IHP+ 2016 MONITORING ROUND

COUNTRY REPORT MYANMAR

COUNTRY	Myanmar
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1 Process of the 2016 IHP+ Monitoring Round

The Ministry of Health, now renamed Ministry of Health and Sports (MOHS) formally committed to participate in the 2016 IHP+ monitoring round in January 2016. The new Health Minister took office in March 2016 and reaffirmed this earlier commitment and assigned relevant divisions within the Ministry to support the process. Monitoring started in the third week of May 2016. A national consultant was recruited with the approval of MOHS and assigned to work alongside the focal person designated by the MOHS. Key persons who completed the IHP+ quantitative and qualitative tools were the Assistant Secretary of the Minister's Office, the Deputy Director General of the Disease Control Division, the Assistant Directors of the Planning and Finance, and senior staff of the International Health Relations Divisions. The consultant met with the Director General of the Ministry of Planning and Finance and his senior staff who developed the Aid Information Management System (AIMS).

The consultant made an inventory of development partners (DPs) and civil service organisations (CSOs) that were active in the health sector in Myanmar and shared the list the MOHS focal person for finalisation. WHO hosted an initial stakeholder meeting in which UN partners were informed of the IHP+ monitoring round 2016. All of the 17 DPs active in the health sector were invited to participate. Two DPs did not respond whereas three did not provide information themselves because their support was primarily channelled through multilateral mechanisms. Twelve DPs submitted complete returns of quantitative and qualitative questionnaires. Several participating DPs had channelled most of their contributions through the multi-donor 3MDG Fund and were therefore not able to answer all questions. The 3MDG Fund Director and his team provided quantitative and qualitative data on the contributions made by all seven participating DPs which was used to complement some responses. A total of 41 CSOs that were active in the health sector were invited to participate in the CSO survey, and approximately 40% responded to the questionnaire. Nearly half of the CSOs were invited to a focus group discussion. Though only one third of those invited took part, the discussions were open, rich and insightful. The private sector was not included in this round of IHP+ monitoring. The response from the government and some bilateral donors was slow as the IHP+ monitoring exercise coincided with the first few months of the transition to the new government.

2 Commitment to establish strong health sector strategies which are jointly assessed and strengthen mutual accountability

2.1 EDC Practice 1: Partners support a single national health strategy

The National Health Plan 2011-2015 (NHP 2011-15) remains in place to guide the national health strategy while a new version of the National Health Plan 2016-2021 (NHP 2016-21) is

being developed under the leadership of the Minister's Office. Other ministries (other than health), CSOs or private sector representatives did not participate in the development of the NHP 2011-15. All development partners stated that they fully aligned their health sector support with national priorities. Although there was no joint assessment of the national health plan until now, there is a plan to undertake one by the end of 2016 with technical support from WHO and JICA.

There are expectations that cooperation and coordination with DPs will improve with the implementation of NHP 2016-21. Currently, the main constraint is a lack of one unified and overarching National Health Plan that is fully costed and sufficiently robust to allow alignment by the DPs. There are various disease-specific and sub-sector strategic plans (NSPs) formulated by respective divisions of the MOHS, such as a NSP for HIV, for TB, for Malaria, for Reproductive Health, etc. With the exception of the NSPs for HIV, tuberculosis and malaria, the NSPs are not consistent in their time frames and therefore may have constraints in synchronising with other programmes. There are also resource constraints to conduct coordinated joint assessments. It may still be difficult to carry out joint assessments in areas that are controlled by ethnic armed groups. However, development of the NHP 2016-21 presents a unique opportunity to conduct a joint assessment. Synchronising the time frame of the assessments and the due dates are important steps. Joint assessments are not only cost effective, they also foster joint ownership, leading to integration and streamlining of national programmes, health financing, financial management, and health information.

2.2 EDC Practice 5: Mutual accountability is strengthened

At present, the national M&E plans and processes do not include mechanisms to strengthen mutual accountability. There is no country-specific Myanmar compact partnership agreement or joint assessment processes as yet, although these are in the process of development. Joint assessments were carried out periodically by UN agencies and respective funding agencies. Strong leadership by the MOHS is needed to include all DPs in a harmonised accountability framework. Some stakeholders suggested that all externally-funded support should be subject to oversight by the Myanmar Health Sector Coordination Committee (M-HSCC).

The M&E plan for the NHP 2016-21 is still in the process of development. Currently there is no standardised national monitoring and evaluation system for health. Different sub-sectors have their individual M&E tools and plans, mostly using WHO recommended guidelines and M&E frameworks. In most areas, the indicators and results frameworks of the MOHS and DPs are aligned, although different frameworks are used in some programme areas. Responding DPs cited challenges in using the national M&E system primarily related to the weak health information system that operated with limited technical skills and technology resulting in poor quality, timeliness, and difficult access to HMIS data. Plans are underway to strengthen data quality as well as the national M&E system in collaboration and cooperation with DPs. DPs are giving increasing attention and support to the quality and robustness of the M&E system, and this has provided opportunities to develop a synchronised M&E system, and to strengthen the quality and utilisation of data.

3 Commitment to improve the financing, predictability and financial management of the health sector

3.1 Practice 2a/b: Health Development Cooperation is more predictable

According to self-reported data, the MOHS executed 92% of its 2015/16 budget while the participating DPs reported a combined budget execution rate of 95%. The latter was a weighted average of budget execution among all participating DPs. The main reasons for under-disbursements by some DPs to the government sector were slow absorption of funds and delays in the implementation of planned activities; lengthy approval processes by both, the MOHS and some DPs; and organisational restructuring within the MOHS. According to the 3MDG Fund, the under-disbursement was primarily in the investment budget and in some priority areas (e.g. private sector work, prisons health) rather than in the service delivery budget. The political transition in 2015-2016 further slowed budget execution. DPs stated that delays could have been avoided by better planning, monitoring and financial management and more regular and joint planning and reviews.

The government budget is established on a yearly basis. There is no rolling 3 year expenditure plan. According to the DPs, 25% of forward expenditures for the next three years were communicated to the MOHS, while the MOHS estimated that it was aware of 17% of DP expenditure plans for the next three years. Some DPs suggested that the MOHS should develop a costed work plan which would provide an opportunity for DPs to inform their own multi-year spending plans.

3.2 Practice 2c: Health Aid is on budget

Although 60% of public health expenditures are funded by external assistance, there is no consideration of the international assistance in the health budget. The MOHS acknowledged that budget forecasting is an essential prerequisite to a balanced budget. This however depends on good information systems which remains a major constraint for the government health sector. The World Bank is now providing assistance to the Ministry of Finance for public financial management and public expenditure reviews. The World Bank IDA loan is on the national budget. Disbursements by UNICEF are reflected in the national budget under the category of loans and grants which can, however, not be disaggregated into contributions to specific sector budgets. None of the remaining participating DPs reported that their contribution was included in the national budget, although they report their funds to the MOHS and the Ministry of Planning and Finance and to the AIMS (managed by MOPF). The development of the AIMS system is well on track and DPs continue to discuss with the new government about the possibility of including their resources in the national budget.

4 Commitment to establish, use and strengthen country systems

4.1 Practice 3: PMF systems are used and strengthened

Myanmar has a reform programme in place to strengthen the PFM system led by the World Bank working in collaboration with the Ministry of Planning and Finance. Currently only the World Bank IDA Loan is using the PFM system. Government acknowledges that DPs are using their own individual financial management systems as the national systems are not yet fully

developed. The DPs are currently not using the public system but expressed willingness to do so once it is fully developed.

The existence of several parallel financing and implementation arrangements by DPs add a significant burden on already capacity-stretched MOHS staff. Support on systems strengthening and capacity building is not yet sufficient. This is an opportune time for Myanmar to transform development assistance in health to support the country's financing transition for future support to the health sector.

4.2 Practice 4: Procurement systems are used and strengthened

The Department of Public Health and the Department of Medical Services prepare a procurement plan annually, aligned with global and regional procurement principles. Currently procurement is mainly sourced from local suppliers although international procurement for service procurement has already started. The DPs do not use national procurement mechanisms but they use national supply management system to some extent. Since the Department of Public Health has started to implement the national health supply chain strategy in 2016, an increasing amount of procurement by DPs has been channelled through government mechanisms. DPs use their own procurement system which is in line with respective organisational standards and guidelines. There is some harmonisation among certain DPs around multi-donor funds such as the 3MDG Fund and the Global Fund. Currently the Department of Public Health is collaborating with DPs as supply chain partners to strengthen the national procurement system. Significant number of DPs still prefer global and regional procurement systems as there are many advantages in using these systems.

4.3 Practice 6: Technical support is coordinated and south-south cooperation (SSC) and Triangular Cooperation (TrC) support learning

The MOHS acknowledged that there is no national technical assistance (TA) plan for the health sector. Some DPs are supporting government to develop a national TA plan. None of the DPs supplies TA in a coordinated manner or an agreed plan. However there is division of labour among the different DPs, particularly the UN technical agencies, to provide TA according to specific areas of expertise. DPs usually share draft TORs with government to get inputs or feedbacks from relevant counterparts before finalising them. They also involve the counterparts in the prioritisation of TA and the selection process, although not consistently. A well-coordinated TA plan built on joint mapping and planning and a clear division of labour among DPs will strengthen the development of a national TA plan in line with National Health Plan. Key steps include the more effective use of the Technical Strategic Groups of the M-HSCC.

The MOHS is currently not formally participating in any south-south or triangular cooperation. DPs have been supporting regional technical cooperation through various channels and venues such as ASEAN and Greater Mekong Region health activities and exchanges. With the reforms taking place in Myanmar, the Government of Myanmar is in a strong position to leverage support for SSC or TrC.

5 Commitment to create an enabling environment for CSOs and the private sector (PS) to participate in health sector development cooperation

5.1 Practice 7: Engagement of CSOs

The MOHS has not consulted CSOs in the design, implementation and monitoring of national health sector policies. However the new MOHS is committed to establishing mechanisms to listen to the voices of communities and CSOs, and to consult them in future planning under the NHP 2016-21. Institutional mechanisms such as the M-HSCC are already in place to involve CSOs in programme development and oversight. However DPs perceive that the current format of discussions at the M-HSCC is very formal and not conducive for civil society representatives to actively participate. According to a focus group discussion with CSOs, they felt that the existing coordination mechanisms are more tokenistic rather than serving as platforms for interactive discussions and decision-making.

DPs suggested that the mandate and governance manual of the M-HSCC should be re-visited and reviewed in accordance with the reforms taking place in the health sector. The sub-national level health sector coordination is not fully functional and needs to be strengthened in line with the democratisation and decentralisation process. Devolution of authority to sub-national levels will expedite establishment of CSOs, CBOs and Ethnic Health Organisations (EHOs), and strengthening of CSO engagement in the M-HSCC structures at state and regional level. Since M-HSCC has evolved from Global Fund's CCM, representatives from affected groups have been predominantly from the HIV-affected community, although there have been recent addition of representatives of other groups (disabilities and NCD).

The Myanmar Health System Strengthening Mechanism is established for a select few DP programmes such as the Global Fund and US PEPFAR, which stipulates CS consultations as a requirement. As CSO involvement should not be limited to provision of services, TA on other areas such as health policy, health system analysis and watchdog activities should be provided increasingly to CSOs. Funding to CSOs should be made more flexible and tailored towards their engagement in policy dialogue. Fund management of CSOs has been weak in the past and TA should focus on this area as well. National NGOs, with support from some INGOs, have been advocating for more space for CSOs to effectively participate in health policy. There are expectations that the new government will promote closer collaboration with CSOs and it is essential that the government and CSOs build mutual trust to foster stronger partnership between the two constituencies.

At present, there is no separate focal point person or unit at the MOHS designated for liaison and coordination with national and local CSOs. There is also no written guideline and protocol for communication with various levels of administration which makes communication depend heavily on personal relationships. At the subnational level, awareness and understanding of civil society organisations and their role in health sector is generally poor. Procedures for registration are lengthy, complex and time-consuming. The Association Registration Law was passed towards the end of 2015 as a result of targeted advocacy efforts by CSOs. However the by-laws and regulations that accompanied the Law were not conducive for civil society development and strengthening. A CSO Registration Working Group led by CSOs was formed

and the group has been trying to remove the by-laws from the new Association Registration Law to ease implementation of this Law.

The development, implementation and monitoring of the NHP 2016-21 is an opportunity not to be missed. With the peace process progressing, more ethnic health organisations are looking for opportunity to engage in the health policy dialogue with the central and local governments. Existing networks of civil society around issues such as drug use, sex work, and HIV can serve as a strong basis for strengthening civil society inputs in policy development.

5.2 Practice 8: Engagement of the private sector

Only seven of the 12 participating DPs stated that they consult with private sector stakeholders. The MOHS did not answer questions about private sector involvement in health policy and strategy processes. This is an indication that private sector institutions and organisations do not yet have an important role in health sector development in Myanmar, although this may change rapidly with the current political reforms. Consultations with private sector stakeholders were not included in this monitoring round.

6 Other observations

Myanmar has gone through a historic political transition in 2015-16, with a general election held in November 2015 and a democratically-elected government taking office in March 2016. The new Ministry of Health (now Ministry of Health and Sports) reaffirmed government's commitment to Universal Health Coverage in the draft National Health Strategy 2016-2021. Sanctions that were imposed by OEDC/DAC countries for the last two decades have started to lift in 2011 when the-then military-backed civilian government opened the country to the world and started democratic reforms. By early 2013 GOM publicly adopted *The Nay Pyi Taw Accord for Effective Development Cooperation* in line with Paris Declaration and the Busan Partnership principles. An Aid Information Management System (AIMS) was established and an increasing number of DPs participate in the system.

At present, Myanmar does not have an overall agreed financing framework for the national or sub-sector strategy. The World Bank, in collaboration with development partners, is facilitating and supporting the MOHS in the dialogue for the development of a comprehensive health financing strategy.

According to the World Bank, Myanmar currently has a great opportunity to transform development assistance in health to support the country's financing transition. There are two dimensions to this transition: (i) the country moving out of low-income status, which will reduce its access to grants and concessional loans in the medium to long term; and (ii) development assistance moving away from off-budget and off-plan to building country systems. This is an opportune time to support both dimensions of this transition, as the country's health sector development partners are considering their next phase of support.

7 Discussion of findings (added 11/04/2017)

Several attempts were made to organise a meeting to present this report and to validate the findings of the assessment and to develop an action plan for effective development cooperation in the health sector. Because of the highly charged agenda for the development of

the NHP, this has not been possible. The report is therefore circulated to all partners who participated in the assessment.

8 List of invited and participating DPs

Nr	List of DPs active in the health sector	DPs invited to participate in 5th IHP+ Monitoring Round	DPs that participated
1	Australia	X	
2	Denmark	X	
3	DFID	X	X
4	European Union	X	X
5	France	X	
6	GAVI	X	X
7	Global Fund	X	X
8	Japan	X	X
9	Norway	X	
10	Sweden	X	X
11	Switzerland	X	X
12	UNAIDS	X	X
13	UNFPA	X	X
14	USAID	X	
15	UNICEF	X	X
16	World Bank	X	X
17	WHO	X	X

EDC PRACTICE	INDICATOR	World Bank	WHO	UNFPA	UNICEF	Gavi	Global Fund	DFID Myanmar	EU	SDC	UNAIDS	Japan	Sweden
EDC 1	DP participated in joint sector or sub-sector assessments	✔	✔	✔	✔	✖	✖	✔	✖	✖	✔	✖	✖
EDC 2a	% of funds disbursed according to agreed schedules	100%	96%	100%	86%	100%	100%	50%	55%	55%	NA	100%	50%
EDC 2b	Planned resources communicated for 3 years	✔	✖	✖	✖	✔	✖	✔	✖	✖	✖	✖	✖
EDC 2c	% of funds registered on budget	100%	0%	0%	100%	?	?	0%	0%	0%	NA	0%	0%
EDC 3	% of funds using national budget execution procedures	100%	0%	0%	0%	?	?	0%	0%	0%	NA	0%	0%
	% of funds using national reporting procedures	100%	0%	0%	0%	?	?	0%	0%	0%	NA	0%	0%
	% of funds using national auditing procedures	100%	0%	0%	0%	?	?	0%	0%	0%	NA	0%	0%
EDC 4	DP uses the national procurement system	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖
EDC 5	DP only uses national health sector indicators to monitor their support	✖	✖	✖	✖	✖	✔	✖	✖	✖	✔	✖	✖
	DP participates in joint mutual accountability processes	✖	✔	✔	✖	✔	✔	✖	✖	✖	✔	✖	✖
EDC 6	DP supplies TA in line with agreed national plan	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	DP supports south south collaboration	✔	✔	✔	✔	✔	✔	✔	✔	✖	✔	✔	✖
EDC 7	DP supports CSOs with financial resources	✖	✖	✔	✔	✔	✔	✔	✔	✖	✔	✖	✖
	DP supports CSOs with training	✔	✖	✔	✔	✔	✔	✔	✔	✖	✔	✖	✔
	DP supports technical assistance	✖	✖	✔	✔	✔	✔	✔	✔	✖	✔	✖	✖
EDC 8	DP provides financial or technical support to strengthen the private sector in health	✔	✖	✔	✔	✖	✔	✔	✔	✖	✖	✖	✔