health and Sports; its switch from top-down planning to a more inclusive bottom-up approach; and its recognition of the importance of health systems strengthening from all perspectives.

Having a strong, cohesive and compact National Health Plan is fundamental to achieving our ultimate objective of improving overall health status of the population. Yet, success will only be achieved through effective and systematic implementation with built-in monitoring system and time-to-time evaluation. This will be guided by Annual Operational Plans, which will involve close collaboration among the many actors and active participation of the communities and community-based organizations.

I would strongly endorse this National Health Plan and do all that is required to ensure its efficient implementation.

Dr. Myint Htwe
Union Minister, Ministry of Health and Sports

CONTENTS

ACRONYMS

AMW	Auxiliary Midwife
BEmOC	Basic Emergency Obstetric Care
BHS	Basic Health Staff
CBO	Community-Based Organization
CD	Communicable Disease
CHW	Community Health Worker
CPE	Continuing Professional Education
CSO	Civil Society Organization
DHPRDM	Department of Health Professional Resource Development and Management
DMR	Department of Medical Research
DoMS	Department of Medical Services
DP	Development Partner
DoPH	Department of Public Health
EHO	Ethnic Health Organization
EPHS	Essential Package of Health Services
FDA	Food and Drugs Administration
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund to fight Aids, Tuberculosis and Malaria
GP	General Practitioner
HEF	Health Equity Fund
HiAP	Health in All Policies
HISI	Health Input Scoring Index
HOSI	Health Output Scoring Index
HITAP	Health Intervention and Technology Assessment Program
HRH	Human Resources for Health
HRIS	Human Resources Information System
HSS	Health Systems Strengthening
HTA	Health Technology Assessment
HTF	Hospital Trust Fund
ICT	Information Communication and Technology
ITHP	Inclusive Township Health Plan
M&E	Monitoring and Evaluation
MHAA	Myanmar Health Assistants Association
MHSCC	Myanmar Health Sector Coordination Committee
MAMS	Myanmar Academy for Medical Science
MMA	Myanmar Medical Association
MMC	Myanmar Medical Council
MMCWA	Myanmar Maternal and Child Welfare Association
MMR	Maternal Mortality Ratio
MNMA	Myanmar Nurse and Midwife Association
MNMC	Myanmar Nurse and Midwife Council
MoHS	Ministry of Health and Sports
MoPF	Ministry of Planning and Finance
MoLIP	Ministry of Labor, Immigration and Population
MPLCS	Myanmar Poverty Living Conditions Survey
NCD	Non-Communicable Disease

NIMU	NHP Implementation Monitoring Unit
NGO	Non-Government Organization
NHA	National Health Accounts
NHP	National Health Plan
NICE	National Institute for Clinical Excellence
NLD	National League for Democracy
OOP	Out-of-Pocket
OPD	Outpatient Department
PER	Public Expenditure Review
PFM	Public Financial Management
PHC	Primary Health Care
PHS	Public Health Supervisors
ITHP	Inclusive Township Health Plan
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
SRMNAH	Sexual, Reproductive, Maternal, Neonatal and Adolescent Health
SSB	Social Security Board
TAG	Technical Advisory Group
TB	Tuberculosis
TMO	Township Medical Officer
TRIPS	Trade Related Aspects of Intellectual Property Rights
TWG	Technical Working Group
UCSB	Union Civil Service Board
UHC	Universal Health Coverage
VBHW	Village-Based Health Worker

EXECUTIVE SUMMARY

CONTEXT

After decades of institutional neglect of the health sector, recent efforts have been made to improve the health status of the population. These efforts translated into a rise in public spending on health from 0.2 per cent of GDP in 2009 (the lowest in the world) to slightly over 1 per cent in 2014. They also led to visible improvements in the fight against communicable diseases – malaria, tuberculosis, and HIV/AIDS.

Despite these efforts, considerable challenges remain. The health status of the Myanmar population is still poor and does not compare favorably with other countries in the region. Life expectancy at birth, for example, is 64.7 years in Myanmar, the lowest among ASEAN countries. Moreover, hidden behind the national averages are wide geographic, ethnic and socio-economic disparities.

The Myanmar health system currently faces many challenges. These relate to the availability and distribution of inputs (e.g. human resources, physical infrastructure, essential medicines and supplies, financial resources) and to weaknesses in key functions such as supportive supervision, referral, supply chain, health management information system, and public financial management. Limited oversight, leadership and accountability further exacerbate these challenges.

Myanmar currently allocates only 3.65 percent of its total budget on health, which is extremely low by global and regional standards. As a result, out-of-pocket (OOP) spending by households remains the dominant source of financing for health. It can push or keep households in poverty and it prevents many from seeking necessary health care.

GOALS

Universal Health Coverage (UHC) is defined as all people having access to needed health services of quality without experiencing financial hardship. Myanmar's political leadership has expressed a strong commitment to accelerating progress towards UHC, which has also become a global priority. The National Health Plan (NHP) aims to strengthen the country's health system and pave the way towards UHC, choosing a path that is explicitly pro-poor. The main goal of NHP 2017-2021 is to extend access to a Basic Essential Package of Health Services (EPHS) to the entire population by 2020 while increasing financial protection.

The NHP also aims to promote further alignment at several levels:

- Among programs (e.g. by encouraging more integrated training, joint supportive supervision, better aligned referral mechanisms, a more streamlined health information system)
- Among development partners (DPs), through stronger oversight and coordination
- Among the different types of providers, through the engagement of Ethnic Health Organizations (EHOs), Non-Governmental Organizations (NGOs), private-for-profit providers, etc.
- Among implementing agencies by ensuring that projects and initiatives contribute to the achievement of the NHP goals

STRATEGY

Extending the Basic EPHS to the entire population will require substantial investments by the Ministry of Health and Sports (MoHS) in supply-side readiness at Township level and below and in strengthening the health system at all levels. It will also require active engagements of health providers outside the public sector, including private-for-profit GP clinics, EHOs and NGOs. Services and interventions will need to meet the same minimum standards of care, irrespective of who provides them.

Geographical prioritization – The NHP will be operationalized nationwide to deliver the Basic EPHS based on existing capacity. Investments to expand Townships' capacity by improving service availability and readiness, however, will be gradually phased in, prioritizing Townships with the greatest needs. This will be based on objective criteria.

Initially relatively crude indices will be used, constructed using available data from both public and private sectors. The Health Input Scoring Index (HISI) summarizes a Township's situation with respect to

infrastructure and health workforce, and compares it to national norms defined in terms of population and area.

The Health Output Scoring Index (HOSI) captures a Township's performance on selected key output indicators in relation to specified thresholds. Assumptions relating to the norms and thresholds can easily be adjusted to assess alternative scenarios. These indices will be refined as more and better data becomes available, such as disaggregated data on poverty and health outcomes. From the prioritized list of Townships, the actual number of Townships, in which investments in service availability and readiness are to be initiated each year, will be determined by overall fiscal space for health and the capacity to deploy additional resources.

Service prioritization – Another form of prioritization is in the definition of the EPHS, which will grow over time, starting with a Basic EPHS to be guaranteed for everyone by 2020. The size of the package largely depends on what the country can afford and deliver. If a service is currently excluded from the package, it only means that access to this service cannot yet be guaranteed for all. The content of the Basic EPHS is currently being defined based on objective criteria. It emphasizes the critical role of primary health care and the delivery of essential services and interventions at Township level and below, starting within the community.

Planning at Township level – Inclusive planning at the local level will be essential to achieve the NHP goals. The planning will be based on a good understanding of current situation: who is doing what and where; which services and interventions reach which communities; where are the gaps and who could fill them. This information will be fed into a national database that will be regularly updated and that will support planning and monitoring efforts at all levels of the system. Using this information, stakeholders at Township level will be able to jointly plan and cost actions that need to be taken to fill coverage gaps and meet the minimum standards of care.

These actions will need to be prioritized to fall within the broad resource envelope (specifying human, material and financial resources) communicated by the State or Region. All of this will be captured in an Inclusive Township Health Plan (ITHP) using national guidelines and templates. These will be introduced nationwide, irrespective of whether the Township is being prioritized for additional investments. States and Regions will have a key role to play in supporting and overseeing the planning and budgeting process, as well as the implementation of the ITHP.

Systems building – The provision of a Basic EPHS at Township level and below is conditional on a well-functioning health system. Supply-side readiness requires all the inputs, functions and actors' behaviors to be aligned. In conjunction with the operationalization of the NHP at the Township level, investments will be needed to strengthen key functions of the health system at all levels. Health systems strengthening efforts will be organized around four pillars: human resources, infrastructure, service delivery and health financing.

A clear health financing strategy will be developed to outline how resources will be mobilized to finance progress towards UHC and how risk pooling mechanisms will be developed to help improve affordability of care and address the substantial barriers to seeking care, especially among the poor and vulnerable. The health financing strategy will, for instance, determine whether a mechanism to target the poor needs to be established or not, and what will be done to ensure the informal (non-poor) sector can access services without experiencing financial hardship.

Temporary measures to reduce out-of-pocket spending on health by poor and vulnerable households will be adopted, harmonized and/or extended while these risk pooling mechanisms are being developed.

Supportive environment – Successful implementation of the NHP will also require a supportive environment. This includes adequate policies developed within a robust regulatory framework, well-functioning institutions, strengthened MoHS leadership and oversight, enhanced accountability at all levels, a strong evidence base that can guide decision making, improved ethics, etc.

Community engagement – While supply-side readiness is at the core of the NHP 2017-2021, the demand side cannot be ignored. The NHP includes elements that will help create or increase community engagement and the demand for essential services and interventions. Focusing on the Basic EPHS, for example, will clarify entitlements and manage expectations. The introduction and strengthening of accountability mechanisms, including social accountability, will help give communities a voice, which in turn will enhance responsiveness of the system.

IMPLEMENTATION

The NHP will be translated into annual operational plans that will elaborate on implementation details. Considerable coordination and close monitoring will be required to ensure implementation remains on track. A strong M&E framework will be developed to that end. The framework will look explicitly at equity under its various forms. Implementation research will be an integral part of the M&E framework. It will help assess whether the NHP is being implemented as planned, and identify areas where corrective measures need to be taken to put implementation back on track. Immediate tasks to be carried out include (but are not limited to):

- The finalization of the Basic EPHS
- The costing of the NHP
- The prioritization of Townships where investments in improving service availability and readiness are to be made
- The development of the NHP M&E framework
- The institutionalization of implementation research
- The preparation of a 'national' approach for the assessment of service coverage at Township level
- The development of a 'national' approach to the elaboration of an Inclusive Township Health Plan
- The identification of most urgent efforts needed to strengthen the health system and further develop the enabling environment

INTRODUCTION

Investing in health is essential not only to improving health outcomes but also to supporting economic growth. Payoffs from investing in health are considerable. Global evidence shows that making the right investments in health stimulates economic growth. Between 2000 and 2011, health improvements accounted for about 11 percent of economic growth in low- and middle-income countries. A strong and coherent health system is the foundation for healthy children, families and communities, contributing to a productive workforce and a population able to take advantage of the opportunities created by economic growth. It also protects families from becoming poor, or from being kept in poverty, due to health care costs. The National Health Plan (NHP) 2017-2021 aims to strengthen Myanmar's health system and improve equitable access to quality essential health services and interventions for the entire population.

Committees and working groups for the formulation of the NHP 2017-2021 were established in September 2016. MoHS letter #33/2016 endorsed the establishment of a Steering Committee chaired by H.E. Union Minister of Health and Sports, a Formulation Committee chaired by MoHS Permanent Secretary, and a Technical Secretariat Group, which comprises a Technical Advisory Group (TAG-NHP) and a Technical Working Group (TWG). The TAG-NHP and the TWG are jointly responsible for the NHP formulation process and for the elaboration of the NHP document, with following guiding principles:

- The NHP will be all-inclusive: key stakeholders of the health sector will be involved, including State/ Region and Township Health Authorities, Civil Society Organizations (CSOs), Non-Governmental Organizations (NGOs), Ethnic Health Organizations (EHOs),Development Partners (DPs), professional associations and councils, and private sector
- The NHP will foster collaboration within MoHS as well as between MoHS and key partners

The NHP formulation process builds on earlier work that was initiated in December 2015 and that culminated, in February 2016, into a first draft of the NHP. When the new government took office, the process was temporarily put on hold until September 2016. In order to build on previous efforts, the process also involved a review of key documents. This review was followed by a series of workshops, a panel and various consultations:

- Ceremony, held on October 12, 2016, for the official launch of the NHP development process
- Workshop 1, held on 20, 21 October 2016 focused on a situational analysis
- Workshop with UN organization and iNGOs, held on November 2-3, 2016, focused on effective collaboration to support the NHP planning process
- EPHS workshop, held on November 10-11, 2016, focused on the technical finalization of the EPHS
- Consultation meeting with CSOs, held on November 21-22, 2016, focused on all-inclusive NHP formulation process
- Consultation meeting with EHOs, held on November 23, 2016, focused on all-inclusive NHP formulation process
- Workshops 2 and 3, held on 28, 29 and 30 November 2016, respectively, focused on policy responses, operationalization of the NHP and Monitoring and Evaluation (M&E) framework
- Workshop with program managers, held on November 29, 2016
- Universal Health Coverage Panel Discussions, held on December 1-2, 2016, to share international experience and inform the NHP
- Workshop 4, held on 12 December 2016, provided an opportunity to solicit feedback from all stakeholders involved in the process on the latest draft NHP
- Dissemination workshop, held on December 15, 2016, shared the finalized document with key stakeholders from both within and outside the health sector

The NHP covers the period from April 1, 2017, to March 31, 2021, i.e., a period of four years.

SITUATIONAL ANALYSIS

POLITICAL AND ECONOMIC CONTEXT

After many decades of military rule, the first democratically elected government took office in April 2016, following a landslide victory of the National League for Democracy (NLD) at the November 8, 2015, elections. U Htin Kyaw became the country's new President and Daw Aung San Suu Kyi became the State Counsellor.

Among the many priorities of the new government, social sectors including health and education are repeatedly emphasized as being critical.

"Some of the best indicators of a country developing along the right lines are healthy mothers giving birth to healthy children who are assured of good care and a sound education that will enable them to face the challenges of a changing world. Our dreams for the future of the children of Burma have to be woven firmly around a commitment to better health care and better education."

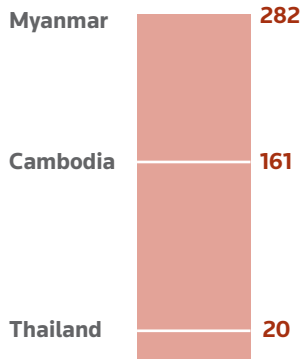
Daw Aung San Suu Kyi
[excerpt from Letters from Burma]

Important progress has already been made in economic reforms, including the enactment of the Financial Institutions Law, the passage of the Investment Law, and continued improvements in revenue administration. The country's economy is growing fast. Last fiscal year, real Gross Domestic Product (GDP) increased by 7.3% (IMF). Safeguarding macroeconomic stability remains the government's top priority.

Progress in other crucial sectors such as the economy and security have direct implications for the health sector and vice versa. The new government sees health as a conduit for peace and harmony, as improved access to health without financial hardship is directly felt by citizens. Thanks to the National Ceasefire Agreement and the intensified peace talks, modest progress can already be observed in the relationship between government and ethnic groups, with an increased willingness to collaborate.

Also noteworthy are the developments in information and communication technology reflected in the rapid uptake of mobile technology throughout the country, which provide new opportunities for the health sector.

Figure 1 – MMR in the region



Source: Myanmar census 2014

HEALTH STATUS AND HEALTH SYSTEMS CHALLENGES

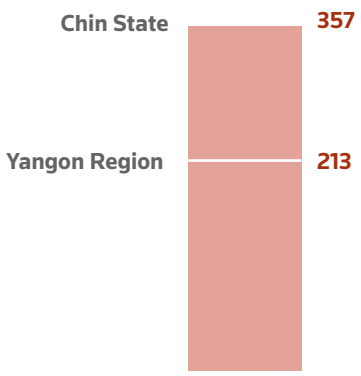
HEALTH STATUS

The health status of the Myanmar population is poor and does not compare favorably with other countries in the region. Life expectancy at birth in Myanmar is 64.7 years, the lowest among ASEAN countries. The maternal mortality ratio (MMR) is the second highest among ASEAN countries at 282 deaths per 100,000 live births (Figure 1). Every year, around 2,800 women die during pregnancy or childbirth (2014 census). The under-five mortality rate (U5MR) is 72 deaths per 1,000 live births – compared to 29 in Cambodia and 12 in Thailand – and the infant mortality rate is 62 per 1,000 live births, compared to 25 in Cambodia and 11 in Thailand (World Bank). Malnutrition is highly prevalent, with more than one third of the children under the age of five stunted.

Both HIV prevalence and TB incidence are second highest among ASEAN countries. Burden of disease associated with non-communicable diseases (NCDs) is increasing at alarming rates; it is estimated to already account for more than 40 per cent of all deaths. Diabetes and hypertension are particularly prevalent and have so far been largely neglected.

Hidden behind the national averages are wide geographic, ethnic and socio-economic disparities. For example, the MMR in Chin State is 357, compared to 213 in Yangon (Figure 2), and the U5MR ranges from 108 in Magwe Region to 48 in Mon State. Children from poorer households are more than twice as likely

Figure 2 – MMR in the country



Source: Myanmar census 2014

to be undernourished than those from better-off households (Myanmar Census 2014).

One of the factors contributing to this situation is the failure of the health system to ensure the availability and accessibility of quality essential health services and interventions.

Health, however, is not the sole responsibility of the Ministry of Health and Sports (MoHS). Many of the health inequities observed in the country are directly related to the social determinants of health (the conditions in which people are born, grow, live, work and age), which are shaped by the distribution of money, power and resources. Actions from sectors other than health are therefore equally important to improve health and address systematic disparities. This requires close collaboration across Ministries and agencies.

HEALTH SYSTEMS CHALLENGES

The Myanmar health system currently faces many challenges. These relate to the availability and distribution of inputs (e.g. human resources, physical infrastructure, supply chain, financial resources) and to weaknesses in key functions such as supportive supervision, referral, health management information system, and public financial management. The lack of oversight, leadership and accountability further exacerbates these challenges.

Human resources for health

Human Resources are critical inputs in the health system to ensure access to quality care. The Health Workforce Strategic Plan (2012-2017) outlines current human resource challenges, including: shortages of human resources, inappropriate balance and mix of skills, inequitable distribution, and difficulties in rural retention. As of November 2016, there were 1.33 health workers (doctors, nurses and midwives) per 1,000 people (MoHS), well below the WHO minimum recommended threshold of 2.3. In terms of distribution, health workers were largely concentrated in urban areas, including Yangon and Mandalay.

A mechanism for the accreditation of educational programs and institutions by external bodies is currently being developed. The Professional Councils are expected to design an accreditation system in line with international standards. Discussions have already been initiated with the Myanmar Medical Council (MMC) and the Myanmar Nurse and Midwife Council (MNMC). In fact, the MNMC has recently drafted accreditation guidelines for training institutions and plans to begin implementing accreditation activities upon official approval.

Pre-service training of all health cadres in Myanmar is the responsibility of the Department of Human Resources for Health (HRH). As of June 2016, there were 12,230medical students and 7,572 students enrolled in nursing and midwifery training institutions, out of a total of 29,528 students in health-related studies (MoHS). These numbers reflect a sharp increase from previous years, further exacerbating the imbalance in comparison to training of Basic Health Staff (BHS), even though the population served by BHS in rural areas is much larger than that served by doctors and nurses.

Lack of clear recruitment and deployment policies further complicate matters. Additionally, there is limited clarity around roles and responsibilities of the different health cadres at all levels of the system. This explains to some extent why midwives are overburdened. Even though they are trained exclusively to carry out midwifery functions, addition tasks not related to midwifery are commonly assigned to them.

Deployment and in-service training are the joint responsibility of the Department of Public Health and the Department of Medical Services. Currently, in-service training tends to be project-oriented and there is limited continuous professional development. Given the dependency on projects, sustainability of these ad-hoc trainings is questionable.

Infrastructure

Having human resources for health is not enough. There needs to be a balanced distribution of infrastructure such as buildings and equipment. Currently, there is no clear nationwide infrastructure investment plan. There is often a mismatch between health administrative maps and catchment areas of health facilities, leading to challenges in estimating

catchment population. Design of health facilities can vary depending on the funding source. This means that not all health facilities have critical amenities such as clean water, sanitation, electricity, warehousing facilities, staff housing and communication facilities. Furthermore, restrictions imposed by financial rules and regulations have led to delays in the tendering process, and lack of an operational budget for maintenance. Efforts to allow budget flexibility for maintenance purposes are ongoing.

Transportation between health facilities is still challenging, increasing barriers to accessing health services.

Service delivery

Service delivery in Myanmar relies on a mix of public, private for-profit, private not-for-profit and EHO providers.

MoHS has been leading a technical exercise since 2014 to define an EPHS. The plan is to have a Basic-EPHS by 2020, an intermediate-EPHS by 2025 and a comprehensive-EPHS by 2030.

The current public sector health services provision focuses on tertiary care, which means station hospitals and below have received less attention over the past few decades. This underinvestment has led to various shortcomings in service availability, readiness and coverage. Furthermore, there is limited public sector service delivery in both conflict-affected and post-conflict affected areas.

It is recognized that the public sector will not be able to reach the entire population with the Basic EPHS by itself. Public sector facilities vary in terms of their level of readiness. While other actors, such as private for-profit providers, NGOs and EHOs, are also involved in service delivery, government oversight and engagement is limited. Among all types of service providers, quality of care shows great variations.

EHOs have long been providing essential services and interventions to populations in conflict-affected areas where public sector services do not reach. Despite recent promising initiatives, standardization of these services among the different EHOs and between EHOs and public sector faces many political and technical challenges. The different cadres of health workers employed by EHOs are currently trained through parallel systems with limited or no recognition from MoHS. Service provision by EHOs relies heavily on donor support, which puts their sustainability at risk.

Existing procurement and supply chain arrangements are highly fragmented along vertical programs and funding sources. This fragmentation complicates coordination and creates inefficiencies. Weak policies and regulations, their limited enforcement and lack of clarity in existing guidelines pose further challenges. Underinvestment in the MoHS procurement and supply chain management system has translated into limited management capacity, infrastructure, and technology. The existing paper-based LMIS prevents timely aggregation of data and limits its use.

There is poor alignment between the Government of Myanmar's Public Financial Management (PFM) system and the financing objectives related to health service delivery at the primary health care level. Existing PFM system and processes hamper rather than enable effective service delivery. There are bottlenecks throughout the budget cycle. To begin with, there is a complete disconnect between planning and budgeting functions and cycles. Budget is not allocated within MoHS based on a clear and transparent formula; it is prepared with little to no consultation with implementers at lower levels and ends up being mostly historical and delinked from actual needs. Communication from central level to the lower levels about available annual budget envelope for coming fiscal year tends to be unclear and untimely. The budget is structured around line items that largely focus on inputs and are disconnected from programs or outputs.

Budget execution (drawing rights) is decentralized only to Township Medical Officers. There is no fund flow to health facilities below the Township level. Re-allocation of funds between budget lines during the fiscal year is almost impossible for implementers. That, combined with the fact that the budget does not match the needs and that unused funds cannot be transferred to the next year, results in low levels of expenditure. Current financial rules are no longer fit for purpose, particularly those relating to advances, travel allowances, phone bills, petrol/gas, and other small operational budget. Financial management capacity is low within MoHS at all levels, with insufficient number of financial management professionals.

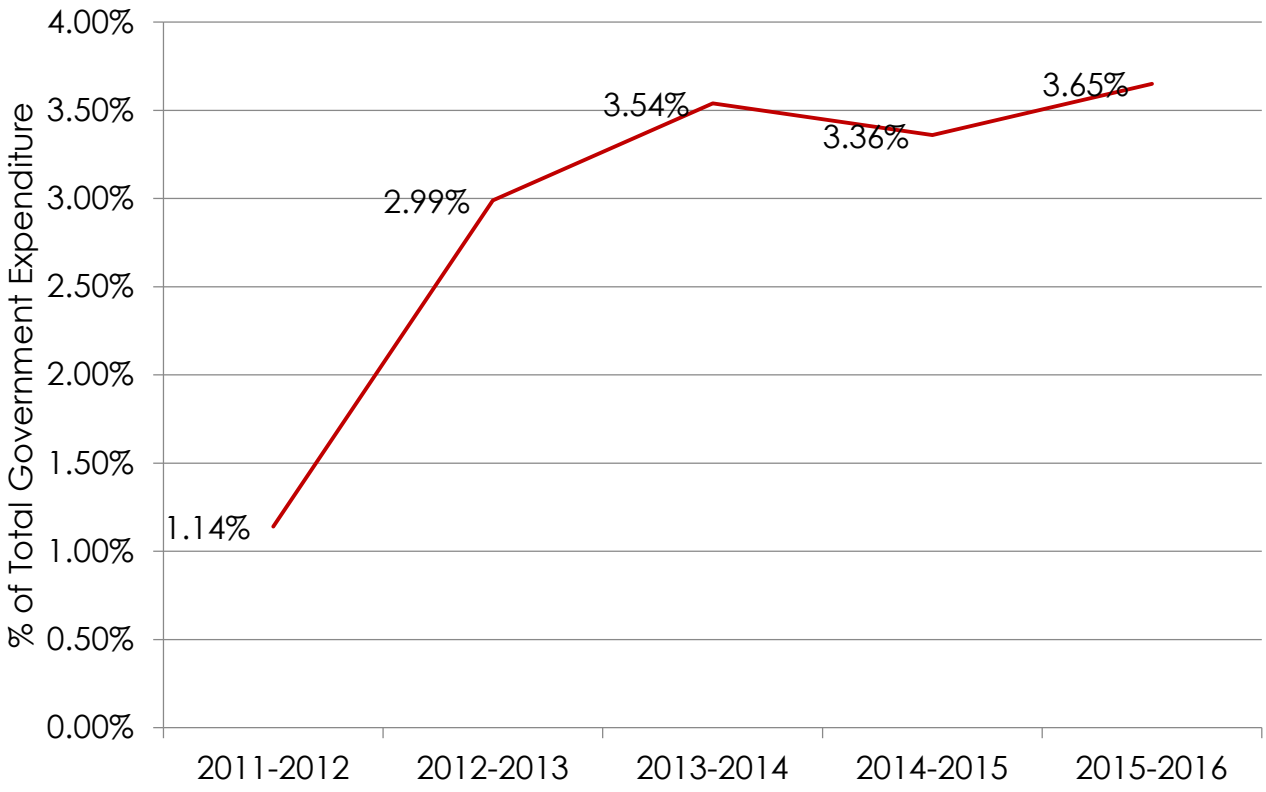
Financial reporting focuses on inputs and on fulfilling audit requirement, rather than on output or achievements. The system is still fully paper based and it is administratively heavy. There is little evidence that information from the financial reports is being used in decision-making.

Health financing

Myanmar currently allocates 3.65 percent of its total budget on health, which is extremely low by global

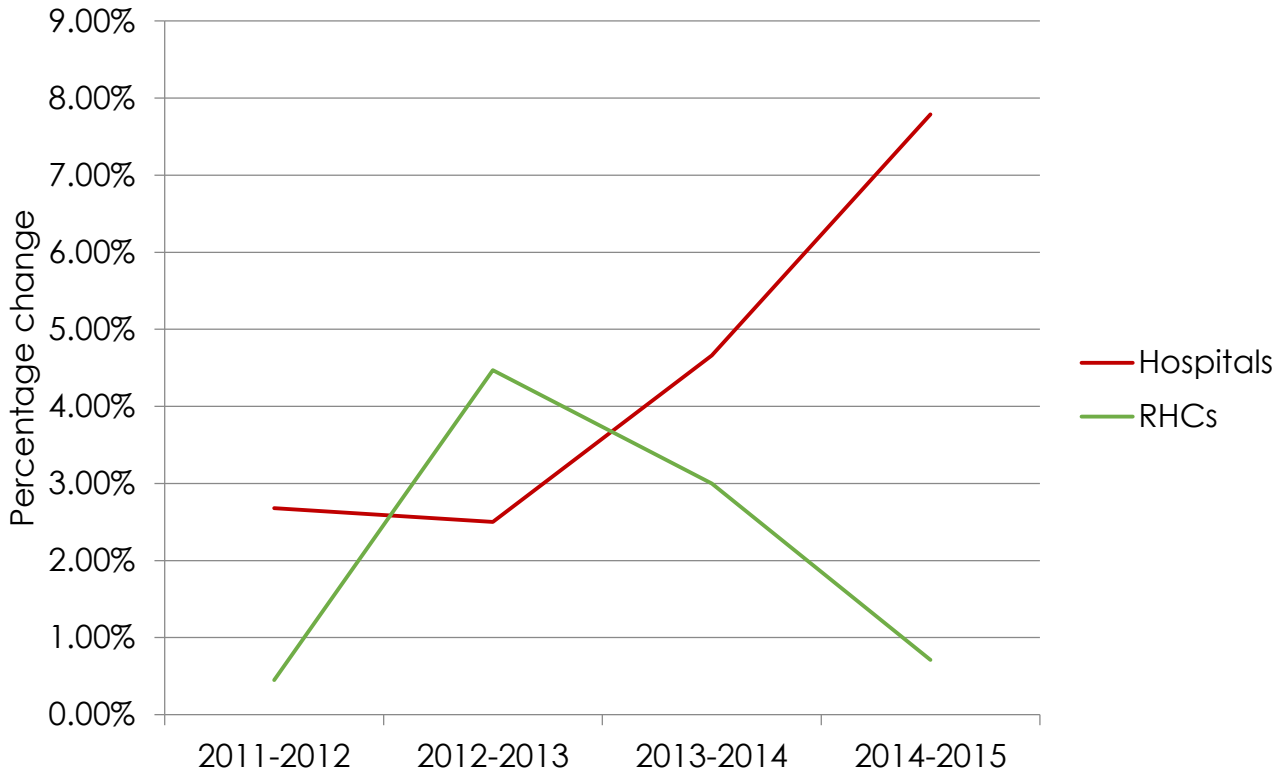
and regional standards (MoPF). Some reprioritization towards social sectors in general, and the health sector in particular, has already taken place in recent years, as shown in Figure 3. The nine-fold increase in absolute amount (from 94 million US$ in 2010-11 to 850 million US$ in 2016-17) was mainly used to finance delivery of health care and expansion of service coverage with a focus on free medical care in hospital settings (MoHS). Funding from other sources, including from development partners (DPs), is largely channeled through parallel systems. In addition to making oversight and coordination challenging, this results in inefficiencies and it does not contribute to strengthening the government's institutional capacity.

Figure 3 – Government spending on health as a percentage of total government expenditure



Source: MoHS

Figure 4 – Rate of increase in number of health facilities



Source: MoHS

GOALS OF THE NATIONAL HEALTH PLAN

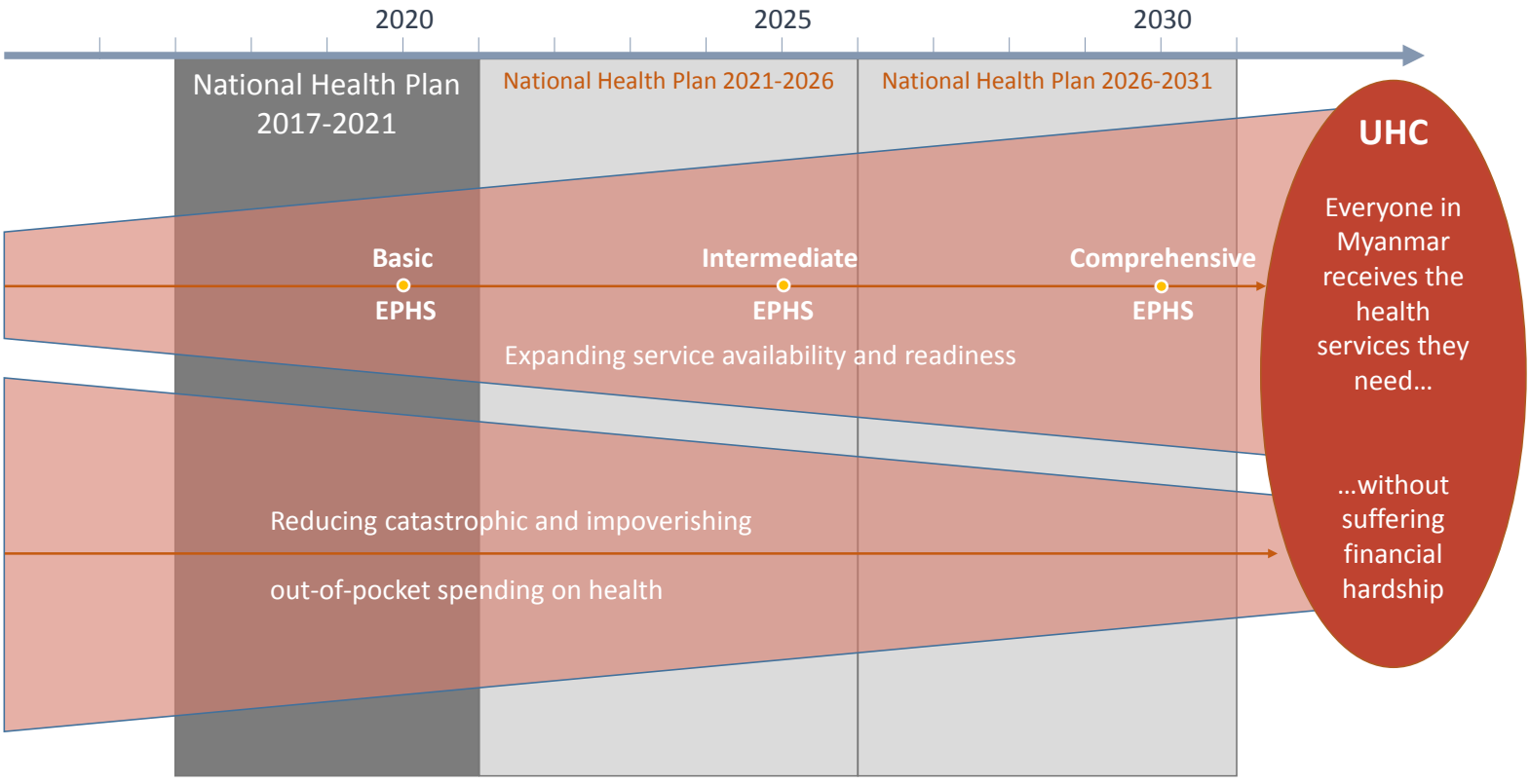
Universal Health Coverage (UHC) – which is defined as all people having access to needed health services without experiencing financial hardship – has become a global health priority. Under the Sustainable Development Goals (SDGs), all UN Member States have agreed to strive to achieve UHC by 2030. The UHC movement in Myanmar has been picking up momentum over the past few years. The country's political leadership has expressed a strong commitment to accelerating progress towards UHC. UHC goals form an integral part of Myanmar's road to sustainable growth and poverty reduction. In support of a broader vision to enhance/uplift health, social cohesion, sustainable human and economic development of Myanmar through a sustainable health system, the NHP aims to strengthen the country's health system and pave the way to UHC, choosing a path that is explicitly pro-poor.

The main goal of the NHP 2017-2021 is to extend access to the Basic EPHS to the entire population while increasing financial protection. The Basic EPHS emphasizes the critical role of primary health care and the delivery of essential services and interventions at Township level and below, starting within the community.

At the same time, considerable efforts will need to go into the strengthening of the health system to support effective delivery of quality services and interventions. These efforts will largely be organized along four pillars, namely human resources, infrastructure, service delivery and health financing.

While supply-side readiness is at the core of the NHP 2017-2021, the demand-side cannot be ignored. The NHP includes elements that will help create or increase the demand for essential services and interventions.

Figure 5 – The National Health Plan 2017-2021 and Universal Health Coverage



Focusing on the Basic EPHS, for example, will clarify entitlements and manage expectations. The introduction and strengthening of accountability mechanisms, including social accountability, will help give communities a voice, which in turn will enhance responsiveness of the system.

NHP is not meant to be a mere compilation of or to replace the strategic plans of the different MoHS programs (see Annex 1).Instead, it is meant to provide a framework that will enhance the effective and efficient implementation of those programs within the broader health system, especially at Township level and below.

The NHP also aims to promote further alignment at several levels:

- Among programs (e.g. by encouraging more integrated training, joint supportive supervision, better aligned referral mechanisms, a more streamlined health information system…)
- Among development partners, through stronger oversight and coordination
- Among the different types of providers, through the engagement of EHOs, NGOs, private-for-profit…)
- Among implementing agencies by ensuring that projects and initiatives contribute to the achievements of the NHP goals

As shown in Figure 5, subsequent NHPs will focus on expanding the package that the entire population should have access to – first to the Intermediate EPHS, and subsequently to the Comprehensive EPHS – while further developing effective risk-pooling mechanisms to guarantee greater financial protection. It should be noted, however, that there is no need to wait until 2020 to start thinking about expanding coverage of services and interventions included in the intermediate or comprehensive EPHS. The groundwork to improve availability and readiness of these services and interventions can already start now.

A focus on the EPHS does not imply that services and interventions that are outside the Basic EPHS will be abandoned. It just means that access to those services and interventions cannot be guaranteed for the entire population by 2020, 2025 or 2030.

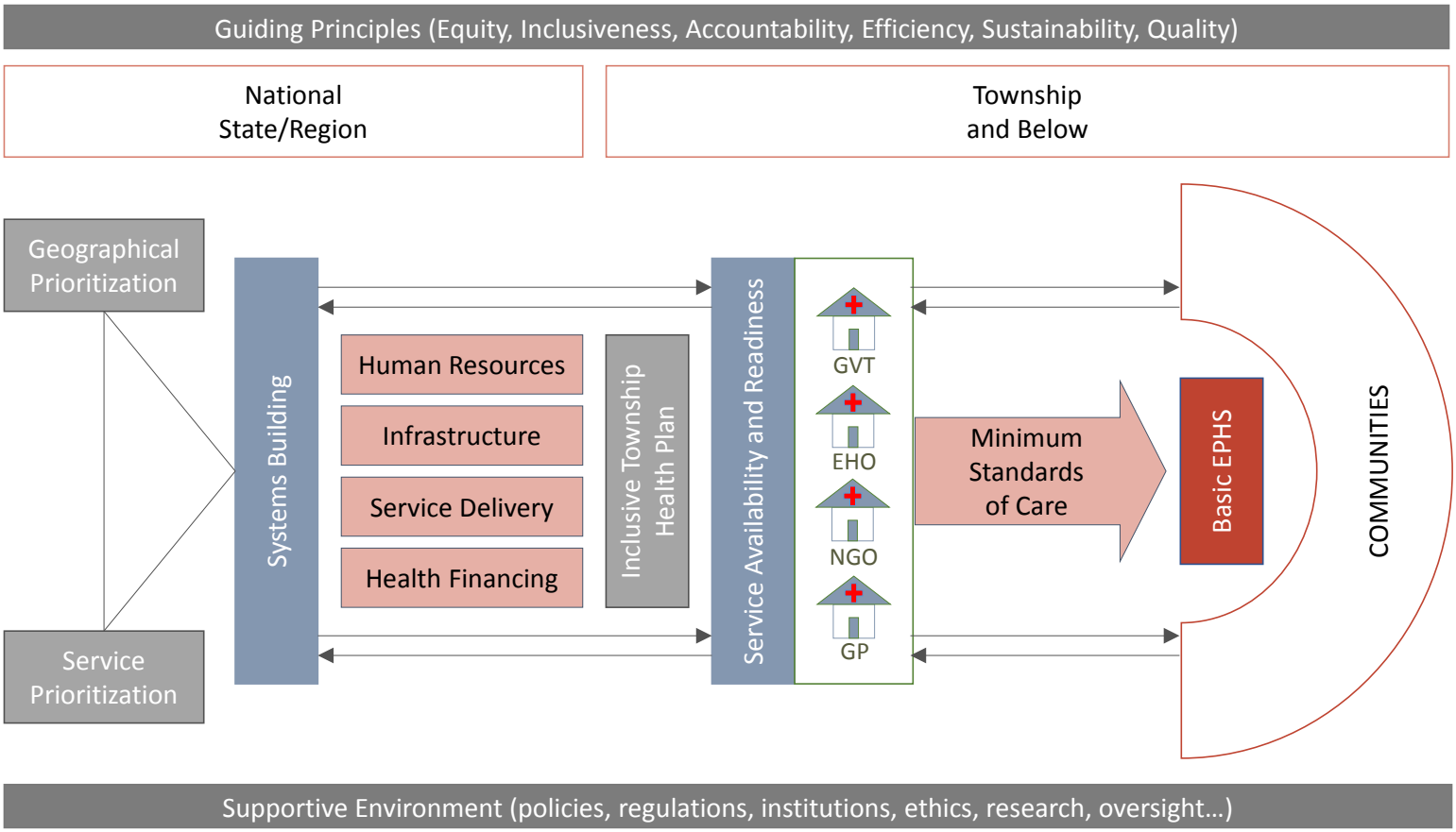
Core public health functions that may not be explicitly addressed in this document (and that are not part of the Basic EPHS) will also need to be further strengthened to support progress towards UHC.

CONCEPTUAL FRAMEWORK

Figure 6 depicts the NHP's conceptual framework, which reflects key features of the NHP strategy. The main goal of the NHP, as stated in the previous section, is to ensure that by 2020, everyone in the country has access to the Basic EPHS. Whether the services and interventions are provided by a government facility or by a provider outside MoHS, they should meet the same minimum standards of care. For government facilities to be able to deliver the Basic EPHS and ensure minimum standards of care are met, considerable investments in supply-side readiness will be needed, starting at the level of the community. Ensuring that other health providers, such as EHOs, NGOs and private GPs meet those same standards will require active engagement and strong MoHS oversight. Inclusive planning at the local level will be essential to achieve the NHP goal. The planning will be based on a good understanding of current situation: who is doing what where, which services and interventions reach which communities, where are the gaps and who could fill them. This information will be fed into a national database that will be regularly updated and that will support planning and monitoring efforts at all levels of the system. Using this information, stakeholders at Township level will be able to plan and cost actions that need to be taken to fill coverage gaps and meet the minimum standards of care. These actions will need to be prioritized to fall within the broad resource envelope (specifying human, material and financial resources) communicated by the State or Region. All of this will be captured in an Inclusive Township Health Plan (ITHP) using national guidelines and templates – in future, there will be only one Township health planning system. States and Regions will have a key role to play in supporting and overseeing the planning and budgeting process, as well as the implementation of the ITHP.

The NHP will be operationalized nationwide to deliver the Basic EPHS based on existing capacity. Given financial and capacity constraints, however, investments to expand Townships' capacity by improving service availability and readiness will be gradually phased in, prioritizing Townships with

Figure 6 – Conceptual framework



the greatest needs. This will be based on objective criteria. Initially relatively crude Health Scoring Indices will be used, constructed using available data on infrastructure, human resources and performance in both public and private sectors; the indices will then be refined as more and better data becomes available, such as disaggregated data on poverty and health outcomes. The number of Townships in which investments into expansion of service readiness will be prioritized each year will be dictated largely by overall fiscal space for health and the capacity to deploy additional human resources to Townships.

Another form of prioritization is in the definition of the Basic EPHS. The size and contents of the package largely depends on what the country can afford and on the country's capacity to deliver. It is currently being defined based on objective criteria such as burden of disease and availability of cost-effective services and interventions. The Basic EPHS has a strong PHC focus.

The provision of a Basic EPHS at Township level of below is conditional on a well-functioning health system. In conjunction with the operationalization of the NHP at the Township level, investments will be needed to strengthen key functions of the health system at all levels. Health systems strengthening efforts will be organized around four pillars: human resources, infrastructure, service delivery and health financing.

Successful implementation of the NHP will also require a supportive environment. This includes adequate policies developed within a robust regulatory framework, well-functioning institutions, strengthened MoHS leadership and oversight, a strong evidence base that can guide decision making, improved ethics, etc.

It is important to note that some population groups may have special needs when it comes to health care (e.g. disabled, adolescents, pregnant teenagers, drug users, transgender…); while these special needs will have to be addressed and barriers to utilization for these groups will need to be removed, the complexity involved in doing so deserves more in-depth analysis and special attention.

The NHP strategy will enhance equity in many ways. For example:

- Access to the Basic EPHS can be free at the point of care, at least in public facilities
- The Basic EPHS has a strong focus on primary health care services and interventions that the poor and vulnerable need most
- Priority will be given to the expansion of service delivery in the Townships with the greatest needs
- ncreased government spending on health will allow reducing out-of-pocket payments by poor and vulnerable households
- In addition to equity, other guiding principles considered during the formulation of the NHP are: inclusiveness, accountability, efficiency, sustainability and quality.

A strong M&E framework will allow to track and measure progress in the implementation of the NHP. The framework will also look explicitly at equity. In addition to socio-economic equity in health, gender equity and other types of equity will also be closely monitored. Moreover, various dimensions of equity will be considered (e.g. equity in health outcomes, equity in utilization, equity in access or equity in financial contribution). Efforts will need to be made to explicitly address equity under its various forms in implementation of the NHP.

The organization of the remaining of this document mirrors to some extent the conceptual framework. It starts with a discussion of the main health systems strengthening efforts needed under each of the four pillars. This is followed by a description of the process for the operationalization of the NHP at local level.The subsequent section goes into the required supportive environment. The implementation of the NHP is discussed next, followed by a brief overview of the M&E framework. An outline of the NHP costing framework is provided in Annex 2.

STRENGTHENING SYSTEMS TO SUPPORT OPERATIONALIZATION OF THE NHP

HUMAN RESOURCES FOR HEALTH

The existing Human Resources Information System needs to be strengthened and updated to better reflect current situation, including numbers of health workers and their distribution, to allow effective planning and forecasting. In addition, non-medical support professions (e.g. biomedical engineers, civil engineers, IT experts, accountants...) will be included in HR plans.

ACCREDITATION OF TRAINING INSTITUTIONS

Accreditation bodies will be developed and promoted. Building on ongoing efforts initiated by MMC, MNMC, MoHS will further support the accreditation of training institutions, both private and public. Moreover, additional opportunities for private health care providers to attend government training institutions will be developed.

Institutions located in or close to Townships where the NHP is to be operationalized will be prioritized. MoHS, together with MMC and MNMC should also seek collaboration with EHOs to develop compatible accreditation mechanisms of educational programs in EHO areas.

PRE-SERVICE TRAINING

The Health Workforce Strategic Plan (2012-2017) expressed the importance of strengthening training institutions' pre-service capacity to provide quality education. Clinical skills and active competency-based learning with a focus on job-related skills will be promoted. Some efforts in that direction are already taking place.

Pre-service curricula for all health workers (salaried or voluntary/BHS or village-based health worker (VBHW)) will focus on the core competencies and skills that are needed to effectively deliver the Basic EPHS.

PRODUCTION AND MANAGEMENT

HRH data and information for planning and forecasting are limited. Further improvements in the nationwide Human Resources Information System (HRIS) are needed to better support decision-making. Eventually, information on HRH employed in the private sector will also be captured by the MoHS HRIS. The production of every cadre of health workers will be based on projected needs, considering the NHP goals. Increased investments are needed to establish new training institutions for BHS cadres in different parts of the country.

MoHS will coordinate with UCSB and MoPF to ensure that sanctioned posts and required budget for deployment of newly graduated health workers better meet the needs. Existing recruitment, deployment, transfer, promotion and career development policies will be reviewed and revised to be more objective and transparent.

Attrition among VBHWs, i.e., AMWs and CHWs,is high. In 2011, for example, only half of the trained CHWs (20,956 out of 40,910) and two-thirds of the trained AMWs (21,034 out of 31,580) were functional .While more recent numbers are not yet available, preliminary information suggests that this situation has not improved dramatically. Causes for the high attrition within the country have been documented. They include, for example, the lack of resources for recurrent costs (e.g. for refresher training, for the replenishment of drugs, for supportive supervision and for travel). Steps to address attrition and improve performance will be taken (e.g. in the short term, ensuring recurrent costs are included in Township plans and budgets; in the long term, exploring options for career development).

Training of VBHWs, including those in EHO areas will gradually be harmonized with national standards. The training will be designed based on the skills and competencies needed to deliver the Basic EPHS at the community level.

RECOGNITION

The Health Workforce Strategic Plan (2012-2017) recognizes that health professionals outside of the public sector will need to be engaged and partnerships will need to be strengthened with the private sector, NGOs, CSOs, EHOs, and DPs around issues such as planning and management of the health workforce.

MoHS has recently shown interest to recognize non-government health workers in ethnic areas. EHO representatives were invited to MoHS and government officials also paid a visit to Myanmar's eastern borders. MoHS officials, implementing partners and EHO representatives then reached an agreement that clinical skills standardization would be one of the first steps towards recognition of EHO health workers. MoHS should express its commitment to take further steps towards recognition of EHO health workers. Relevant stakeholders should subsequently agree on a framework that clearly outlines the competencies and skills required for the delivery of services and interventions included in the Basic EPHS. The framework willencompass the different types of health workers and it will be linked to their respective roles and responsibilities.

RECRUITMENT AND DEPLOYMENT

A key challenge in human resource management is the disconnect between production and deployment of health workers. The insufficient number of human resources, which applies to all cadres, is not due to a lack of production; the problem is with recruitment and deployment. In other words, there are more health workers produced than can be recruited by the public sector. It would also be beneficial to discuss this issue with the Union Civil Service Board to clarify existing policies around quotas on filling sanctioned posts and to identify steps to address delayed deployment. Newly graduated health workers who are not able to find employment in the public sector should be allowed to work outside the public sector to ensure their skills are maintained. At the same time, human resource management will be improved to overcome current disconnect between production, recruitment and deployment. Decision-making with respect to the deployment of human resources will be gradually decentralized to States and Regions. It will be based on the local needs with a focus on the delivery of the Basic EPHS at Township level and below.

There are ongoing efforts to overcome human resource gaps through a so-called 'temporary employment' program, which allows health professionals that are not civil servants to be appointed in hard-to-reach areas, based on needs expressed by Regional/State Public Health Directors. An example is the midwives model where screening and recruitment is done by the Myanmar Nurses and Midwives Association (MNMA); funding is provided by DPs; MoHS coordinates and manages the program. Use of such mechanism on a larger scale will be promoted as a temporary measure to fill human resource gaps for the delivery of the Basic EPHS, prioritizing the Townships in which the NHP is being operationalized.

TASK SHIFTING

A rigorous skills needs assessment will be conducted at the different levels of the health system and for the different cadres to identify areas where task shifting should be considered. Job descriptions will then be revised accordingly. Accompanying training materials will be developed to upgrade health workers' skills and prepare them for their new roles.

The staffing norm that was recently agreed upon of having a Public Health Supervisors (PHS-II) for every midwife will be adopted more broadly as a form of task shifting. As recommended in the final report of the Myanmar SRMNAH Workforce Assessment (2016), all tasks relating to disease control and environmental sanitation should be removed from the job description of midwives to become the responsibility of the PHS-IIs. This will allow midwives to spend more of their available working time carrying out the duties for which they were specifically trained.

IN-SERVICE TRAINING AND CONTINUOUS PROFESSIONAL EDUCATION

In-service training will be fully institutionalized and better integrated; it will be tailored to the different cadres' needs in terms of skills and competencies to deliver the Basic EPHS according to their respective roles and responsibilities. The roll-out of the in-service training will be tuned to the prioritized operationalization of the NHP. Close collaboration with Program Managers will be essential in this area. Consideration will also be given to coordinating training dates amongst various programs to avoid taking the health workers away from their duties for too long. Continuous professional education to support the delivery of the Basic EPHS will reach all health workers, including those outside MoHS.

Training curriculum of VBHWs, in particular CHWs and AMWs, as well as refresher courses for existing cadres also need to be reviewed and updated so as to be tailored to the delivery of the Basic EPHS.

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RETENTION

Training institutions for health professionals should be established in locations other than major cities and students should be recruited from rural areas around those institutions (including from ethnic communities) to enhance rural retention. Graduates from these training institutions should be immediately deployed, preferably to their native area. Locally based recruitment and deployment of health workers will help to ensure understanding of the local context and languages. Particularly for VBHWs, priority should be given to speaking the languages most relevant to the communities. This will require making necessary language accommodations in curricula and trainings.

Additional consideration will be given to ensuring rural retention as 70% of the Myanmar population resides in rural areas. Appropriate financial incentives will be provided for those serving in rural and hard to reach areas. Transportation allowances, daily allowances and overtime compensation also need to be updated to better reflect the local context. Non-financial incentives are needed as well, such as training opportunities, accelerated promotion, better living conditions, a conducive environment to ensure job satisfaction, etc. Moreover, a clear career path linked to performance and educational background needs to be offered, also to AMWs and CHWs.

Additional and more flexible career development opportunities need to be offered to health workers in rural areas, such as distance learning and certificate courses. In addition, there is a need for introducing appropriate delegation of authority with respect to human resource management to the State/Region level.

INFRASTRUCTURE

As part of the operationalization of the NHP at local level, and more particularly based on the assessment of existing infrastructure and the subsequent identification of the coverage gaps, a comprehensive list of all health facilities to be constructed, rehabilitated and/or equipped, considering the local context, will be created and regularly updated – this will be part of the national database referred to earlier. Sequencing of investments will need to consider prioritization made at Township level, as part of the Inclusive Township Health Plan. This prioritization will account for existing CBO, EHO and private sector health facilities to take advantage of potential synergies. It will also be aligned with the human resources deployment plan to avoid empty facilities. This exercise will result in an integrated infrastructure investment plan, which will be based on updated, cost-effective and standardized designs of health facilities.

When implementing the plan, accountability in the execution of contracts related to the construction or rehabilitation of health facilities will be enhanced by ensuring that the terms of the contract provide guarantees to the contracting entity and by putting in place mechanisms to objectively assess the extent to which the terms of the contract have been met. The implementation of this plan will need to be closely monitored and evaluated.

New health professional schools should be established in locations other than major cities.

With respect to the tendering of equipment, specifications need to be standardized. Restrictions to international procurement of equipment and drugs/supplies, which have led to misuse by some local businesses, should be removed.

The effectiveness of facilit y grants sent to public sector health facilities under the Essential Health Services Access Project (EHSAP) will be assessed, in particular with respect to their ability to address maintenance needs and identify/address bottlenecks.

Under Health in All Policies (HiAP), synergies with respect to infrastructure development need to be explored with other sectors.

SERVICE DELIVERY

HEALTH MANAGEMENT INFORMATION SYSTEM

A data culture will be promoted for evidence-based decision making. This comprises the demand for quality and timely data, its collection, analysis and use.

A functional HMIS unit that is situated at the Minister's office, MoHS, and with the mandate to establish a more integrated and expanded HMIS is urgently needed. This unit should build on the ongoing exercise to assess all existing information systems and develop a comprehensive HIS strategy, which should include feasible mechanisms for systematic data collection starting at the community level and which should cover e-health. Important will be to integrate the many parallel systems that are currently supported and promoted by vertical programs, and to move to the already agreed-upon common platform (the DHIS-II). This will substantially reduce the burden on health workers throughout the health system. Also important will be to ensure interoperability with information systems related to other functions of the health system – such as HRIS and LMIS – vital statistics (e.g. birth and death registries) and other information such as the NCD database and the Master Patient Index (MPI). As the MPI is being further developed and rolled-out, alternative ways for personal identification of service users will be explored, including the use of biometrics. Household surveys and facility surveys will also be part of the HIS architecture. They should be repeated at regular intervals; indicators across the different surveys and survey types should be harmonized.

The HMIS will be gradually expanded to also include information from providers outside MoHS. Purchase of services from private and EHO providers will be conditional on submitting a required set of data.

Introduction of DHIS-II will be accompanied by adequate capacity building and resources. Roll-out should follow the same sequence as the operationalization of the NHP.

EXTENDING SERVICE DELIVERY TO THE COMMUNITIES

There is a need to more clearly differentiate between community-based services and outreach services. This involves determining which services need to be available on a continuous basis within a community and which services can be provided on a scheduled basis through outreach services, in order to be most feasibly and effectively delivered to meet community health needs. In addition to routine outreach service delivery, mobile clinics may be an appropriate temporary solution to deliver services to communities(other than those that can be delivered by village-based health workers) in some contexts, while more permanent solutions (e.g. through the construction of new health facilities) are being implemented. Careful consideration of the appropriate mix of services and service providers will be needed to ensure effectiveness and efficiency of this approach (e.g. there is a limit to the range of services that can be effectively provided during a short duration in a village; disruption of services at facilities to staff mobile clinics should be avoided).
All health workers (whether community-based or outreach) involved in the delivery of health promotion, prevention and treatment services must be fully recognized and institutionalized within the health system to ensure efficient use of resources, necessary oversight and quality service provision (regardless of whether the health workers are voluntary or salaried).

This means:

- Inclusion in national level policy frameworks, plans and budgets at all levels
- Integration into HRH plans for necessary oversight, retention and quality:
    - Defining roles and responsibilities
    - Determining quantity and distribution for recruitment
    - Standardizing training in line with national policies
    - Ensuring continuous supervision, support and performance management
    - Recognizing and motivating through standardized incentives
    - Building in the potential for employment and career development
- Integrated data and reporting that supports performance management, informs decision making and contributes to national HMIS
- Integrated service delivery to make the most of patient contact (e.g. referral for immunization during sick child consultation)
- Supply of commodities and equipment through the national LMIS
- Linkage with health governance structures from national to community level for accountability
- Inclusion of initial, recurring and operation costs (e.g. initial training, refresher training, basic kits, replenishment of drugs, travel costs) in government budget allocations

Ensuring that all VBHWs, including CHWs and AMWs, are confident to take on the duties assigned to them is critical to their effectiveness. Sufficient skill-based training and consistent support and supervision from

BHS is required – this requires resources to support and it needs to be taken into account for the uptake and delivery of interventions.

BHS will be supported to undertake their roles in monitoring, supervising and supporting VBHWs. Currently no resources are in place for this. Optimizing roles of BHS at RHC and SRHC, especially midwives and PHS-IIs will be important to this discussion

REFERRALS

Previously, a 'step-wise' referral system was used in the public sector, with patients being referred up the chain from RHC to Tertiary levels as needed. Currently that system is no longer systematically used, and by-passing has become common practice that is accepted by the providers. The step-wise referral system needs to be revitalized with updated guidelines aligned with the Basic EPHS to guarantee continuum of care.

Different systems have been put in place in different parts of the country to remove financial barriers associated with referrals and encourage timely referral. These systems differ in the type of referrals (e.g. only emergency) considered, in the types of expenses covered, in the payment mechanisms (e.g. upfront versus reimbursement) and in the actual amounts. Building on lessons from these different experiences, a national approach will be developed and adopted by all partners throughout the country.

PROCUREMENT AND SUPPLY CHAIN MANAGEMENT

A recently established National Supply Chain Task Force (NSCTF) provides coordination and leadership for the public sector supply chain system, which should be further strengthened and promoted as the national platform.

The MoHS National Health Supply Chain Strategy for Medicines, Medical Supplies, and Equipment (2015-2020) outlines opportunities to strengthen the public sector supply chain. Some of the elements included in the proposed strategy are:

- The development of capacity to gradually move to a pull system as per local needs
- The development of a centralized procurement system
- The integration of existing parallel systems into one LMIS, starting with essential medicines and reproductive health products, and subsequently expanded to also include vertical programs
- The computerization of the LMIS, ensuring interoperability with the HMIS
- The professionalization of supply chain personnel, through proper capacity building and with professional development options and career paths
- The update of policies and regulations (e.g. relating to the write-off and disposal of expired drugs; allowing for the distribution and accounting of supplies allocated to VBHW)

Given that majority of out-of-pocket expenditures are spent on drugs, further work needs to be done on better understanding prescription behavior, drug pricing, and health-seeking behavior. For example, a comprehensive assessment of the pharmaceutical sector is needed. This includes a review of policies and regulations, and a thorough study of the pharmaceutical market, public and private spending on medicines, pricing, distribution and logistics, rational use of drugs, and prevalence of poor quality and/or counterfeit products. The findings from this assessment will guide efforts to strengthen the pharmaceutical sector in a phased manner. Another assessment could be on whether domestic production of essential medicines is feasible and makes economic sense.

Necessary measures need to be undertaken to minimize the negative impacts and to best utilize the Trade Related Aspects of Intellectual Property Rights (TRIPS) Agreement.

It is recommended that incentives for better performance and for the use of generic, WHO-prequalified medicines be considered and that prescribing of medicines be separated from their dispensing to avoid perverse incentives.

Until alternative delivery channels for medicines become accessible to all, working with drug vendors will remain an option. After that, the list of medicines that unlicensed drug vendors can sell will be restricted while at the same time drug vendors without a pharmacist's license are being gradually phased out.

It is important for the NHP implementation that the national essential medicines list is aligned with the EPHS.

FUND FLOW AND FINANCIAL MANAGEMENT

The allocation of the health budget among and within different departments of MoHS will be based on explicit criteria and follow clear guidelines. Estimated annual budget and budgeting instructions will be communicated to all levels of the health system at the start of the annual planning process. Planning calendar and processes need to be synchronized with both planning cycle and budgeting cycle, so that central level budgeting considers the costed plans that

come from Townships and from States and Regions. The new Procurement Guidelines will be adopted and disseminated for efficient budget execution, and reporting requirements will be streamlined and simplified as much as possible within the confine of the financial rules and regulations.

Existing data systems for planning, budgeting and expenditure tracking will be reviewed and an electronic records and reporting system will be developed and instituted, accompanied by necessary inputs and capacity building. The latter will include training of mid- and senior-level staff on the use of financial data for decision-making).The responsibility for overseeing the delivery of a sustained capacity building program around financial management will be assigned to a unit within MoHS, with clearly defined roles and responsibilities.

Recruitment and deployment of professional financial management personnel to State/Region Health Departments and Township Offices will be expedited, through both contracting (in the short-term) and Government recruitment process.

The groundwork for implementation of greater risk pooling and strategic purchasing will already be laid. This includes identifying PFM bottlenecks in consultation with MoPF and other relevant stakeholders. Intermediate measures will be considered while new PFM guidelines are being developed. Within the existing line-item budget system, for example, MoPF approval could be requested to create/designate a new budget code (e.g., 03xx) to enable fund flow to public health facilities per new allocation formula (e.g., capitation) and pilot performance-based payment.

The feasibility of harmonization and alignment of development assistance (both fund flow and financial management) will be assessed. A plan of action will then be developed to enable better alignment and eventually pooling of resources.

QUALITY OF CARE

Services and interventions guaranteed in the Basic EPHS should meet the same minimum quality standards, irrespective of the different types of providers. Quality of the services rendered by the different types of providers will be assessed against common standards using the same tools. This will require the development of the standards and accompanying guidelines, as well as the tools and systems to assess whether the standards are met, including through accreditation and licensing.
In addition to technical quality, which aims to ensure safety and effective outcome – service quality will also be promoted. This emphasizes client experience and relates to effective communication, respect, confidentiality, organized and responsive service setting where the client can choose from options with sufficient understanding and autonomy.

In parallel, the adoption of quality improvement processes at the level of the health facility will be encouraged and facilitated.

In addition, clinical governance tools, such as clinical audit, quality dashboard, client feedback mechanisms, continuous supportive supervision, no-blame-culture and incident reporting, service quality studies and other tools can be used to monitor and assure quality of services. In-country experiences with the use of such tools will be reviewed for possible countrywide adoption.

Standard treatment guidelines need to be developed and/or updated. In addition, a process will be institutionalized for their periodic review and improvement.

Both the role and the capacity of the Food and Drugs Administration (FDA) need to be further strengthened to ensure, for example, adequate quality control of medicines (including traditional medicines),food safety and combating sales of counterfeit drugs.

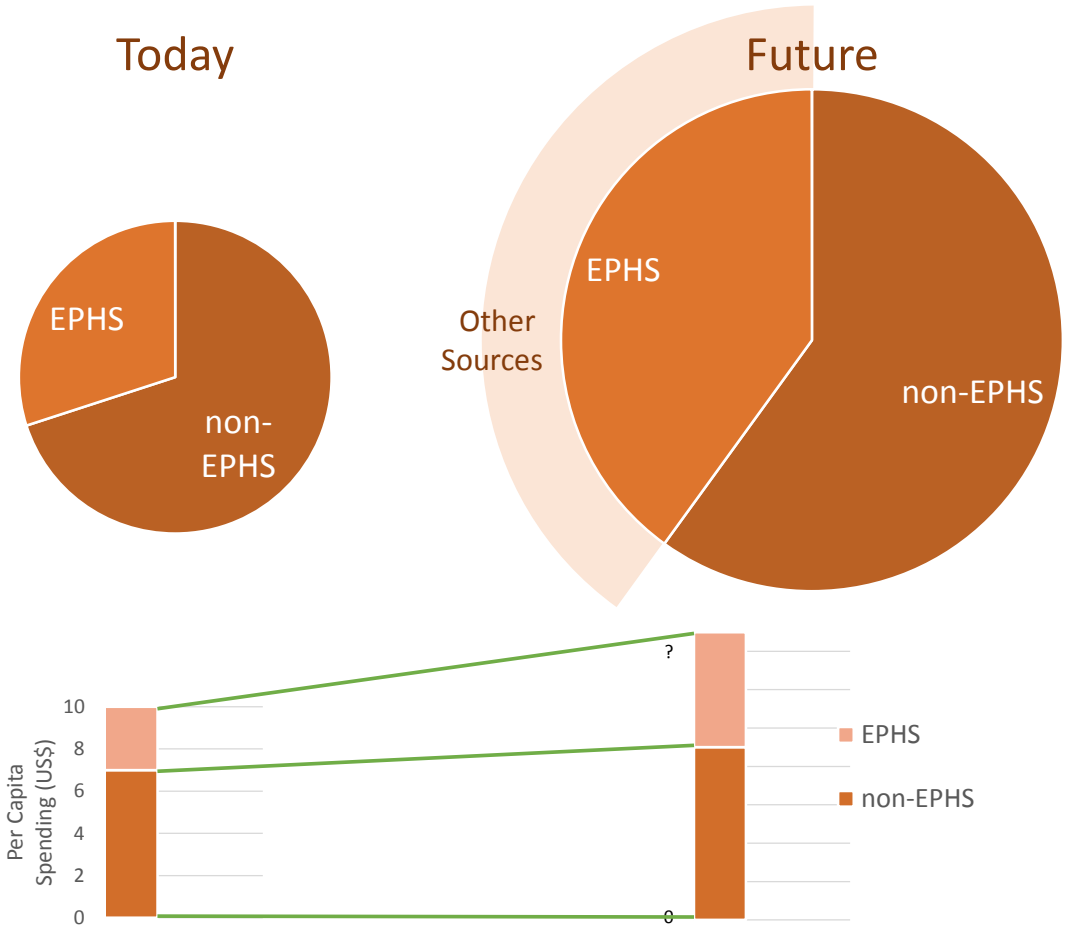
Guidelines, standards (e.g. minimum supervision visits per period of time) and tools for integrated supportive supervision need to be reviewed and updated, in line with the Basic EPHS. Resources will be made available to facilitate periodic quality supervision. Appropriate job aids and integrated algorithms will be developed to support health workers in providing quality care, which will require collaboration across programs.

Competency-based licensing and re-licensing of health professionals, including outside MoHS,will be further developed and rolled-out. Professional councils (including, for example, MMC, MNMC and Traditional Medicine Council (TMC)) will be the focal licensing bodies. They will need to work together with MoHS and ASEAN counterparts, preparing to be ready for AFTA and other regional and international instruments.

Providers' prescription behavior needs to be monitored and the use of provider payment mechanisms to incentivize more rational prescribing will be considered. Strategic purchasing (e.g. performance-based payment mechanisms) can be instrumental in incentivizing provider behaviors that can result in improved quality of care.

Figure 7 – Mobilizing resources to achieve the NHP goals

Government Spending on Health



Accreditation of health facilities, whether public, private-for-profit, NGO or EHO, needs to be introduced. An independent accreditation body, with required capacity and processes, will need to be established for that purpose. Before accreditation mechanisms are in place, services and capacity of international accreditation bodies could be utilized.

DEMAND FOR SERVICES

More resources and improved service readiness do not automatically guarantee improved responsiveness and client satisfaction, which are critical if we want the population to use the services. Responsiveness of services can be enhanced by ensuring sensitivity to culture, religion, gender and language, and by promoting positive staff attitude.

Township, Village Tract and Village Health Committees will be reformed to better promote enhanced community involvement. Terms of reference for these committees will be reviewed and revised based on lessons learnt from existing initiatives and in collaboration with other Ministries. Meaningful participation of EHOs and CSOs in these committees will be ensured where relevant. Routine information flow and feedback mechanisms will be established through these governance structures/committees based on existing experience in country. This will help to enable meaningful dialogue and collaboration between health providers and communities, both to improve health service demand and responsiveness.

While proper risk pooling mechanisms are being developed, temporary measures to reduce financial barriers to access will be considered and possibly extended to increase demand for services, especially among the poor and vulnerable. These measures may include Health Equity Funds, Hospital Trust Funds, maternal voucher schemes and the reimbursement of emergency referral costs. Lessons from these experiences will inform the development of more sustainable provider payment mechanisms.

HEALTH FINANCING

RESOURCE MOBILIZATION

Achieving the NHP goals will not be possible with current level of government spending on health. Whether sufficient financial resources can be mobilized to achieve those goals will largely depend on the

following:

- What is the country's expected economic growth rate?
- How much can the government's current budget allocation to health (3.6 percent) be increased, i.e., how much can health be further prioritized within the total government budget and what other sources of additional funding can be tapped into (e.g. earmarked funding for health)? This is largely a political decision.
- Within current government spending on health, what share goes to the Basic EPHS (supply-side readiness, services delivery, systems building…), and how much can the share be increased over the next four years? This is also a political decision.
- How much external financing for health (not already included in the budget) goes to the Basic EPHS (supply-side readiness, services delivery, systems building…) and how much can the amount be increased over the next four years? This is about getting development partners on board.

GOVERNMENT SPENDING ON HEALTH

Myanmar's rate of economic growth is projected to be 8.2 percent per annum in the medium term. What that means is that total fiscal space can be expected to grow thanks to the conducive macroeconomic environment. Even if current allocation to health (3.65%) remains unchanged, the health budget may already increase in absolute terms ('the same slice but from a bigger pie'). Awareness of the conducive environment, however, can help MoHS advocate to MoPF for greater allocation to the health sector. While making a case for increased allocation to health, MoHS will also explore increasing health sector-specific resources, such as taxes that are earmarked for health. Simulations and projections of both the public health impact and the financial impact of various types of sin taxes (i.e., on alcohol, tobacco products, sugar drinks), as well as estimations of the potential financial impact of other kinds of earmarked taxes, should be prepared in close collaboration with MoPF. Advantages and potential drawbacks of earmarking should be carefully considered, again with MoPF. For the most promising option(s), a bill should be drafted. Health sector-specific resources also include social security contributions, currently collected by the Social Security Board (SSB). Revenues from these contributions will increase as SSB further expands coverage of the formal sector, also to public sector workers and to dependents of those who contribute.

While mobilizing additional resources for health is important, equally critical is to increase the efficiency of existing government spending on health by addressing some of the leading sources of inefficiency, such as:

- The underuse of generics and the higher than necessary prices for drugs and medical supplies
- The inappropriate or ineffective use of medicines
- The use of sub-standard and counterfeit medicines
- Medical errors and sub-optimal quality of care
- The oversupply and overuse of equipment, investigations, procedures
- By-passing and unnecessary hospital admissions
- Inappropriate or costly staff mix
- Unmotivated workers leading to low productivity
- Waste, corruption and fraud

A mechanism to collect and manage philanthropic giving and Corporate Social Responsibility (CSR) should be designed and developed to increase the share of funding from these sources that supports systems building (as opposed to being rather ad hoc).

The discussion so far has focused on increasing fiscal space for health. At the same time, MoHS will need to rethink the internal allocation of its health budget. If the Basic EPHS is to be made accessible to everyone by 2020, investments in service readiness, especially at Township level and below, and funding for the actual delivery of services and interventions included in the EPHS will need to increase, along with the financing of broader health systems strengthening efforts.As shown in Figure 7, these investments will need to increase not only in absolute terms, but also in relative terms; in other words, a larger share of the total health budget will go to the Basic EPHS and the accompanying supply-side readiness and health systems strengthening efforts. That does not mean, however, that what the government currently spends outside the Basic EPHS will decrease in absolute terms. Government spending in other parts of the health system will need to be sustained. Also, funding from sources other than general revenue, mainly development assistance, will need to be mobilized to help finance the expansion of the Basic EPHS.

The information in the Public Expenditure Review (PER) needs to be updated and the National Health Accounts (NHA) need to be prepared. Key findings from both analyses will be communicated to policy makers to make the case for changes in budget allocations.

The NHP will need to be costed as soon as possible. Indicative budget estimates will need to be prepared to already sensitize budget committees, MoPF and DPs. These will include clear financial projections with several scenarios showing how much is needed to improve service readiness and to deliver the Basic EPHS while strengthening key health systems functions. Guided by these financial projections, MoHS will seek to increase the budget allocation to health

and to revise allocation of the health budget itself. A clear health financing strategy will also be developed as soon as possible.

DEVELOPMENT ASSISTANCE FOR HEALTH

Development assistance is estimated at less than 10 percent of total health expenditure in Myanmar. It focuses largely on public health, such as control of communicable diseases and strengthening delivery of maternal, newborn, and child health services. As such, it represents around 60 percent of total financing for public health. Most development assistance is still off-budget. It is managed and/or implemented by UN agencies, NGOs, CSOs, and National Professional Associations. At present, the largest providers of development assistance are Global Fund for AIDS, Tuberculosis, and Malaria (GFATM), pooled funds of bilateral aid from seven countries managed by UNOPS (3MDG Fund), Global Alliance for Vaccines Initiative, the World Bank Group, and JICA.

Managing development assistance and ensuring alignment of this assistance with national goals and priorities continue to pose a huge challenge for the country. Stronger coherence and coordination have been hampered by various factors, including:

- The absence of a clear government strategy or roadmap with which development partners can align themselves
- The multitude of parallel financing, governance and implementation arrangements, along with fragmented information systems – these reduce government's oversight, increase inefficiencies and represent an additional burden for government officials and providers
- The weak capacity and authority within MoHS to coordinate development partners
- The inadequacy of existing coordination mechanisms, such as the Myanmar Health Sector Coordinating Committee (MHSCC), to meet emerging needs and priorities

The transition towards sustainable financing and implementation systems, with strong government oversight, is key to strengthening governance of the health sector. The implementation of the NHP provides an opportunity to better align development assistance. The NHP could serve as the foundation around which development partners converge and organize their financial and technical support.Some of the largest sources of development assistance are or will soon be considering their next phase of support. This provides an opportunity to promote such alignment.

MoHS's capacity to better coordinate, manage information on, and monitor progress and deliverables of development assistance will be strengthened. Moreover, existing coordination mechanisms to jointly monitor and discuss progress and achievement of milestones and to consult new proposals for financing and technical support should be reformed. Efforts will focus on areas where fragmentation is the greatest, including financial management, procurement, supply chain, and information systems.

PURCHASING

Purchasing relates to the transfer of funds to health care providers for the delivery of specific services or interventions.

Engaging health providers outside MoHS

When it comes to essential health services and interventions that are part of the Basic EPHS, a considerable segment of the population currently seeks care outside the public sector. This can be from a range of health care providers such as private-for-profit GP clinics, Ethnic Health Organizations (EHOs) or Non-Governmental Organizations (NGOs).At present, some of these providers (e.g. EHOs and NGOs) rely largely on funding from donors, which can be expected to gradually decrease in the medium term, while others (e.g. GP clinics) generate most of their revenues from user fees charged to patients.

All these providers have an important role to play in the country's move towards UHC. They can all contribute to achieving the goals of the NHP, i.e., to ensure that the whole population can access a Basic EPHS without suffering financial hardship. For that, MoHS needs to actively engage them. This engagement is critical for following reasons:

- The public sector alone will not be able to reach the entire population of the country with the Basic EPHS; collaboration across all health care providers is essential to ensure equitable coverage, to build synergies and avoid duplication in service delivery
- MoHS has a role to play in ensuring that services and interventions from the Basic EPHS meet the same minimum quality standards, irrespective of who provides them
- Health information should not be limited to the public sector; it will include data from all health care providers to give a full picture of health service coverage and to enable a comprehensive assessment of the health needs of the population
- Increasing financial protection will require a significant reduction in what households spend on health care out of their pocket

- Myanmar needs to prepare itself for the so-called health financing transition – as the country gets richer, external assistance for health will gradually decrease; at the same time, it needs to address current fragmentation in health financing, which creates considerable inefficiencies

One effective form of engagement is through strategic purchasing, which explicitly considers the incentives introduced by a given provider payment mechanism in order to ensure a desired provider behavior.

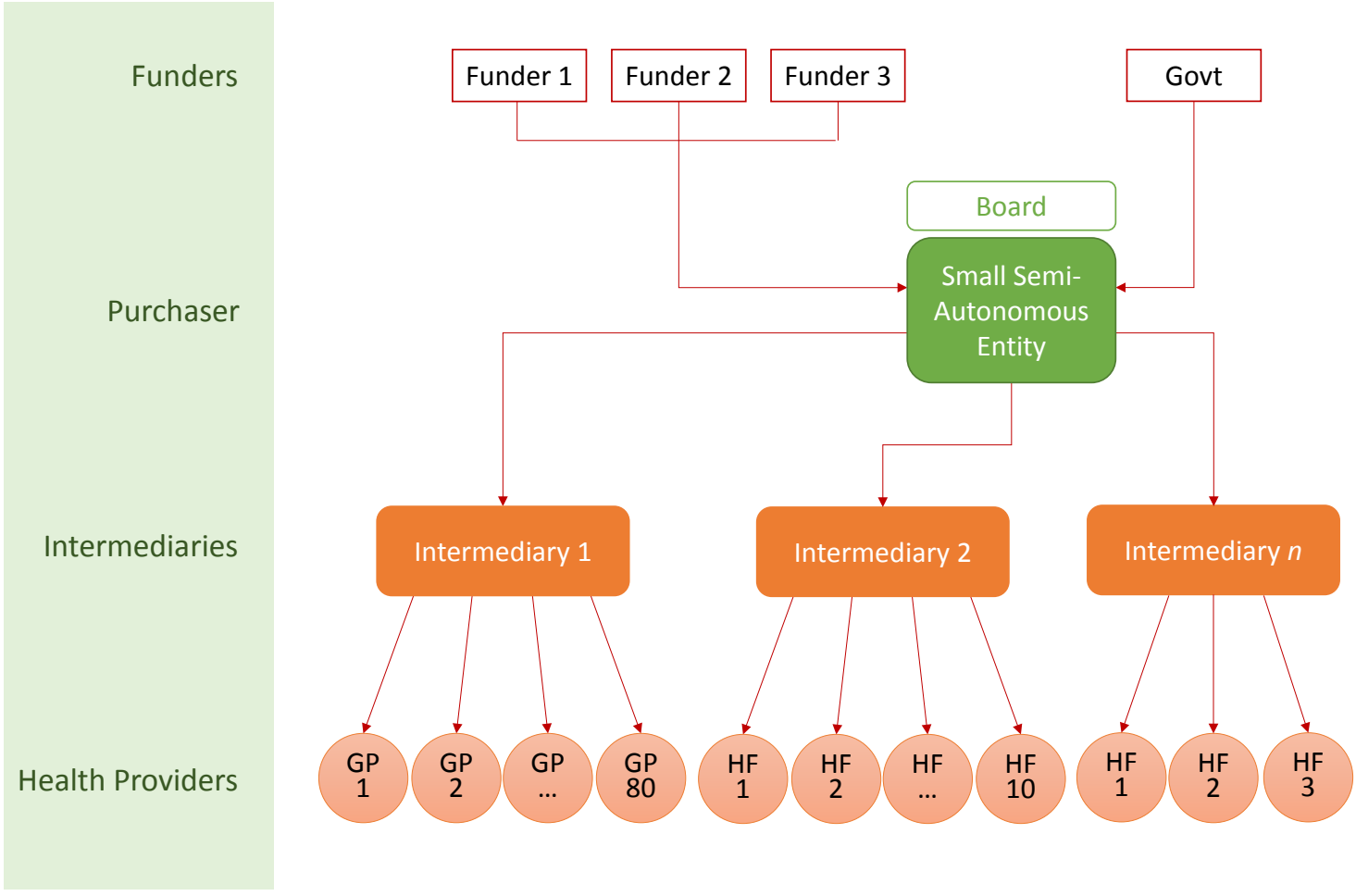
In-country experience in strategic purchasing is limited. A pilot project will soon be launched in which the role of purchaser will be simulated. The 'purchaser' will sign contracts with private-for-profit GP clinics. For the duration of the contract period, those providers will be delivering a well-defined package of essential promotive, preventive and curative services to poor and vulnerable households that have registered with them in exchange for a capitation payment and additional performance-based payments. The money for those payments will come from development partners. This experiment will provide extremely valuable lessons around health purchasing and contracting of non-governmental health providers. MoHS will take active part in the built-in implementation research.

Developing the functions of a purchaser

The functions of a purchaser will need to be developed, including the accreditation of providers, the contracting of providers and the definition of the most appropriate provider payment mechanisms. Equally important will be to develop suitable institutional arrangements that enable the smooth and efficient operation of the purchasing function.

As a firsts step, the skills built in the ongoing pilot project described above will be transferred from the iNGO to a small semi-autonomous body steered by a board on which key stakeholders, such as Ministry of Health and Sports (MoHS), GP Society, EHOs and Civil Society, will be represented (see Figure 8). The main tasks of this entity will be to expand, replicate and adapt similar purchasing arrangements with the different types of providers, while further strengthening above-mentioned functions.Along those lines, a small pilot will also be launched to test the purchasing of the Basic EPHS, by this same entity, from MoHS providers. Most of the funding will initially come from development partners. Early on, however, the government will also start channeling funds through this entity to contracted providers. The share of government funding will gradually increase. For

Figure 8 – Developing the functions of a purchaser and engaging providers outside MoHS



this to be possible, parallel efforts will be needed to change Financial Rules and Regulations to make such transfers possible.

FINANCIAL PROTECTION

Out-of-pocket (OOP) spending by households remains the dominant source of financing for health. A recent nationally representative survey found that OOP spending comprises roughly 75 percent of total health spending. It is a major cause of catastrophic expenditure by households, and can push or keep households in poverty. In addition, it prevents many from seeking necessary health care.

Supply side investments –particularly in primary care facilities, human resources, and essential medicines – are critical to bringing down OOP spending. By bringing quality services closer to communities, health seeking behavior can be improved, households need to spend less on transportation, spending on medicines outside the public facility can be reduced.

On the demand-side, risk pooling mechanisms will need to be developed to help improve affordability of care and address the substantial barriers to seeking care, especially among the poor and vulnerable. The health financing strategy referred to earlier will need to provide clear directions in terms of the development of effective risk pooling mechanisms. It will for instance need to determine whether a mechanism to target the poor needs to be established or not, and what should be done to ensure the informal (non-poor) sector can access services without experiencing financial hardship. The role of the Social Security Board (SSB), which is implementing social health insurance for the formal sector, will also be considered when developing the strategy, especially in the discussions around the potential move to a system with a single purchaser. Finally, due consideration will be given to options to reduce out-of-pocket spending on health by poor and vulnerable households that could be put in place as temporary measures until more robust risk pooling mechanisms are developed (e.g. catastrophic package; extension and harmonization of existing mechanisms to cover referral costs, etc.).

OPERATIONALIZING AT THE LOCAL LEVEL

Resources and capacity are limited. Prioritization is therefore unavoidable. It will be based on explicit criteria to ensure transparency and accountability. The prioritization will take three forms: (i) prioritization in terms of services, (ii) geographical prioritization, and (iii) prioritization within each Township.

PRIORITIZATION IN TERMS OF SERVICES

A set of promotive, preventive and curative health services and interventions of acceptable quality to which everyone in Myanmar should have guaranteed access, without financial hardship. When provided in public sector health facilities, these services and interventions will be free of charge at the point of care.

Why focus on an essential package?

- To ensure the limited resources are spent wisely
- To improve equity

Not having a package is like an empty promise. It implies that everything should be available, while we very well know that is not possible. The main idea behind the EPHS is that:

-
- Everyone in the country should have access to the health services and interventions included in that package (irrespective of who delivers the services and interventions!)
- No one in the country should suffer financial hardship when accessing the services and interventions included in that package

The EPHS becomes a commitment from the government and an entitlement for the population.

The EPHS should be:

- Effective – it should include services and interventions that will result in the greatest improvements in population health
- Realistic – it should include services and interventions for which access can be guaranteed for everyone by a given year, irrespective of who delivers those services and interventions
- Affordable– it should be affordable for the country, considering(i) the different sources of funding and (ii) the condition that no-one should suffer financial hardship when using the services and interventions

MoHS launched an inclusive exercise to define the EPHS in February 2015.With technical inputs from the different programs, health services and interventions were prioritized based on following criteria:

- Burden of disease / epidemiological relevance
- Cost-effectiveness of services and interventions
- Societal values and priorities
- Affordability and fiscal space
- Feasibility and supply side readiness
- Equity – (services and interventions that disproportionately benefit the poor and vulnerable)

Based on this prioritization, essential services and interventions will be included in a basic package, an intermediate package or a comprehensive package, to be made available to the entire population by 2020, 2025 and 2030, respectively. This was illustrated in Figure 5.

While the exercise is still ongoing –further prioritization is needed to ensure the package is both affordable and deliverable– the package will likely include essential services and interventions related to RMNCAH, the main communicable diseases, some of the non-communicable diseases, nutrition and basic treatment of minor conditions. It will have a strong primary health care focus.

An important next step with respect to the EPHS will be to define an institutionalized process for the periodic revision of the package. The entity in charge of this process will also need to improve coherence between the essential medicines list and the EPHS.

GEOGRAPHICAL PRIORITIZATION

The NHP will be operationalized nationwide to deliver the Basic EPHS based on existing capacity. Investments to expand Townships' capacity by improving service availability and readiness, however, will be gradually phased in, prioritizing Townships with the greatest needs. This will be based on objective criteria. Initially

relatively crude Health Scoring Indices will be used, constructed using available data from both public and private sectors. Two of the three indices summarize a Township's situation in terms of infrastructure and health workforce in relation to national norms defined in terms of population and area. The third index captures a Township's performance on selected key output indicators, again in relation to specified thresholds. Assumptions relating to the norms and thresholds can easily be changed to assess alternative scenarios. More particularly, the health scoring indices, illustrated in Figure 9, Figure 10 and Figure 11, include:

- The Health Input Scoring Index (HISI): This relates to the two indices constructed using information on health access points (health facilities) and health workforce (degree of functionality of health facilities is not yet taken into account). The optimal score is given by value zero. It reflects a situation with sufficient health access points and health workers to provide the Basic EPHS in the Township. The score is greater or smaller than zero if access points and workforce exceed or remain below the set norms.
- The Health Output Scoring Index (HOSI): This composite indexcombines information on hospital bed occupancy rate, new TB case detection rate and EPI coverage. It can take any value between zero and one. At this point, the minimum threshold has been set at 0.3. A higher threshold would result in all townships being categorized as sub-optimal.

A matrix summarizing the HISI for each State and Region can be found in Annex 2.

Figure 9 – Health Workforce Scoring among States and Region (as of 2016 November 30)

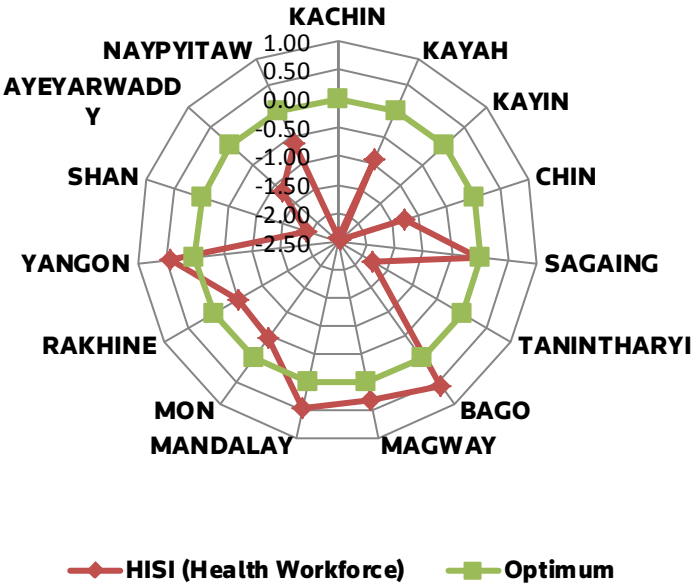


Figure 10 – Functioning Health Facilities (Health Access Point) Scoring among States and Region (as of 2016 November 30)

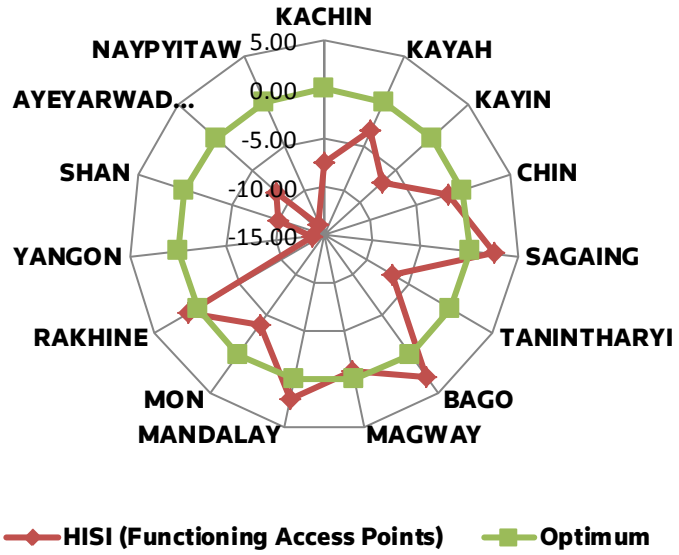
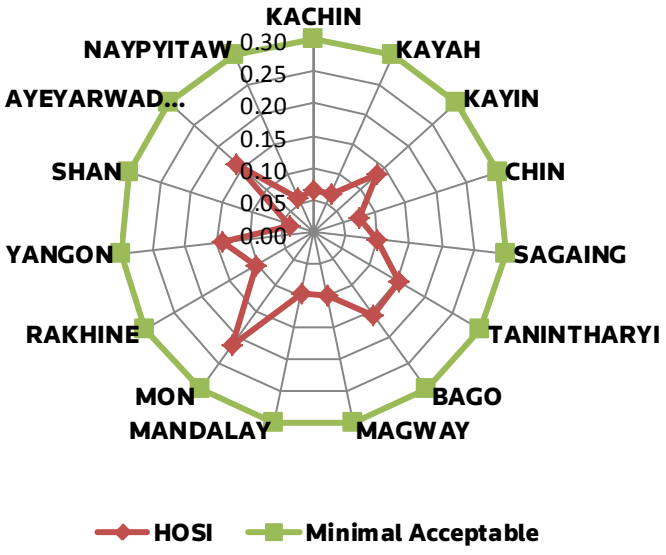


Figure 11 – Health Output Scoring among States and Region (As of 2016 November 30)



PLANNING AT TOWNSHIP LEVEL

Geographical prioritization will help sequence efforts to improve service availability and readiness at Township level. Each of the Townships identified for focused support will develop an InclusiveTownship Health Plan (ITHP). Two critical elements will need to be in place to enable this planning exercise: (i) a 'national' approach for the preparation of a ITHP, and (ii) a 'national' approach for the assessment of service coverage at Township level. Moreover, an indicative resource envelope (including material, human and financial resources) for the ITHP will need to be communicated to each of the Townships. In Townships that are not yet receiving the focused additional support, a simplified template will already be introduced.

Townships will apply the national guidelines and use the accompanying templates to prepare their ITHP and corresponding budget, considering the indicative resource envelope and with a focus on filling the gaps in a prioritized manner. Considerable training and assistance will need to be provided to facilitate this process.

'NATIONAL' APPROACH FOR THE PREPARATION OF AN INCLUSIVE TOWNSHIP HEALTH PLAN

National template and guidelines will need to be developed for the preparation of the ITHP. These will draw upon the different tools and models that have been designed and used by specific development and implementation partners in the past, considering lessons learned and addressing to the extent possible the different models' respective limitations. The template and guidelines will include a detailed description of the process (which will be inclusive), training modules, training delivery plan, support material, etc. They will build an explicit link between the results of the service coverage assessment conducted in the Township (see below) and the Township's ITHP. This includes the following:

- How to identify the service delivery gaps based on the assessment and considering the different types of health providers (MoHS, EHO, NGO, private-for-profit...)
- How to define the needs (including infrastructure, HR, training, community mobilization, etc...) based on identified gaps and who is to fill address those needs
- How to prioritize what needs to be done to fill those gaps in order to reach the 2020 goal, considering financial and other (e.g. HR) constraints
- How to prepare the ITHP for the first year (and later the second year, the third year, etc) based on the prioritization.

The template and guidelines will also facilitate the costing of the plan and assist with budgeting (within a pre-defined budget envelope).
Specific guidelines will be prepared for the States and Regions, which will have a key role to play in supporting and overseeing the planning and budgeting process, as well as the implementation of the ITHP.

'NATIONAL' APPROACH FOR THE ASSESSMENT OF SERVICE COVERAGE AT TOWNSHIP LEVEL

A national database will need to be developed to organize data on service availability and readiness to deliver the Basic EPHS, including the different levels and delivery approaches (i.e., community-based, outreach and facility-based) and the different types of providers (public, EHO, NGO, private for-profit). This could be an adaptation of the SARA methodology and tools and/or other existing tools (used in Myanmar or elsewhere). The database will allow for assessments made at different points in time to be compared. This will make it possible to measure progress over time. The assessment will also look at the availability and functionality of village health committees.

Conduct the assessment in all selected Townships prioritized for year 1 and enter all the information into the database – that becomes the baseline for those Townships. Rather than having each Township do this exercise independently, it may be worthwhile having it organized and carried out in all selected Townships by one or more entities that could then repeat the exercise in the next batch of Townships the subsequent year. DHIS2 has been used for similar exercises in other countries. If DHIS2 is to become the platform for Myanmar's HIS, hosting the database in DHIS2 will also be considered here.

DEVELOPING A SUPPORTIVE ENVIRONMENT

POLICIES AND REGULATIONS

The current National Health Policy was developed in 1993. Given the substantial social and political changes that have taken place since then, this policy will be updated to reflect current context.
Evidence informed policies will be developed following a clear policy cycle, and policy makers should be kept accountable throughout (from formulation to implementation).
Several comprehensive national policies will need to be drafted or reviewed (through a broad-based multi-stakeholder process), such as:

- National health policy
- National drug policy
- Population policy
- HIS policy
- HRH policy (including task-shifting and dual practice) and Human Resource Master Plan

A strong legal framework will need to be developed to support the implementation of the National Health Plan and more broadly the country's move towards UHC. This framework will need to be based on a comprehensive review of existing policies and legislations. It will also need to cover the amendment and/or drafting of new legislative tools such as laws, rules, regulations, directives, guidelines, orders, etc.

OVERSIGHT

The responsibility of overseeing implementation and monitoring of the NHP will primarily be with the MoHS (see section on Supporting Implementation of the NHP below).

The role of the Technical Advisory Groups, the Myanmar Health Sector Coordination Committee (MHSCC) and other existing coordination bodies with respect to the implementation of NHP will be clearly defined, limiting overlap and clarifying lines of authority.

The oversight function of MoHS will need to be strengthened, especially in relation to private sector, implementing partners and development partners. MoHS should also take the lead in Health in All Policies (HiAP)-related discussions.

ACCOUNTABILITY

Accountability during NHP implementation will be enhanced if following elements are addressed:

- Laying down legal and policy foundations for UHC
- Securement of sufficient resources for NHP implementation
- Establishment of clear delegation of authority
- Provision of access to information on NHP implementation for all stakeholders, including the community
- Ability of the plan to adapt in accordance with the changing context and lessons learned

CSOs have an important role to play in social accountability through community mobilization and advocacy, or by introducing checks and balances and acting as a watchdog with respect to health service planning, delivery, and monitoring, especially as it relates to the Basic EPHS to which the population will be entitled. Their capacity needs to be built to successfully carry out these functions. The Myanmar CSO informal health network that was formed during the second Myanmar CSO health forum can help civil society mobilize community and enhance public awareness around the NHP.

Effective communication strategies, adapted to the different target audiences, need to be developed by MoHS to share key information on NHP implementation.

The revised terms of reference of local health committees (at village, village tract and Township level) will specify these committees' role with respect to accountability. Adequate composition of these committees, including proper representation of civil society, should be guaranteed. Also, Community Feedback Mechanism will be developed.

IMPLEMENTING THE NATIONAL HEALTH PLAN

SUPPORTING IMPLEMENTATION OF THE NATIONAL HEALTH PLAN

A dedicated unit will be established within the Minister's Office, MoHS, with a clear mandate to facilitate smooth implementation of the NHP – the NHP Implementation Monitoring Unit (NIMU). NIMU will have a mixed set of skills and expertise including legal (maybe seconded from Attorney General's Office), financial management (from MoPF or Auditor General's Office), public health, clinical, health financing. NIMU will also oversee NHP-related communication with internal and external stakeholders including the media.

The scope of work of NIMU includes:

- Facilitate engagement among various stakeholders to communicate and build consensus around NHP's goals and strategies
- Coordinate efforts to implement the NHP
- Liaise with relevant stakeholders inside and outside MoHS and with other health-related sectors
- Oversee NHP M&E
- Commission studies to fill knowledge gaps
- Contribute to sharing best practice, tools and techniques
- Support informed decision making
- Capacity building as needed and as it relates to the implementation of the NHP

The NIMU will report directly to the Minister and Permanent Secretary and relevant Director General(s) One of the first tasks of the NIMU will to organize the translation of the NHP into an annual operational plan, which will elaborate on the NHP implementation details. The first year's operational plan will include, for example, the final version of the Basic EPHS, the costing of the NHP, detailed instructions and/ or guidelines for the prioritization of townships, the development of the national service availability and readiness database, the preparation of the ITHP, etc.

IMMEDIATE ACTIONS

After dissemination of the final version of the NHP, some of the immediate tasks to be carried out include:

- Establish NHP NIMU within the Minister's Office, MoHS, with both internal and external financial and technical support
- Finalize Basic EPHS
- Cost the NHP and determine associated budget
- Prioritize Townships for operationalization of the NHP
- Develop the NHP M&E framework
- Prepare the first year's operational plan
- Develop assessment tool and develop national
- database
- Develop 'national' approach to ITHP

MONITORING AND EVALUATION FRAMEWORK

The general goals of the NHP's M&E framework are:

- Reduce excessive and duplicative reporting requirements
- Serve as a general reference and provide guidance for standard indicators and definitions
- Enhance efficiency of data collection investments
- Enhance availability and quality of data on results
- Improve transparency and accountability
- Guiding Principles for the NHP's M&E framework include:
- It should be country-led
- It should track the progress of NHP implementation
- It should provide some degree of flexibility (while guaranteeing a common core set of indicators)
- It should build, to the extent possible, on existing systems and processes to avoid duplication
- It should foster partnerships and coordination
- It should simultaneously fulfill global reporting requirements (e.g.SDG, including UHC)
- The M&E framework will reflect the inputs, outputs, outcomes and impact of the NHP, with particular attention to the four pillars (HRH, Health infrastructure, Health Financing and Service Delivery). Indicators will be selected according to the logical framework.

The M&E framework will also allow tracking changes with respect to HIS, governance and equity. Evaluation will be periodically performed, i.e., at mid-term and at the end of the NHP period. Periodic evaluations will:

- Analyze whether and why expected results were achieved or not
- Examine implementation process
- Explore unintended results
- Highlight accomplishment, draw lessons, and offer recommendations for improvement

Implementation research will also be incorporated in the NHP. It help assess whether the NHP is being implemented as planned, and identify areas where corrective measures need to be taken to put implementation back on track.

At the national level, M&E will be overseen by NIMU. At State and Region level, the State/Regional Health Authorities will be in charge of M&E. They will provide regular feedback to Townships.

The M&E framework willinclude provisions for the monitoring of the performance of DPs and implementing partners.

ANNEXES

ANNEX 1: MOHS PROGRAM AREAS AND PROJECTS

Sr.	Program Area	Projects
1.	Communicable Diseases Program	1. Epidemiological Surveillance and Response 2. Disaster Management and Public Health Emergency 3. Expanded Program of Immunization 4. Zoonotic Diseases Control 5. National Tuberculosis Control 6. Leprosy Control 7. National AIDS and Sexually Transmitted Diseases Control 8. Vector Borne Diseases Control 9. Trachoma Control and Prevention of Blindness 10. National Hepatitis Program
2.	Non-Communicable Diseases Program	1. Control of chronic diseases - Cardiovascular diseases - Diabetes mellitus - Cancer - Chronic respiratory diseases 2. Tobacco control program 3. Accident and injuries 4. Mental health and substance abuse 5. Snake bite control 6. Community-based rehabilitation 7. Neurological disorder - Stroke - Epilepsy
3.	RMNCH+ program (Life Cycle Approach)	1. Reproductive health 2. Neonatal and Under-five child health development 3. Adolescent health (school and out of school) 4. School health 5. Primary dental and oral health 6. Elderly health care
4.	Improving Hospital Care	1.Quality of Health Care Service in Hospitals 2. Patient safety and medical security 3. Myanmar essential drugs 4. Nursing care and improving nursing quality 5. Laboratory and blood safety 6. Logistic information 7. Regulation of private health care
5.	Traditional Medicine	1. Human resources for health development (traditional medicine) 2. Promoting quality of traditional medical care 3. Production of quality traditional medicine 4. Promoting traditional medical research and development 5. Herbal garden development

6.	Human resources for health	1. Training of human resources for health 2. Upgrading training institutes, facilities and faculties 3. Continuing medical education and development of ICT network 4. Strategic plan for development of human resources for health
Sr.	**Program Area**	**Projects**
7.	Promoting Health Research	1. Research on Health Policy & Health System 2. Research on Communicable Diseases 3. Research on Non-Communicable Diseases 4. Research on Environmental Health 5. Research on Traditional Medicine 6. Research on Academic & Technology Development 7. Research on Capacity Strengthening 8. Research on Dissemination & Knowledge Management
8.	Addressing Determinants of Health	1. Environmental Health Risk Assessment and Control 2. Occupational Health and Safety 3. Air and Water Pollution Control 4. Water and Sanitation 5. Healthy City and Urban Health 6. Hospital Waste Management 7.Consumer Protection 8. Food safety and Control 9. Pharmaceuticals and Medical Devices Quality and Safety 10. Consumer Protection (cosmetics) 11.Health Promotion 12. Gender and Women Health 13. Tobacco Control
9.	Nutrition Promotion	1. Protein Energy Malnutrition Control 2. Iodine Deficiency Disorders Elimination 3. VitaminA Deficiency Elimination 4. Iron Deficiency Anaemia Control 5. Beri Beri Control 6. Over-nutrition and Obesity Control 7. Household Food Security
10.	Strengthening Health System	1. Promoting Leadership and Governance 2. Health Care Financing 3. Health Information Management System 4. International Health Regulations 5. Township Health System Development
11.	Rural, Peri-urban and Border Health	1. Rural Health development 2. Border Area Health Development 3. Peri-urban Health 4. Public Health Nursing 5. Migrant Health

ANNEX 2: COSTING FRAMEWORK FOR THE NATIONAL HEALTH PLAN

This annex describes steps to calculate a rough estimate of the cost of the NHP. This will include the cost associated with the improvement of supply-side readiness, and that associated with the actual delivery of services and interventions included in the basic EPHS. It will also include a rough estimate of the cost associated with the various health systems strengthening activities that need to be implemented. This approach may need to be revised as we go depending on challenges encountered and data availability.

STEP ONE

Determine at what level(s) of the health system and in what type(s) of MoHS health facility (e.g. Community; Sub-RHC; RHC/UHC; Station Hosp.; Township Hosp.; District Hosp.; Tertiary Hosp.; etc.) each of the services and interventions included in the Basic EPHS should be delivered. This step will result in a level/facility type-specific package of services and interventions.

Table 1 – Matrix of services and interventions included in the Basic EPHS by leval and type of health facility

	Community	HF type 1	HF type 2	HF type 3	...	HF type i
Service/ Intervention 1						
Service/ Intervention 2						
Service/ Intervention 3						
Service/ Intervention 4						
...						
Service/ Intervention n						

STEP TWO

For each level and for each type of MoHS health facility, determine the total cost of delivering the level / facility-specific package (determined in step one), assuming a 'typical' community / facility with a 'typical' catchment population.

This will be done using a combination of empirical data from costing studies and information gathered as part of the EPHS definition exercise.

Expected numbers of 'cases' or 'units' for each service and intervention can be calculated by applying the proportions used in the EPHS costing exercise to the 'typical' catchment population, and considering 'reasonable' referral rates. To capture the high level of uncertainty, estimates could be expressed as a range (between X and Y).

Table 2 – Estimated cost by level or facility type

	Catchment population	Cost for typical facility (considering services/interventions that need to be delivered) Infrasrt.	Equipm.	Vehicles	HR	D, V & MS	Maint.	...	TOTAL
Community									
HF type 1									
HF type 2									
HF type 3									
...									
HF type i									

STEP THREE
Using information from the SARA and possibly other sources, get a very rough estimate of the proportion of MoHS facilities in each quality category: poor, medium and satisfying minimum standards of care. First get to an acceptable definition of these three categories.

STEP FOUR
For each level and for each type of MoHS health facility, determine two types of costs, using information from step two and considering different scenarios:

- The cost of improving service availability and readiness to deliver the basic EPHS (from none to satisfactory; from poor to satisfactory; from medium to satisfactory, and possibly also from poor to medium) – agree on what to include in this cost (e.g. construction, purchase of equipment, upgrade of health workers' skills…)
- The cost of providing at least some of the services included in the Basic EPHS in a MoHS health facility where service availability and readiness is poor, medium or satisfactory – here as well, agree on what to include in the cost estimates (e.g. do we include amortization of capital items?)

Table 3 – Estimated cost for different scenarios

	Improving service availability and readiness			Service delivery		
	none > satisafactory	poor > satisfactory	medium > satisfactory	poor	medium	satisfactory
Community						
HF type 1						
HF type 2						
HF type 3						
…						
HF type i						

STEP FIVE
For each service and intervention included in the basic EPHS (or for each group of services and interventions), what is our best estimate of the current proportion of the total population that either has no access or that seeks care from each of the 'sectors' (public, private-for-profit, NGO, EHO).How do we expect that distribution to be by 2020, considering the potential for the private-for-profit, NGO or EHO sectors to expand coverage and assuming that the public sector will take care of the remaining uncovered populations? The estimates could to some extent be informed by findings from the recent DHS and from the Myanmar Poverty and Living Conditions Survey 2014/2015.

This step will allow us to get an idea of the expansion in MoHS service provision that is needed between now and 2020 if the NHP goal is to be achieved. Likewise, it will provide some idea of the required expansion of service provision for the other sectors (especially EHOs and NGOs).

Table 4 – Health seeking behavior

Health seeking behavior (proportion of population)						
	Group of Services and Interventions 1	Group of Services and Interventions 2		Group of Services and Interventions 1	Group of Services and Interventions 2	
No access						
Public						
Private-for-Profit						
NGO						
EHO						
Other						

STEP SIX
Using the estimates from steps three and five (more particularly, the proportions relating to 'no access' and to the utilization of services in the public sector), fill out the table below, assuming a certain pace of improvement (that may need to be revisited later).

Table 5 – Projected expansion of MoHS service delivery

	Coverage (%) by type of facility / level + projections															
	2017/18				2018-19				2019-20				2020-21			
	X				X				X				X			
Community																
HF type 1																
HF type 2																
HF type 3																
…																
HF type i																

STEP SEVEN
Brainstorm on what other elements need to be consider for the NHP costing exercise.
For example:

- The cost of developing the coverage database (including the cost of the data collection)
- The cost of developing and rolling out the ITHP process
- The cost of strengthening the different functions/systems needed for effective service delivery (e.g. supply chain, public financial management, HMIS…)
- The cost of developing skilled human resources (e.g. increasing and improving pre-service training capacity, developing in-service training, improving licensing and accreditation…)

In addition, we need to estimate the current share of the budget that is related to the delivery of services and interventions included in the basic EPHS, and how this could realistically evolve over the coming years.

STEP EIGHT
Combine the information from steps four and six to obtain an estimate of the annual budget needed to (i) expand service availability and readiness for the MoHS delivery of the Basic EPHS, and (ii) actual MoHS delivery of services and interventions included in the Basic EPHS.

Considering the different constraints, including fiscal space constraints, constraints in human resources etc., and keeping in mind that MoHS budget is to cover more than just this, repeat steps six and seven as needed.

Possible additional steps
- This exercise could be expanded to also estimate funding needs (from development partners) for improvement of service availability and readiness and for the actual delivery of the basic EPHS by NGOs and EHOs.
- The evolution in the share of public funding that can be channeled to these providers for the purchase of the basic EPHS could also be estimated. This relates to our other discussion on the piloting of a purchasing entity.

ANNEX 3: HEALTH ACCESS POINT AND HEALTH WORKFORCE

Table 1displays, for each state and region, the number of Townships that are either below the optimum or at/above the optimum in terms of two different dimensions: health access points and health workforce. The percentages between parentheses indicate the proportions of Townships that are below optimum for both dimensions. In other words, the higher the percentage, the worse the state or region is doing.

Table 1 – Health Access Points and Health Workforce Matrix

	Health Access Point	Health workforce	
		Optimum and above	Below the optimum
Kachin	Optimum and above	0	1
	Below the optimum	0	17 (94%)
Kayah	Optimum and above	0	3
	Below the optimum	1	3 (43%)
Kayin	Optimum and above	0	0
	Below the optimum	0	7 (100%)
Chin	Optimum and above	0	4
	Below the optimum	0	5 (56%)
Sagaing	Optimum and above	1	6
	Below the optimum	1	29 (78%)
Tanintharyi	Optimum and above	0	1
	Below the optimum	0	9 (90%)
Bago	Optimum and above	0	6
	Below the optimum	0	21 (75%)
Magway	Optimum and above	0	8
	Below the optimum	1	16 (64%)
Mandalay	Optimum and above	0	2
	Below the optimum	2	24 (86%)
Mon	Optimum and above	0	2
	Below the optimum	1	7 (70%)
Rakhine	Optimum and above	1	4
	Below the optimum	0	12 (71%)
Yangon	Optimum and above	0	5
	Below the optimum	13	27 (60%)
Shan	Optimum and above	1	1
	Below the optimum	0	53 (96%)
Ayeyarwaddy	Optimum and above	0	8
	Below the optimum	0	18 (69%)
NPT	Optimum and above	0	0
	Below the optimum	3	5 (63%)

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