



# WHO Country Cooperation Strategy 2008-2011

## Myanmar



World Health  
Organization

Country Office for Myanmar

# **WHO Country Cooperation Strategy**

## **2008–2011**

### **Myanmar**

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## Preface

The collaborative activities of the World Health Organization (WHO) in the South-East Asia Region are designed to improve the health status of the population of Member countries. Although WHO already has been playing a significant role in the strengthening of health policies and programmes in the Region, Country Cooperation Strategies (CCSs) are meant to identify how the Organization can further support countries in improving health development .

The South-East Asia Region was one of the first WHO regions to develop CCSs and the first region to develop a CCS for each of its Member countries. Working with Headquarters, the Region has improved the quality of the CCSs to make them more strategic and to provide a sharper focus for WHO's work. This involves closer participation of the Ministry of Health, other relevant ministries and key development partners in drafting the CCS, ensuring that their inputs are a key consideration in developing WHO's strategic agenda in the country.

All 11 Member countries the Region have prepared a CCS during the past six years. In the case of Myanmar, the previous CCS was developed in 2000 and implemented during 2002-2005. It has provided guidelines for the WHO Country Office to plan and coordinate its work effectively with national and international counterparts for health development in Myanmar. Since then, the country has experienced many emerging changes in its health situation. The government has invested efforts in strengthening health care facilities in the country, while key partners have also made significant contributions within the framework of national health development.

Analyses of the current health situation and the likely scenario over the next four years have together formed the basis of the priorities outlined in this CCS. The inputs and suggestions from the Ministry of Health, whose officials have been the major collaborators in developing the document, are appreciated. In addition, the advice and recommendations of the health development partners in Myanmar were invaluable in guiding the development of the CCS. This consultative process will help ensure that WHO inputs provide the maximum support to health development efforts in the country.

We recognize that a strong and capable WHO country office is a key to successfully achieving the strategic agenda of the CCS. Therefore, we will continue to strengthen the Country Office in Myanmar over the CCS period (2008-2011). The

staff of the WHO Regional Office for South-East Asia will use this CCS to determine regional priorities and support collaborative activities in Myanmar. Furthermore, we will also seek assistance as necessary from WHO Headquarters in order to bolster these efforts.

Finally, I would like to thank all those who were involved in developing this CCS for Myanmar. We expect that the work of WHO, along with the Ministry of Health, other relevant ministries and our development partners will lead to further improvements in the health of the people of Myanmar.

A handwritten signature in black ink, reading "Samlee Plianbangchang". The signature is written in a cursive, flowing style.

Samlee Plianbangchang, M.D., Dr.P.H.  
Regional Director

## Foreword

The purpose of this document is to outline the directions and priority areas that the World Health Organization (WHO) will focus on during 2008-2011. As a medium-term strategy, the WHO Myanmar Country Cooperation Strategy (CCS) is designed to cover four years, from 2008 to 2011. The CCS will provide clear guidance for collaboration among WHO and its partners working for health in Myanmar.

While the Eleventh General Programme of Work 2006-2015 sets out the broad directions for the work of WHO, the Medium-term Strategic Plan of 2008-2013 defines the specific priorities of the Organization. The Myanmar CCS not only reflects organization-wide priorities of WHO but also national health priorities, since all the key stakeholders have actively involved in its development. As was the case for previous CCS (2002-2005), the new CCS, even at its draft stage, has served as a framework for WHO collaborative workplans for the 2008-2009 biennium.

Myanmar is one of the developing nations demonstrating strong efforts to undertake the challenges of multiple health problems even with limited resources. WHO has been providing technical support to the Government through the Ministry of Health (MoH) as part of its normative function. In addition, the WHO Country Office for Myanmar is leading resource mobilization as well as facilitating fund flow mechanisms to support health activities in the country. Because external assistance to health sector is a major source of funding, it is a unique and important role for WHO to play between the Government of Myanmar and interested donors that have restrictions on providing direct financial support.

With support from bilateral agencies, donors and WHO, the country has made considerable progress in promoting and implementing health programmes. Positive trends have reflected the successes achieved in immunizations, the DOTS programme for tuberculosis (directly observed treatment, short-course), malaria, HIV/AIDS, avian and human pandemic influenza preparedness and many other areas. The 2008-2011 CCS has described the WHO-MoH collaborative work plan in that line, and will continue its role in providing direction.

It is my pleasure to present this document on WHO's strategic agenda to the local and the international development partners who are contributing to the health and well-being of the people of Myanmar. We hope that this document will be useful to mobilize and streamline more support for activities related to the health sector. The CCS 2008-2011 will also serve as the main reference for developing the health

chapter in the *Myanmar UN Strategic Framework* and as guidelines to achieve the health objectives of the Millenium Development Goals (MDGs) by 2015. This CCS will ensure the continuation of what has been achieved in the previous bienniums and in order to work more efficiently it will focus on (i) improving the performance of the health system; (ii) bringing down the burden of disease; and (iii) improving health conditions for mothers, children and adolescents as a priority.

WHO will remain committed to continuing its overall assistance and to assisting the country's efforts to improve health status of the people of Myanmar.

A handwritten signature in black ink, appearing to read 'Adik Wibowo', with a stylized, cursive script.

Adik Wibowo  
WHO Representative to Myanmar  
Yangon

January 2008

## Executive summary

This WHO Country Cooperation Strategy (CCS) for Myanmar presents the directions and priority areas that WHO will focus on in Myanmar during the period 2008-2011, in line with WHO global and regional policy frameworks and following an assessment of the comparative advantage that the Organization enjoys. The updated CCS is built on the experiences and achievements during the period of the first CCS (2002-2005), which was reviewed during 2006-2007, in close collaboration with the Ministry of Health and development partners, by a team of staff members from the WHO Country Office, Regional Office for South-East Asia and headquarters.

Myanmar is a developing nation with an estimated population of 55.4 million. Despite a significant economic growth rate in the recent years, there are important disparities in rural areas, where about 70% of the population resides and which benefit much less than urban areas. Major infectious diseases are in the list of priorities under the National Health Plan 2006-2011. Malaria is the leading cause of reported morbidity and mortality in the country. A majority of malaria infections are now highly resistant to commonly used anti-malaria drugs. Myanmar is among the 22 countries globally with the highest burdens of tuberculosis (TB). The overall prevalence of human immunodeficiency virus (HIV) among adults is estimated at 0.67%. The prevalence of multi-drug resistant TB (MDR-TB) and TB-HIV co-infections are emerging problems. The country has aligned its response with the WHO global action plan for pandemic influenza and has been prepared for a possible outbreak of avian and human pandemic influenza since early 2006. Myanmar has taken steps to implement the International Health Regulations (2005), or IHR. Dengue and dengue haemorrhagic fever (DHF) appears to be an increasing problem with seasonal epidemics in certain parts of the country. Leprosy, though no longer a public health problem in Myanmar, still needs attention, for example by sustaining leprosy control activities and providing quality leprosy services focusing on prevention of disability and rehabilitation of persons affected by leprosy.

Noncommunicable diseases, such as diabetes mellitus, cardiovascular diseases (including hypertension) and cancers, are emerging as important health problems as a result of various risk factors. Tobacco use, both by smoking and chewing, is fairly common. Although snakebites are a major problem, it is difficult to estimate their exact number because relatively few cases come to the hospital. Mental illness and avoidable blindness are also emerging health issues. Official statistics show that injuries stand first among the leading reported causes of morbidity and third among the

causes of mortality, in Myanmar. Disasters are also a major concern. Natural disasters common in Myanmar are floods, cyclones, storms, earthquakes and landslides. Human-induced disasters include urban fires, which usually occur in the hot dry season. Around 80% of the population in Myanmar have access to improved water supply and sanitary means of excreta disposal. Malnutrition, including micronutrient deficiencies, continues to be a public health concern in Myanmar.

A five-year Strategic Plan for Child Health Development (2005-2009) has been formulated. Although there has been notable improvement in the health status of children, much more needs to be done to sustain the gains made. Improving quality and coverage of immunization services need special attention for protecting children from vaccine-preventable diseases. In the aftermath of the polio outbreak reported from Maungdaw township of Rakhine State, sub-National Immunization Days and country-wide National Immunization Days for poliomyelitis eradication were organized in 2007. Despite a series of preventive campaigns, measles outbreaks still occur. Nationwide mass measles campaigns were carried out in 2007 to reduce measles mortality.

There is little information available about the adolescent health situation, and very few programmes specifically address this issue. Following a recent WHO review, a five-year Strategic Plan for Adolescent Health (2006-2010) was launched in December 2006. The estimates for the year 2000 on maternal mortality indicated a maternal mortality ratio (MMR) of 360 per 100 000 live births. A recent study showed a slight decrease but the MMR in rural areas was estimated to be about 2.5 times that in urban areas. It is estimated that unsafe abortions may account for approximately half of all maternal deaths. The five-year Strategic Plan for Reproductive Health was formulated and launched by the Ministry of Health in 2004.

The Government of Myanmar has, as one of its social objectives, committed itself to “the uplift of the health, fitness and educational standards of the entire nation”<sup>1</sup>. The National Health Committee, chaired by the Secretary of the State Peace and Development Council, is a high-level interministerial and policy-making body for health matters concerning the country. Health committees exist at each administrative level, providing a mechanism for intersectoral collaboration and coordination. Four health-related medium- and long-term plans have also been developed, including the National Health Plan (NHP) 2006-2011. NHP contains the following health system goals: improving health, i.e. to raise average levels and reduce inequalities; improving responsiveness to people’s expectations; and improving fairness in the distribution of financial contributions. A number of national strategic plans exist for particular domains such as reproductive health, child health, adolescent health, HIV/AIDS, TB and malaria, and for water supply, sanitation and hygiene.

The Ministry of Health is responsible for the preventive, promotive, curative and rehabilitative health services at all levels through seven departments and hospitals and clinics at various levels. At the township level, health services are provided by the township hospital, station hospitals, urban and rural health centres and sub-rural health centres. Health staff at community levels provide health services using the primary health-care (PHC) approach with the participation of voluntary health workers such as auxiliary midwives and community health workers. There are competent staff members at all levels with the capacity to mobilize the workforce and the communities for short-term, intensive campaigns. There was also a remarkable increase in the number of various categories of the health workforce, as many new health-related universities and training institutions had been founded between 1988 and 2007. The public health-care system, however, is critically under-resourced, with major problem areas concerning issues of access and coverage. Insufficient human resources at the periphery, paucity of drugs and lack of basic information for monitoring are critical. Traditional medicine also plays an important role in the public health system and is currently accorded a high profile and considerable support by the government. Services and drugs are made available free of charge. While the private sector has expanded rapidly and is currently estimated to provide 75%-80% of ambulatory care, private service providers have had limited involvement in public health programmes.

The United Nations plays a major role in contributing to health activities. The main contributors include WHO, the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA) and the Food and Agriculture Organization of the United Nations (FAO). WHO is currently participating in technical partnerships through UN working groups and technical and strategy groups. The contribution of nongovernmental organizations (NGOs) to the health development of the country is also remarkable. The Ministry of Health has signed memorandums of understanding with 31 international NGOs and 10 national NGOs on collaboration in health development, particularly in the areas of maternal and child health, primary health care, environmental sanitation, control of communicable diseases, rehabilitation of the disabled and border health.

Although government health expenditures increased three-fold between 2000-2001 and 2005-2006, the health sector is highly under-resourced. In 2003 general government expenditures on health, as a percentage of the total expenditures on health, was 19.4% while the remaining 80.6% was from the private sector.. External assistance is a major source of financing in the health sector. In 2004, Myanmar received total official development assistance (ODA) of US\$ 121 million, of which roughly 13% went to the health sector. However, very few countries are providing direct financial support to the Government of Myanmar due to restrictions imposed by their national governments and the European Union to this form of assistance. Instead, development assistance to the health sector is channeled mainly through global partnerships such as the Global TB Drug Facility (GDF), WHO Global Malaria

Programme and the Global Alliance for Vaccines and Immunization (GAVI), and directly to international NGOs (INGOs) and national NGOs working in the country. One of the major challenges posed by current aid modalities is to ensure that development assistance aligns with national programmes and policies while at the same time ensuring that conditions imposed by donor countries are respected. Furthermore, funding mechanisms that bypass the government and directly support INGOs and NGOs and external development partners may lead to further weakening of a fragile health system. This may also lead to the creation of parallel health structures and programmes that do not necessarily follow national norms and standards.

WHO is accountable for the implementation of the WHO-Myanmar collaborative programmes although most of the implementation of in-country activities is undertaken by counterparts in MoH. National and international staff members of the WHO country office provide technical and programme management support. When required, staff members from the Regional Office and headquarters provide extensive support as well.

Between 2008 and 2011, WHO will build on the work of the 2002-2005 CCS, expanding support for health development in Myanmar and moving progressively from project to programme support. In consideration of the health situation in Myanmar, the priorities of the Ministry of Health and its health development partners, the Country Cooperation Strategy for 2008-2011 outlines the following areas of priority for WHO:

- (1) Improve health system performance.
- (2) Reduce excess burden of disease.
- (3) Improve health conditions for mothers, children and adolescents.

In these priority areas, WHO will support the stakeholders in accordance with its core functions. For all programmes and services, emphasis will be placed on equity, fairness and progress towards universal access. WHO will continue to act as the centre for information on health, providing updated information on health development and guidelines, norms and standards. The current organizational structure of the WHO Myanmar Country Office (WCO) is still appropriate to cater to the needs of the Myanmar CCS 2008-2011. The organogram of the country office can always be reviewed according to the priority issues during a particular period of a CCS. The country team will have to be supported at the highest levels in the Ministry of Health and in the Regional Office if WHO wishes to ensure its country programme is making the difference that it can potentially make in Myanmar. The WHO Representative will use all possible opportunities to communicate about WHO's strategic agenda in and with Myanmar in order to mobilize and streamline more support for the health sector and bolster the organization's capacity to support its development.

## Introduction

The World Health Organization (WHO) initiated the formulation of the WHO Country Cooperation Strategies (CCS) in 1999. In 2001, Myanmar was among the first Member countries of the WHO South-East Asia (SEA) Region to complete its CCS, covering the period 2002-2005. In keeping with WHO global and regional policy frameworks, and following an assessment of WHO's comparative advantage in supporting Myanmar's health development, this updated CCS presents the directions and priority areas that WHO will focus on during the period 2008-2011. It outlines WHO strategic approaches and operational principles to support Myanmar in achieving its national health-sector development goals and objectives. In this, the Organization will adhere to the functions that have been mandated by its governing bodies — those of providing policy and technical support; catalysing change and building sustainable institutional capacity; engaging in partnerships; monitoring the health situation and assessing health trends; setting norms and standards and monitoring their implementation; and shaping research and disseminating knowledge. The CCS will serve as the guiding document for the development of the WHO country workplan.

The Country Cooperation Strategy for Myanmar for 2008-2011 was reviewed in collaboration with the Ministry of Health and development partners by a team comprising members of the WHO Country Office, the South-East Asia Regional Office (SEARO) and WHO headquarters. Key informant interviews were held with national and international partners in health and other sectors. A workshop was conducted reviewing the collaborative programmes with the Ministry of Health, along with briefing and debriefing sessions that were held with the Minister of Health and Directors-General of the ministry. The team reviewed national, rural, sectoral and subsectoral health plans, implementation progress reports and the latest available information. A briefing session with the main stakeholders provided useful feedback to the review team.

The Country Cooperation Strategy for Myanmar of 2002-2005 had identified six areas of priority: the health system, excess burden of disease, women's health and reproductive health, child and adolescent health, health and environment, and major risk factors hazardous to health. Following the revision process and consultations

during the mission, the priorities of WHO in Myanmar for the period 2008-2011 have been identified as follows:

- (1) Improve the performance of health system.
- (2) Bring down the burden of disease.
- (3) Improve health conditions for mothers, children and adolescents.

WHO Myanmar wishes to acknowledge the valuable contribution made by all partners in health. We express our sincere gratitude to the Ministry of Health of the Government of the Union of Myanmar for their valuable time and useful inputs, as well as partners in the UN system and national and international stakeholders.

## Country health and development challenges

### 2.1 Country context: A brief overview

The Union of Myanmar is a developing country with a significant annual economic growth rate of 12% of GDP in 2002-2003<sup>1</sup>. There are, however, some palpable disparities with rural areas (having about 70% of the population) benefiting from the economic advancement to a lesser degree than urban areas. There are also groups of highly vulnerable populations such as certain ethnic communities and migrant workers.

The population of Myanmar is estimated to be around 55 million, with an approximate annual growth rate of 2%. Life expectancy at birth is between 60 and 64 years<sup>2</sup>. Approximately one-third of the population is under 14 years of age, close to 60% is in the working age group (15-59 years) and around 8% are older than 60. Overall, 78.8% of the population has access to safe drinking water; 92.1% in urban areas and 74.4% in rural areas. The net school enrolment rate is lower for children from poor than non-poor households, at 80.1% and 87.2%, respectively, according to an unpublished integrated household living conditions assessment survey in 2006 of the UNDP. The Human Development Index for Myanmar is 0.581<sup>3</sup>.

Administratively, the nation is divided into 14 states and divisions, 65 districts, 325 townships, 59 sub-townships, 2759 wards and 64 976 villages. Myanmar falls into three well-distinguished natural divisions: the Western Hills, the Central Belt and the Shan Plateau in the East, which continues into the region of Tanintharyi. Three parallel chains of mountain ranges running from north to south divide the country into three river systems (the Ayeyarwaddy,



**Myanmar: Map of states and divisions**

Source: Health in Myanmar 2002.

Sittaung and Thanlwin). The nation has rich natural resources (oil, gas and coal), considerable climatic and ethnic diversity (135 national ethnic groups speaking over 100 languages and dialects) as well as breathtaking scenic beauty.

Myanmar's population density varies from 10 per square kilometre in Chin State to 390 per square kilometre in Yangon Division. The major ethnic groups are Bamar, Chin, Kachin, Kayah, Kayin, Mon, Rakkhine and Shan. A large majority are Buddhists (mainly Bamar, Shan, Mon, Rakkhine and some Kayin), while the rest are Christian, Hindu, Muslim or Animist. Certain areas of the country are hard to reach, especially in Kachin State, Kayah State, Shan State, Tanintharyi Division and Sagaing Division.

Myanmar enjoys a tropical climate with three distinct seasons: rainy, cold and hot. The hot season runs from mid-February to mid-May. The rainy season comes with the southwest monsoon, which lasts from mid-May to mid-October. The cold season commences from mid-October.

The private sector now plays a major role in all spheres of economic activity. The largest country in geographical mainland South-East Asia, Myanmar was admitted to the Association of South-East Asian Nations (ASEAN) in 1997.

Myanmar has adapted the Millennium Development Goals (MDGs) within the context of its National Development Plans. The country, without major assistance from external sources, has been cooperating with UN agencies to respond to basic needs of the people, especially in the social sectors at the grassroots level.

Since November 2005 all government ministries have been relocated to the new administrative capital of Myanmar, Nay Pyi Taw, located in Mandalay Division about 320 km. north of Yangon. The new capital can be accessed by air, train and road.

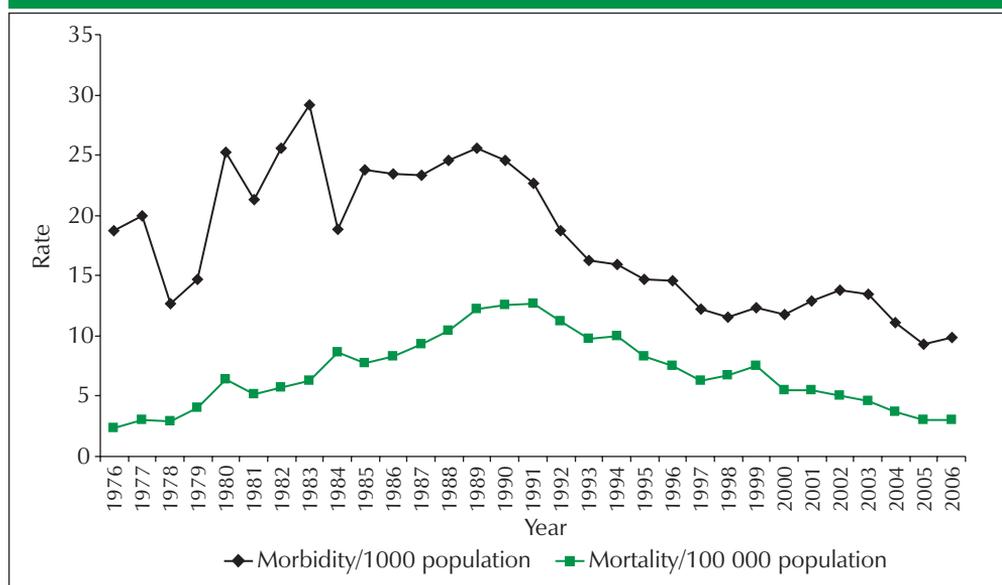
## 2.2 Health situation

### Disease pattern

About 70% of the population in 284 out of 325 townships live in malaria endemic areas<sup>4</sup>. Forest-related workers, new settlers in forest fringes, upland subsistence farmers, migrant workers and ethnic communities constitute high-risk groups. Children under five years of age and pregnant women are also at high risk due to their biological vulnerability. Malaria is the leading cause of reported morbidity and mortality in the country, with 538 110 cases and 1647 deaths due to the disease, both probable and confirmed, reported in 2006<sup>4</sup>. The total number of clinical malaria cases may be much higher, because self-treated cases and those treated by the private sector or by traditional healers are largely unreported<sup>5</sup>. *Plasmodium falciparum* accounts for 75% of malaria infections and is now highly resistant to commonly used anti-malaria drugs such as chloroquine and sulfadoxine-pyrimethamine<sup>6</sup>. In 2005, an external review<sup>7</sup> of the Malaria Control Programme confirmed that significant progress has been made

since 1990 in reducing malaria morbidity and mortality (around 9.51 per 1000 and 2.91 per 100 000, respectively, in 2006; see Figure 2.1). Despite this encouraging trend, serious challenges remain, including scaling up preventive measures like the use of insecticide-treated mosquito nets, addressing multi-drug resistance and improving equitable access to (and the quality of) diagnosis and treatment. The National Malaria Control Programme is well established and the strategies are in accordance with the Revised Malaria Control Strategy (2006-2010) in the SEA Region that was endorsed by the Sixtieth Regional Committee in 2007, as well as with the current WHO Global Malaria Programme strategies. Key partners such as WHO, UNICEF and the Japanese International Cooperation Agency (JICA) are providing funds for drugs, rapid diagnostic tests, equipment, training, operational research and technical assistance.

**Figure 2.1:** Malaria morbidity and mortality rate in Myanmar, 1976-2006



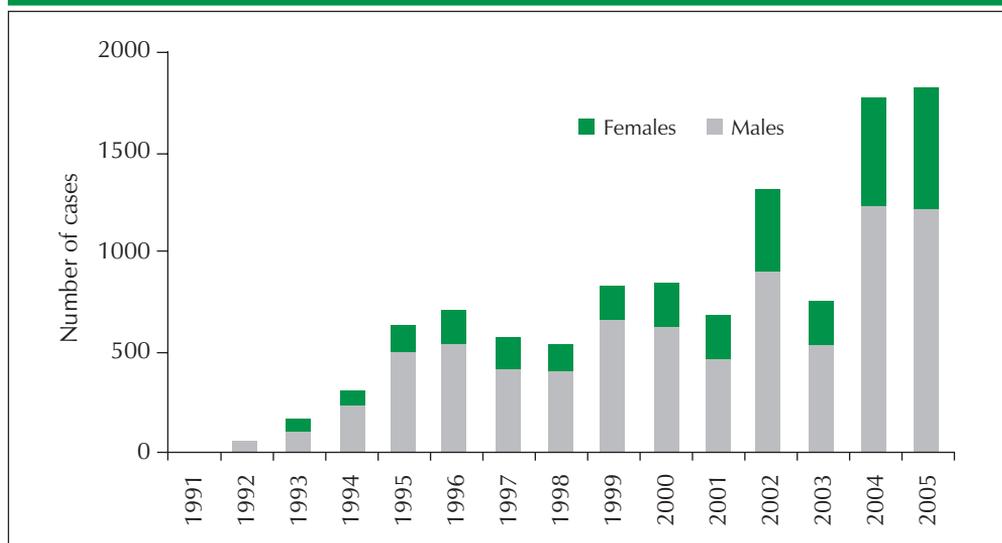
Source: National Malaria Control Program Reports.

Myanmar is one of the 22 high-TB burden countries globally, the number of deaths amounting to 5457 in 2006<sup>8</sup>. The Human Immunodeficiency Virus (HIV) prevalence in the general population is 0.67% (National AIDS programme) and the estimated HIV-prevalence among adult TB patients is 7.1%<sup>9</sup>. The first representative nationwide drug resistant survey, carried out and reported on in 2004, showed 4% and 15.5% of new and previously treated TB patients had multi-drug resistant TB (MDR-TB), respectively. A sound five-year strategic plan matched by good overall programme performance has enabled the National Tuberculosis Programme (NTP) to reach global TB control targets in 2006. However, current estimates for incidence and prevalence of TB in Myanmar are based on a prevalence survey conducted in 1994 and require updating through a new national TB prevalence survey.

In 2006, about 123 593 TB patients were reported, out of which 40 241 were sputum smear-positive new TB patients (infectious)<sup>8</sup>. The Global Fund to fight AIDS, TB and malaria (GFATM) supported activities in 2005 which lasted for one year until the GFATM termination plan was completed. While the National Tuberculosis Programme had been able to progress so far using domestic resources and limited external funding to maintain the core functions of the TB control programme, there is now a need to rapidly scale up additional necessary interventions to combat TB/HIV and emerging MDR-TB. Weaknesses in the laboratory network are being addressed and in-country capacity for cultures and drug sensitivity tests built. TB-HIV collaborative activities are being expanded from the initial pilot sites, given the extent of the HIV epidemic in the country. Private health-care providers are increasingly involved in order to allow greater access to services. The reporting system is being improved and operational research relevant to the programme conducted. A critical need is to guarantee the support of first-line anti-TB drug supply, which is granted by Global Drug Facility (GDF) since 2001 but will finish in 2009 (the support will end in 2009).

Under the National AIDS Programme (NAP), WHO and UNAIDS estimated that 240 507 adults were infected with HIV in Myanmar in 2007. The official number of deaths due to AIDS cumulatively till the end of 2006 was 5521 while 1483 AIDS cases and 69 872 HIV-positive cases were reported to the public health system. The overall prevalence among adults is 0.67% in Myanmar while the prevalence among populations at higher risk of exposure, such as sex workers and injecting drug users (IDUs), were 33.5% and 42.46%, respectively. In 2007, there was an estimated number of 14 439 new adult infections, drawing attention to urgency for scaling up HIV

**Figure 2.2:** Reported AIDS cases, distribution by sex, Myanmar, 1991-2005



Source: National AIDS Programme, Myanmar.

prevention activities, particularly among vulnerable groups. Myanmar has an estimated 71 912 people living with HIV who are in advanced stages of infection (WHO Stages 3 and 4), and thus in urgent need of antiretroviral therapy (ART).

In June 2005 the Ministry of Health launched ART in the public health sector; several programmes had been initiated by NGOs in 2003. By the end of 2007, it is estimated that approximately 11 500 patients were receiving ART. Although modest compared to the needs, this represents an increase of more than double compared to the previous year. Four TB-HIV pilot projects have started in Myanmar. The multisectoral National Strategic Plan that will lead the national response to HIV/AIDS in the next few years was completed in 2006. The plan highlights the need for strengthening the health system and involving communities to scale up prevention and care and support services. The new Three Diseases Fund (3D Fund) for HIV/AIDS, tuberculosis and malaria is expected to be a major source of funding (see Chapter 3).

Myanmar has been prepared for a possible outbreak of avian and human pandemic influenza since early 2006 and responded immediately to the first such outbreak in animals in the country in March 2006. The country has aligned its response with the WHO Global Action Plan for Pandemic Influenza, and a National Strategic Plan for Prevention and Control of Avian Influenza and Human Influenza Pandemic Preparedness and Response has been developed by the Ministry of Health. Efforts in the coming years will focus on establishing, training and retraining rapid response teams at all levels, including state/division, district and township. For early detection and diagnosis, the National Influenza Centre will be established at the National Health Laboratory in Yangon, with technical collaboration with the National Influenza Centre, Thailand. Currently, the country has the capacity to identify virus subtypes, including H5N1, in humans.

Myanmar is preparing for the implementation of the IHR (2005)<sup>10</sup>. The IHR (2005) were adopted by consensus at the Fifty-eighth World Health Assembly on 23 May 2005, and the new regulations came into force from 15 June 2007 for all Member countries, including Myanmar, who do not reject or make reservations to them within a stipulated period. The purpose and scope of the new IHR (2005) are “to prevent, protect against, control and provide a public health response to the international spread of disease in a way that is commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade”. The new regulations are not merely limited to certain diseases but are also applicable to new or evolving disease threats. The provisions also update and revise many of the technical and other regulatory functions, including certificates applicable to international travel and transport, and the requirements for international ports, airports and ground crossing points. Myanmar as a WHO Member country has agreed to the new requirements and obligations concerning the reporting, verification and assessment

of public health events of international concern, the implementation of WHO recommended control measures and the development of core capacities for surveillance and response. The Ministry of Health, in collaboration with other ministries concerned and WHO, has integrated IHR (2005) in the National Health Plan 2006-2011. A core capacity assessment was conducted with technical support from the WHO Regional Office for South-East Asia and the IHR national focal point.

Dengue and dengue haemorrhagic fever (**DHF**) appear to be an increasing problem, with seasonal epidemics in certain parts of the country, especially in Yangon, Mandalay and Bago Divisions and in Mon State. Leprosy, no longer a public health problem in Myanmar, still needs attention, in particular for issues such as sustaining control activities and providing quality services focusing on prevention of disability and the rehabilitation of affected persons.

**Noncommunicable diseases** (NCDs), previously labelled “diseases of affluence”, progressively proliferate across the social spectrum and affect the poorer and rural sections of the population as well. Cardiovascular diseases are emerging as important health problems on account of risk factors including hypertension, tobacco consumption, diabetes mellitus, a high salt intake, obesity and dyslipidaemia. The reported prevalence of hypertension per thousand population is 1.9/1 000, which is much lower than the rates of approximately 20% reported by surveys conducted in many parts of the country<sup>11</sup>. A study conducted in capital cities of all states and divisions (2001) showed that 14.6% of females aged between 18 to 60 years were over weight and 3.8% were obese. Among males, 7.2% were overweight and 1.4% were obese<sup>12</sup>.

Cancer is also a major public health problem, and most of the cases are identified in the late stages due to lack of public awareness and inadequate early detection programmes. According to the study utilizing the WHO STEP-wise approach to surveillance of NCD Risk Factors (STEPS) conducted in Yangon Division in 2003, it was found that the prevalence of diabetes was 14.42% in urban and 7.4% in rural areas. The overall prevalence for both urban and rural areas was found to be 12.14%. There is an urgent need to raise awareness levels on diabetes and to improve the existing diabetic care system. An information-based system for diabetes and other NCDs needs to be established. Old age, large waste-hip ratios, obesity, hypertension, stress factors caused by urbanization, and high cholesterol, triglyceride and HDL levels are potent risk factors for diabetes and pre-diabetes. Physical inactivity was found to be only a weak risk factor.

**Tobacco** use (both smoking and chewing nicotine) is fairly common and has likely implications for the development of NCDs in the future. A sentinel prevalence study in 2001 reported that 40% of adults currently use tobacco<sup>13</sup>. There have been significant developments since the launch of the Myanmar Tobacco Free Initiative Project in 2000, and Myanmar became a party to the WHO Framework Convention

on Tobacco Control in 2005. The Control of Smoking and Tobacco Products Consumption Law was enacted on 4 May 2006.

According to the 1998 ocular survey, the blindness rate in Myanmar is 0.6% (600 per 100 000 population) and the leading cause of blindness is cataract. The Trachoma Control and Prevention of Blindness Programme is functioning at 16 secondary centres with primary eye care training provided to basic health staff. Rapid assessments of trachoma in three districts have been conducted in one year. Regular village eye health examination and school eye health examination and treatment have been provided. During 2007, 640 cataract outreach surgical sessions were conducted and a total of 20 968 inpatient cataract surgeries were performed in these sites. However, there is still a further need to reduce avoidable blindness rate by increasing the cataract surgery rate for both outreach as well as inpatients. Implementation of activities aimed at prevention and early intervention against deafness are yet to be implemented on a countrywide basis. There is a lack of health staff trained in primary ear care strategies.

Mental illness is one of the major emerging health problems. Several community surveys conducted between 1976 and 2004 in urban and suburban areas found that mental disorders ranged from 56 to 86 per 1000 population. Psychoses ranged from five to six per 1000 population; mental retardation from one to four per 1000 population; and epilepsy from two to four per 1000 population. Mental health care has shifted from hospital care to community care. However, community-based mental health programmes are implemented in selected townships only.

Snakebites are also a cause for concern. However, it is difficult to estimate their exact occurrence because relatively few cases are referred to hospitals. Most snakebites are reported from the central part of Myanmar and Bago West Division. The total number of reported cases of snakebites for the whole country was 7682 in 2002. The number of deaths reported was 579, with a case fatality rate of 7.5%. Snakes commonly found in Myanmar include the viper, cobra, krait and sea snakes. Antivenom is available for the viper and the cobra<sup>12</sup>.

Official statistics show that injuries stand first among the leading reported causes of morbidity and third among the causes of mortality in Myanmar. Injury surveillance data reveals that most injuries occur in the age group of 21-30 years. Workplace and travel-related injuries represent the highest rate.

Disasters are also a major health concern. Myanmar has a long coastline (about 2400 kilometres) which runs along the eastern flank of the Bay of Bengal. According to the *Tsunami Risk Atlas*, most of the coastal areas of Myanmar fall within the risk zone. However, historical records show that very devastating tsunamis are rare in Myanmar and the neighbouring parts of the Bay of Bengal. Natural disasters common in Myanmar are floods, cyclones, storms, earthquakes and landslides. Floods occur

in areas traversed by rivers or large streams. Human-induced disasters include urban fires, which usually occur in the hot dry season.

## Newborn, child, adolescent and maternal health

Data from the “Overall and Cause-Specific Under-Five Mortality Survey 2002-2003” (MoH/UNICEF) data showed that the under-five mortality rate was 66.1, infant mortality rate (IMR) was 49.7 and Neonatal Mortality Rate (NMR) was 16.3. Infant deaths contribute about two-thirds of under-five mortality, while neonatal deaths are responsible for approximately one-third of mortality among infants. A recent stakeholder analysis in health found newborn care to be considerably neglected<sup>14</sup>. The same survey showed that the main causes of under-five mortality were due to acute respiratory infections, diarrhoea, brain infections, low birth weight, premature births and malaria.

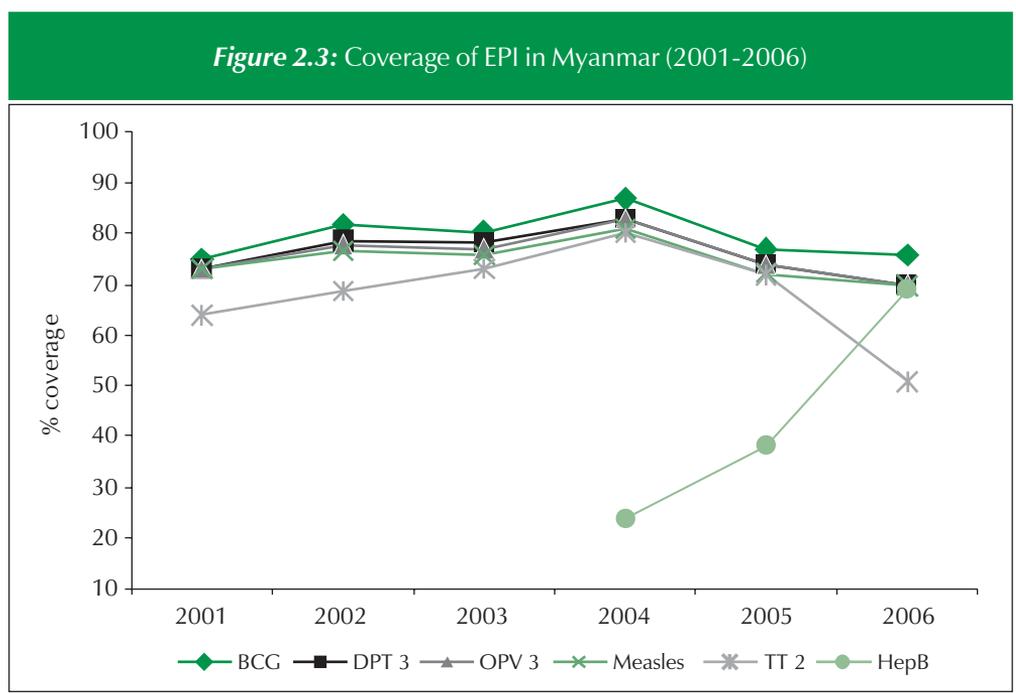
The five-year Strategic Plan for Child Health Development (2005-2009) takes into account the National Health Policy, National Health Plan, Health Development Plan and Myanmar Vision 2030. It considers the disease burdens of children in the country and available evidence-based interventions. Under-five mortality rate declined from 82.4 per 1000 live births in 1996 to 77.7 per 1000 live births in 1999 and to 66.1 per 1000 live births in 2003. Infant deaths accounted for 73% of all cases of under-five mortality, and neonatal deaths contributed to about one-third of infant deaths in the country. While morbidity and mortality from vaccine-preventable diseases had markedly declined, pneumonia, diarrhoea, malaria, malnutrition and neonatal conditions still remain major causes of ill health and child mortality in the country. Although improvements in the health status of children have been noted, much more needs to be done to sustain the gains made and contribute to the achievement of health-related Millennium Development Goals by 2015. The objective of the **five year strategic plan for child health development** is to improve the quality of health care in order to reduce morbidity and mortality of neonates, infants and children under five, and to achieve normal growth and development of children in Myanmar. The plan focuses on improving skills of all health-care providers with training in: standard case management procedure of integrated management of maternal and childhood illness (IMMCI) and essential newborn care training for skilled birth attendants (SBAs); strengthening the referral network and the existing supervision system; promoting normal growth and development of children; ensuring the availability of essential drugs and equipment; improving appropriate key community and family practices, field research and routine data collection, to obtain baseline data for prioritization of health problems; and evidence-based decision-making.

Following the review of the integrated management of maternal and childhood illness (IMMCI) programme (the term “integrated management of childhood illness”

was revised in the Myanmar context) in 2001 and 2002, a full-fledged National Strategic Plan for Child Health was developed during 2003 and 2004.

The Expanded Programme on Immunization (EPI) in Myanmar has made remarkable achievements since its start in 1978. EPI now reaches all 325 townships in Myanmar. Hepatitis B immunization was introduced in the routine immunization programme in 2003 in a phased manner, and the entire country was covered by 2005. The country completed the inventory of cold chain equipment in 2006, and a comprehensive multi-year plan (CMYP) for immunization covering 2007-2011 has been developed. Vaccine supply and routine services have been well maintained and there have been no stock-outs for any antigens at national, state and divisional level during 2007.

Although Myanmar was polio-free from 2000 to 2005, one polio case (VDPV) was reported in April 2006 from Pyin Oo Lwin township of Mandalay Division. In 2007, a major polio outbreak was reported from Northern Rakhine State with detection of 11 wild poliovirus cases and 4 cases of vaccine derived poliovirus have been reported from Kayin, Bago East, Yangon and Mon. In response to the polio outbreak, the DoH was assisted in the planning and implementation of a mop-up campaign in Rakhine and adjoining states targeting around 2.5 million children during May-July 2007, and two rounds of National Immunization Days have been conducted in November and December, in which more than 7 million children were immunized in each round.



Source: Expanded Programme on Immunization (EPI).

Measles is considered a major public health problem. Though the number of reported measles cases has significantly decreased from 2 291 in 2001 to 735 in 2006, measles outbreaks still occur despite a series of preventive campaigns. To reduce measles mortality, the Government of the Union of Myanmar conducted a nationwide Mass Measles Campaign from January to May in 2007, targeting about 7.2 million children in the age group of nine months to five years.

Malnutrition continues to be a public health concern in Myanmar, with four nutrient deficiency states identified with major nutrition problems. At the national level the percentage of children under five who are moderate to severely underweight (weight-for-age below -2SD) is 31.8%; the percentage of those moderate to severely stunted (height-for-age ratio below -2SD) is 32.2%; and those moderate to severely wasted (weight-for-height below -2SD) is 8.6%<sup>15</sup>. Approximately one in seven children under four months of age are exclusively breastfed (17.8% in urban areas and 13.6% in rural areas), a level considerably lower than recommended.

According to a survey conducted in 2003, the prevalence of anaemia among pregnant women was 71% and that among schoolchildren was 75%. A nationwide multiple micronutrients survey in 2004-2005 showed that the prevalence of anaemia among children under five was 76%. Anaemia was more common in the coastal and delta regions. This may be due to insufficient intake of iron-rich foods, poor knowledge on cooking methods that could enhance the absorption of iron from the gastrointestinal tract, and worm infestations. Endemic goitre, which has been identified in the hilly regions of Myanmar since 1896, has also been found in the plain and delta regions, and in particular in areas that experience floods every year. The Iodine Deficiency Disorders (IDDs) Elimination Programme is a collaborative effort between the Ministry of Health and Myanmar Salt and Marine Chemicals Enterprise of the Ministry of Mines. The visible goitre rate among six- to eleven-year-old children nationally is reported to have declined from 33% in 1994 to 12% in 2000, 5.5% in 2003 and less than 5% in 2006. The last xerophthalmia survey, in the year 2000 revealed that the prevalence of Bitot's spots among children aged under five was 0.03% in both urban and rural communities, far below the cut-off level for being a public health problem, which is 0.5%.

Very few programmes specifically address the issue of adolescent health. A recent review supported by WHO identified some of the main issues affecting the health of adolescents in the country, leading to the formulation of a draft five-year Strategic Plan for Adolescent Health (2008-2012).

The most recent estimates on maternal mortality prepared by WHO, UNICEF and UNFPA indicated a maternal mortality ratio (MMR) of 360 per 100 000 live births<sup>16</sup>, which translated into about 4300 maternal deaths in 2000. A recent study — *Nationwide Cause-Specific Maternal Mortality Survey* — undertaken by the DoH in 2005 estimated the MMR to be 316 per 100 000 live births. However, the range of

MMR even among the states and divisions, with 136 as the lower and 527 as the upper estimate, is considerable. Maternal mortality in rural areas was estimated to be about 2.5 times that in urban areas. The *Fertility and Reproductive Health Survey 2001* estimated that approximately 70% of deliveries are performed at home, and that 44% of all births in Myanmar are attended by midwives and nurses while about 43% are not attended by a skilled health worker. Since many deliveries occur at home, there is a need to improve the skills of those attending to these as well as to improve the referral system and the provisions for essential and emergency obstetric care at health-care facilities. Low contraceptive prevalence and unmet contraceptive needs were the likely significant factors contributing to the number of abortions being performed. It is estimated from the limited and unpublished hospital-based information available that unsafe abortions may account for approximately half of all maternal deaths. The five-year Strategic Plan for Reproductive Health was formulated and launched by the Ministry of Health in 2004.

The situation of women and girls in Myanmar is not very different from that of men and boys. Some research was conducted on the role of gender in the community and on the basic knowledge on gender issues that is imparted to health staff. There is still little information available about the gender situation in Myanmar. Gender analysis and actions, capacity building and gender health-related research would improve the quality of health care and access to health services. This would also help involving men in more family and community health needs and benefit women, children and adolescents.

Currently around 79% of the population in Myanmar has access to improved water supply while 83% has access to sanitary means of disposal of excreta. However, there are wide disparities in levels of access to improved water supply between different states or divisions of the Union and also between urban and rural areas. On an average, only 53% of rural schools have been provided with adequate water supply. In some townships, this figure may be as low as 10%. It must be noted that improved water supply does not necessarily imply safe supply. The sporadic outbreak of diarrhoeal disease indicates that there is a further need to promote good hygiene practices and ensure the continued supply of safe water. WHO has provided technical assistance in improving the quality of water by implementing water safety plans in pilot townships. However, putting these plans in place in other townships needs to be accelerated.<sup>17</sup>

### **2.3 The national health-care system**

Though comprehensive and disaggregated data on coverage and utilization of health services are not available, disparities remain a major concern. Access to health information and health services is very limited for some population groups particularly

vulnerable to health problems. These include people living in rural, remote and border areas, and low-income families in peri-urban areas.

## The national health administration

The National Health Committee, chaired by the Secretary (1) of the State Peace and Development Council, is a high-level interministerial and policy-making body for health matters concerning the country. Health committees exist at each administrative level, providing a mechanism for intersectoral collaboration and coordination.

The Ministry of Health has seven departments: for Health, Health Planning, Medical Sciences, three departments for Medical Research (for Lower Myanmar, Upper Myanmar and Central Myanmar) and Traditional Medicine. The largest of the seven is the Department of Health, which employs 93% of over 58 000 personnel employed by the Ministry of Health, and accounts for approximately 75% of the ministry's expenditure. It is responsible for the preventive, promotive, curative and rehabilitative components of Myanmar's health service, and for supervising the health departments at the state, division and township levels as well as the hospitals and clinics. Some other ministries are also involved with health care, mainly curative in nature, for their employees and families.

The health departments at the state or divisional level are charged with planning, coordinating, supervising and monitoring the health departments at district and township levels. Actual implementation of health services is undertaken by township health departments, each of which serves between 100 000 and 200 000 people on an average and is headed by a Township Medical Officer (TMO).

## Health services

At the township level, both curative and preventive health services are provided by the township health departments. Township hospital staff take part in curative aspects and training. Township health departments are staffed by health assistants (HA) of grade (1) and township health nurses who take care of the promotive and preventive aspects of the health services. There are also station hospitals situated in strategic areas of the townships and four to five rural health centres (RHCs) including an urban health centre. Rural health centres are staffed by a health assistant, a public health supervisor (PHS), lady health visitor (LHV) and a midwife (MW), who are trained mainly in public health and primary health care (PHC). Table 1 outlines the development of health facilities since 1988.

At the level below each rural health centre are, on an average, four to five sub-rural health centres, each of which are staffed by a midwife and a public health supervisor of grade (2). Health staff at the community level provide promotive, preventive, curative and rehabilitative services using the PHC approach.

Each sub-rural health centre provides health-care services to a cluster of five to ten villages in which there are usually voluntary health workers (auxiliary midwives and community health workers). Both auxiliary midwives and community health workers are volunteers and receive no remuneration. Home births may be attended by auxiliary midwives but they are not authorized to administer injectable medication.

Volunteers and members of local NGOs and faith-based organizations are also active in the field of health. For example, the Myanmar Maternal and Child Welfare Association (MMCWA) and Myanmar Red Cross Society (MRCSS) have members from many villages. With the support from health committees and local administrative authorities, these members can be mobilized to assist in and promote the delivery of health-care services in the villages they live in.

**Table 2.1:** *Development of health facilities*

<b>Health facilities</b>	<b>1988-1989</b>	<b>2002-2003</b>	<b>2003-2004</b>	<b>2004-2005</b>	<b>2005-2006</b>
Government hospitals	631	780	790	824	826
Total no. of hospital beds	25309	32770	33683	34654	34920
No of primary and secondary health centres	64	84	84	86	86
No of maternal and child health centres	348	348	348	348	348
No. of rural health centres	1337	1413	1424	1452	1456
No. of school health teams	80	80	80	80	80
No. of traditional medicine hospitals	2	12	14	14	14
No. of traditional medicine clinics	99	213	237	237	237

Source: Health in Myanmar 2006.

Traditional medicine also plays an important role in the public health system. The government accords high importance and provides considerable support to traditional medicine. Services and drugs are made available free of charge.

While private sector health care has expanded rapidly and is estimated to provide 75%-80% of ambulatory care currently, private service providers have had very limited involvement in public health programmes. A number of members of the Myanmar Medical Association from its branches in several cities and towns were provided training recently on issues such as reproductive health and malaria.

## Resources and support systems

Although government expenditure on health has increased three-fold between 2000-2001 and 2005-2006, the health sector is highly under-resourced. In 2003 the total expenditure on health as a percentage of Myanmar's Gross Domestic Product (GDP) was 2.8 while general government expenditure on health as a percentage of the total expenditure on health was 19.4<sup>18</sup>. While health services are free, drugs are often not available in adequate quantities in public health institutions. Patients are therefore compelled to purchase them from the market. Private expenditure on health as a percentage of total expenditure on health was 80.6% in 2003<sup>17</sup>. Consequently, households having to make high out-of-pocket payments for the treatment of ailments are faced with an onerous economic burden on account of health care.

Private and public health services present four major challenges for the health sector, that of affordability, availability, access and adequacy.

As seen in Table 2, there were a total of 18 725 practising medical doctors in Myanmar in 2005-2006, of whom 12 161 were engaged in private practice and 6564 in state service. This represents an increase from figures of 12 268 medical doctors, 7891 practising privately and 4377 in state service, in 1988-1989.

**Table 2.2:** Health manpower development in Myanmar

Health manpower	1988-1989	2002-2003	2003-2004	2004-2005	2005-2006
Total number of doctors	12268	16570	17081	17564	18725
-Public	4377	6180	6331	6473	6564
-Cooperative and private	7891	10390	10750	11091	12161
Dental surgeons	857	1227	1285	1365	1870
-Public	328	517	543	580	620
-Cooperative and private	529	710	742	785	1250
Nurses	8349	15502	16382	17864	19922
Dental nurses	96	109	123	158	162
Health assistants	1238	1728	1739	1767	1771
Lady health visitors	1557	2559	2679	2796	2908
Midwives	8121	14097	15130	16245	16699
Health supervisor (1)	487	529	529	529	529
Health supervisor (2)	674	1144	1199	1339	1359
Traditional medicine practitioners	279	563	769	769	889

Source: Health in Myanmar 2006.

Health-related universities in Myanmar include four medical, two dental, two nursing, two for medical technology, two pharmacological and one community health institutions. A university of public health was established in July 2007. In addition, there are 46 nursing schools and an Institute of Traditional Medicine. The University of Traditional Medicine was established in 2001. Basic training on traditional medicine has been included in the curriculum for the MBBS courses in universities of medicine. Introducing traditional medicine training in allopathic medicine courses was also a notable achievement.

The scope and quality of health information in the current scenario has some important limitations. Many units and sources, both within and outside the Ministry of Health, are involved in data generation. Some areas are also not easily accessible. In addition, transborder movement of population and internal migration for employment pose considerable challenges for the health system as well as dissemination of health information.

## National plans

The Government of Myanmar has, as one of its social objectives, committed itself to “the uplift of the health, fitness and educational standards of the entire nation”. According to the National Health Policy formulated in 1993, “health for all” and equitable access to basic health services represent the main principles guiding health and health system development. The “Myanmar Health Vision 2030” (2001-2002 to 2030-2031) represents an aspiring 30-year plan to meet present and future health challenges of the country encompassing a wide gamut of social, political and economic objectives.

The Rural Health Development Plan 2001-2006 seeks to address the disparities in health and health services between urban and rural areas. The project for upgrading hospitals has been adapted to include existing district, township and station hospitals in the country — including those in border areas — to increase access to referral-level health care by the population. The special four-year plan for promoting national education (in the health sector) aims to enhance the capacity of human resources for health and bolster medical institutions involved in the training of health personnel.

The MoH has formulated the National Health Plan 2006-2011<sup>12</sup> based on the PHC approach. The plan is interlinked with the four plans mentioned above — Myanmar Health Vision 2030, the Rural health Development Plan 2001-2006, the project for upgrading hospitals and the National Plan for promoting national education — and represents an integral part of the national economic and development blueprint. One of the main objectives of the National Health Plan is to strengthen health services in rural areas. Having adopted the WHO Framework for Health Systems Performance, the National Health Plan contains the following health system goals:

- Improving health (raise average levels of health and reduce inequalities).

- Improving responsiveness (to people's expectations).
- Improving fairness of financial contribution.

A number of national strategic plans also exist for particular domains such as reproductive health, child health, adolescent health, HIV/AIDS, TB and malaria, and for water supply, sanitation and hygiene.

## 2.4 Major strengths and challenges

In May 2006 the MoH conducted a workshop on developing the National Health Plan 2006-2011. The meeting identified the following problems relating to health and health services delivery that will have to be addressed in the coming years:

- Need to improve rural health-care coverage.
- Persistence of the disease burden.
- Persistence of maternal, infant and child mortality levels that need further reduction.
- Need of a financial mechanism that ensures adequacy, equity and efficiency.
- Need of a systematic plan for human resources for health.
- Excessive workload of basic health staff.
- Need for organizational expansion and to strengthen managerial capacity.
- Need to strengthen health research.
- Need of quality data for National Health Information Systems.

Myanmar has a structured health-care system based on the primary health-care approach. There are competent staff at all levels with the capacity to mobilize the workforce and the communities for short-term, intensive campaigns. The public health-care system, however, is critically under-resourced, with major problem areas concerning issues of access and coverage. While large regions and vulnerable population groups require attention, the current funding pattern is highly inequitable. A lack of human resources at the periphery, and paucity of drugs and of basic information for monitoring is critical. While the main disease control programmes (malaria, TB and HIV/AIDS) have registered success stories, they still face important challenges. In the absence of an overall strategy to improve health-care delivery, the momentum of positive results may not be sustained.

The health situation is characterized by a heavy burden of disease and injuries, high mother-and-child morbidity and mortality, and important disparities. Poverty, migration, access to water and sanitation, and accidents are important determinants of the standard of health.

## Development assistance and partnerships: Aid flow, instruments and coordination

### Foreign assistance and aid modalities

Despite a three-fold increase in government health expenditure from 2000-2001 to 2005-2006<sup>12</sup>, the infrastructure and performance of the health sector has been affected as a result of it being chronically under-resourced. External assistance is a major source of financing in the health sector although information on the exact magnitudes of funding is not available. According to the Organization for Economic Cooperation and Development (OECD), Myanmar in 2004 received a total official development assistance (ODA) of US\$ 121 million, of which roughly 13% went to the health sector. Few countries are providing direct financial support to the Government of Myanmar due to restrictions imposed by their national governments. The EU's common position limits funding to humanitarian assistance.

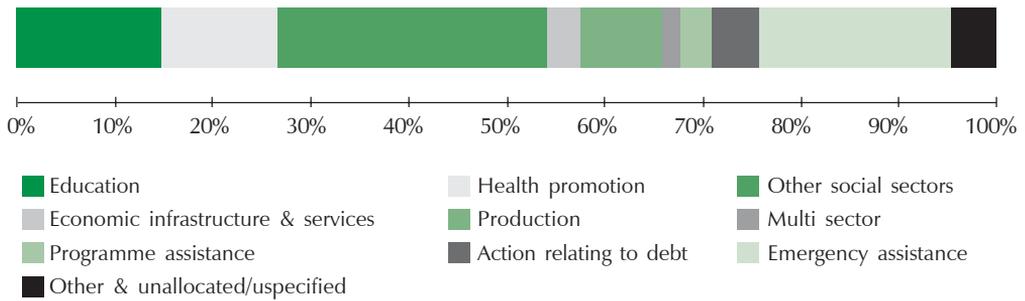
### Myanmar

Receipts	2002	2003	2004
Net ODA (USD million)	121	126	121
Bilateral share (gross ODA)	74%	71%	69%
Net ODA/GNI	–	–	–
Net Private flows (USD million)	-10	-32	-2

For reference	2002	2003	2004
Population (million)	48.8	49.4	49.9
GNI per capita (Atlas USD)	–	–	–

Top ten donors of gross ODA (2003-04 average)	(USD m)
1 Japan	35
2 United Kingdom	12
3 EC	11
4 Australia	8
5 Unicef	7
6 UNDP	7
7 Norway	6
8 Korea	6
9 United States	6
10 UNTA	5

## Bilateral ODA by sector (2003-04)



Source: OECD, World Bank

Instead, development assistance to the health sector is channelled mainly through global partnerships such as the Global TB Drug Facility, WHO Global Malaria Programme and GAVI, and directly to INGOs and NGOs working in the country. The UN plays a major role in contributing to health activities. The main contributors include WHO, UNICEF, UNDP and FAO.

## UN agencies

There are currently 11 UN agencies, funds and programmes operating in Myanmar. These are the UNDP, UNICEF, WHO, World Food Programme (WFP), FAO, Office of the United Nations High Commissioner for Refugees (UNHCR), UNFPA, United Nations Office On Drugs and Crime (UNODC), Joint United Nations Programme on HIV/AIDS (UNAIDS), International Labour Organization (ILO) and International Organization for Migration (IOM). WHO is an active member of the UN country teams and is committed to implementing a common UN approach as outlined in the *Strategic Framework for UN agencies in Myanmar*. The document, developed in 2005, provides an overview of UN principles and priorities and a broad strategic framework for all UN assistance programmes in the country. Five thematic areas have been identified as priority areas for intervention: (i) alleviating acute income poverty, (ii) improving food security and nutrition, (iii) ensuring access to essential health and education services and interventions, (iv) ensuring a protective environment, and (v) reducing regional disparities. In the implementation of the activities WHO coordinates with other UN agencies working in health areas, and with UNICEF, UNFPA and FAO in particular.

UNICEF is actively supporting Myanmar in the provision of vaccines (providing approximately 90% of the vaccines used to inoculate children against the seven major vaccine-preventable diseases) and equipment, in routine immunization campaigns

and expansion of coverage to hard-to-reach areas. UNICEF also supports the improvement of quality and availability of health services through training, ensuring standard and emergency obstetric care facilities at the township level, and through malaria prevention and control. In the area of nutrition UNICEF promotes exclusive breastfeeding, provides potassium iodate, and supplies vitamin A to children and iron supplements to pregnant and lactating mothers nationwide. UNFPA is supporting Myanmar through a special programme of assistance that covers 93 out of 324 townships. The special programme covers five component projects, namely (i) reproductive health services, (ii) behaviour change communication, (iii) data analysis of fertility and reproductive health survey, adolescent reproductive health and prevention of HIV/AIDS. FAO is supporting Myanmar in its efforts to control avian flu outbreaks in all poultry species and prevent the transmission of the virus to humans.

WHO is currently participating in UN work groups working on HIV/AIDS, food security and nutrition. In addition, the WHO Country Office, Myanmar, has been designated as the overall coordinating agency dealing with international response to avian and human influenza within the UN system and the international community.

## Technical partnerships

In line with the policy recommendations of the 3Diseases Fund, the Country Coordinating Body for AIDS, TB and malaria was established to coordinate the national response to the three deadly diseases. Based on the existing Technical Working Groups under GFATM, three Technical and Strategy Groups (TSGs) were formed in 2006 each for HIV/AIDS, malaria and TB. The TSGs are responsible for coordinating and reviewing the national strategy; preparing the three-year rolling operational plan and budget; coordinating with implementing partners at the national and local levels; and inculcating best practices and lessons learnt. Each TSG is answerable to the Country Coordinating Body. WHO is the secretariat for the TSGs for TB and malaria and a core group is meeting on a regular basis to steer TSG work. For TB, a sub-group on Public-Private Mix (PPM) DOTS is overseeing and providing technical assistance to the public-private partnerships on the disease. For malaria, four sub-groups (malaria prevention, malaria case management, advocacy and BCC, and monitoring and evaluation) have been established.

External joint monitoring missions are conducted for the National TB Programme by independent international and national partners, including WHO, to review the programme's progress towards meeting global targets and to recommend the way ahead. The five-year National Strategic Plan 2006-2010, the National Operational Plan for TB 2006-2009 and the more recent National Strategic Framework for Management of Drug-Resistant TB were developed collaboratively with all partners led by the NTP and facilitated by WHO.

## Nongovernmental organizations

The UN theme group on health commissioned a study in 2002 of stakeholders in health in Myanmar. The study summarized health activities of the main stakeholders, together with reported estimates of funding levels and population covered, as well as perceptions on and expectations about the role of the UN system. The theme group on health identified six priority areas — malaria, tuberculosis, reproductive health, newborn care, immunization and childhood illness — on which the analysis was based. Findings indicated that in this context, reproductive health received maximum attention from stakeholders and funding the HIV/AIDS programming in particular. Newborn care, on the other hand, has received minimum focus and funds.

Furthermore, coverage, even by those stakeholders with nationwide activities, is not universal. Remote and hard-to-reach areas continue to present challenges in each of the six areas identified. Due to funding and other restrictions, most NGOs and some UN agencies focus activities and funding on specific townships which, according to many respondents participating in the study, may have tended to increase disparities. Also, funding levels varied widely. While increased attention and funding for HIV/AIDS prevention was necessary, it is possible that continued, depressed funding levels may generally deflect attention from other health priorities.

The MoH has signed MoUs with 31 INGOs and 10 national NGOs on collaboration in health development, particularly in the areas of maternal and child health; primary health care; environmental sanitation control of communicable diseases (notably HIV/AIDS and TB); malaria prevention and control; rehabilitation of the disabled; and border health. In 2006, the government introduced Guidelines for UN Agencies, International Organizations and NGOs/INGOs on Cooperation Programme in Myanmar. The guidelines outline the requirements of the Government of Myanmar with regard to developing MoUs, registration of NGOs, staff appointments, travel in the country and implementation of activities.

## Coordination responsibilities

The International Health Division, under the direct supervision of the Ministry of Health, is responsible for coordination of all health-related activities among partners for health development in Myanmar. These include national NGOs, INGOs, bilateral and multilateral international agencies and inter-ministerial coordination bodies.

The WHO Country Office provides technical support to the Ministry of Health and its International Health Division to ensure that proposals seeking support for health system strengthening remain consistent with the National Health Plan 2006-2011 and are evidence-based. The country office also provides technical assistance for implementation of health system strengthening strategies and policies as well as

monitoring and evaluation of progress, use of data on performance to revise annual plans, and the submission of annual progress reports to donors.

## Global Initiatives

### Global Alliance for Vaccines and Immunization (GAVI)

The Government of the Union of Myanmar is receiving financial support from GAVI funds to introduce new vaccines, strengthen vaccine management and the cold chain system in EPI, and to develop guidelines and training material for strengthening human and institutional capacity for immunization. In 2004 the country received US\$ 974 800 as investment money for routine immunization and US\$ 1 000 000 for introduction of a new vaccine (hepatitis B). In 2005 the country received a second instalment of US\$ 974 800 as investment money and US\$ 842 440 as the first instalment of “reward” money for its achievement in reaching out to more children with its immunization projects. During 2007, Myanmar received US\$ 903 020 as the second instalment of the “reward” money. Based on the recommendations of the national Interagency Coordinating Committee (ICC), US\$ 1 000 000 from the reward money is being utilized for cold chain strengthening and upgradation of vaccine depots in the country. GAVI has opened up a health systems strengthening (HSS) window to financially assist GAVI-eligible countries to strengthen national health systems and ensure improved and sustained health outcomes. The WHO Country Office is assisting the Ministry of Health to develop the project proposal and a country-specific action plan.

### WHO Global Malaria Programme

The WHO Global Malaria Programme is responsible for formulating malaria policy and strategy, providing operations support and capacity development, and coordinating global efforts by WHO to fight malaria. The department establishes and promotes — based on evidence and consensus — WHO policies, normative standards and guidelines for malaria prevention and control, including monitoring and evaluation.

Among others, it provides technical support to the WHO Country Office in Myanmar by supporting one fixed-term position for ‘P’ staff (designated medical officer) as well as by supporting the Mekong Malaria Programme Coordinator (see next section).

The Roll Back Malaria (RBM) Partnership was launched in 1998 by WHO, UNICEF, UNDP and the World Bank to provide a coordinated global approach to fighting malaria. The RBM Partnership has expanded exponentially since its launch and now comprises a wide range of partners. The RBM mission calls for collaborating to enable sustained delivery and use of the most effective prevention and treatment modes for

those affected by malaria through the promotion of increased investment in the health system and incorporation of malaria control into all relevant multisector activities. WHO is one of the partners of and hosts the secretariat of the RBM Partnership.

The RBM Partnership has not been officially established in Myanmar but the National Malaria Control Programme and WHO Country Office have adopted and promoted its principles. For example, a national malaria technical working group was established in 2002 and that has now evolved into the current National Malaria Technical and Strategy Group chaired by the DoH, of which WHO acts as the technical secretariat. It serves as a mechanism for partners to work together for a common goal in the context of the National Strategic Plan for Malaria Prevention and Control. The strategic plan is in accord with the Revised Malaria Control Strategy (2006-2010) in the SEA Region that was endorsed by the Sixtieth Session of the Regional Committee in 2007, and with WHO's current Global Malaria Programme strategies.

## **Stop TB Partnership – Global Drug Facility – UNITAID**

The Global Drug Facility, housed at WHO headquarters and managed by the Stop TB Partnership secretariat at Geneva, has been providing the most crucial support for TB control in Myanmar since 2001 through yearly grants of anti-TB drugs covering up to 100% of the annual patient load. This in turn catalyzed DOTS expansion nationwide, raising the budget to more than US\$ 2 000 000 for 2008, up from US\$ 250 000 in 2001. Annual external monitoring missions are held by the GDF to monitor the in-country drug management right down to the grassroots level. These have reported good progress. A new international drug purchasing facility, UNITAID, providing drugs for HIV/AIDS, TB and malaria, also based at the Stop TB Partnership at WHO Geneva, will provide the NTP with second-line anti-TB drugs to manage a first group of 200 MDR-TB patients. Myanmar, one of the 22 TB high-burden countries, is a member of the global DOTS Expansion Working Group (DEWG), an inter-institutional arrangement between the World Health Organization and many Stop TB Partnership partners involved in expanding the coverage of DOTS. The DEWG meets once a year in conjunction with the annual World Conference on TB and Lung Diseases hosted by the International Union against TB and Lung Diseases (IUATLD). Since 2006, the NTP Manager is a member of the core committee which steers the work of the DEWG. The existing TSG TB functions as the Stop TB Partnership forum in Myanmar.

## **3 Diseases Fund (3DF): HIV/AIDS, tuberculosis and malaria**

Following the decision by the GFATM to terminate its Round 2 and 3 grants provided to Myanmar, a consortium of six donors (Australia, the Netherlands, European Commission (EC), Norway, Sweden and the United Kingdom) established the 3 Diseases Fund (3DF) to develop a project to fill the emerging critical gap in programme implementation. The move stemmed out of a deep-rooted concern over the

implications of terminating the said grants on the health of the people of Myanmar. A Bridging Fund for TB and Malaria was established in 2006 to ensure continuity of life-saving activities previously funded under the GFATM before the 3DF funds arrived. In accordance with the EU common position on Myanmar, the 3DF project is to be implemented by UN agencies, NGOs, the private sector and civilian administrations at the township or lesser levels. Funds will not be channelled through the central or state/divisional level. The Ministry of Health has, therefore, requested WHO to be the executing agency for the National Programmes for TB, AIDS and Malaria. A new arrangement for support to national programmes and activities at the township level has, consequently, been developed by WHO. The WHO Country Office will manage and monitor the distribution of 3DF funds to 325 townships supporting these three national programmes.

In line with the recommendations and proposals of the 3DF donor consortium, the Ministry of Health constituted the new Country Coordination Body chaired by the Minister for Health with membership from other relevant ministries, civil societies, UN agencies, INGOs and local NGOs for overall coordination of programme planning, implementation, and monitoring and evaluation of the national response related to AIDS, TB and Malaria.

## **Challenges related to development assistance and partnerships**

One of the major challenges posed by the current aid modalities is to ensure that development assistance aligns with national programmes and policies while conditions imposed by donor countries are at the same time respected. Furthermore, funding mechanisms that bypass the government and directly support INGOs and NGOs and external development partners may lead to further weakening of a fragile health system. This may also lead to the creation of parallel health structures and programmes that do not necessarily follow national norms and standards.

In the roll-out of the 3D Fund activities, it will be no mean challenge for WHO to disburse, manage and monitor a large grant for AIDS, TB and malaria on time in collaboration with the relevant national programmes within the Organization's policy basis while simultaneously fulfilling the requirements and expectations of the 3DF donors that are set forth by the European Commission's common position on Myanmar.

A major cause for concern is the termination of the GDF's support in 2009, after ending an already exceptional seventh year of support, which might set back the hard-won gains made and excellent results achieved by the NTP. Meanwhile, a grant from the UN Central Emergency Response Fund (CERF) is already helping to build a limited buffer stock.

## The work of WHO in Myanmar

### 4.1 Brief history of WHO in Myanmar

Myanmar became a signatory to the World Health Organization's Constitution on 1 July 1948 and is currently one of the 11 Member States of the WHO South-East Asia Region. A basic agreement was signed between WHO and the Government of the Union of Myanmar in 1957. Thus, WHO is one of the longest-serving UN agencies operating in Myanmar. WHO has become the lead adviser to the MoH through its close and continuing support to the public health system in the country. In keeping with its mandate WHO provides technical assistance to the Ministry of Health by making available the services of experts in different areas of health, organizing and conducting seminars and training programmes, and forming functional expert working groups. WHO also helps prepare and execute pilot projects and research in Myanmar in collaboration with different departments under the Ministry of Health and promotes the training of select professionals of the Ministry of Health.

The various WHO-funded plans of action are derived from national health plans and help catalyse the respective national programmes.

The WHO Country Office is located in a commercial building in Yangon. There is no WHO field office in Myanmar but there are 17 Regional Surveillance Officers posted in states and divisions who have been recruited to facilitate the implementation of the Immunization and Vaccines Development Programme. There is one Administrative Assistant to assist each of them. They also help in disbursements of 3DF payments at the township level. All the ministries (including health) have shifted to Nay Pyi Taw, the new administrative capital of Myanmar situated about 392 km from Yangon

### 4.2 Country Cooperation Strategy 2002-2005

The Myanmar Country Cooperation Strategy for the period 2002-2005 — the first CCS for the country — outlined the strategic agenda for WHO in Myanmar in six priority areas:

**Health System:** During this CCS period WHO intended to provide support to improve the delivery of health services in Myanmar as well as to develop and promote

policies based on public health principles. The emphasis was on: i) research and policy support for health involving both the public and private sectors; ii) providing norms and standards and strengthening the regulatory framework for health; iii) strengthening policy, planning and management for the health workforce, drugs and consumables, health facilities and equipment.

Excess burden of disease: WHO would support Myanmar's efforts to reduce excess morbidity and mortality due to both communicable and noncommunicable diseases, especially in poor and marginalized sections of the population. The emphasis would be on prevention and integrated control of key diseases. Special emphasis would be on HIV/AIDS prevention in tandem with other United Nations agencies and NGOs. Disease surveillance would also be bolstered.

Child and adolescent health: The health of neonates and young children would be improved through improved prenatal and neonatal care, nutrition and the Expanded Programme on Immunization (EPI). Care for children would be improved through the Integrated Management of Childhood Illnesses (IMCI). Further strategies and programmes would be developed to improve adolescent health.

Women's health/Reproductive health: Special efforts would be made to reduce morbidity and mortality of women, especially during childbirth. Reproductive health and obstetrical services would be strengthened with emphasis on the quality of care and improved capacity of midwives and other skilled birth attendants (SBAs).

Environmental health: Health would be improved by emphasizing health promotion and reducing risks from the environment, and prioritizing water supply and sanitation. Community education and health promotion would be emphasized, as well as efforts to improve water supply, reduce hospital waste and eliminate breeding places for mosquitoes causing malaria and dengue fever.

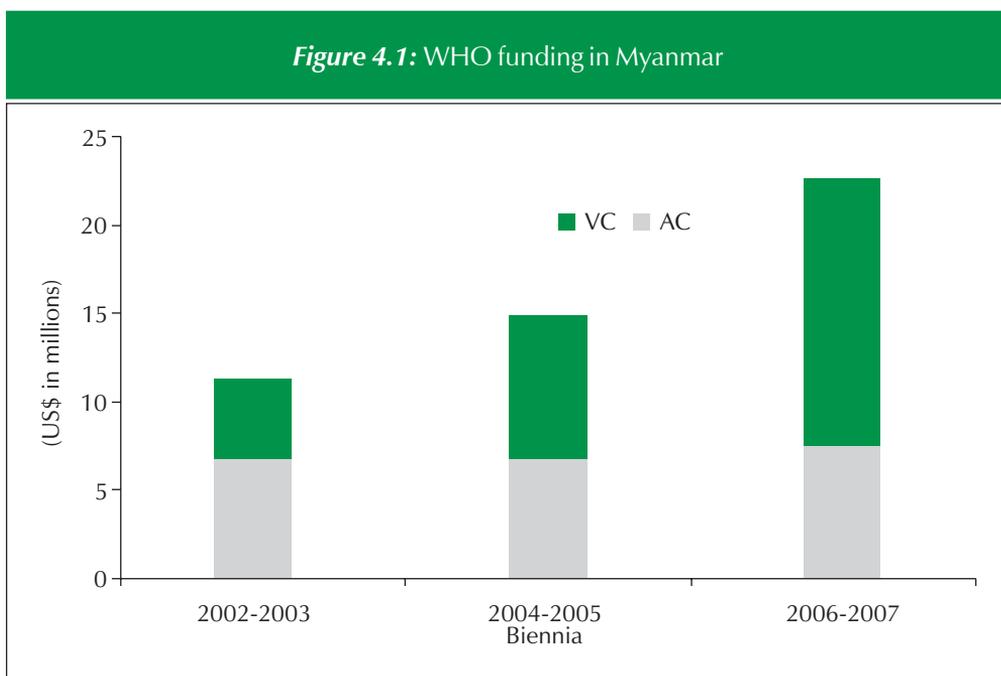
Major risk factors hazardous for health: The major emphasis here would be to ensure safe blood supply and reduce tobacco consumption, both key risk factors to health. Improved food safety would also be supported.

### **4.3 Financing the WHO-Myanmar collaborative programme**

Figures in the WHO Budget provide the basic means of analyzing the implementation of its work. Funding for the WHO-Myanmar collaborative programme comes from two sources: (i) the Assessed Contributions (AC) collected from WHO Member States, and (ii) Voluntary Contributions (VC), provided by donors, usually to support special projects. The amount of funds received through the two sources during the 2002-2003 biennium was US\$ 11 754 510 and that during the 2004-2005 biennium was US\$ 14 885 147. In the Country Cooperation Strategy for 2002-2005, the majority of funds from VCs

supported CCS priority areas. In consultation with the Ministry of Health, 85% of AC funds were allotted to 2002-2005 CCS priority areas. The total budgeting figure for the 2006-2007 biennium as of 31 December 2007 is US\$ 22 647 388. Voluntary Contributions for different technical programmes tend to fluctuate. For example, UNFPA provided US\$ 2.4 million for strengthening reproductive health services in Myanmar between 2002 and 2005, and US\$ 198 875 in 2006. This contribution was discontinued in 2007. Italy provided US\$ 470 588 for “improvement of essential newborn care in Myanmar” to be implemented by 31 December 2007. Fidelis, through the International Union against TB and Lung Diseases, provided a US\$ 200 000 grant for community-based DOTS in hard-to-reach areas of Sagaing Division.

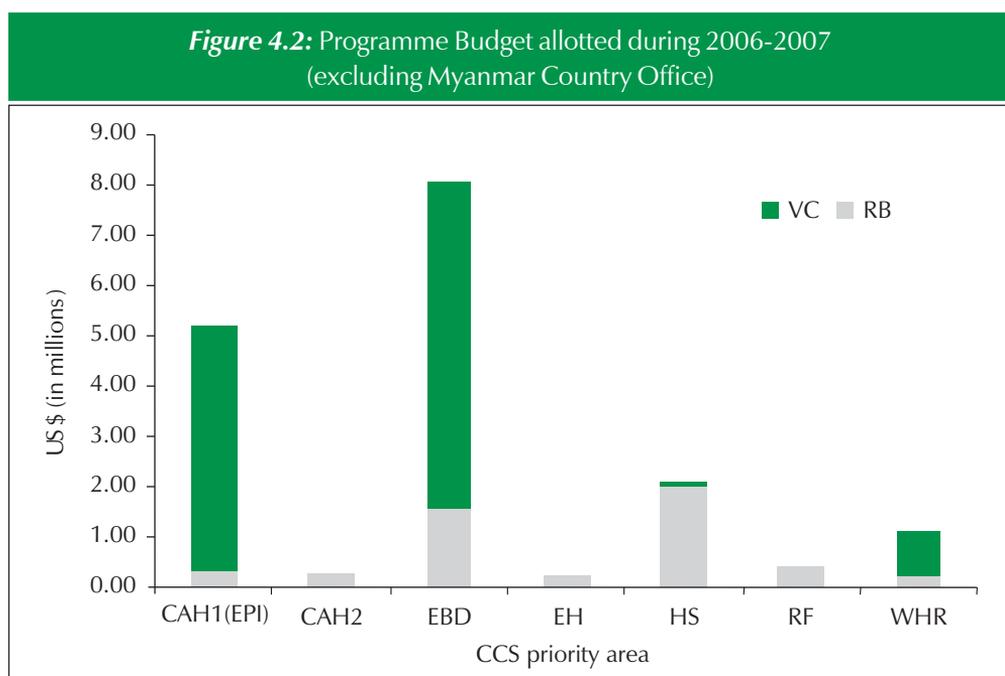
After the termination of the GFATM grants for TB (Round 2) and malaria and HIV/AIDS (Round 3) in August 2005, the 3Diseases Fund provided a direct grant of US\$ 1.7 million to WHO vide the Bridge Fund to cover the critical gap that ensued after the sudden termination of GFATM and before the 3DF became operational. Larger proposals, on a competitive basis, have been approved by the 3DF Fund Board for a total amount of US\$ 5.7 million for the first year of the 3DF programme, to implement activities for three national programmes (ATM) and two national NGOs. Following the outbreak of avian influenza in poultry in March 2006, new donors such as the United States Agency for International Development (USAID) and the World Bank provided funds to WHO and FAO. Figure 4.1 shows the trends in funding for WHO’s work in Myanmar from 2002 through 2007. As can be observed, there has been only a small increase in AC funding whereas VC funds have increased considerably over this period.



Source: VC allotments from AMS Grant Management System.

In order to present an accurate picture of the current funding for WHO work, the 2006-2007 biennium programme budget allotments were used and organized by the CCS priority areas. While the budgets represent the work planned for the biennium, the allotments are funds actually received. On account of the large amount of funding for EPI activities, the CCS priority area of child and adolescent health was divided into two components: CAH1 for EPI and CAH2 for any other funding for child and adolescent health activities. Finally, funds used for the Myanmar Country Office were excluded from this analysis.

The results of this analysis are shown in Figure 4.2 with a total of about US\$ 5 million for the Assessed Contributions (AC) and another US\$ 12.4 million for VC funding, totalling US\$ 17.4 million for this two-year period. Only about 29% of WHO’s funds for Myanmar are now from the Assessed Contributions as VC funding has increased over previous



bienniums. The lion’s share of the funding is for the excess burden of disease, a CCS priority area with over US\$ 8 million in allocation in the current biennium. This is followed by child and adolescent health with nearly US\$ 5.5 million. However, most of the funds are earmarked for the EPI with only about a quarter of US\$ 1 million for other CAH programmes and no VC funding. This means about US\$ 13 million is allotted for the EBD and EPI programme areas, representing about three-quarters of the total funds to be spent in WHO’s current work in Myanmar. The CCS priority area of the health system receives about US\$ 2 million, mostly supported by the Assessed Contributions and with only a small amount of VC funding. Women’s health and reproductive health receive most of the VC funds. Health and environment and risk factor priority areas receive small amounts of funding entirely from the Assessed Contributions.

## 4.4 WHO Staff to implement the collaborative programme

The WHO workplans are implemented in collaboration with Myanmar's Ministry of Health (MoH). Most of the implementation element of in-country activities is undertaken by counterparts in the MoH through various agreements. However, WHO is accountable for the implementation of the WHO-Myanmar collaborative programme and staff members of the Organization provide technical and programme management support for the same.

To support the implementation of the collaborative programme, WHO contracts national and international staff members under various arrangements. Since the scope of the collaborative programme expands due to the availability of VC funding, staff requirements at the country office have increased. Table 4.1 lists the human resources working under various types of contracts arranged in accordance with CCS priority area as well as for the Myanmar Country Office.

**Table 4.1:** Human resources currently assigned to support implementation of the WHO-MoH collaborative programme, 2007

	LTS		NPO		STP		SSA		Total	
	RB	VC	RB	VC	RB	VC	RB	VC	RB	VC
CAH1(EPI)						3		19	0	22
CAH2			0.2						0.2	0
EBD		5	0.5	5		3		6	0.5	19
EH			0.2						0.2	0
HS	0.5		0.5						1	0
RF			0.2						0.2	0
WRH			0.4			2		1	0.4	3
Country Office	2.5						4		6.5	0
Total	3	5	2	5	0	8	4	26	9	44

**Note:** LTS – Long-term international staff; NPO – National Professional Officers; STP – Short-term professionals (international) and SSA (Special Service Agreement) – National staff on service contracts

The total complement of human resources at the WHO Myanmar Country Office is 53 with only nine of them supported by Assessed Contributions and 44 through VC funding. In line with the Budget discussed in the previous section, most human resources are involved in the EPI programme and with those projects related to the excess burden of disease, especially regarding HIV/AIDS and tuberculosis control. The gradual growth in the number of WHO personnel in the Myanmar office, both nationally and internationally recruited, is reflected in Table 4.2.

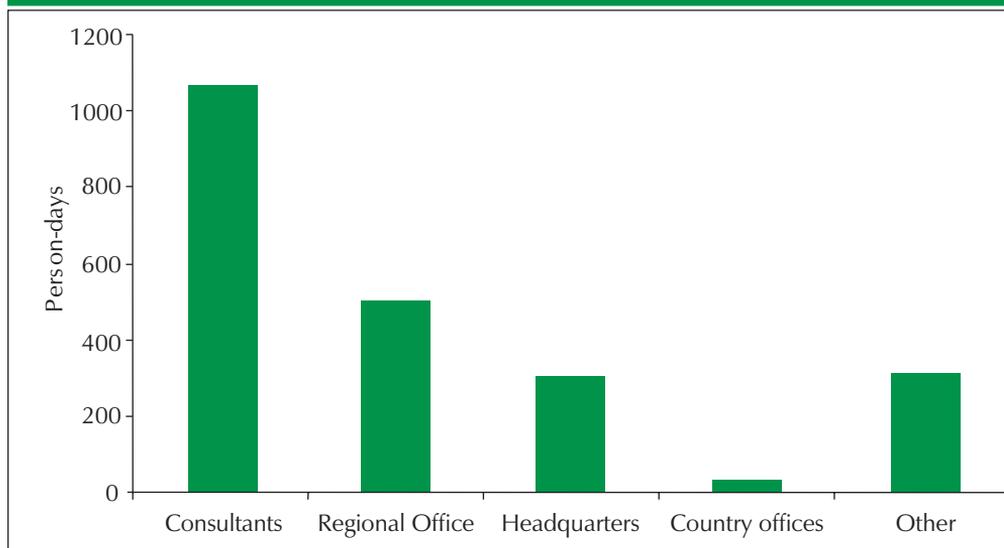
**Table 4.2:** Staffing trends

Biennium	International staff	National staff
2002-2003	9	23
2004-2005	12	38
2006-2007	16	45

### 4.5 Support provided from the Regional Office, headquarters and short-term consultants

While day-to-day support for the implementation of the collaborative programme is carried out by staff members of the country office, staff from the Regional Office and Headquarters and other country offices provide extensive support too. In addition, short-term consultants are recruited to supplement the work of the staff members. An analysis was carried out on the number of mandays of support provided by both WHO staff members and short-term consultants from January 2005 through December 2006. During this two-year period, the figure turned out to be 2230 person-days of support. As can be seen in Figure 4.3, over 1000 person-days come from short-term consultants, with the Regional Office and Headquarters providing about 500 and 300 person-days respectively.

**Figure 4.3:** Person-days of technical support classified by source during 2005-2006



An analysis was carried out using these same technical support visits during 2005 and 2006 to determine the programme areas being supported. Figure 4.3 provides this breakdown with over a quarter of the total person-days in the area of HIV/AIDS alone. The EPI programme area and tuberculosis were the second and third largest programmes for technical support accounting for about half of all the technical support. Malaria, the health system, emergency and humanitarian assistance and disease surveillance (mostly for pandemic preparedness) together accounted for a quarter of total support. The remainder of the programme areas received only minimal support during this period.

## 4.6 Conclusions

At the close of the CCS 2002-2005 period, the WHO-Myanmar collaborative programme has grown in terms of financial and technical support, providing strong assistance to health development in Myanmar. However, the amount of work accomplished is not evenly distributed in the six CCS priority areas. Recent developments have shown that the clear majority of WHO support is in the field of communicable disease programmes on HIV/AIDS, tuberculosis control and various EPI activities, particularly polio surveillance and measles. Support has been provided, to a lesser extent, for malaria control and surveillance, and for avian influenza preparedness. Thus the majority of the Organization's work has concerned the excess burden of disease and child health, and vaccine preventable diseases in particular.

Even within this EBD priority area it should be noted that noncommunicable diseases and mental health received only minor support from WHO. Most of the financial support for WHO's work in these two CCS priority areas came from voluntary contributions.

It is noteworthy that support for improving the health and nutrition levels of women and children, outside of the EPI, was limited. There was only about US\$ 1 million of VC funding for women's health and less than US\$ 500 000 from the AC that was outlined in the CCS for 2002-2005. This raises the question whether WHO could provide greater levels of support for the key MDGs related to mothers and children and if additional donor funding could be raised in this area. Work on health system strengthening received over US\$ 2 million in the most recent biennium with much of this used to improve the management of the local health system. Support for environmental health was almost negligible in terms of funds and technical assistance offered to the country. Finally, for the priority area of risk factors, funding was limited though there was some progress in the areas of safe blood supply and tobacco control.

## WHO Policy Framework: Global and regional directions

### Global challenges in health

The General Programme of Work (GPW) is the highest policy document of WHO. The Eleventh GPW (2006-2015) sets out the direction for international public health for the period of 2006 through 2015. The document notes that there have been substantial improvements in health over the last 50 years. However, significant challenges remain, as highlighted in the following four gaps:

**Gaps in social justice:** Clearly, poverty is a key factor that impedes access to quality health services. There are populous gaps in the levels of health of different sections of the same society. In some countries the life expectancy of the poor is 20 years lower than that of more privileged members of society. Poverty and poor health form a vicious cycle. Other factors that reduce equitable access to health services are discrimination by ethnicity or gender, and women's health, which is often not adequately addressed.

**Gaps in responsibility:** Health problems today are no longer merely the responsibility of those working on health but also require positive action by those outside the health sector. International conflicts and national crises often lead to the disruption of social services which include health care. Globalization and international trade has a direct impact on health, especially in pharmaceuticals and the movement of health professionals. In many countries ministries of health often do not have the capacity to adequately influence important causes of ill-health outside the health sector.

**Gaps in implementation:** The technology to implement cost-effective interventions to improve health is often available but not implemented because of shortage of funds, lack of human resources or the absence of an effective health system. Available resources may often be allocated to high-cost curative services and are often concentrated in urban areas, leaving inexpensive and effective interventions in rural and remote areas neglected.

**Gaps in knowledge:** Global advances in science and technology have improved the effectiveness and efficiency of medical services and the prevention and treatment

of diseases. However, information about the means to use these advances for health development is often not available in many countries. Also, the lack of information about health conditions and existing rigidities in many countries have in turn made it difficult to formulate and manage effective health policies and interventions. Even operational research for those most in need of health services is generally not conducted, thereby reducing the efficiency of key programmes.

## Global Health Agenda

In order to reduce these gaps over the coming decade, the Eleventh GPW outlines a Global Health Agenda consisting of seven priority areas:

- (1) Investing in health to reduce poverty.
- (2) Building individual and global health security.
- (3) Promoting universal coverage, gender equality and health-related human rights.
- (4) Tackling the determinants of health.
- (5) Strengthening health systems and equitable access.
- (6) Harnessing knowledge, science and technology.
- (7) Strengthening governance, leadership and accountability.

The Global Health Agenda is relevant to everyone working in the field of health development. WHO will contribute to this agenda by concentrating on its core functions, which have been built on the comparative advantages of the Organization. In accordance with the Global Health Agenda and WHO's core functions, the Organization has set the following priorities:

- (1) Providing support to countries in moving to universal coverage with effective public health interventions.
- (2) Strengthening global health security.
- (3) Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health.
- (4) Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health.
- (5) Strengthening WHO's leadership at the global and regional levels and supporting the work of governments at the country level.

WHO will pursue these priorities through its Medium-term Strategic Plan (2008-2013) and the biennium budget. The Director-General of WHO has clearly placed considerable focus on the work of the Organization at the country level. The regional

offices and headquarters have been directed to emphasize support for country work and implement these priorities in Member States, especially in countries where health needs are the most pressing.

#### WHO's core functions

- Providing leadership on matters critical to health and engaging in partnerships where joint action is needed.
- Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge.
- Setting norms and standards, and promoting and monitoring their implementation.
- Articulating ethical and evidence-based policy options.
- Providing technical support, catalysing change, and building sustainable institutional capacity.
- Monitoring the health situation and assessing health trends.

## Regional Policy Framework

The SEA Region has the second largest population among the six WHO Regions and the highest burden of disease. While there has been great economic development in this Region in recent years, the problems of poverty and poor health remain significant. Many Member countries here have faced health emergencies in the last decade and the threat of disease outbreaks is ever present. At the same time, NCDs have become an increasingly important cause of morbidity and mortality in countries of the SEA Region. Therefore, the Global Policy Framework of WHO is appropriate for the countries of the Region, with special attention paid to strengthening the capacity of Member States to support public health interventions.

The South-East Asia Region has always placed a strong emphasis on its work in Member States. Of the total budget provided to the Region, 75 per cent is allocated for countries, the highest for any WHO region. The Regional Director for South-East Asia has recently enhanced the degree of delegated authority to country offices to enable them to plan and implement programmes with a higher degree of independence and be more accountable for their work. At the same time, he has emphasized that the Regional Office staff should give the highest priority to support the work in these countries.

## Strategic Agenda for 2008-2011: Priorities jointly agreed for WHO cooperation in and with Myanmar

The CCS for the period of 2002-2005 had set out a strategy to increase the contribution of WHO towards health development in Myanmar. To develop this strategy, it was necessary to make choices as to in which aspects of the country's work on health and health development is WHO best placed to support, and where the bulk of its limited resources (including staff time) will be focused. This approach has been continued while developing WHO's strategic agenda for 2008-2011.

Before 2002, WHO's support was primarily for small-scale projects covering a large number of sectors. The capacity of the Myanmar Country Office was extremely limited, with it not being able to provide continuous technical support even to key programme areas. Currently, WHO is providing extensive support for several key programme areas, especially in the health system, HIV/AIDS, malaria, TB and reproductive health. In addition to supporting policy development and providing technical assistance in specific programme areas, the office has been involved in efforts to attain more funding for these programmes, either through the 3D Fund or other bilateral and multilateral donors.

Between 2008 and 2011 WHO will build on the work accomplished by the 2002-2005 CCS, expanding support for health development and moving progressively from project to programme support. Given the health situation in Myanmar, the priorities of the Ministry of Health and its health development partners, the CCS for 2008-2011 outlines the following areas of priority for WHO:

- (1) Improve health system performance.
- (2) Reduce excess burden of disease.
- (3) Improve the health conditions of mothers, children and adolescents.

In these priority areas, WHO will support all stakeholders in accordance with its core functions as outlined in Section 5 of this document: WHO will provide leadership and collaboration with partners, shape research agenda including the dissemination of valuable knowledge, establish and disseminate norms and standards, articulate policy options, provide technical support while building sustainable institutional capacity,

and monitor the health situation and trends. For all programmes and services, emphasis will be placed on equity, fairness and progress towards universal access.

## 6.1 Improve the performance of the health system

WHO will go beyond a general endorsement of “strengthening the health system” to advocacy and support and to specific actions to significantly improve access and the use of acceptable, affordable and technically correct care for the people of Myanmar, especially for vulnerable groups such as women, children and those living in remote areas. Emphasis will be placed on services provided at the township and community level. The improvement in performance of the health system will be measured by increased access to and utilization of quality health services, especially for priority health concerns shown under priority areas 2-3 above. WHO will also assist the government and partners to develop proposals to support the strengthening of the health system.

Actions to be taken to improve the health system performance must include:

- (1) Deployment of an adequate number of trained, equipped and supportively supervised basic health workers;
- (2) Ensuring the availability of essential drugs and supplies delivered through a correctly managed logistics system;
- (3) Collecting, reporting and analysing a minimum set of health data with prompt action on the findings; and,
- (4) Optimum use of scarce resources through improved management.

Concrete actions to improve the performance of the health system will also be needed on the health information system, financing of health care including new options such as health insurance, improved management right down to the township level, and improvement in infrastructure at all levels, including primary and secondary health care. This will require concerted action by all partners and not just WHO alone.

WHO will support operational research as needed to tackle emerging issues and improve services delivery. WHO will continue its support to the Ministry of Health’s Management Effectiveness Programme and, if requested, assist in an evaluation, including external evaluation, of this initiative. As additional programmes are implemented at the township level (for example, the 3Diseases Fund), WHO will support operational research to show what is working and what is not, and to assess synchronization with the national health programme.

WHO will advocate for an integrated health system which builds on existing disease-specific programmes. For example, in cases where efficient drug delivery logistics

are in place for the control programme of a specific disease, these can be expanded over time to include other drug and vaccine supply components.

Considering the critical under-financing of the health sector in Myanmar, the work on national health accounts that is currently underway must be completed and followed by a data-informed policy analysis and reallocation of resources depending on the findings. Similarly, human resources allocation and training must be rationalized according to the needs of the entire health sector and not only the objectives of specific programmes. This can be done only through a coherent health system approach.

WHO will continue to support the development of national policy and action plans and, if requested, assist in the development of specific plans and proposals for improvement of the health system. As programmes and partners are funded through novel financing arrangements such as the 3DF, special efforts must be made to avoid creating a de facto parallel health system outside of the national health management infrastructure.

To improve the performance of the health system in Myanmar an adequate number of public health experts, some of them equipped with advanced skills, has to be ensured. This will require incountry capacity for public health training at the postgraduate level in addition to continuing support to undergraduate public health training programmes. WHO will provide technical and, to the extent possible, material support to the development of the newly established University of Public Health in Yangon, and will advocate for similar assistance from other development partners as well. This is in line with the Public Health Initiative now being implemented in the WHO South-East Asia Region.

One of the Organization's core functions is to provide leadership and encourage viable partnerships. The Organization will continue and strengthen its successful collaboration with the Ministry of Health's International Health Division, which is responsible for coordination of health-related activities among partners; and will promote information sharing, collaboration and coordination among all partners, especially national and international NGOs. WHO will need to be more active in this area in order to ensure the coordination of health programmes under the 3Diseases Fund.

## **6.2 Reduce excess burden of disease**

Priority attention will be accorded to leading causes of morbidity and mortality such as malaria, tuberculosis and HIV/AIDS. For these problems, WHO will continue to support improved surveillance, expanded access to preventive and curative services, monitoring of drug resistance and policy review. These disease-specific initiatives will be implemented in a system-strengthening manner. A properly functioning health

system which provides ready access to first-level care, a functioning referral system, and correct referral care will improve outcomes for a much wider range of health problems, including vaccine-preventable diseases, leprosy, and locally endemic and neglected diseases.

For malaria, WHO will support increased coverage of malaria control services which assure equity and high quality. Technical support will be provided for quality assurance of diagnostics (microscopy, rapid tests, etc) and for operational research on malaria control among high-risk groups such as forest workers, migrant workers and ethnic minorities, since they generally live in forested areas of the country. The problems of drug resistance and of fake drugs will be addressed. All these activities will be carried out in line with the National Strategic Plan for Malaria Control (2006–2010).

WHO's support to tuberculosis control will include assistance for development of TB control policies and its translation into programme implementation, including on TB/HIV co-infection, MDR-TB, PPM DOTS and Childhood TB; capacity building to implement and sustain the new Stop TB Strategy based on DOTS with the focus on underserved populations; scaling up of intersectoral partnerships; improving community awareness and utilization of DOTS; monitoring and evaluation (including TB software); operational research on programme implementation; and fielding of prevalence surveys to measure progress towards the MDGs. All WHO activities will be in support of the National Operational Plan for TB (2006–2009). There is a substantial funding gap for planned TB programmes, and WHO will advocate for increased funding support, first and foremost for life-saving anti-TB drugs.

In the case of HIV/AIDS, WHO will continue to work on strategic planning and programme development; prevention (including promotion of 100% condom use, STI control, VCCT, blood safety and opioid substitution therapy); care and support (including ART, management of opportunistic infections and home-based care); and surveillance. This will be in compliance with the HIV/AIDS National Strategic Plan (2006-2010) and the United Nations' "Division of Labour" (an agreement among UN agencies on which agency is responsible for which task).

Attention will also be paid to surveillance and control of new and re-emerging communicable diseases in line with the WHO Bi-Regional Strategy on Emerging and Re-Emerging Diseases. WHO will continue its coordinating role for preparedness and response for avian influenza, and will use AI as an entry point for strengthening national capacity for implementing the International Health Regulations (IHR) (2005). Complete implementation of IHR (2005) will also require intensified cooperation and exchange of information with the five countries with which Myanmar shares land borders (India, Bangladesh, China, Thailand and Laos), recognizing the fact that some of the border regions are poorly accessible due to the terrain. As such the population in the border areas are particularly vulnerable to disease due to their inaccessibility and WHO will encourage and participate in initiatives to improve health services in these areas.

WHO will advocate for and support a public health or population-based approach to the prevention of NCDs including cardiovascular disease and diabetes. Prevention through population-wide risk factor modification has been demonstrated to be highly cost-effective, and is the only realistic option for NCD control in countries with limited financial resources. A pertinent example is tobacco control, which can have a huge impact on the burden of cardiovascular and pulmonary disease. WHO will support the implementation of tobacco control in collaboration with the National Tobacco Control Committee according to the National Plan of Action of 2000. As in the other priority areas selected by WHO, operational research will be needed to assess the effectiveness of behaviour change communication and other interventions for NCD control among the population.

Other health problems that will continue to receive WHO's attention are violence and injuries (including gender-based violence), environmental health risks (including water-borne diseases), alcohol abuse, snakebites, and nutrition issues (including infant feeding and micronutrient deficiencies). Most of these issues involve complex societal and cultural factors. WHO will encourage participation of all partners, including UN agencies, NGOs and communities, according to their comparative advantages.

### **6.3 Improving health conditions for mothers, children and adolescents**

For Myanmar to achieve the Millennium Development Goals related to reduction of maternal and child mortality, it will need to focus on ensuring continuum of care for mothers and newborns, and also ensuring the availability of skilled care attendance during pregnancy, childbirth and postpartum. Women should deliver in a first-level health facility where prompt referral of obstetric emergencies and management of asphyxia and sepsis in newborns is available.

The availability of one SBA per village is ideal. However, currently there are only 17 703 SBAs for the 64 976 villages in the country. In view of this, WHO will support, as a transitional strategy, a partnership of midwives, auxiliary midwives (AMWs) and traditional birth attendants (TBAs). Under the guidance of midwives, AMWs and TBAs will support maternal and newborn health services with a limited package of activities.

Strengthening community participation through the empowerment of individuals, families and communities in utilizing maternal and newborn health (MNH) services will contribute significantly to the achievement of MDGs 4 and 5. WHO will continue to support the WHO Collaborating Centre for Midwifery and Nursing, building on previous efforts in this direction which include the training of trainers for community health nursing development through the leadership and management accreditation programme.

All these activities will be carried out in line with the National Reproductive Health Strategic Plan (2004–2008) and the five-year Strategic Plan for Child Health Development 2005-2009.

There is the felt need of clarifying the division of labour between various partners supporting the national health system on maternal and child health, including UN agencies and UNICEF and UNFPA in particular. In accordance with its core functions, WHO will concentrate on the provision of norms, standards, guidelines (including case management protocols) and policy guidance, adapted to the country situation and made available to health workers. WHO recognizes the comparative advantage of the involvement of the government, UN agencies and nongovernmental partners for actual services delivery.

Financial support, including external assistance, is disproportionately low for maternal, neonatal and child health when viewed in the context of the disease burden of illnesses and deaths during and after childbirth, during the neonatal period, and in infancy and childhood. WHO will advocate with all partners, especially donors, for increased support in this area.

WHO would continue to support Myanmar's Expanded Programme on Immunization (EPI), which has logged remarkable successes since its inception in 1978. The EPI programme now reaches all townships. Hepatitis B was in a phased manner made part of a routine immunization programme in 2003 and covered the entire country by 2005. To reduce measles mortality the Government of Myanmar completed a nationwide Mass Measles Campaign between January and May 2007, targeting about 7.2 million children in the age group of nine months to five years. Following the polio outbreak of 2007 the Ministry of Health had responded promptly to stop the transmission of the polio virus to all parts of the country. WHO will continue to provide technical and financial support to states and divisions and conduct supplementary immunization activities in the coming years to ensure that Myanmar maintain a polio-free status,.

The WHO Country Office is supporting Regional Surveillance Officers (RSO) and the Measles and Polio Laboratory Network in Myanmar with support from DFID. The quality of acute flaccid paralysis (AFP) surveillance has matched international standards in adequate specimen collection and non-polio AFP reporting rate. Surveillance for neonatal tetanus and measles has been successfully integrated with AFP surveillance. Other vaccine-preventable and emerging diseases are being studied for possible inclusion in the integrated surveillance system.

## Implementing the strategic agenda: Implications for WHO Country Office

### 7.1 Organization of the WHO Myanmar Country Office

The current organizational structure of the WHO Myanmar Country Office (WCO) is appropriate to cater to the needs and meet the targets of the Myanmar CCS for 2008-2011. The organogram is regarded as “flexibly functional”, which can always be reviewed according to the priority issues during a particular period of a CCS. Functionally, there are at the moment nine thematic teams of technical programmes (TB, malaria, HIV/AIDS, IVD, avian influenza-IHR, reproductive health-new born care, health system-human resources for health, a technical grouping on leprosy-traditional medicine-health education-oral health-school health-healthy settings-elderly health-tobacco-injury-disability, and another technical grouping of child health-mental health-snakebites-DM-CVD-diabetes-blindness-deafness-food safety and water sanitation). Each technical unit under the groupings has on an average two to four Professional staff (both international and national) and a couple of secretaries to assist them. One international staff is informally assigned as focal point for each thematic team. The technical work of the Professional staff is directly under the supervision of the WHO Representative (WR). A weekly meeting called the Monday Afternoon Meeting (MAM) was initiated in mid-2005 to accommodate the reporting sessions. In order to align the work of the country team on the strategic agenda outlined in the previous section, and to improve internal collaboration and increase efficiency through a streamlined reporting structure, the technical responsibilities of Professional staff will be distributed according to the relevant CCS priorities and strategies. These are: improving the health system performance; improving health conditions for women, children and adolescents; and reducing excess burden of disease.

The health system team — which will also be responsible for planning and monitoring of the WHO country programme — will work “across” programmes and ensure a consistent approach to key elements of the health system including provision of drugs, laboratories, human resource development (including training), health information, costing and funding within its gamut.

The family health team (health of women, children and adolescents) will focus on shaping an overall, coherent approach to this crucial agenda and collaborate with

key partners such as UNICEF and UNFPA in a way that each organization works to its comparative advantage. The team will continue to have a fairly “hands-on” approach and managerially a heavy programme of work related to immunization.

The disease team will include, in addition to the existing competent technical expertise on malaria, TB and HIV/AIDS, a programme management cell for the 3DF funding with technical and managerial competencies.

Future developments related to avian and human influenza may also call for bolstering capacity in the country office, especially in the context of pandemic preparedness in the IHR (2005).

## 7.2 Sustaining a core team for WHO in Myanmar

The dedication and competence levels of staff at the WHO Myanmar Country Office are impressive. However, the current pattern of multiple short-term contracts is neither rewarding nor supportive of the team in its efforts to be more focussed on a streamlined work programme. It also has an element of insecurity for the staff and entails the spending of considerable time and effort in trying to find immediate, and often not sustainable, means of extending contracts.

Reallocation of some of the existing funding (e.g. for APWs and SSAs), revision of responsibilities of existing staff and hiring of new expertise will go in tandem with the effort to mobilize resources. Besides considering the priority areas, more attention and efforts aimed at allocating and sustaining staff for the neglected and “difficult-to-get-financial-support” diseases (such as dengue, leprosy, lymphatic filariasis, leishmaniasis) need to be given. An effective health system is the backbone for rendering good quality health care and delivery of services at the district and community levels and the WCO needs to devote more staff to this area.

To maintain efficiency levels of WCO staff, and in view of the uncertainty of availability of the voluntary contribution staff cost, the staffing pattern would be changed accordingly.

From 2002 the UNFPA-WHO project worth US\$ 1 million enabled the WCO to cover international staff for the work under reproductive health, MPS and gender. The Italian grant covered newborn health. With both projects coming to an end in 2007, the WCO needs to seek continuous funding for the above areas, especially since they are CCS priorities. With the 3DF being available to Myanmar for TB, HIV and malaria, a dedicated unit was established as a core team for those three diseases. The AI team was established in 2006, supported by voluntary contributions of several donors. These two units are predicted to grow in the coming years: the 3DF will deal with strengthening health-care services and delivery at the township level and the AI unit will be expanded to include the work on IHR (2005).

## 7.3 Building and strengthening the capacity of the Country Office

The limited resources for health in Myanmar has made the WHO-MoH collaborative programme one of the main sources of funding for supporting the ministry in executing the national health programmes where WHO as a normative agency has also been requested to provide technical support. This encouraged the WCO to mobilize resources in order to provide necessary support to the country to its best capacity. The increased amount of the voluntary contributions implied an increase in the workload of the administrative component of the WCO, where it demands continuous capacity-building of the General Services staff in order to work efficiently and effectively. The Myanmar Country Office will continue its capacity-building efforts through sending staff to the Regional Office for enhanced training in various aspects of the administration, to promote exchange of staff with the Member countries of the Region, and to continue language classes for local staff. Professional staff will continue to participate in various technical meetings at the national, international and global level in order to be able to provide updated information and quality support to their national counterparts and other partner agencies. The WHO Representative (WR) to Myanmar will continue to participate in and be involved with WHO regional and global learning programmes such as the regional and global WRs' Meeting and the Global Leadership Workshop.

### Improving the working environment

Six UN agencies together with WHO have relocated their offices to the Traders Hotel, Yangon. In this arrangement by collective move UNICEF has provided secured connectivity on a cost-sharing basis. This has enabled WHO to use GPN and facilitated the planned roll-out of GSM in 2008.

With the transfer of the capital to Nay Pi Taw commencing mid-2006, a weekly courier service between Yangon and Nay Pi Taw has been initiated by the UN system on a cost-sharing basis.

### Managing knowledge

WHO will continue to act as the centre for information on health, and cater to providing updated information on health development and guidelines, norms and standards. The external review mission to review existing WHO-MoH collaborative programmes which were organized will continue, since such missions are highly appreciated for their objective observations and findings. WHO will continue to help the country come up with verified data and information through introduction of new statistical models, estimations, conduct of surveillances and other methods. WHO will further support active participation of country experts and national counterparts in the international forums to enable them to share information and findings of various

research activity. WHO continues to assist the MoH in the development of a comprehensive website on avian influenza, which is to be shared widely.

### **Strengthening support from the Regional Office and Headquarters**

For Myanmar to obtain the maximum benefit of support, the strategies would be geared towards: a) improve working relationships with the regional offices and headquarters, especially for seeking technical assistance; b) request information on the latest updates on health matters; c) mobilize funds to sustain staff support at the WCO, and d) seek assistance for resource mobilization. Another strategy would be to enhance relationship with other WRs in the Region, especially the WRs of countries that share their borders with Myanmar and countries with common interests. The horizontal collaboration could benefit the sharing of information and experiences.

### **Enhancing partnerships**

Partnership is the key to success. The Myanmar CCS for 2008-2011 will be shared and disseminated with Member countries of the the SEA Region, the SEA Regional Office and headquarters. It will also be distributed to the WCOs of countries bordering Myanmar, including Laos, Vietnam, Cambodia and China, besides Thailand, Bangladesh, Nepal and India which belong to the SEA Region. The first-named countries belong to the Western Pacific Region, but are also linked with Myanmar and Thailand through the Mekong Sub-Region. The Myanmar Country Office requests the SEA Regional Office and headquarters to promote the Myanmar CCS at the regional and global level and to make maximum use of the strategy as a tool for advocating priority health needs and for mobilizing resources. The strategies in partnerships will be on: a) maintaining and improving working relationships with existing INGOs, NGOS, and bilateral and multilateral partners working in health; b) enhancing collaboration with global organizations, such as with Global Alliance for Vaccine Initiatives (GAVI), GDF the Stop TB Partnership and UNITAID; c) increasing efforts for partnerships with new alliances and forums; d) continue sending senior national officials and experts to international meetings for exposure to recent international health matters and to build networks and share information; e) continue to involve international experts from WHO or relevant organizations in conducting external reviews of the WHO-governmental collaborative work in order to come up with neutral and validated data; and, f) to host international seminars/workshop/training courses in Myanmar.

### **Expediting the ways of work**

Due to the prevailing situation, authorizations to visit the country and those for field trips need at least four weeks to be sanctioned. All visitors to Myanmar need to factor these constraints. Staff from headquarters and the SEA Regional Office should route all moves to collaborate with any organization in Myanmar and must do it through

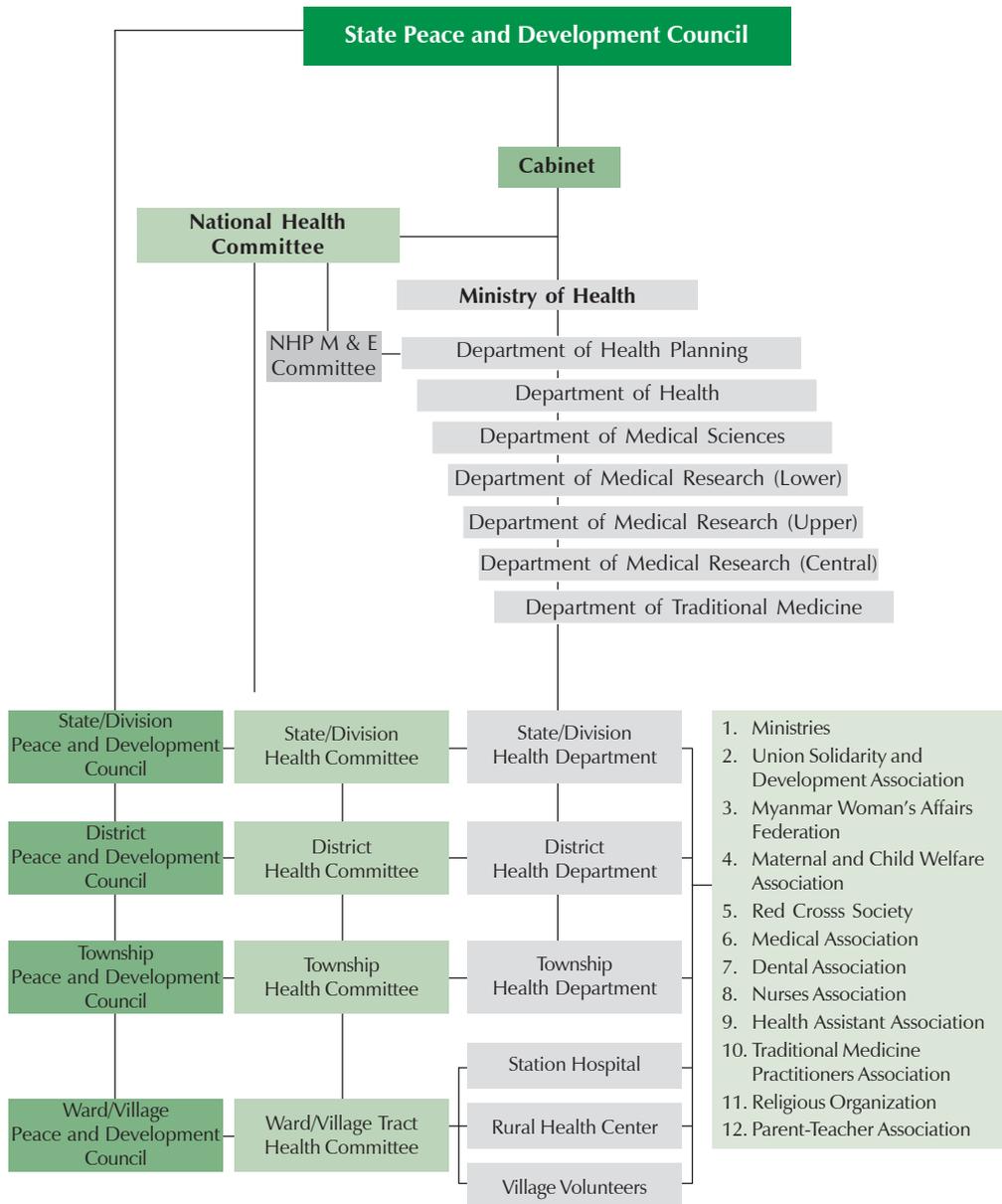
the Country Office. Likewise, when the Myanmar Country Office is in need of technical support from headquarters and countries of other regions, support should be sought through channels that maintain close consultation with the SEA Regional Office.

## **7.4 Communicating and linking the WHO strategic agenda with biennium workplans**

Besides some immediate readjustments in the team and its work programme for the next bienniums within the CCS period, in close consultation with its national partners, the challenges linked to the current planning framework both in WHO and in the MoH, and to donor-led investments in country activities, should not be underestimated. The country team will have to be supported at the highest levels in the MoH and in the Regional Office if WHO wishes to ensure that its country programme makes the difference that it can actually make in Myanmar.

The WHO Representative will use all possible opportunities to communicate about the Organization's strategic agenda in and with Myanmar in order to mobilize and streamline more support for the health sector and bolster the organization's capacity to support its development.

## Myanmar health services delivery system



## Annex 2

### List of abbreviations

3DF	3 Diseases Fund
AFP	acute flaccid paralysis
AI	avian influenza
AMW	Auxiliary midwife
ART	antiretroviral therapy
ARV	antiretroviral
BHS	basic health staff
CEU	Central Epidemiological Unit
CNR	case-notification rate
CCS	Country Cooperation Strategy
CSO	Central Statistical Organization
CVD	cardiovascular disease
DoH	Department of Health
DOTS	Directly Observed Treatment Short-course (for tuberculosis)
DST	Drug Sensitivity Test
DPAS	Global Strategy on Diet, Physical Activity and Health
EC	European Commission
EPI	Expanded Programme on Immunization
EBD	excess burden of diseases
FAO	Food and Agriculture Organization of the United Nations
FHAM	Funds for HIV/AIDS in Myanmar
GDP	Gross Domestic Product
GPW	General Programme of Work
GFATM	Global Fund against AIDS, Tuberculosis and Malaria
GAVI	Global Alliance for Vaccines and Immunization
GMP	good manufacturing practices
GPN	Global Private Network
GSM	Global Management System
HA	health assistant
HMIS	Health Management Information System
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
ICC	Interagency Coordination Committee (for GAVI)
ICD-10	International Statistical Classification of Diseases

ILO	International Labour Organization
IEC	information education and communication
INGO	international nongovernmental organization
IMMCI	Integrated management of maternal and childhood illness
IHR	International Health Regulations
IDD	iodine deficiency disorders
IMR	infant mortality rate
IOM	International Organization for Migration
IDA	iron deficiency disorder
JICA	Japan International Cooperation Agency
LHV	lady health visitor
LCS	local cost subsidy
MDR-TB	Multi-drug resistant tuberculosis
MEP	Management Effectiveness Programme
MW	midwife
MoH	Ministry of Health
MISC	multiple indicator cluster survey
MMCWA	Myanmar Maternal and Child Welfare Association
MDGs	Millennium Development Goals
MRCS	Myanmar Red Cross Society
NAP	National AIDS Programme
NEQAS	National External Quality Assessment Scheme
NCDs	noncommunicable diseases
NGO	nongovernmental organization
NHL	National Health Laboratory
NIPPP	National Influenza Pandemic Preparedness Plan
NMR	neonatal mortality rate
NSP	National Strategic Plan
NSS	new sputum smear
NTP	National Tuberculosis Programme
ODA	Official Development Assistance
OECD	Organization for Economic Co-operation and Development
PPM DOTS	Public-Private Mix Directly Observed Treatment Short-course (for tuberculosis)
PMCT	prevention of mother-to-child transmission
PHC	primary health care
PEM	protein energy malnutrition
PHS	public health supervisor
RHCs	rural health centres
SEARO	South-East Asia Regional Office

SARS	Severe Acute Respiratory Syndrome
SIA	supplementary immunization activities
STEPs	NCD risk factor surveys based on STEP's methodology
STI	sexually transmitted infection
TBA	traditional birth attendant
TCP	Targeted Condom Promotion Programme
TB	tuberculosis
TSG	Technical and Strategy Groups
TMO	Township Medical Officer
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
VCCT	voluntary counselling and confidential testing
VSAT	very small aperture terminal
WFP	World Food Programme
WHO	World Health Organization

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## Country Cooperation Strategy 2008-2011 Myanmar

This Country Cooperation Strategy (CCS) for Myanmar is a medium-term vision of the World Health Organization's efforts to support health development in Myanmar in the next four years. It is based on analysis of the current health situation in the country, health policies and programmes of the Ministry of Health, the work of other health development partners in Myanmar and the previous work of WHO in the country. The CCS was developed through close consultations with the Ministry of Health and key health development partners in Myanmar. The strategic agenda outlined in the document presents the priorities and actions that WHO can most effectively carry out to support health development, guiding the work of WHO in Myanmar at all levels of the Organization. The strategic agenda for WHO's work in Myanmar will center around three priorities: (1) Improve the performance of health systems; (2) Bring down the burden of disease; and (3) Improve health conditions for mothers, children and adolescents. Work to improve health systems will concentrate on the local level and aim towards improving the utilization and quality of services in health facilities, especially in remote areas. WHO will continue emphasizing the reduction of HIV/AIDS, tuberculosis and malaria, while advocating for increased attention to noncommunicable diseases, a growing cause of mortality in the country. The Organization will work closely with the Ministry of Health and key partners to help Myanmar achieve the Millennium Development Goals (MDGs), especially those involving the health of mothers, infants and children. WHO Country Office staff will be strengthened and reorganized in teams working on these three priority areas. In addition, the office will expand its cooperation with other health development partners working in Myanmar.



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