Review

of

State/Region Health Planning and Management

MOHS/JICA Health System Strengthening Project

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I sincerely hope the recommendations which were extracted from the review to be taken-up for the future formulation of the state and region health plans.

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Table of contents

I. Background 7

II. Objectives of the review 7

III. Methods 7

IV. Main findings 8

A. Literature review 8

1. History of health planning in Myanmar 8

2. Decentralization on health administration in Myanmar 9

3. State/region health plans under decentralization 11

4. Township health plans under decentralization 12

B. Interviews 12

1. Formulation of the state and region health plans 12

2. Implementation of state and region health plans 18

3. Health plan monitoring and evaluation 24

4. Others 27

V. Discussions and recommendations 27

A. Discussions 27

1. Necessity of the state and region health plans 28

2. Possible state/region health plans 30

3. Collaboration among the stakeholders 31

4. Authority delegation to the states and regions 33

5. Monitoring and evaluation of the state and region health plans 34

6. How to collect and reflect the People's voice for the state and region health plans 35

B. Recommendations 35

1. Recommendations for the central level 35

2. Recommendations for the state and region level 35

VI. Conclusion 36

Reference 37

Abbreviations

Original	Abbreviation
Country Health Programming	CHP
Department of Health Planning	DHP
Department of Health	DOH
Department of Medical Services	DMS
Department of Public Health	DPH
Global Alliance for Vaccine Initiative – Health System Strengthening	GAVI-HSS
Inclusive Township Health Plan	ITHP
Ministry of Health	MOH
Ministry of Health and Sports	MOHS
MOHS/JICA Health System Strengthening Project	MJHSSP
National Comprehensive Development Plan	NCDP
National Health Plan	NHP
People’s Health Plan	PHP
state and region Department of Medical Services	state and region DMS
state and region Department of Public Health	state and region DPH
Three Millennium Development Goal Fund	3MDGF
Township health plan	THP
Township medical officer	TMO

I. Background

MOHS/JICA Health System Strengthening Project (MJHSSP) is providing technical support to develop capacity for the management of the state/region health plans in Myanmar. In principle, health systems are to provide health services effectively and efficiently through proper management of the plan. However, roles and responsibilities of the health administration in formulating and managing health plans at state/region level are still not so clear. Also, it is necessary to have a good understanding of how improvement in the planning management can benefit state/region health departments. On establishment of the new government, decentralization in Myanmar is widely being discussed. In this context, it is high time to revisit and clarify the role and responsibility of the state/region health administration.

II. Objectives of the review

- To gain insight into how health planning and management can be undertaken at state and region level
- To better understand the purpose and significance of activities of MJHSSP to support the health planning and management at state and region level

III. Methods

- Literature review: It includes the documents officially published by the government and some grey literatures
- Interviews/consultations: Interviews were conducted by the MJHSSP team to the interviewees who have potential roles in state/region health plan management. The interviewees consist of the Directors of the state and region DMS and DPH, the state and region Social Ministers or their representatives, and representatives of the local NGOs from Kayah State, Ayeyarwaddy and Magway Regions, as well as the Deputy Directors General, Directors and Deputy Directors from the central DMS, DPH and the Minister's Office of MOHS.

IV. Main findings

A. Literature review

1. History of health planning in Myanmar

Origin of the National Health Plan (NHP)

Health planning has been a part of the National Development Plan from the very beginning of the post-colonial era. Pyi Daw Thar Plan, an overall national development plan for the period 1954-1960, included health as one of its components. Although it was in a top-down manner lacking wider participation of all the stakeholders, successive national health plans were developed taking into consideration the health needs, the policies and developmental context of the country. [1] In the wake of global health movements like "Health for All" and Primary Health Care (PHC) in the 1970s, Ministry of Health (MOH) started formulating People's Health Plans (PHPs) at various level of administration down to the village level according to the national plan. [2]

With the change of government in 1988 and after the closing of the third PHP (1986–1990), the health plans were renamed as National Health Plans (NHPs) and formulation of successive NHPs was based on an adaptation of the previous approach. Sectoral involvement, which was initially strong in the process of the plan formulation, could not be sustained and strengthened. Involvement of other stakeholders (patient groups, community and private health care providers) was not much in evidence. [1]

NHP (2011-2016) under the previous government

With the inauguration of the new government based on the 2008 Constitution, the NHP (2011-2016) became the first 5-year integral and sectoral component of the National Comprehensive Development Plan (NCDP) which is a set of four 5-year plans covering a 20-year period from 2011 to 2031. NHP (2011-2016) consisted of eleven program areas including the strengthening of health system and the countermeasures against non-communicable diseases as well as the control of communicable diseases and the improvement of health of mothers, neonates, children, adolescent and elderly. [2] The NHP (2011-2016) was formulated by the Central Committee and the Working Committee formed in MOH with the participation of related ministries, NGOs and social organizations, though it was mostly limited to the governmental sector. [1]

NHP (2017-2021) under the current government

After the newly elected democratic government took its office in April 2016, the Ministry of Health and Sports (MOHS) put extensive effort to formulate the NHP (2017-2021). The newly formulated NHP aims to accelerate the progress towards Universal Health Coverage (UHC) which becomes a global priority in health sector to strengthen the country's health system with pro-poor and all-inclusive approach involving of multiple stakeholders. The four year NHP set its goal to extend access to the Basic Essential Package of Health Services (EPHS) for the entire population by 2020 along with the increase of financial protection. The NHP will focus on the system strengthening on the four main pillars (human resource, infrastructure, service delivery and health financing) at all levels at the same time ensuring the substantial investment in the supply-side readiness at the township level and below. MOHS intends to strengthen the planning capacity at the township level to be an inclusive one. The NHP also stresses the importance of a data culture which will promote the evidence-based decision making for health planning. The NHP does not refer much on the expected functions of the states and regions, though it clearly mentions the important roles of states and regions in supporting and overseeing the planning, budgeting process and implementation of the Township Health Plans (THPs) [3]

2. Decentralization on health administration in Myanmar

History of health sector decentralization

Health sector decentralization was initiated in Myanmar in 1965 when the Region health departments were formed with responsibility to supervise health administration in a form of de-concentration and had an authority to place and transfer health staff in their respective regions with the limited financial authority, just spending the government budget allotted to them. Following the period of 1990s, the authority of the states and regions on staff allocation matters were more limited; only for the temporary measures to fill vacant posts under the necessary situations. For regulatory matters, the states and regions could take monitoring and enforcement roles of the health-related laws set by the central. [1]

Under the 2008 constitution, decentralization has been advanced through the establishment of the Hluttaws in the states and regions and the formation of the

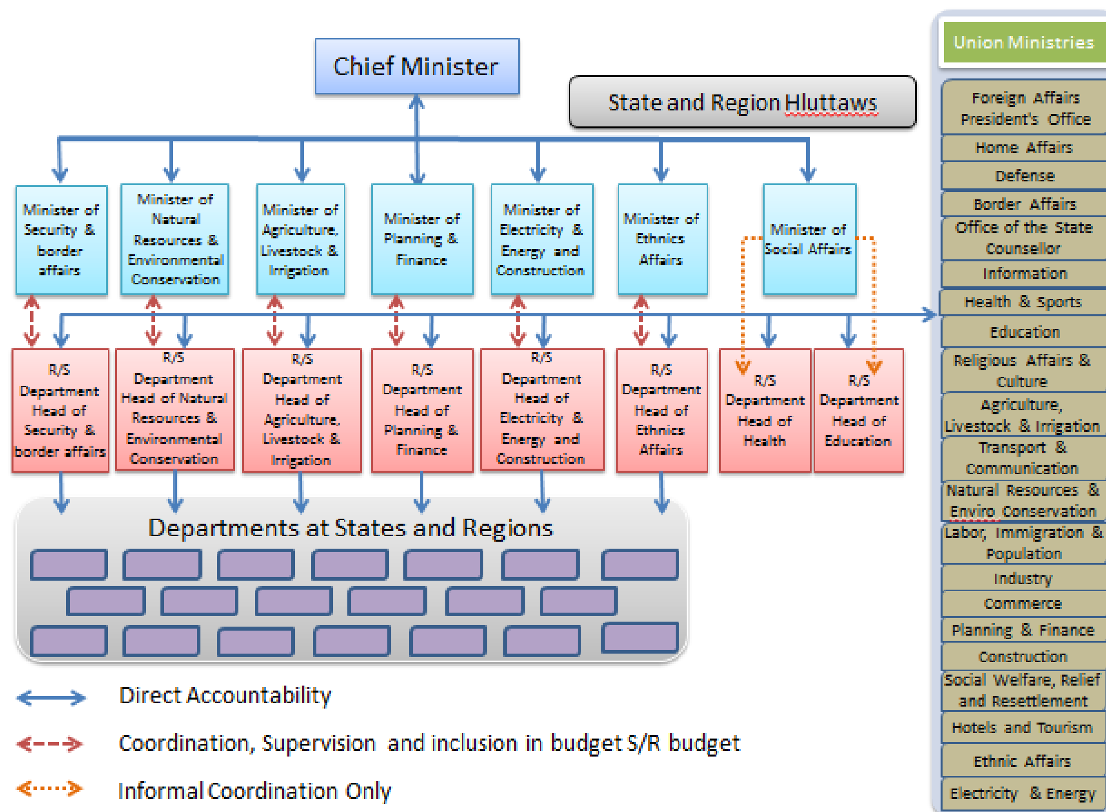
state and region governments holding the power for administrative and financial execution, legislation and collection of own tax and revenue. [4]

Responsibilities of the states and region governments

The 2008 Constitution has clarified some formal division of responsibilities and powers between the central Union Government and new state and region governments. [5] According to the constitution, however, the responsibilities of the state and region governments in social sectors are very limited especially health and education. Union ministry has direct accountability on the state and region health departments. The state and region government has only an informal coordination with the state and region health department and the budget does not include the health, education and social welfare. For these sectors, the Union Ministries determines those budgets. (See *the Figure 1*.) [4]This fact gives a major impact on the form of public participation and accountability in these sectors. The culturally determined mindset of adhering to a hierarchical chain of command is still firmly entrenched. [6]

Figure 1: Organization of State and region government in Myanmar

(Edited from: the Diagram, Indicative Organization of state and region governments in Myanmar in "State and region Governments in Myanmar" [4] [7]



Poor functions of the health committees at the local level
National Health Committee was established in 1989 as an initiative landmark to improve the multi-sectoral involvement and partnership for health. The committee became a high-level policy making body, but its function at township and village levels were reported inadequate to perform desirable functions to coordinate and direct participation of people in the health planning especially in the remote areas. [1] [2] [8] A World Bank report suggested that the committees need to be strengthened to play a stronger role in engaging community members and improving health services. [9]

3. State/region health plans under decentralization

The origin of the state and region health plans are seen in the process of the delegation of administrative authority from MOH to the divisional and township health departments in 1965, and the formulation of the People's Health Plans (PHPs) in the 1970s as mentioned earlier. MOH had started formulating PHPs using a country health programming (CHP) approach, in which PHP committees were established at various level of administration down to the village level to plan to implement and evaluate health activities in their respective jurisdictions according to the national plan. [1]

In line with the formulation of NHP (2011-2016), MOH also developed the state and region health plans for the states and regions. According to *the Region Policy and Plan Guideline*, the state and region health plans took the following facts into consideration during plan formulation;

- Union Government Policy
- National Health Policy and Visions of the MOH
- National Health Plan (NHP) and its objectives
- Millennium Development Goals
- Health Sector Reform Strategies
- Prioritize health programs or sector that need international assistance and support
- Region economic and social situation
- Medium and long-term health plan of state and region governments

The guideline also defined that the state and region health plans have to be incorporated into the state and region development plans with clear identification

of the source of budget and financial gap to implement short and long-term health care program. [10]

4. Township health plans under decentralization

Township health plans

At the township level, several types of health plans were created by the outside funding supports. Coordinated Township Health Plan has been developed under GAVI-HSS project aiming to improve the coverage of skilled birth attendants and vaccination. [11] Also, 3MDGF supported formulation of Comprehensive Township Health Plan for MNCH, TB, HIV and malaria etc. [12]

The ability of the township health department is very limited to coordinate health plan planning with other sector departments and with other health service providers in the township. In addition, the township medical officer (TMO) does not have the means or the mandate to respond to locally specific needs or bottlenecks in service delivery. Lack of operational budget combined with a centralized decision-making structure has a serious impact on the efficiency and effectiveness of service delivery and on the optimal use of the limited manpower at the townships. [6]

B. Interviews

Intensive interviews were made by this review team to the key stakeholders for the state and region health plans both in the state/regions and the central MOHS. The interviewees were questioned on their experiences and opinions on the formulation, monitoring and evaluation, and other related issues on the state and region health plans.

1. Formulation of the state and region health plans

The interview results reveal facts and recognitions of the interviewees and provide basis for recommendations on health plan management at the states and regions.

History of the state and region health plans: start as a meso plan under the NHP (2011-2016)

According to officials at both central and state/region, the state and region health plans were developed at each state and region in the year of 2012 with the

instructions of the Department of Health Planning (DHP) of MOH, which used to be responsible for development of health plans at all levels and was abolished in 2015. After the development of the NHP (2011-2015), DHP gave guidelines and trainings to the S/R health directors for development of five-year state/region health plans, termed "meso-plans, as holistic state/region health plans. Therefore, each state and region health department developed their meso plans and submitted them to the central ministry.

One state/region Medical Service Department official explained that these meso plans contained both public health and hospital services activities although hospital side was just a small part with few activities. When the meso plans were formulated, the NHP (2011-2016) set the national priorities and the meso plans followed these priorities. Also, the meso plans were based on the needs of the state and regions. On the other hand, the plans did not include a budget plan or a proper M&E framework, as mentioned by an official at the central.

Instruction for the formulation of meso plans from the central

According to the several officials interviewed, the meso plans developed in 2012 were not fully utilized for the purposes of allocating resource, reviewing the progress and evaluating the performance. One of the main reasons is lack of proper instructions from the central. The state/region officials expected more detailed instruction from the central especially on the policies, the objectives and strategies of NHP, roles and the budget framework of the meso plans, as one official commented, *"The meso plan was needed to answer what we do, why we want to do and how much we want to spend on that. However, the definition and purpose of the meso plans was not clear yet."* Other official also explained that the meso plans should have been developed based on the available resources at the states and regions. They told the central ministry should have indicated clear goals and objectives of the meso plans in the NHP so that the state/region health departments could have drawn up their own health plans in more realistic and implementable ways.

The central officials also recognized that there were insufficient instructions for the meso plan development. One central official said, "*The central could not provide sufficient information on the vision, objective setting, prioritization and the budget ceiling for each state and region prior to the planning process*".

Impact of organizational change of the ministry

After the structural change of MOH in 2015, the five-year meso plans have not been representing the plans of neither the state/region DPH nor DMS, as mentioned by an official from the central. Any further instructions on the plans did not come from the central. Several officials expressed that as new staff positions in the two departments have not been filled, the state and region health departments do not have a proper planning unit.

The organizational change has both positive and negative impacts. As the Department of Health Planning (DHP) at the central was abolished, the meso plans and their guidelines became inactive automatically. At the same time, no clear instructions were coming from the newly established central departments to the states and regions. On the other hand, there was a positive comment that the vision and scope of DMS became more specific and clear after changing the organization structure, which mainly focus on the quality of service and patient satisfaction at the hospitals.

Current Planning System

Currently, implementation of health programs by the both DPH and DMS at the states and regions is based on the plans developed by the central departments. Moreover, 100 days plans, which were instructed to formulate and implement under the new Ministry in 2016, were developed at both the central and the states and regions. Most of the activities in the plans were regular activities to be reinforced during the 100 days.

An official of DMS at the central said that the central departments develop the state/region and township health plans according to their needs annually. The township health departments develop their micro-plans and based on the township plans the state/region health departments prepare proposals and submit them to the central yearly. MOHS decides the budget plans for the state and region and township health offices by reviewing the proposals, annual reports and assessment results from the monitoring and supervision. Also, the central ministry makes sure that the developed health plans are in line with the National Comprehensive Development Plans made by the Ministry of Planning and Economic Development, especially in the deployment of staff, infrastructure and training.

The central officials show their willingness to provide necessary guidance for the state and region health plans once the new NHP (2017-2021) has been formulated. They said that the central ministry should set clear goals and objectives in the NHP so that the state/region health departments can draw up their own health plans according to the priority of their own states and regions.

Approaches of the state and region health plans formulation: Top-down or bottom-up

There were both positive and negative views on the current centralized planning system among the interviewees at both state and region and central levels. An official of state DPH said, *"Top down planning doesn't reflect the local needs as the decision of the central sometime come from political pressure"*. On the other hand, an official of the central commented that it is more practical to make the disease specific program plans at central because most of the disease specific programs are donor funded and the MOUs are managed at the central level. Moreover, an official from state and region DMS said, *"Currently, planning and decision making is highly controlled by the central DMS, and it is functioning well at the region department."* An official of public health side stated that if the decentralization would not be promoted in the future, the centralized plans are more applicable and the state and region health departments will play only a role of the implementer.

Health Planning at the state and region health departments (state and region DMS and state and region DPH)

There were various perspectives on health planning at states and regions. An official of the RDMS in Ayeyarwaddy Region mentioned that after the structure change of the ministry, the health plans were developed separately by region DPH and region DMS, whereas township plans included both public health and medical services components. The officials also stated that state and region health plans were formulated by compiling the township micro-plans and adding necessary activities specially designated to the state/regions. This plan was based on the situation analysis, problem identification of the service availability and accessibility and the prioritization of the needs. Requests from the parliament members and people voices were also considered in the plan.

An official in Magway explained that all hospitals have to submit annual plans to the central DMS in order to request their needs such as equipment, medicines,

infrastructures and human resource. The central DMS decides budget for hospitals based on the number of beds, and the needs and the priority of the states and regions. The central DMS also plans trainings for all state and regions. Another DMS official said, *"At this moment, the state and region DMSs have neither long nor short term plans. The department is mostly occupied with ad hoc activities"*.

For the DPH side, on the other hand, vertical programs with the support of various donors are highly controlled at the central level, as explained by an official. The plans of various vertical programs are separately developed at the central and come to the states/regions and townships for the implementation. Therefore, the plans of vertical programs are not integrated at both the state/regions and the townships. Another state and region official of DPH stated that the state health plan is assumed as just a combination of coordinated township health plans.

Feasible planning

Both the central and state and region level officials stated that annual plan is more feasible at state and region level. An official at state and region level said, *"Due to the annual budgeting system, it is difficult to formulate a long-term plan."* An official at the central also commented that the state and region health plan is necessary and should be developed yearly.

Furthermore, officials at the central commented that as there are two separate departments, it will be difficult to merge the two plans and should be developed individually. Other official added that the plans of both sides cannot be integrated in one state and region health plan, as each plan is developed with a different purpose at DMS and DPH, curative one and preventive one respectively.

Necessary inputs for health planning at state and region level

According to an official at state and region level, specific units for health planning are needed at all level. Also, the state and region health departments need general staff and supporting technical experts such as accountant, pharmacist, procurement and logistic officers and engineers at every level of administration to formulate, manage and utilize the plan. Several officials emphasized that the capacity building trainings in planning and financing are also needed for the state

and region health departments as well as the clear definition of the role of the state and region health departments and the state and region health plans.

Planning at township level

Plan formulation at the state and region level has poor linkage with THPs due to different systems of planning at township level. According to a central official, THP was not standardized in all 330 townships. There are different guidelines on THP, as various donors supported the township health planning. Components and activities included in the THP also vary with donor interests such as MCH, EPI and Nutrition. GAVI HSS supports 120 townships and 3MDG is also supporting many townships for THP. The coverage is not equally distributed even in single state and region. The instruction has not come from the central to standardize the planning at the townships.

One official said, "*It would be easy for state and region departments to oversee and manage if the THPs are integrated and standardized*". The contents of the current township health plan are donor dependent and not standardized. Moreover, the vertical program plans were not integrated into the THPs, which made it difficult for state and region level officials to manage them.

Involvement of state/region governments in health planning and management

Interview findings reveal that there is involvement of local government in health planning and management. However, the extent of their involvement varies and the types of coordination between the local governments and the state and region health departments differ. In Kayah State, although the region government is not involved in the planning process of the health departments, they always cooperate with the state and region health departments for solving the problems. In Ayayarwaddy Region, the government representatives are involved in the health planning process at the townships and the state and region. State and region plan is formulated with inputs from the state and region government representatives and finalized with their agreement. In Magway Region, there is no active involvement of the region government in health planning. There is only an informal coordination between the local government and health departments lacking regular reporting mechanism.

There is a room for improvement in coordination in health planning and management at state and region level. One social minister at state and region level stated, *"Close coordination between the Region government and health departments should be strengthened for effective planning and management to fulfill the needs in the region"*. Political commitment can be achieved by strong collaboration with state and region government in the plan formulation process at all levels.

Linkage with the state and region government Plan
Currently, the state and region development plans are not in place, but the local governments will develop it by integrating all sectoral plans including health sector plan according to the policy of the new government, as explained by the local social ministers. The state and region government considers incorporating health programs into the state and region development plan such as upgrading road condition and building staff houses to improve health service delivery and safety for health staff in the rural area. The former government did not handover any official state and region development plan to the new government. The new state and region government just follow the instruction from the Union Government. A state and region Social Minister commented that it is impossible to develop a state and region development plans in the current situation without proper policy guidance and instruction from the Union Government.

2. Implementation of state and region health plans

The review explored the possible factors influencing the state and region health plan implementation. In addition to the administration structure, resource management and the delegation of authority could be considered as a factor that affects the plan implementation.

a) Administration structure

Current roles of the state and region health departments for the state and region health plan implementation
Officials at state and region health departments explained that their departments are responsible for the overall administration management to provide health services to the people in the states and regions, which include the management of human resources, finance and procurement/supplies. The supervision of the township health departments' function and the coordination

with the relevant stakeholders are also important functions of the state and region health departments. The state and region DMS supervises all the hospitals in the state/regions except those above 200-beds which are directly managed by the central ministry.

Officials at state and region added that the change of the MOHS organizational structure caused some difficulties at states and regions and townships to perform their routine functions as the staff had not been assigned to the new positions properly.

Collaboration between the state and region health departments and the state/region governments

Collaboration between the state and region health departments and the state and region governments is essential for the effective implementation of the state and region health departments. According to officials of the state and region governments, state and region Social Minister has a coordination role between health and other sectors to improve health service delivery by supporting local procurements of medicines, recruitment of health staff and construction of the health facilities in their states and regions. Taking the procurement of medicines as example, the state and region Social Minister chairs the tender committee at the state/region level. However, the state and region governments do not have separate budget for health whereas the central health ministry provides the budget to their state/region departments.

Coordination with NGOs

Some of the state and region DPH officials stated that they need more coordination with NGOs to avoid the activity overlapping at townships. Coordination meetings are conducted regularly in Kayah and Ayeyarwaddy, quarterly and biannually respectively. There is no proper instruction from the central on how to coordinate NGOs working in the states and regions. Townships are selected for NGO activities at central level without the recommendations from the state and region health departments. Moreover, reporting of the NGO activities to the state and region DPH are not regular and standardized.

b) Resources and their management process

Human resource for health, medicines/medical supplies, budget, infrastructures are the major resource factors which influence the smooth implementation of the state and region health plans together with their proper utilization.

Human Resources

Lack of human resources for health plan implementation is significant. In one region, only eight officials out of forty-nine are being appointed. Out of seventeen state and region DMS offices, only six or seven Director positions are being appointed. Thus, in most of the state/region DMS, Medical Superintendents (MS) of the state and region hospitals take dual functions of both MS and Director of state and region DMS. At township level, although the position of TMO is under the administration of DMS, TMO takes dual functions of both DMS and DPH due to the insufficient human resources. According to a central official, MOHS recently recruited nearly 2,000 medical doctors to fill vacant posts while there are about more than 7,000 unfilled sanctioned posts for the whole country. Another constraint is that about 1,000 medical doctors go to attend post graduate degrees annually by taking one or two-year leaves.

Medicines and medical supplies

Procurement system for medicines and medical supplies was changed in recent years. Formerly, the Central Medical Store Department (CMSD) used to take responsibilities on the procurement, storage and distribution of medicines and medical supplies for all public hospitals in country. It has been for two years since the system is changed, and currently the state and region DMSs manage the local procurement of medical supplies for hospitals with less than 200 beds including township/station hospitals in the states and regions. The new system somehow improves the estimation of requirement of drugs. However, the complexities of the procurement procedures made it difficult for technical staff to manage it, so that training program for the Supply Chain Management System (SCMS) have been provided with the state and region staff and more pharmacists and compounders have been appointed. A central official appreciated that the local management became better with the practice and experience. An official added that the capacity building training and

strengthening of the Logistic Information System are still needed to improve procurement management.

Infrastructure

Health facilities and their related infrastructure also influence the implementation of the state and region health plans in several ways. From the service delivery point of view, an official of the central ministry mentioned that the states and regions have constraints to implement the plan effectively due to the lack of supply side readiness. Insufficient infrastructure such as RHCs makes it difficult to implement the health plans in actual practice especially for the health service provision to the people in remote area. A region government official from Magway also commented, "*Roads to the health facilities should be improved for health providers' access to the rural area and their safety, and comfortable accommodation should be provided*". From the administrative point of view, an official of state and region health department stated that the structural change of the ministry weakens the public health administration as there is only one township DPH office out of 26 townships in Ayeyarwaddy.

Budget

Along with the decentralization movement, the state and region governments have their own budget allocated from the central government although the amount of the budget cannot cover all the needs. The state and region government is supervising the collection of taxes in the region. Fifteen percent of the taxes can be used by the state and region government to provide several activities to fill the needs within the states and regions. For example, in Magway, the region government allocates these budgets from the taxes mostly to education and construction of roads in the region. The state and region budget tends to go to other sectors rather than health sector because the central MOHS directly allocates budget to the state and region health departments.

Budget for state and region DMS, an official from Ayeyarwaddy explained, contains the activities on medical treatment plan, drug procurement, HR cost, maintaining and upgrading equipment, laboratories and infrastructure, trainings and administration for all hospitals in the states and regions. An official from the central ministry added that the state and region health

departments have to follow the rules and regulations set by the union government for the procurement of drugs and equipment and the construction of building.

Budget for state and region DPH, the officials from states and regions commented, is too small to fulfill the needs of the states and regions. Implementation of the state and region health plans heavily depends upon the approval timing of the budget by the central ministry; as the budget approval from the central is delayed, the state and region health departments cannot start activities timely within the budget year. Additionally, official from the central ministry said that financial supports by DPs are decided at the central ministry and the state and region health departments rarely know such information.

Moreover, insufficient information and instruction, especially on the budget ceiling, from the central in planning process naturally make the state and region health plans impractical. An official explained that estimation of cost will be more realistic if the central can provide the proper feedback information on the budget proposals from the state and region health departments.

c) Delegation of Authority

In addition to the administration structure, resources and their management process mentioned above, the extent of the authority delegated from the central to the states and regions surely influences the smooth implementation of the state and region health plans.

Delegation of the authority on the appointment of HRH

Although the central ministry delegates some range of authority to the state and region health departments to recruit health staff, there are still many requests from the state and region health departments to widen their authority.

Medical Service Executive Committee, chaired by Director of state and region DMS, was established at states and regions for selection of the candidates in new appointment and transfer of health staff within and outside the state/region. However, the committee has only to recommend the candidates and the final decision of the appointment and transfer were remained to the

central. Forty-two doctors were recruited in this process last year in Kayah State.

Another interviewee stated that the state and region health departments manage the transfer of hospital staff such as hospital nurses, administration staff but not medical doctors. Although the state and region health departments can issue relieving orders, transfer and recruitment of medical doctors are totally under the control of the central DMS. The other official said, "*Although the rule of civil service allows the state and region directors to recruit general staff, it has become more centralized for last 3 years".* In this regard, the local government has only a role of giving recommendations in transfer of staff within the region, as one of the Region minister said, "*If health professions are needed in a region, the Region government informs it to the Region health department and then the Region health department requests to the central ministry".*

On the other hand, the central ministry responded that the central ministry itself also has a limited authority in the management of HRH and cannot fulfill the basic requirement of health workforce in providing health services at state and region level. The central ministry only assigns staff after the recruitment process of the Union Civil Service Board according to the statement of Ministry of Planning and Finance. An official said, *"There are no clear rules and regulations in the local recruitment of staff with short-term contract and the procedures of transfer."*

Delegation of the authority on budgeting and procurement

According to officials at state and regions, limited budget and the delay of its allocation make it difficult for the state and region health departments to implement the state and region health plans. Budgeting for the state and region health plan is allocated by the central ministry based on the proposal submitted annually from the state and region health departments, whereas the ministry budget is decided by the Union Cabinet. Financial and accounting rules and regulations are not much flexible to reflect the needs efficiently, as an official said, *"Current financial rules of the government are one of the key constraints to do proper planning."* Financial rules in which the fund for line items cannot be carried over to the next year also exacerbate the delays of the implementation of the state and region health plans. Also, it is difficult to include activities out of the line items such as trainings.

3. Health plan monitoring and evaluation

As already mentioned, the 5-year meso plans did not include a proper M&E framework with indicators and targets. There is only annual evaluation mechanism at the states and regions.

Monitoring & Supervision

Monitoring and supervision system exists in both departments at the central and the states/regions according to the interviewees. An official of the central DMS said that there are four groups led by the Deputy Directors General, which are responsible for monitoring of general hospitals. The state and region DMS have their own supervision plan to visit hospitals at districts and townships. The state and region medical services departments conduct supervisions to townships more frequently than the central. There is no significant difference between the central and the state and region level in the supervision of hospitals.

In the DPH side, the state and region health departments conduct supportive supervision to the township level with using checklist. Supervision from states/regions to the townships is conducted by respective staff of the state and region DPH and specific vertical programs. However, there are several difficulties; such as transportation, proper documentation of supervision checklists, lack of supporting staff and small budget for supervision. Monitoring and supervision budget allocated from the central ministry cannot cover the actual cost.

Evaluation

According to the comments of almost all interviewees, the annual and mid-term evaluations of the planned activities are conducted at all levels. At the time of evaluation, the progress of activities and the basic health indicators such as MMR, IMR and EPI coverage are checked and the cross-cutting issues such as HRH and infrastructure are reviewed. Vertical programs under DPH have separate monitoring plans at every level and implement them bi-annually.

At state/region level, Community Health Care Review Meetings are held for evaluation of the achievements of township health departments yearly. The state and region health departments submit annual evaluation reports to MOHS. Based on the evaluation reports, the state and region health department proposes the Region needs to the central ministry. An official said that evaluation, review of implementation progress and situation analysis are going quite well at all level,

and these are not conducted based on the pre-formulated plans. In DMS side, an official said, there are no proper frameworks of M&E at all level, and it is needed to develop more performance indicators.

Utilization of these reports at central ministry for planning and decision making is unclear, as an official at state/region level said, *"The state and region evaluation reports are submitted to the central ministry annually. Based on the evaluation reports from the townships, the state and region health departments propose their needs to the central ministry. However, it is not clear that the state/region evaluation reports are used or not at the central ministry in planning process."* An official at central also commented that the evaluation reports are not extensively used in planning.

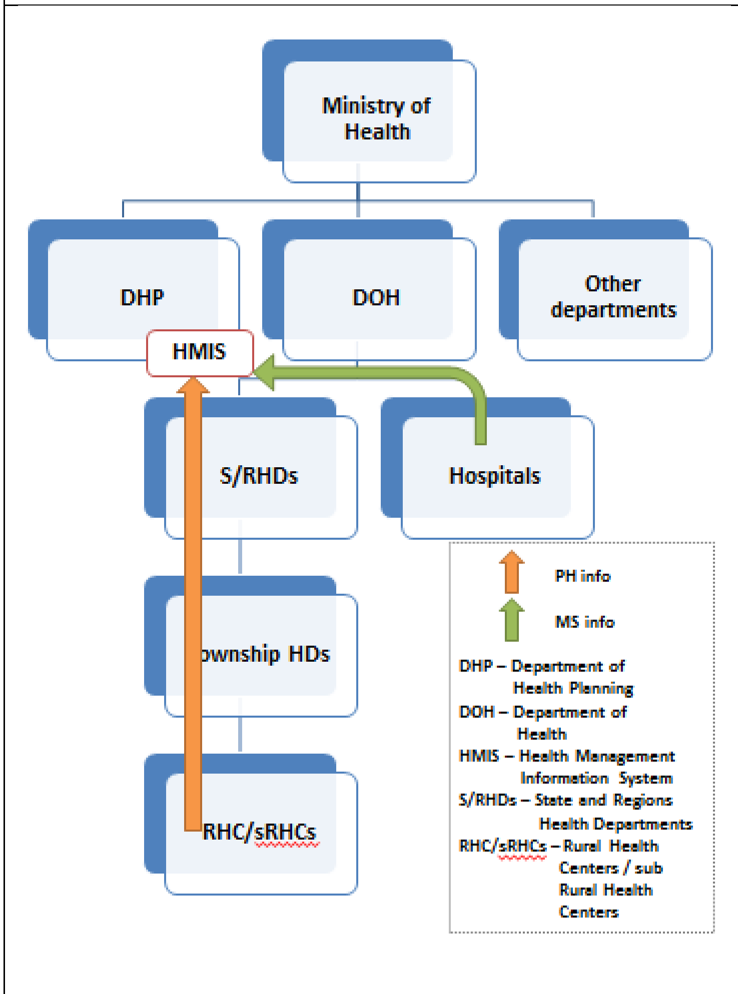
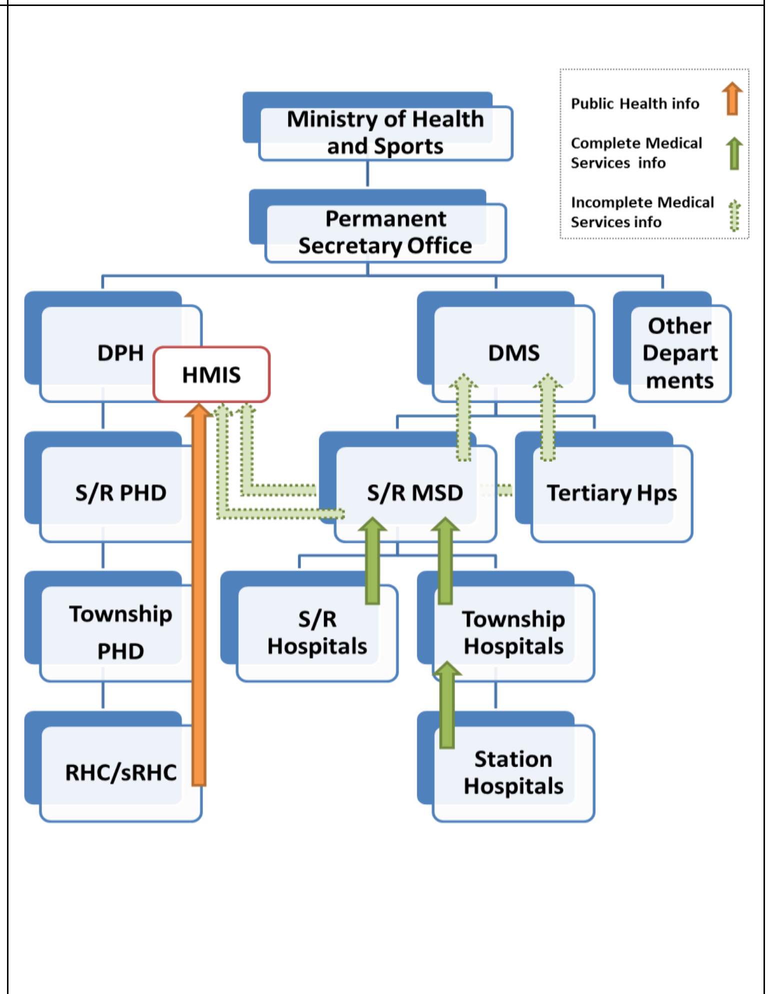
Information System

Health information in MOHS used to be managed in the Health Management Information System (HMIS) Unit under DHP. In the new structure of MOHS, both DPH and DMS have a division for the information management named Inspection and Audit Division, whereas the Ex-HMIS Unit function remains in the Inspection and Audit Division of DPH.

The state and region health departments review the monthly HMIS reports coming from townships. Also, the HMIS reports are checked for data validity and consistency biannually at state and region level. Monthly reports, HMIS reports and program specific reports are used as the main sources for the analysis and evaluation.

There is some confusion with the health information flow. Reporting channel is not clear whether hospital data should be reported to DMS or HMIS Unit under the DPH, as one official said, *"Hospital data are reported to the Inspection and Audit Division of DPH more regularly than that of DMS. These situations are created by the unclear-cut demarcation of the information flows of the two departments at both central and states and regions".* (See Figure 2.1 and 2.2)) As a result, the HMIS Unit became overloaded so that they cannot share annual data timely to all levels and DMS side has limited hospital information. Staff for information management is not enough at all level. DPH has appointed statisticians and DMS has appointed Medical Record Technicians (MRTs) both at states and regions for data compilation and analysis but there are still many

vacancies. Reporting is delayed sometimes due to the shortage of technical staff for data entry. The publications of the annual statistical reports had been delayed for more than two years.

Figure 2.1 Data flow before the ministry structure reform in 2015	*Figure 2.2 Data flow after the ministry structure reform in 2015*
	

4. Others

Mechanism how to collect people's voice for state and region health plans

The interview results show that as the government is encouraging listening of community's voices, the local governments have several mechanisms to listen to the messages from the community; such as complaint letters, investigation visits and through parliament members and Community-based organizations.

Several approaches at the state/region health departments can also be seen, as the continuation of special activities in the 100-day-plan period. In Ayeyarwaddy Region, there were meetings between the community and health staff in five townships to listen the people's voices. Reception desks were set-up to provide information. Also, a new activity called 'Discharged Break' is to ask feedback and opinions to the patients at the time of discharge, which are current mechanisms to listen the people's voice in the hospitals of several states and regions. Moreover, discussion activities between community and BHS are implemented at RHC through Accountability, Equity and Inclusion (AEI) Program introduced by a DP.

Although both the state and region governments and health departments are trying to listen to the people's voice, it needs to be strengthened more. A social minister commented, *"People's voices should be listened more and mechanism in conveying their voices should be strengthened by both Region government and health departments in provision of health services".* An official added that, *"People would like to get responses from health staff. If people are aware that their voices have been responded to, they feel more eager to make their voices and express their views"*

V. Discussions and recommendations

A. Discussions

In this section, focus will be on key issues such as how to create best ways to make use of the expected functions of the state and region health plans for the improvement of the health administration at the states and regions. The discussions deal with the following key issues based on the facts and comments/opinions collected through the literature review and the interviews;

- Necessity of the state and region health plans
- Possible state/region health plans
- Collaboration among the stakeholders
- Authority delegation to the states and regions
- Monitoring and evaluation of the state/region health plans
- How to collect and reflect the people's voice to the state/region health plans

1. Necessity of the state and region health plans

As seen in the interview results, though the perceptions of the state and region health plans among the interviewees vary, a certain enthusiasm to formulate and implement the state and region health plans is observed. The necessity of the state and region health plans is discussed here.

State and region health plans to support the implementation of NHP and ITHPs[1]

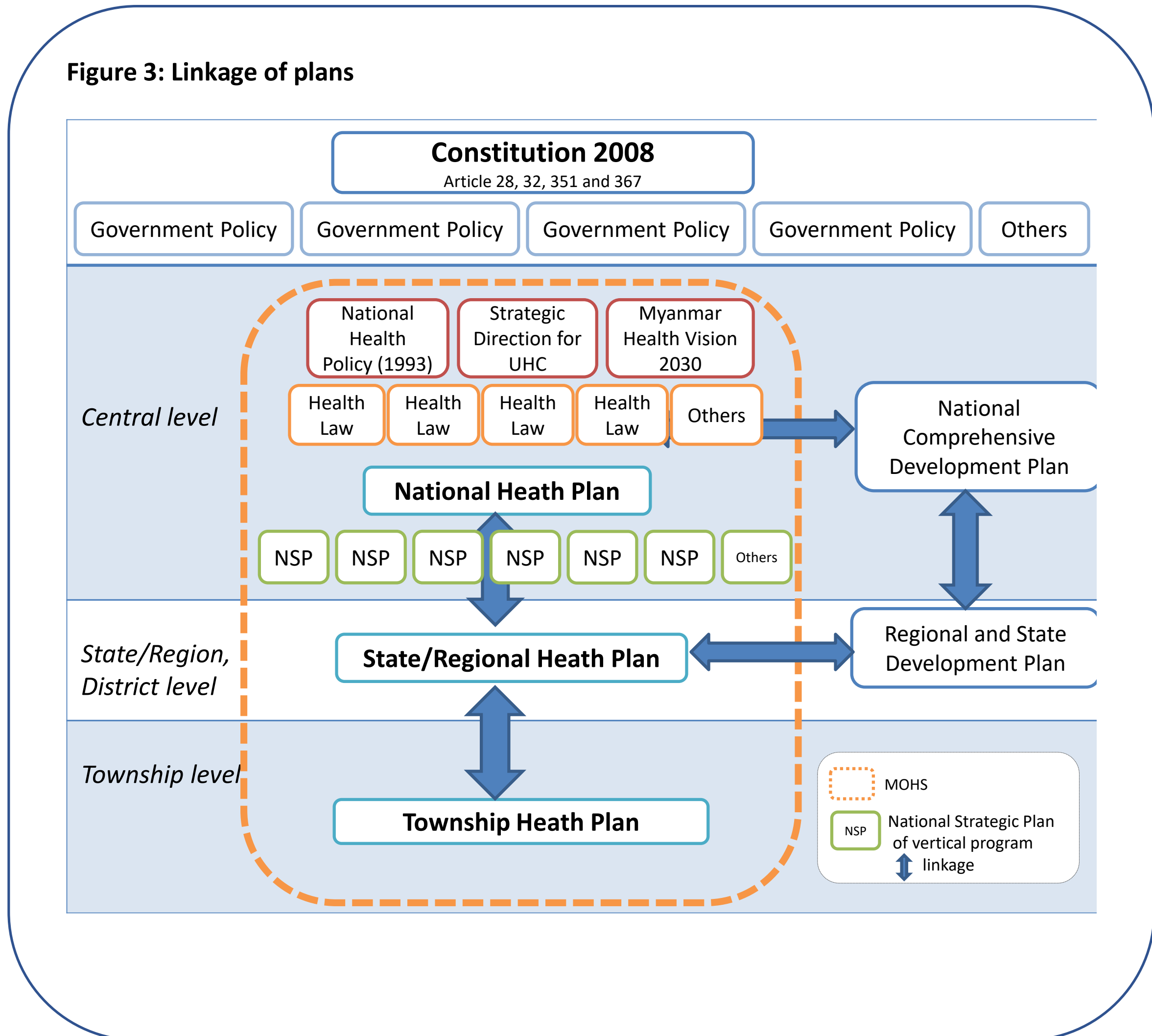
The state and region health plans have important roles in managing the health activities of the state/region health departments. It was observed that these departments are responsible for certain duties like overall health administration management, the supports and supervision of the township and the coordination among the relevant stakeholders in the states and regions with limited resources. The NHP (2017-2021) mentions, *"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."* [3] The state and region health plans play indispensable roles between the NHP and the THPs. As a summary of the THPs in their respective area, state and region health plans will help the central ministry for its understandings and management of the THPs. Also, the state and region health plans can be a part of the implementation plans of the NHP at states and regions. The state/region health departments interpret the NHP into state and region health plans taking the local situation, local needs, condition and available resources into consideration. The priorities in the states and regions can be considered in the state and region health plans.

Moreover, state and Region health plan can be a document in line with the state/region Development Plan and the National Comprehensive Development

[1] The NHP (2017-2021) will promote to formulate Integrated Township Health Plans (ITHP).

Plan as well as NHP and national strategic plan of each vertical program. (See Figure 3)

Figure 3: Linkage of plans



State and region health plans to strengthen the unity of the stakeholders

There are positive effects on the state/region DMS and DPH to formulate their health plans by themselves for fostering the ownership of the plans, creating a system of team work, setting the proper prioritization of the needs and collaboration with other stakeholders. The formulation process of the state and

region health plans itself may promote the team-work spirit among the stakeholders in the states and regions. For example, state DMS in Kayah State started formulating a document of "Special efforts 2017" in which they stated the planned activities with the mission, vision and the core values of the department. Throughout the formulation workshops, the officials discussed key elements and shared what they want to realize in the state DMS. These processes built the basis of teamwork and strengthen the cohesion of the stakeholders in a practical way rather than by trainings.

Moreover, the state and region health plans promote accountability of the state and region health departments through advocating their activities to the people. The state and region health plan is a document through which the people can understand all activities related to health and state and region health departments' intentions.

2. Possible state/region health plans

Despites all those above-mentioned merits of state and region health plans, the interviewees claimed that the roles of the state and region health plans are not clearly defined in official documents such as the NHP and strategic plans. Clear definition of the role and proper guidance/instruction are indispensable. The interview results indicate insufficient guidance for state and region health plans is one of the reasons why the meso plans were not properly formulated nor utilized. Therefore, proper guidance and instruction are needed for state and region health plans with information of budget ceiling. Other considerations that can be made for state and region health plans are as followings,

Two independent plans with the common goals or objectives: As many officials stated, it seems more practical to formulate the state and region health plans separately at the DPH and the DMS at the states and regions. However, it is desirable to set common goals or objectives between DPH and DMS to solve the health problems effectively. Also, it is necessary to link the goals or objectives of state and region health plans with the state and region development plans as well as the NHP.

Annual based plan with long term vision: Based on the results of the interviews, annual-based formulation of the state and region health plans seems to be more feasible and practical than the multi-year-based plans under the present situation. On the other hand, some programs like the delivery of basic Essential Package of

Health Service to all population may require certain period to be achieved. To pursue such long-term objectives, the state and region health plans may need to have a medium- or long- term vision and goals in line with the NHP, which can be broken down to the series of the implementation activities in the annual plans.

Flexibility according to the local context: Some of the state/region officials stressed that certain formats are needed for the state and region health plans formulation. The formats can facilitate and standardize the process of the formulation of the state and region health plans and also include essential information which the central ministry requires. On the other hand, the format should be provided with some flexibility for formulating the plans according to their local contexts. For example, the focused program areas of state and region health plans of Magway and of Kayah will be different as the local conditions are different. These differences cannot be managed without flexibility. Moreover, this flexibility may enhance originality and creativity, which may be good solutions to solve problems at state and region.

3. Collaboration among the stakeholders

Collaboration between state and region departments and the central ministry: The central ministry needs to function not only as a supervisor but also as a supporting partner to the state and region departments which jointly makes the state and region health plans. If officials at the central join the formulation process, the state and region health departments can obtain proper instruction from the central officials as well as the central officials understand the state and region health departments' decisions and what they expect from the central.

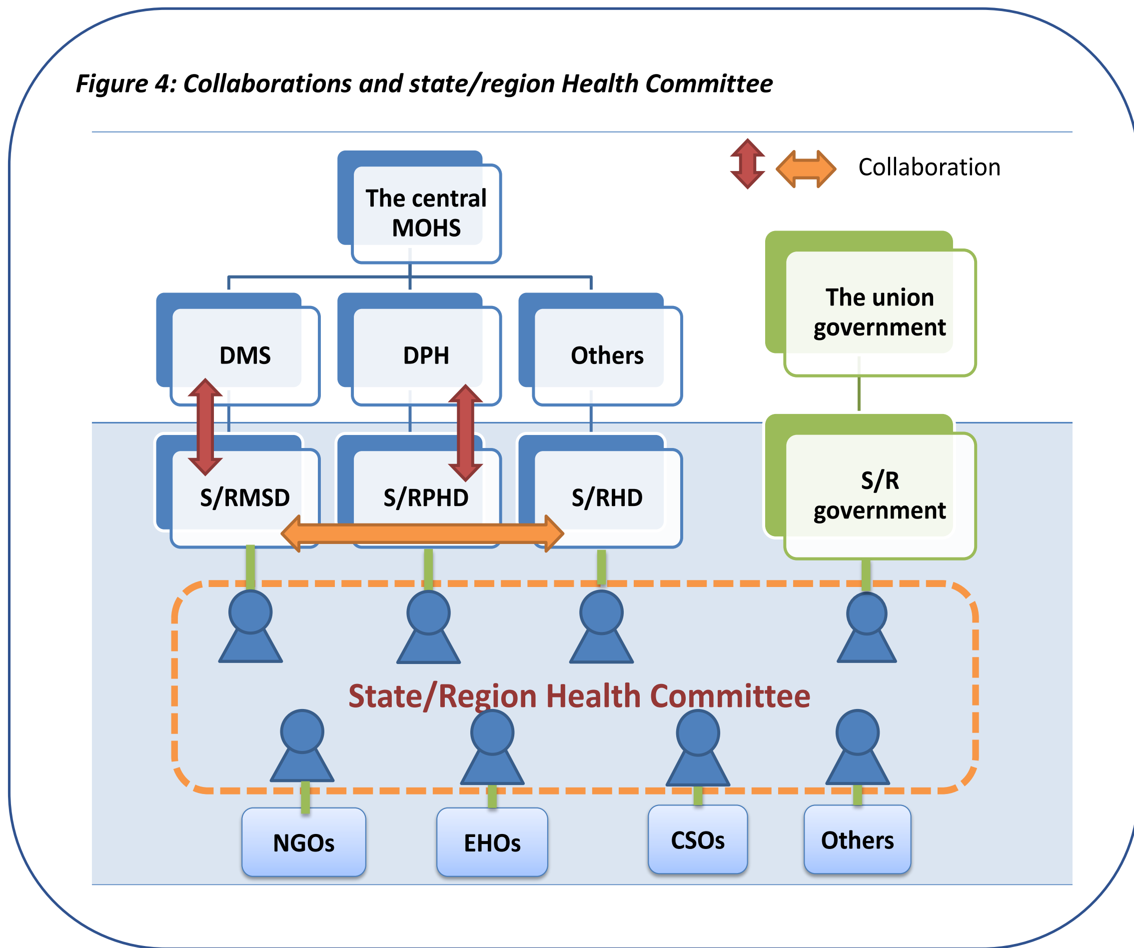
Planning divisions of the central departments are supposed to deal with the state/region departments and to coordinate among the central departments in working with the states and regions. They can also be responsible for intra-departmental coordination to oversee all the vertical programs within the department. Although the close coordination between central and the state/region departments is needed, it is also necessary for the central department to acknowledge the ownership of the state/region departments throughout from the planning to the implementation of their plans.

Coordination and cooperation between the state and region DPH and state and region DMS: Interviewees from the states and regions stated that the current state and region plans are made not in a unified but in separated forms by the state and

region DPH and state and region DMS on annual bases. They perceived it as a practical way to formulate usable state health plans. However, it is obvious that the good collaboration between the DPH and DMS in the states and regions can avoid gaps and duplications in the provision of the sequential preventive and curative care and services against any kinds of health issues.

Revitalization of the state and region Health Committees: Through the review of the literatures, it was found that health committees existed at various administrative levels under the leadership of National Health Committee in the past for facilitation of health program implementation among different stakeholders. However, the interview results showed that the current existence and functional status of these committees are questionable.

Revitalization of state/region health committees and expanding its functions are possible ways to promote the involvement of all stakeholders in formulating and managing the state and region health plans. The state/region health committees can function as an arena where all stakeholders for the health issues get together. The feasible composition of the committee members will be the representatives of the state and region government, of the state and region DPH and DMS, of civil societies, of community-based organization (CBO), and of ethnic health organization (EHO). The involvement of the central health ministry should be minimized as it may lead to the central control and weaken the independency of the health committee at states and regions. (See Figure 4.)



4. Authority delegation to the states and regions

As many of both central and state and region officials commented delegation of a certain authorities from the central to the states and regions are desirable, especially those on plan formulation, budgeting and procurement, and the appointment of health staff.

Authority for the formulation of state and region health plans: One of the reasons why the meso plans were not much practically utilized was the lack of the ownership of the plan as there were not much flexibility of the contents to respond the local needs. It will be required for the central ministry to give minimum and basic instructions with the commitment based on the scope and framework of the NHP and flexibility for the modification of the contents of the plan to reflect the local needs and priority for the state and region health departments.

Authority of budgeting and procurement: Uncertainty of the budget ceiling made the state and region officials difficult to formulate a realistic and feasible state and region health plans. The union government including the financial authority and MOHS should make a certain commitment on the budget ceiling and delegate the authority for the detail budget items and procurement to the state and region health offices. If so, state and region health departments can develop the detail budget plan according to their need and spend the fund to operate the plans in a timely manner.

Authority on the recruitment and appointment of health staff: Although a certain authority on the recruitment and assignment of the health staff have already shifted to the states and regions, it should be further promoted especially for the local recruitment of the health staff. It can assure the retention of health staff and widen the flexibility of appointment and of transfer of those staff including medical doctors responding to the actual needs of their own states and regions.

Capacity building of the state and region health departments: Considering the scarcity of the manpower and its capacity, a stepwise delegation of the authority would be feasible as some of the interviewees advised. Proper technical guidance and trainings should be provided to the assigned staff at the states and regions.

5. Monitoring and evaluation of the state and region health plans

The interviews to the officials of the states and regions health departments revealed that the M&E mechanism for the state/region plans (meso plans) did not function well. The reasons were that the M&E framework was not clearly defined and the budget ceiling for the plan was not properly indicated and committed from the central ministry. Besides that, many of the activities being implemented in the states and regions were not listed in the original plans and initiated afterward without revising the plans so that it made M&E of the plans difficult to be practiced.

The other factors which hinder the effective M&E system are shortages of the budget for supervision, means of transportation for supervision, and supporting staff for M&E work. As the new minister stressed the importance of a data culture, stable information and data reporting systems are to be strengthened for the functional M&E.

6. How to collect and reflect the People's voice for the state and region health plans

There are several good examples of the ways to collect the people's voice at the states and regions such as the field investigation and the reception desk setup at the hospitals. These are expected to be strengthened more. Even though various mechanisms of collecting people's voices have been identified, it is not clear how peoples' voices are reflected in the plan and implementation.

The state and region health plans will be functioning as a useful tool to communicate with the people. People can understand the future direction of the state and region health departments' activities and the progress of the activities through the state and region health plans. Also, the activities in the plan should be ensured that the plan itself can be a proof of inclusiveness of people's voices in health planning.

B. Recommendations

Based on the issues which were discussed above, some recommendations are extracted here in brief.

1. Recommendations for the central level

a. Clear definition of the state and region health plans should be developed and clear guidelines and instructions with budget ceiling should be provided to formulate the plans including M&E framework.

b. The resource allocation should be assured. Also, it should be considered to delegate some authority to the state and region level for the effective implementations.

c. Timely feedback to the evaluation reports coming from the state and region is needed.

d. There need to be more assistance of central officials into planning process of the state and region health plans.

2. Recommendations for the state and region level

a. The state and region health plan formulation should be strengthened by building the capacity of state and region health department officers.

b. Coordination among the stakeholders to formulate the state and region health plans should be promoted. Revitalization of the state and region health committee is one of the solutions.

c. The state and region Health Plan should possibly be formulated as follows;

- Annual plans with long-term vision set at the state and region level.
- Separately developed by the state and region DMS and the state and region DPH with common goals set at the state and region level
- Linked with the NHP, following the main strategy and policy of the NHP
- Flexible, original and creative

d. The M&E should be properly implemented according to the M&E framework with the effective usage of information system

VI. Conclusion

Throughout of the literature review and the interview, it was recognized that the state and region health departments have a vital role of supporting townships for their implementation of various health programs and activities on the ground. The central ministry also expects the assistance of state and region health offices to disseminate the ideas of the NHP to all townships. State and region health plans will work as an effective tool to conduct all these roles at the state and region health offices in an efficient way,

The review concludes that for the formulation of the state and region health plan, clear definition and functions of the state and region health plans and proper instruction on how to formulate the plans from the central are to be initially clarified. Also, proper allocation of the human and financial resources with delegation of the authority to certain extent to the state and region offices will be needed for the use of these resources through the effective utilization of the state and region health plans.

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