Purpose and process

It has been three years since the Commission on Information and Accountability for Women’s and Children’s Health (CoIA) delivered its ten recommendations aiming to strengthen accountability for resources and results with special attention to women and children. Processes involving multiple stakeholders at regional and country level have resulted in assessments and plans. The recommendations have been translated into country accountability frameworks that define priority areas for strengthening birth and death registration, monitoring of results, use of eHealth, tracking resources, maternal death surveillance and response, national mechanisms for review and accountability, and advocacy.

Implementation of priority activities in Myanmar’s Country Accountability Framework (CAF) is now well underway. The purpose of this assessment was to review the progress to date, identify challenges, lessons learnt and priorities for further work. The review contributes to an overall review conducted by Every Woman Every Child of the office of the UN Secretary-General.

The review was conducted by the World Health Organization and The Global Fund, in close collaboration with national stakeholders and partners. The assessment included a desk review (country self-assessment, accountability roadmap, country progress report, and documents on monitoring and reviews) and a country visit. A national workshop then brought together a broad range of stakeholders from RMNCH as well as from disease specific programmes to work on the CAF. A visit was conducted to a township hospital and a welfare organization, and additional stakeholders were interviewed.

High-level political commitment for RMNCH

There is strong political commitment for RMNCH at the level of President in Myanmar, and RMNCH services are now to be given free of charge. Government spending on health is intended to increase rapidly; an eight-fold increase was made over four years, from an annual expenditure of US$ 60 million in 2009-10 to a budgeted US$ 520 million in 2013-14. Much of the increased allocation in 2013 was used for making medicines and other commodities available in health facilities. The Government of Myanmar is also in the process of defining a basic package of services included in a new programme for Universal Health Coverage.
Figure 2: Total MoH spending on health in million Kyats

Note: Fiscal years 2009-10 to 2011-12 are expenditure and 2012-13 onwards are budget

Up to 80% of the cost of health services has been paid by clients. Recent initiatives should reduce such out-of-pocket expenditures.

There have been numerous achievements in implementing the CoIA roadmap. A civil registration and vital statistics (CRVS) strategy has been drafted; the District Health Information System software version 2 (DHIS2) is to be rolled out in all states/regions, and a website for RMNCH has been established. The Government of Myanmar takes an active part in implementing the planned activities, thus building the capacity and skills of public sector employees. The Government is also often able to achieve results in a more cost-efficient way than international development partners.

Progress and challenges

The large number of partners entering Myanmar presents its challenges

Myanmar has opened up after sanctions against the country were lifted, and many development partners have established themselves in the country. Some partners remain reluctant to transfer funds directly to the central Government due to concerns about former and present human rights violations. This is contrary to the principles of the International Health Partnership (IHP+) and increases the challenge of aligning partner activities to government priorities. It has led to the establishment of parallel structures in many parts of programme implementation, resulting in the underutilization of existing government capacity, and increasing the challenge to build additional capacity.

In 2012 the “3 MDG” basket fund was set up, pooling resources from major donors including AusAID, DANIDA, EU, Swiss Cooperation, Sida, UKaid and USAID. Presently, the fund has US$ 335 million, of which 74% is intended for RMNCH, 15% for HIV, TB and malaria and 11% for health system strengthening.

The large number of organizations entering Myanmar presents a challenge for the Government. Often, partner projects are not aligned with government priorities, and the Government is neither aware of how resources are spent nor what results are achieved. In addition, the Government has little experience cooperating with non-governmental organizations (NGOs); this new collaboration should be encouraged and strengthened.

Maternal deaths are reviewed and maternal mortality drops

In 2010, fewer than 10% of the townships of Myanmar had maternal death reviews (MDR) in health facilities. Following the CoIA workshops, MDR is now being implemented in all townships in Myanmar. MDR committees are formed in both health facilities and community-based settings.
Table 1: Reporting and reviewing of maternal deaths 2011 – 2013

<table>
<thead>
<tr>
<th>Maternal deaths</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number reported</td>
<td>1,517</td>
<td>1,208</td>
<td>922</td>
</tr>
<tr>
<td>Number reviewed</td>
<td>478</td>
<td>670</td>
<td>863</td>
</tr>
<tr>
<td>Percentage reviewed</td>
<td>32</td>
<td>55</td>
<td>94</td>
</tr>
</tbody>
</table>

The proportion of deaths reviewed in Myanmar has increased from 32% in 2011 to 94% in 2013. At the same time, the reported number of reported maternal deaths has decreased, as shown in the table above.

MDR in Myanmar uses two WHO-recommended review methods: community-based maternal death reviews (verbal autopsies), and facility-based MDR done in hospitals as clinical audits. The system involves a hierarchy of reporting, from the basic health unit, which conducts the verbal autopsy to the township health authority to the region/state health authority to the central level. It requires taking actions (responses) and keeping track of deaths (surveillance) which are crucial elements in Maternal Death Surveillance and Response (MDSR). Myanmar plans to implement all elements of MDSR by the end of the current year; this transition process is guided by the CoIA roadmap.

The expansion of MDR has proven the value of reporting maternal deaths. It has also served as a catalytic action, enhancing interest of local authorities in MNCH activities, and providing evidence for the introduction of specific interventions.

Some areas in Myanmar are hard to reach. Delivering and reporting on health services in these areas remains challenging, and synergies between collecting information on maternal deaths and civil registration can be particularly important to utilize.

Myanmar is improving the Civil Registration and Vital Statistics (CRVS) system

CRVS Coordinating Committee: Myanmar established a Coordinating Committee for strengthening civil registration and vital statistics (CRVS). Headed by the Deputy Minister of Immigration and Population, the committee has members from all relevant ministries, with 13 different government bodies represented. No development partners are included. This committee has regular meetings every one or two months. Similar committees exist at each administrative level down to the village level, with the aim of conducting CRVS training and obtaining full coverage of registration.

Myanmar aims to strengthen and upgrade the CRVS system in accordance with international standards, to make the system more complete and reliable, and to enhance collaboration in producing a vital statistics report.

Rapid CRVS assessment conducted: The Government conducted a rapid assessment of the CRVS system in the country and submitted it for approval to the CRVS Coordinating Committee. WHO plans to support the Government in conducting a more comprehensive assessment.

Birth registration high in urban areas: According to the 2009–2010 Multiple Indicator Cluster Survey (MICS), a total of 72.4% of under-five children were registered at birth, which includes 93.5% of children in urban areas but only 63.5% of children in rural areas. The rate of birth registration varies across states and regions, with Yangon and Shan (East) highest, at 95.2% and 95.4%, respectively, and Chin

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A birth certificate is crucial for school enrolment, especially in urban areas. A birth registration campaign is planned in cooperation between the Government of Myanmar and UNICEF.

Capacity building needed for registering cause of death: Deaths may be recorded in different ways, for example, as a death certificate and registration at the public health system, or as a deletion from household registries. Because death certificates are needed for funerals, deaths are more likely to be registered in urban areas. There was an early indication of increased reporting of deaths after the Committee for CRVS was established at the community level in early 2014. Verbal autopsy is used for ascertaining causes of deaths occurring outside health facilities, but the accuracy and practice of verbal autopsy are still weak.

International Medical Death Certificates are used for recording deaths in health facilities. However, International Classification of Disease (ICD-10) coding is only done in central and state/regional hospitals. To remedy this, the Ministry of Health Department of Health Planning has started training hospital statisticians and medical doctors; three workshops were conducted in 2013, for some 75 medical personnel from hospitals with 150 or more beds. Following the training, 82% of the hospitals are reporting according to ICD-10.

Challenges identified through the rapid CRVS assessment:
1. There is no comprehensive legal framework for the vital registration system.
2. There are two different paper-based systems for registration of vital events. No data-based computerized system exists. Paper-based data storage is unsafe and confidentiality is not ensured.
3. Vital registration covers all townships but is limited in hard-to-reach areas.
4. Practice for identification of cause of death is poor, even among medical doctors.

Working towards better monitoring of results

Fragmented national data system: Most prioritized health programmes have a monitoring and evaluation framework integrated into the general strategy. These include primary health care and referral, family health care, nutrition, child health, immunization, diseases under national surveillance, malaria, cardiovascular diseases, accident prevention, school health, environmental health, prevention of blindness, mental health, tuberculosis, leprosy, sexually transmitted diseases, trachoma and prevention of blindness, zoonosis, health education and vital events. This in turn leads to a fragmented national monitoring and evaluation platform and data system.

The hospital in the Thanlyin Township, visited as part of the mid-term assessment, reports on 30 forms to the Government alone. Much of the data collection and reporting is done by nurses and midwives. Midwives working in the maternal and child clinic reported spending two hours every day filling in forms, after normal working hours.

“A lot of assessments of progress have been done. We’re thinking it would be good to have one common framework for measuring results. This is true also for the tools used for monitoring, they should preferably be aligned. At the township level, it creates a lot of confusion when they have so many new tools and indicators that are not aligned.”

Deputy Director from the Ministry of Health, Myanmar
Health Management Information System (HMIS) will be upgraded to DHIS2: The routine health management information system covers almost the entire country, with the exception of nine of the 330 townships. Myanmar has initiated planning and training on the implementation of computerized aggregated indicators at the central and state/regional levels, and plans to implement electronic collection of information in some townships, aiming to eventually cover the entire country.

The HMIS form migrated to DHIS2 will be the same form as previously used, and training is being given in public and private hospitals on how to fill it in. The MoH receives reports from about 40% of the private hospitals. Training of trainer workshops at the state and regional level were conducted in 2013 for a total of 290 participants. Initiatives to harmonize and consolidate reporting from different programmes into one system are neither planned nor on the agenda.

Services in health facilities assessed: Using the catalytic funding, a Service Availability and Readiness Assessment (SARA) was conducted in a limited sample of 25 facilities from three states and regions. Unfortunately, generalizations from the survey to the whole country are not possible. That said, results indicate that all types of services relating to maternal, newborn and child health were available at least at hospitals in which there was adequate infrastructure including communication, electricity, and private spaces. Prevention of mother-to-child transmission was offered at almost all the surveyed facilities, but drug expiration was of serious concern. Development partners and funding agencies are now eager to support the implementation of SARA to a national level to provide a basis for policy making.

Demographic and Health Survey is planned: There is now a concrete plan to conduct the first ever Demographic and Health Survey in Myanmar in 2015. The first meeting of a steering committee was held in April 2014 and a first meeting of a technical committee has been conducted. This survey will build on coverage data from MICS surveys, which were conducted in 1995, 2000 and 2009-10.

Dissemination of information: Public health statistics are regularly published on the MoH website, which makes public health and hospital reports publicly available. An interactive RMNCH website has been established by the MoH Department of Health Planning.

The 11 core indicators: Recent information is available on nine of the 11 indicators, either from the national HMIS system (2012) or from the most recent MICS (2010). Several definitions in HMIS differ from the ones used by CoIA. As an example, the HMIS asks for postnatal care for mothers and babies within three days of birth, whereas the reference period for the recommended CoIA indicator is two days.

eHealth and innovation planned

The Ministry of Health and the Ministry of Communication and Information Technology are working together to finalize the eHealth strategy by the end of 2014. Plans also exist to develop Myanmar’s eHealth Enterprise Architecture. WHO provided technical assistance to initiate this work, but further assistance is required.

The Ministry of Communication and Information Technology is planning to develop an eGovernment Master Plan with technical assistance from the Asian Development Bank. MICT plans to incorporate inputs from various ministries, including the MoH. At the same time, the MoH is preparing to include both ongoing and future initiatives on eHealth in the general government plan. As stated by the Director of ICT in the MoH, “Four wings” are needed to enhance eHealth development: governance, systems development and implementation, services/capacity, and use of standards.

2 www.moh.gov.mm
3 http://203.81.81.151/rmnch/ [permanent name will be www.moh.gov.mm/RMNCH]
Figure 3: The four wings of eHealth development

Source: Department of Health Planning, MoH

A survey in one state showed that hospitals have access to electricity, although many health centres do not (25% of rural health centres and 39% of sub-rural health centres). It also showed that although computer literacy and usage is low, 98% of health workers use mobile phones, with a majority using SMS in the surveyed areas. These findings indicate that, although internet is not yet available at state/regional level in Myanmar, there are opportunities for eHealth, especially considering increasing investment in development infrastructure in Myanmar.

**Partners involved in review processes**

Numerous review processes are in place. The Department of Health conducts an annual evaluation of primary health care; the Department of Health Planning conducts HMIS evaluations annually or biannually, depending on funding support. Region/state Health Directors, other officials from respective regions/states as well as township Medical Officers and township HMIS focal persons are involved in HMIS evaluation at region/state level. At the central level, all project managers from the Department of Health, all region and state Health Directors, Statisticians and officers from Department of Health Planning participate. No other partners are involved in HMIS evaluations.

Myanmar has also established Reproductive Health Steering and Working Committees that conduct quarterly meetings to review the maternal and child health situation; members include UN organizations, NGOs and INGOs. Maternal and child death reviews take place in every township.

There is no overarching annual review of the health system in Myanmar. However, a review of the Health System was carried out in 2012, and in 2013 the Asia Pacific Observatory developed the Myanmar Health in Transition series which is currently with the MoH for final endorsement.

**Advocacy efforts need strengthening**

MNCH services delivered at township level (using GAVI Health System Strengthening funds) have played a key role in advocating for better planning, and in testing strategies for delivery and financing of health services for women and children, particularly in hard-to-reach areas. Dissemination of assessment findings from 20 townships influenced similar assessments in other townships. Health system strengthening for MCH at township level has influenced other major programmes funded, for instance, by the “3 MDG” basket fund and JICA. The National Universal Health Coverage strategy was also influenced by the positive findings of the GAVI-funded health system strengthening work.

Plans are under way to advocate to the three target constituencies in the roadmap: members of Parliament, the media and civil society.

**Health accounts available**

Myanmar has produced National Health Accounts covering 1998 to 2011, with the 2010-11 data published in 2013. Requests have been made for opportunities to build capacity in the System of Health Accounts (SHA) 2011 so that sub-accounts could be developed for RMNCH as well as for HIV, TB and malaria.

Individuals pay a considerable part of expenses for health services in Myanmar. In 2013, the Government increased increased government expenditure on health and plans to make RMNCH services free of charge should reduce out-of-pocket payments, which are considerable.
the health budget considerably to improve access to medicines and other commodities. This should reduce out-of-pocket expenditures on health. The situation should further improve as a result of a current initiative to introduce Universal Health Coverage, and to make RMNCH services free of charge. Plans are being made to include reporting of resources spent in the regular HMIS system. The MoH has limited access to financial information from partners. Amounts often have to be estimated from figures specified in memoranda of understanding that often also cover non-health related activities.

Conclusions and moving forward

To date, major steps have been taken and progress can be seen in Myanmar. An excellent example of multi-stakeholder involvement is the establishment of CRVS committees at different levels. This will inform and improve the completeness and quality of MDR/MDSR. Such multi-stakeholder engagement is critical.

For the mid-term assessment, a range of recommendations were developed. Stakeholders in Myanmar should discuss prioritizing these recommendations and agree on timelines and lead agencies for action. The CoIA roadmap may need to be updated to reflect the recent progress and delays. Meanwhile, good practices should be identified and shared widely to improve implementation.

An overarching health sector strategy and annual reviews will provide a national platform (supported by eHealth) for strategic directions and decisions on various health and disease programme issues. This should be led by the MoH, but further involvement of development partners, including funding partners and NGOs, and engagement of the private sector will become essential for catalyzing the scale-up. The forthcoming introduction of Universal Health Coverage is a major undertaking. Implementation is likely to be challenging, and progress should be monitored and reviewed in order to increase the chances of success.

Enhanced cooperation between health development partners and the Government of Myanmar is needed. In light of the increasingly open and democratic political situation in the country, this seems particularly important with regards to establishing mechanisms for disbursing donor funds through government channels.

Further, the high influx of development partner organizations makes it imperative to align their efforts with government priorities. The Compact currently under development will be a useful tool in this regard. Another way to ensure this alignment may be through developing the national HMIS to address the core information needs of development partners. More inclusive planning on HMIS is needed, in particular to prepare for DHIS2 development and rollout. Such a system should take advantage of the ongoing development of infrastructure such as the installation of mobile phone networks over the coming years, supported by the private sector. This requires careful planning and coordination now, as well as the engagement of private sector partners.