

WHO

Country Cooperation Strategy

Myanmar

2013-2017

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WHO Country Cooperation Strategy 2013-2017 Myanmar

Executive Summary

The WHO Country Cooperation Strategy (CCS) 2013-2017 for Myanmar provides a coherent medium term vision of WHO's technical cooperation and define its strategic framework for working in and with Myanmar. It aligns closely with the national priorities of National Health Policy, Strategies and Plans and well harmonized with UN system's effort for the country development. The present CCS is built on the experience and achievements of the previous CCS 2008-2011 and taking into consideration the emerging country situation. It also follows the guidance of twelfth General Programme of Work (GPW). 12GPW provides a six-year 2014-2019, vision for the organization, with a reduced number of categories and criteria for priority setting; five programmatic categories and one administrative category from a previous total of thirteen strategic objectives. It is a set of global health agenda for all and establishes a strategic, results-based and accountable framework of WHO.

Myanmar emerges from decades of isolation with much hope and support from the global and regional communities. The country has a high potential for rapid growth and development given its natural resources and its abundant of youth population which makes nearly 40 percent of the population. Despite a given economic growth and a consistent effort for further development, it faces multiple constraints and risks that may limit its progress. Major improvements in the health status of the population are also crucial to inclusive growth. Both in geographical and socio-economic dimensions, there are important disparities in rural areas, where about 70 percent of the population resides. Their benefits are much less than those in urban areas. In health sector, there are several constraints for further improving in health status of the people: deficiencies in access to basic health services, inequities and service availability gaps, disparities in availability and affordability of essential medicines, the need for provision of adequate infrastructure and further increase in public expenditures on the sector, a shortage of health personnel as well as shortcomings in training and gaps in the provision of basic materials to services.

However, Myanmar has made progress towards the MDGs. As the country endeavours to attain its health objectives, trends in key health indicators show a gradual improvement. Infant Mortality Rate (IMR), Under Five Morality Rate (U5MR) and Maternal Mortality Ratio (MMR) have declined between 1988 and 2007. With regard to MDG4, U5MR has declined steadily, from 130 per 1000 live births in 1990 to 65.8 in 2007. Regardless, achieving overall target of 38.5 in 2015 remains a challenge. In rural areas, the rates are almost twice that of urban areas. IMR, meanwhile, also indicates a decreasing trend, to 53.2 in 2007, but likewise faces challenges to meet MDG target of 28.3 by 2015. Meanwhile, immunization data are encouraging; Myanmar has been free from wild polio virus transmission and measles immunization has increased from 67.7 percent in 1990 to 88 percent in 2011. Recently in November 2012 Myanmar has introduced Haemophilus influenza type b (Hib) as Pentavalent (DPT+HepB+Hib) vaccine in the immunization program. Based on these trends, the 2015 target of 90 percent is expected to be fulfilled. Reducing maternal mortality under MDG5 represents a major challenge and will require significant efforts to meet the goal. About 88 percent of deliveries take place at home with maternal deaths overwhelmingly predominant in rural areas. The proportion of births attended by skilled health personnel has increased from 51 percent in 2001 to 65 percent in 2009.

MDG6 offers a major opportunity for achievement by 2015. Myanmar already has achieved the goal of a 50 percent reduction in malaria morbidity and mortality since 2007, with use of insecticide-treated nets (ITN) more than doubling between 2004 and 2008. At the same time the TB death rate targets has also been achieved and the TB incidence target is on track. However additional efforts are needed to meet the MDG target of halving the TB prevalence rate by 2015 as compared to 1990. The main challenges include finding the many undetected/unreached TB cases in Myanmar, scaling-up MDR-TB management and reducing the dual burden of TB and HIV/AIDS. With regard to HIV/AIDS, the epidemic is considered stabilized nationally since 2000, with hot-spots of high HIV transmission identified at

several locations. There exists a need for continued focus on most-at-risk groups to maintain initial positive achievements. Major challenges also exist to scale up HIV treatment, which now covers only about 1 in 3 of those in need.

As the Government has a strong commitment for a comprehensive development, including health sector, the Framework for Economic and Social Reform (FESR) was developed and outlines the policy priorities for the government in the next three years which identifies key parameters of the reform process. FESR is an essential policy tool of the government to realize both short and long-term potential of Myanmar. The government will set out the policy agenda for coming three years, focussing on immediate actions or 'quick wins' as well as those issues require more analysis and/or consensus building for specific decision. In health sector, Government of Myanmar (GOM) will focus on a number of innovative measures in health financing. Particular attention will be paid to allocating more resources to rural primary health care, infectious disease control and maternal and child health, in view of the acute need to improve health indicators in all these areas.

At the ministry level, an aspiring 30-year long term health development plan, 'Myanmar Health Vision 2030' has been drawn up to meet the future health challenges. Aligning with the fifth five year National Development Plan, and within the objective frame of the short term third five year period of the Myanmar Health Vision 2030, the MOH has formulated the National Health Plan 2011-2016 (NHP). The plan is also interlinked with Rural Health Development Plan, 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. It has also taken into account of the prevailing health problems in the country, the need to realize the health related goals articulated in the MDG, significance of strengthening the health systems and the growing importance of social, economic and environmental determinants of health. In successive phases of NHPs, Myanmar has developed several strategies and plans. In all these endeavours of developing strategies and plans, resource mobilization, implementation and in monitoring processes, WHO has closely aligned its work with all stakeholders in health, has actively involved and contributed in providing technical advice for the development of health sector in Myanmar.

Poverty is the principal root cause of constraint in improving the health status, compounded by factors affecting vulnerability, difficult to reach areas and conflict among various ethnic groups. The government has undertaken remarkable effort in building up understanding amongst various ethnic groups for establishment of peaceful environment that fosters development. To address poverty, UNDP has introduced Human Development Initiative (HDI) since 1994, and provided a significant impact in building up community capacity leading towards self-reliance. In moving forward the socioeconomic growth of the country, Official Development Assistance (ODA) plays a significant role in health sector programmes. The total amount that ODA has committed for health was USD 109.5m in 2002 to USD 390.7m in 2009, out of which commitment for health was USD 22.6m (20.7 percent) in 2002 which increased to USD 61.2m (15.7 percent) in 2009. The aid environment is expanding and reaching to all development sectors. UN Country Team is also engaging with a common framework - UN Strategic Framework in assisting the country. It is now at its second cycle, and the present UN Strategic Framework 2012-2016 addresses four priority issues: encouraging inclusive growth, increasing equitable access to quality social services, reduce vulnerability and promote good governance.

WHO is the lead agency in health sector of the country. WHO has actively collaborated with health sector of the country in all the development processes and for capacity building of the health systems. In cooperation with the country, WHO had developed the second WHO-CCS for Myanmar, within the framework of 11GPW, which was closely aligned with priorities of NHPSP and well harmonized with UN Strategic Framework. The CCS, for the period 2008-2011 focussed on the three well-defined priority areas: improve health system performance; reduce excess burden of disease; improve the health conditions of mothers, children and adolescents.

The third strategic agenda, CCS 2013-2017 has been formulated in alignment with the NHP 2011-2016, and is well harmonized with the UN Strategic Framework 2012-2015. In the development process, the

social developments emerging out of the national reform process and key challenges of health confronting the country were carefully synthesized while formulating the strategic agendas and priorities. A close observation was given to the contributions to health development by other external partners in identifying challenges and gaps in health sector cooperation and lesson learnt from a review of WHO's cooperation over the last CCS cycle. It also follows the guidance of the Twelfth General Programme of Work and regional orientations and priorities. A special consideration was also given in enhancing the achievement of MDGs, principally to the health related targets by 2015. The strategic priorities are:

1. Strengthening the health system;
2. Enhancing the achievement of communicable disease control targets;
3. Controlling the growth of non-communicable disease burden;
4. Promoting health through the life course; and
5. Strengthening the surveillance systems and readiness to respond threats to health.

The priority areas will be addressed through a coordinated programme of work that will seek to harness the potential strengths of the stake holders. The first priority area is to enhance the national capacity to strengthen the health system, support equity in health and increased access to services and to promote an adequate and sustainable health care financing mechanism. The second priority area is to enhance the achievement of the communicable disease control targets and MDGs; the third priority area is to control the growth of non-communicable disease burden and minimize the prominent risk factors prevalent in the environment. The fourth area addresses to strengthen health system through improving health conditions of women, child and adolescent and ensure accountability through reporting on progress towards reproductive and sexual health as parts of achieving the MDGs. The fifth priority area is to prevent disease outbreaks through strengthening health system and strengthening the rapid response. For each of the strategic priorities, a set of main focuses and strategic approaches have been formulated.

In addition to the 5 priority areas, WHO will continue its core functions as directed by its governing bodies and will actively cooperate with Myanmar for any other public health challenges. The impact of these changes on budgets and staffing with required skill and competencies in the country office are expected to be moderate. The CCS will be implemented in close alignment and in harmonization with national strategic agenda and UN Strategic framework. WHO will focus its effort in achieving the targets identified by the health sector of the country.

Section 1: Introduction

The WHO Country Cooperation Strategy (CCS) is a medium-term vision for its technical cooperation with the Member States, in support of the country's National Health Policy, Strategy or Plan (NHPSP). It is WHO's key instrument for aligning with the national agenda while harmonizing with the organizations of the UN system and other partners in the country. It is also an Organization-wide reference for country work in planning, budgeting and resource allocation within the result-based management framework and is guided by the General Programme of Work (GPW) of the Organization.

The formulation of the Country Cooperation Strategy (CCS) is a joint exercise between the Country and WHO with active involvement of partners in health. It defines the boundaries, focus, policy directions and value premises that help frame the CCS, which will enhance WHO's contribution and resulting in an optimal health impacts to the people of the country. The CCS is consistently used at all level of the WHO governance. It is the basis on which the country office, in collaboration with the regional office and headquarters, will develop the 'one WHO country plan', review its staffing, and mobilize human and financial resources to strengthen WHO support to the country, within the approved programme budget.

WHO has initiated the CCS process since 2000 and launched the first Myanmar CCS covering for the period 2002-2005. Based on the lesson learnt, keeping in line with WHO Global and Regional Policies development and closely aligned with the Country's development and outcome of the assessment of WHO's comparative advantage in supporting Myanmar NHPSP, CCS 2008-2011 was adopted and again it was later extended to 2012.

As Myanmar opens up, it will be subject to sweeping changes in the global and regional geopolitical and socioeconomic environment. The expected economic growth will certainly determine the promotion of human development. The development goals among all sectors are synergistic, interlinked and crosscutting. All these favourable developments will advances the momentum more on track to meet MDG targets especially MDGs 4, 5 and 6 which are currently shaping up in the right direction. There are several prominent and remarkable milestones which have been taken place in health sector during this period:

- Considering the rapid changes in demographic, epidemiological and economic trends, a long term Myanmar Health Vision 2030 has been laid down to improve the health status of the population. It is a long-term (30 years) health development plan. The long term vision will guide the medium-term national health plans. The main objectives of the Vision is to uplift the health status of the people through developing a health system in keeping with the changing political, economic, social and environmental situation; ensuring the universal coverage of health services for the entire nation; making the communicable diseases no longer public health problems; ensuring the availability of quality and quantity of essential medicines and human resources; modernizing the Myanmar Traditional Medicine; and developing Medical and Health Research to the international level.
- A National Health Plan 2011-2016 is in relation to the fifth five-year National Development Plan. The plan has been developed taking into account the prevailing health problems in the country, the need to realize the health related goals articulated in the UN Millennium Declaration, significance of strengthening the health systems and the growing importance of social, economic and environmental determinants of health. The Plan ensured that the quality health services are accessible and in equitable manner to all citizens. The Plan also highlights the programs for strengthening the health system; expanding health care coverage in rural, peri-urban and border areas; and expansion of human resources and infrastructure.
- There is no specific decentralization policy for the health sector. However initiatives for decentralized planning have been initiated through health system strengthening efforts for 20 townships in 2012. Financing and human resources appointments are mainly centralized

functions of the Ministry of Health (MOH). There are now pressures to develop a system of 'Meso Planning', whereby States and Regions develop middle level plans as inputs to a National Health Sector Plan. At the highest level, the constitutional reforms took place in 2008, where the legislative power was shared between the Central Parliament and Regional and State Parliaments.

In the process of the current CCS 2013-2017 formulation, internally a working Team led by the WHO Representative was formed. The team captured all the strategic directions of the Global WHO policy, strategic agenda and priorities spelled out in 12th General Programme of Work and WHO Reform Agenda. Side by side, the Team adhered closely to the current development within the country in respect of NHPSP, socio-economic dimensions and the changing epidemiology within the country keeping a close association with Organizations in UN System and partners in health. The Team also conducted an internal assessment of the performance, achievements and constraints of the last CCS 2008-2011. This was then followed by meetings with Government and Partners in health. A synthesis of key findings and external perceptions are well taking into account in the formulation process of the current CCS.

Section 2:

Health and development challenges. Attributes of the National Health Policy, Strategy or Plan and other responses

2.1 Macroeconomic, political and social context

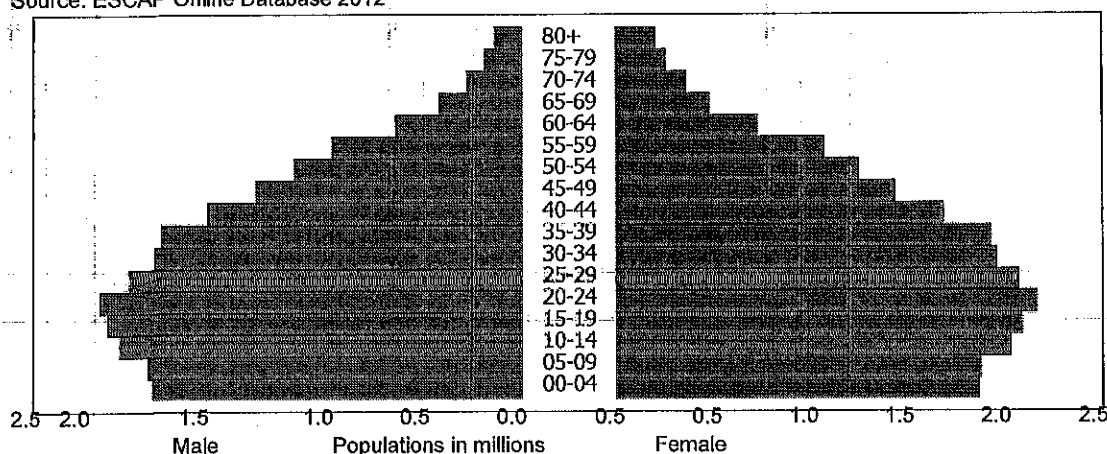
Administratively, Myanmar is divided into 14 States and Regions with 69 districts, 330 Townships, 82 sub Townships, 396 Towns, 3045 wards, 13,276 village tracks and 67,285 villages. It has an estimated total population of 61.3 million in 2011, and has 135 ethnic groups. The major ethnic groups are Bamar, Chin, Kachin, Kayah, Kayin, Mon Rakhine and Shan. 89.4percent of the population are Buddhist, with Christian, Muslin and Hindu minorities.

Demographically, Myanmar is currently at the steady transition to an aging population, but with dominant population groups still very young. The trends in fertility and mortality would suggest that Myanmar is at an early stage of demographic transition. The crude birth rate has declined from 50 to 29 births per 1000 in rural areas between 1988 and 2009, and the crude death rate has almost halved in rural areas from 9.9 per 1000 to 5.8 per 1000 in the same period. The population 0-14 years has declined from 39 percent in 1980 to 29 percent in 2010. Conversely the population above the age of 60 has increased from 2 percent in 1980 to 9 percent in 2010. The urban population grew from 25 percent in 1990 to 34 percent in 2009. The modern economy is also increasing the pressures on migration for seasonal work in rural areas of the country. The population is expected to reach 66 million by 2020 (ADB).

The country's youthful population will generate a demographic dividend now and in coming decades. The 15-28 age cohort currently has 13 million young people who are contributing and will continue to contribute their effort and skills to enhancing productivity and competitiveness. This cohort alone accounts for nearly 40 percent of the working population. People below working age also constitute a large portion of the population – 25 percent. With proper schooling and skills or professional training, in the years ahead, they will provide the human capital necessary to drive Myanmar's economic transformation. At the other end of the demographic spectrum, the old age dependency ratio is low, with the share of people 65 and over equal to only 7.4percent of the working age population. (Fig. 1)

In its national strategies and vision, the country aims and committed to build an economically developed nation that exceeds the human development targets of the MDGs. The country has achieved economic growth since adopting a market oriented system in 1988, with trade soaring by more than a factor of 20 by 2009-2010. Growth rates have been moderate, combined with a continuous trade surplus in recent years, reduced inflation, and relatively minor impacts from the global financial crisis. Inflation has been brought down to a single digit and fiscal deficits are being kept at 4-6percent of GDP. The growth performance may well exceed expectations in the foreseeable horizon. If Myanmar's development follows this pattern, ADB expect that its GDP per capita would reach \$2000-\$3000 by 2030 – more than 3 times the current level.

Fig 1. Age and Sex distribution in Myanmar, 2011
Source: ESCAP Online Database 2012



2.2 Other major determinants of health

The country also faces multiple constraints and risks that may limit its progress. Key constraints include the deficient infrastructure and human capital development. However growth has been the most effective tool for reducing the poverty and it has made some progress in this area although there is further room for improvement. The latest Integrated Household Living Conditions Assessment (IHLCA) survey indicates that one in every four Myanmar citizens is considered poor. Income disparities are geographically linked. The IHLCS report shows that 84 percent of poverty is found in rural areas and disparities are pronounced across states. The central state of Chin has a poverty incidence of 73 percent. This is in stark contrast to the 11percent poverty incidence in Kayah, which has the lowest among states. High poverty rates occur in the coastal states of Ayeyarwady, Rakhine, and Tanintharyi and the land locked states of Shan and Kachin. About one-third of these states' populations are poor.

Wide variations in access to basic services such as housing, water and sanitation also exist across the states and rural and urban areas. From 2005-2010, overall access to safe drinking water increased modestly from 63 percent to 69 percent. The poor continue to benefit less from access than the rich, and urban areas benefit more than rural areas – 81 percent of the urban population had access to safe drinking water in 2010, versus only 65 percent of rural dwellers.

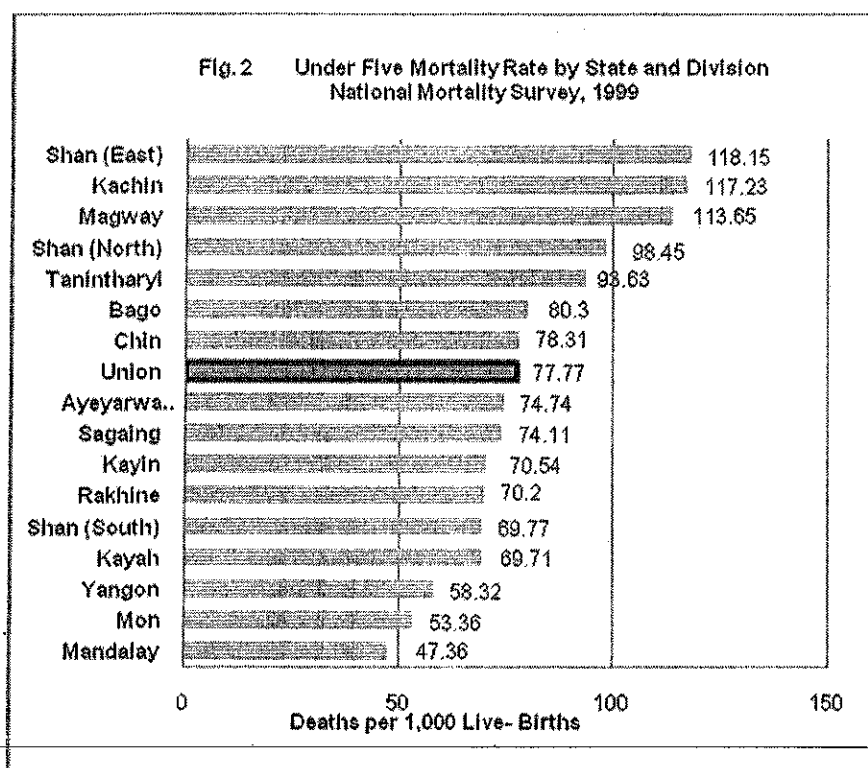
Myanmar has identified protein energy malnutrition and micronutrient deficiencies (including iron deficiency anaemia, iodine deficiency disorders, and vitamin A deficiency) as its nutritional problems. With successive improvement in the prevalence of underweight children under age five years, the country is potentially on track to reduce such prevalence to a target of 19.3 percent by 2015, but further intensive interventions are required. In addition, many people are undernourished because they do not consume enough calories; moreover, satisfactory national averages hide significant variation by region and income group.

Education is a right and is particularly crucial to Myanmar, given the country's young population and its history of placing high value on education and culture. Basic education is the responsibility not only of the Ministry of Education but also the Ministry of Development of Border Areas and National Races, in border and ceasefire areas, and in the Ministry of Religious Affairs, which run a system of monastic schools that continues to serve primarily poor children. Responsibility for higher education, in which most students study using distance education modality is shared among 13 ministries.

The gaps to access to electricity between income groups and across states are large. About 34 percent of rural residents have access to electricity versus of urban residents. However, according to the government sources, electrification ratios are much lower. In 2011, Yangon City had the highest electrification ratio (67percent), followed by Nay Pyi Taw (54percent), Kayah (37percent), and Mandalay (31percent). However, the common impression in 2012, though the official statistics are not available yet, electrification ratio has been much improved throughout the country.

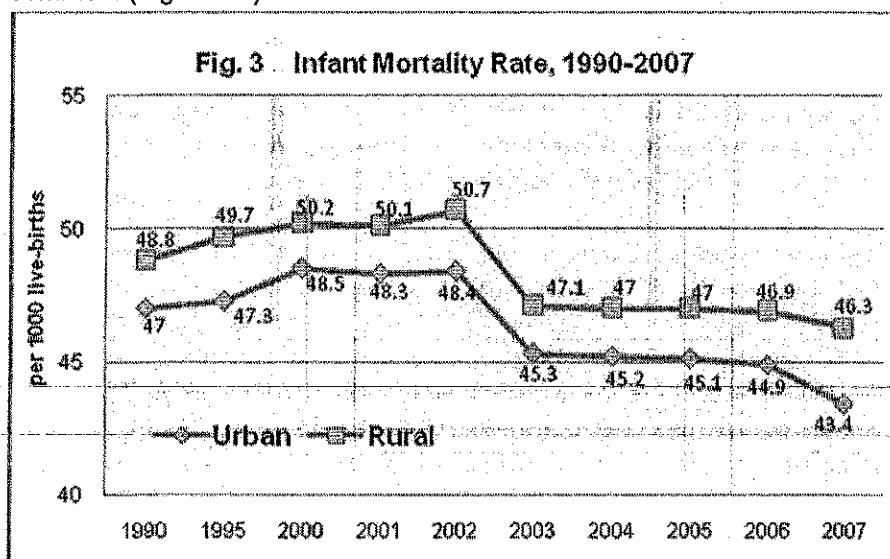
2.3 Health status of the population

The country is consistently endeavouring, with its limited resources to attain its health objectives and trends in key health indicators show a gradual improvement. According to official sources, Infant Mortality Rate (IMR), Under Five Mortality Rate (U5MR), and Maternal Mortality Ratio (MMR) have all declined between 1988 and 2007. Over the same period, life expectancy has increased for both men and women. In 1988, life expectancy at birth was 56.2 years for males and 60.4 years for females in rural area and in urban area, life expectancy at birth for males and females were 59 years and 63.2 years respectively. In 2007, life expectancy at birth was 64 years for males and 69 years for females in urban area and in rural area life expectancy at birth for males and females were 63.2 years and 67.1 years respectively.

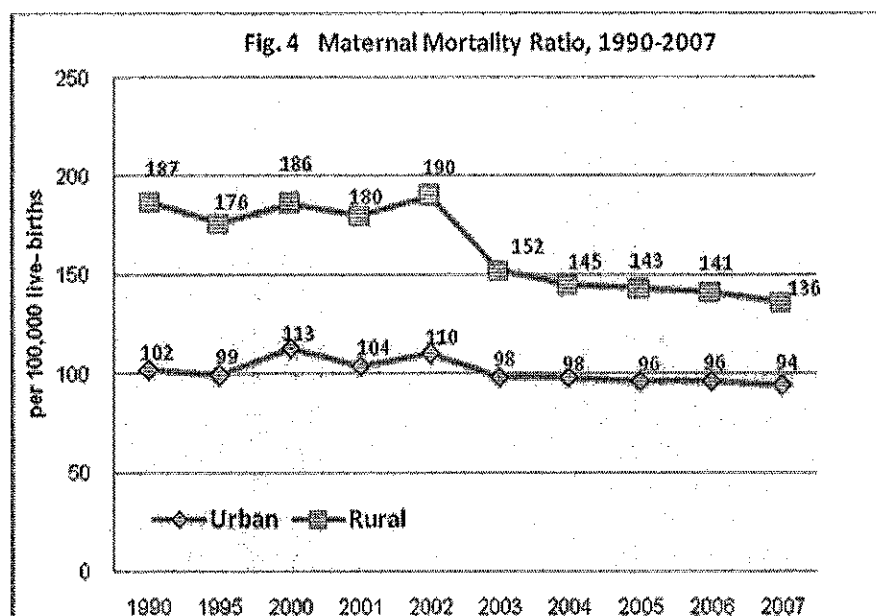


Source: Myanmar Health Statistics 2010, Ministry of Health

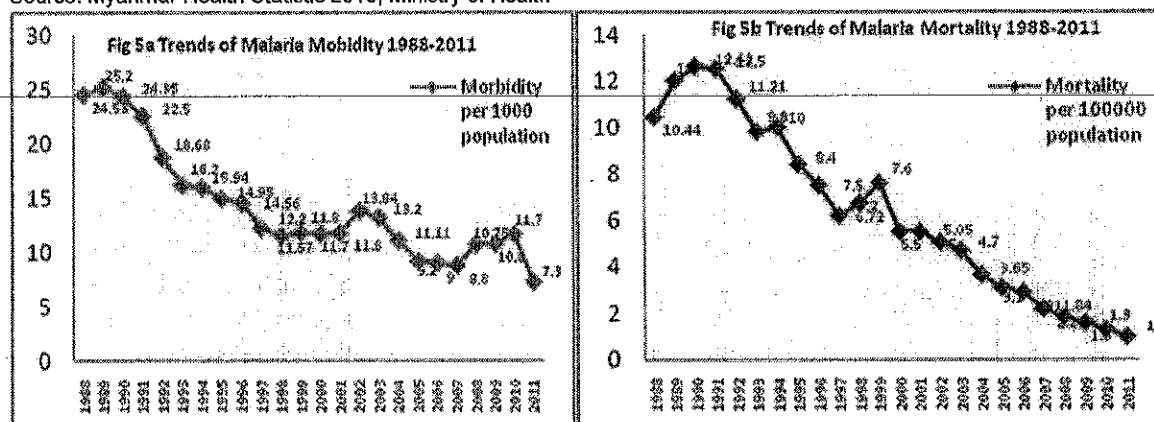
According to the Central Statistical Organization (CSO), MNPED, the U5MR has declined steadily, from 77.77 per 1,000 live births in 1999 to 64.2 in 2007. Moreover, the survey conducted jointly by the Government and United Nations Agencies indicated significance differences between urban and rural areas among regions of the country, with rural U5MR (72.5 per 1,000 live births in 2003) almost twice that of urban rates - 37.3, (Fig. 2). IMR meanwhile, also indicates a decreasing trend to 43.4 in 2007 (CSO). MOH data shows 28.2 for urban and 30.0 per 1,000 live births in 2008. In respect of immunization data, the joint Government-United Nations surveys show that the measles immunization has increased from 67.7 percent in 1990 to 83.6 percent in 2007. The MMR estimate from latest health survey in 2004-2005 stood at 316 per 100,000 live births, although 2008 UN estimates placed the figure at 240. About 88 percent of deliveries take place at home, with maternal deaths overwhelmingly found in rural areas. Major causes of maternal mortality in the country include not only postpartum haemorrhage and eclampsia, but also complications arising from unsafe abortions. Delays in reaching health facilities, because of poverty, lack of knowledge, remote location or lack of transport, also are common. (Fig. 3 & 4)



Source: Myanmar Health Statistics 2010, Ministry of Health



Source: Myanmar Health Statistic 2010, Ministry of Health



Source: Health in Myanmar 2012, MOH

As such, the overall health status data and analysis indicate significant disparities between regions and groups in access to, and quality of, health services, particularly affecting ethnic minorities, poor people, and people living in remote areas. Women from the poorest households received assistance from skilled attendants during delivery in 51% of cases, compared to 96.1% of women from the richest households. The MICS survey in 2010 found the states and regions with largest proportion of delivery Similarly, more children in rural areas are stunted than in urban areas, and is most common in Rakhine and Chin states, where rates of stunting are 49.9 per cent and 58 per cent respectively. Analysis by background characteristics demonstrates that 5 out of the 10 poorest children are stunted by a traditional birth attendant are Ayeyarwaddy (35.2 per cent), Rakhine (30.2 percent), Bago (East) (29.6 per cent) and Chin (25.1 percent). It was noted in Shan North that 24.9 per cent of women delivered their baby without any assistance at all (in Chin State this is also high at 10.4 per cent).

Among specific diseases, the leading causes of death and illness are TB, Malaria and HIV/AIDS. The TB prevalence rate (as confirmed by the 2009-2010 nationwide TB surveillance survey), is three times higher than the global average and one of the highest in Asia. In 2011, WHO estimated that there were 506 prevalent and 381 incident TB cases per 100,000 population, respectively. During the same year, 143,140 TB cases were notified. With a 4.2 % prevalence of multidrug-resistant TB (MDR-TB) among new TB cases and 10% previously treated patients, there were an estimated 5,500 MDR-TB cases among notified pulmonary TB cases in 2011 out of which only 400 received adequate diagnosis, treatment and care (7%). Extensively drug resistant TB (XDR-TB) has been detected since 2007. About 10% of TB cases are co-infected with HIV/AIDS. Malaria is a major cause of death and illness in adults and children. Estimates of the number of cases of malaria range from 4.2 million to 8.6 million a year

and 76 per cent of the population lives in malaria endemic areas. Figure 5a&b presents the declining trend of both morbidity and mortality.

With regard to HIV/AIDS, the epidemic is considered to have stabilized nationally since 2000, with 'hot spots' of high transmission in several locations. This is reflected by prevalence among the general population (15-49 years old) of 0.61 percent. Moreover, the proportion of young people aged 15 to 24 with correct knowledge of HIV has increased, from 21 percent in 2003 to 75.2 percent in 2007. Major challenge at present is, to scale up HIV treatment, which now covers only about 1 in 3 of those in need. National surveillance system focuses on the surveillance of the epidemic prone communicable diseases, emerging infectious diseases and post disaster communicable diseases. Currently, the goal of eradicating poliomyelitis and eliminating measles are set up and all the Basic Health Staff are endeavouring to achieve those goals. The elimination status of maternal and neonatal tetanus has been sustaining through effective strategies. There is an increasing evidence of rubella disease burden in country. The prevalence rate of leprosy was less than one per 10,000 since 2003 and the registered cases were reduced to 2542 at the end of 2011. As far as trachoma is concerned, the active trachoma rate in the central dry zone of Myanmar was 43 percent in 1964 and reduced to under 2 percent in 2000. As trachoma blindness is greatly reduced, cataract becomes the main causes of blindness in Myanmar. Cataract is responsible for about 61 percent of the blindness the rate in all ages is 0.52 percent.

The country is currently facing double burden of diseases – Communicable Diseases and Non-Communicable Diseases. Chronic non-communicable diseases with shared modifiable risk factors – tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol includes: cardio-vascular disease, diabetes mellitus, cancer and chronic respiratory disorders. Non-communicable diseases/conditions of public health importance prevalent are: accidents and injuries, disabling conditions (blindness, deafness, and community based rehabilitation), mental health, substance abuse and snake bite. National STEPS survey (2009) reported that the prevalence of currently smoke was 33.6 percent in males and 6.1 percent in females; the prevalence of hypertension was 31 percent in males and 29.3 percent in females; and prevalence of overweight ($BMI \geq 25 \text{ kg/m}^2$) was 21.85 percent in males and 23.07 percent in females and obesity ($BMI \geq 30 \text{ kg/m}^2$) was 4.3 percent in males and 8.4 percent in females among the sample population.

Myanmar is also facing the emerging issue of a growing number of geriatric population. Among the six million older people in the country about 10% are estimated to be vulnerable persons. A study on the health of the elderly revealed that high blood pressure, heart disease, strokes, cancer, lung diseases related to smoking and musculoskeletal problems are the common issues. Some initiatives for healthy and active ageing have been introduced with technical support from WHO and partners. Health care of the elderly programme using community-based has been started in NHP 1993-1996.

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 the country fall within the risk zone. On 2 May 2008, Cyclone Nargis made landfall in Myanmar, crossing the south of the country over two days, and devastating the Ayeyarwady delta region. According to official figures, 84,500 people were killed and 53,800 went missing. A total of 37 townships were significantly affected by the cyclone. The UN estimates that as many as 2.4 million were affected. A three year Cyclone Nargis relief and recovery operation is conducted by Myanmar Red Cross Society with support from IFRC. In March 2011, an earthquake of Richter scale 7 hit Shan State resulting 64 deaths and 92 injuries. The heavy torrential rain due to the effect of O2B Cyclone caused the flood again in Pakukku in October 2011, which claimed 161 lives and 29,751 were affected.

Based on all these disasters experiences, MOH activated the Strategic Health Operation Centre and despatch the initial response team soon the event takes place. So also under the stewardship of the National Disaster Management Committee, the MOH has been working together with Department of Meteorology and Hydrology of Ministry of Transport, Ministry of Social Welfare, Relief and

Resettlement, other related ministries, UN organizations and NGOs for disaster management, particularly damage and loss assessment of the health facilities, sustaining and restoring of health services and control of communicable diseases. The priority activities for disease prevention and control included the establishment of Early Warning, Alert and Response System (EWARS), immunization of susceptible population, proper camp management, food and water safety and prompt response to the outbreaks.

2.4 National responses to overcoming health challenges

2.4.1 National Health Policies, Strategies and Plans

In responding to overcome the health challenges, there are provisions for health services in the current National Constitution (2008): the Union shall earnestly strive to improve education and health of the people; enact the necessary law to enable the people to participate in matters of education and health; care for mothers and children, orphans, fallen Defence Services personnel's children, the aged and disabled; mothers, children and expectant women shall enjoy equal rights; and every citizen shall have the right to health care.

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 to meet the overall needs of the country reaching not only to rural areas but also to the border areas. The policy highlights the sufficient production of human resources within the context of long term health development plan; and to strictly abide the existing rules and regulations mentioned in the drug laws and by-laws. In view of the changing economic system, the policy encouraged to augment the role of co-operative, joint ventures, private sectors and non-governmental organizations in delivering health care and to explore the alternative health care financing. The policy directed to intensify and expand the environmental health activities and conducting research activities not only on prevailing health problems but also to provide attention in conducting health system research. The policy also reinforces the services and research activities of indigenous medicine to international level; guided to implement health activities in close collaboration with other relevant ministries and to strengthen collaboration with other countries for national health development.

At the national level in the country, there is a National Health Committee (NHC) which was formed in 1989 and re-organized in April 2011. It is a high level inter-ministerial and policy making body concerning health matters. The NHC takes the leadership role and gives guidance in implementing the health programmes systematically and efficiently. The high level policy making body is instrumental in providing the mechanism for intersectoral collaboration and coordination. It provides guidance and direction for all health activities.

Considering the rapid changes in demographic, epidemiological and economic trends both nationally and globally, an aspiring 30-year long term health development plan, 'Myanmar Health Vision 2030' has been drawn up to meet the future health challenges. The plan encompasses the national objectives i.e., political, economic and social objectives of the country. This long term visionary plan with its objectives will be guided on which short term national health plans are to be developed. Among its objectives, in uplifting the health status of the people, it includes: to make communicable diseases no longer public health problems; to ensure universal coverage of health services for the entire nation; to train and produce all categories of human resources for health within the country; to ensure availability in sufficient quantity of quality essential medicine and traditional medicine within the country. The plan spelled out 9 main components and expected the improvement of nation's health indicators, which are presented in Table 1.

Table 1. Expected outcome Indicators of Myanmar Health Vision 2030

Indicator	Existing (2001-02)	2011	2021	2031
Life expectancy at birth	60-64	-	-	75-80
Infant Mortality Rate	59.7	40	30	22
Under-5 Mortality Rate	77.77	52	39	29
Maternal Mortality Ratio (per 1000 live births)	2.55	1.7	1.3	0.9

Source: Health in Myanmar 2012, Ministry of Health

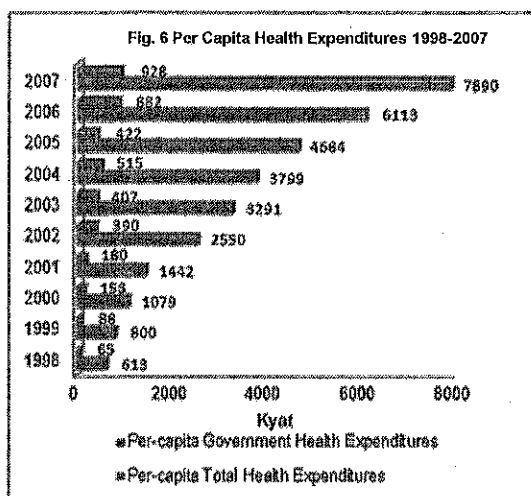
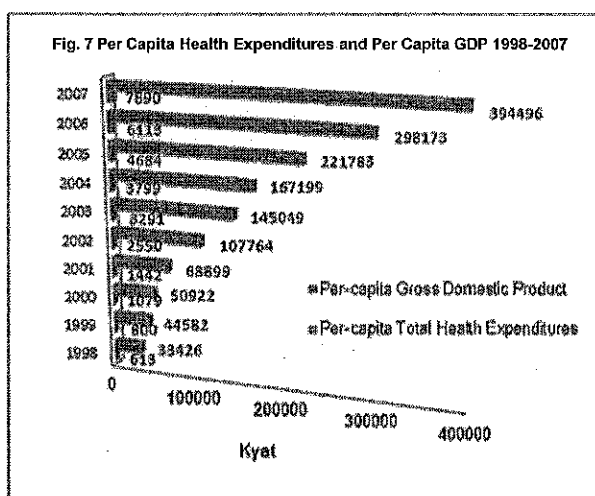
Aligning with the fifth five year National Development Plan, the MOH has formulated the National Health Plan 2011-2016 (NHP). It is also developed within the objective frame of the short term third five year period of the Myanmar Health Vision 2030. The plan is also interlinked with Rural Health Development Plan, 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. Consequently, to achieve the objectives of the NHP(2011-2016), 11 program areas have been identified, taken into account of the prevailing health problems in the country, the need to realize the health related goals articulated in the MDG, significance of strengthening the health systems and the growing importance of social, economic and environmental determinants of health. The NHP 2011-2016 was a top-down exercise. In 2012, MOH worked with the States and Regions to develop 'Meso Plans' – which used a more 'bottom-up planning approach' using data and information provided from all states and regions.

Within the framework of the Myanmar Health Vision 2030 and successive phases of NHPs, Myanmar has developed several strategies and plans. In all these endeavours of developing strategies and plans, resource mobilization, implementation and in monitoring processes, WHO has closely aligned with the nationals and partners, actively involved and contributed its technical advice. The followings are selected few, related with areas contributing to MDGs and in responding to overcoming health challenges:

- Universal Health Coverage
- Health Financing
- Strategic Plan for Reproductive Health 2009-2013
- Strategic Plan for Child Health 2010-2014
- Health System Strengthening
- National Strategic Plan for HIV/AIDS Control, 2011-2015
- National Malaria Control Programme, 2011-2015
- National Strategic Plan for Tuberculosis Control, 2011-2015
- Comprehensive Multi Year Plan on Expanded Program on Immunization, 2012 - 2016

Universal Health Coverage (UHC) is securing access for all to appropriate promotive, preventive, curative and rehabilitative services at an affordable cost. It aims to improve the health status of the poor and vulnerable, especially women and children. The goal of the strategy is to help country attains universal coverage that ensures access to quality health services for better health outcomes. Attaining universal coverage requires urgently government attention and action. It advocates substantial reductions in out-of-pocket payments, which remain both the single main cause of household impoverishment and financial barrier in accessing health services.

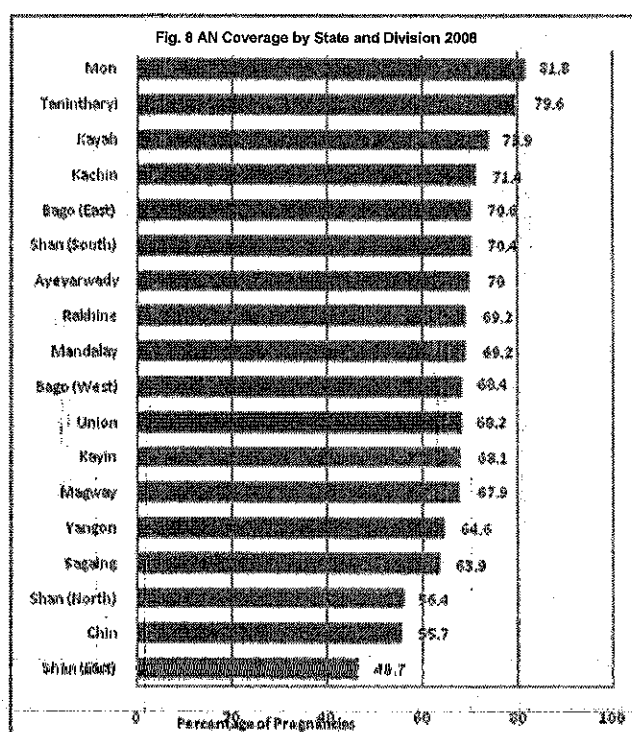
Aiming towards the UHC, further improvement in **health financing** becomes critical. The target indicators for monitoring includes: out-of-pocket should not exceed 30-40 percent of total health expenditure; total health expenditure should be at least 4-5 percent of the GDP; over 90 percent of the population is covered by prepayment and risk-pooling schemes; and close to 10 percent of vulnerable populations with social assistance and safety-net programmes (Fig. 6 & 7). For reducing the out-of-pocket payments and increasing prepayment measures have being taken through: increasing tax based



Source: Myanmar Health Statistics 2010, Ministry of Health

financing; expansion of coverage for social health insurance by preparing social security law (2012), amending the social security act 1954; introduce Maternal and Child Health Voucher Scheme in one township (2012) based on its feasibility study conducted in 2010; Township Based Health Protection Scheme (TBHP) in terms of Community Based Health Insurance be introduced in one Township based on its feasibility study in 2011; proper documentation of social assistance provided by Community Based Organizations (CBO) and Faith Based Organizations; and increasing and sustainable assistance from international partners.

Recognizing the importance of universal access to **reproductive health** in achieving the MDGs 4 and 5, the following core strategies has been laid down: setting enabling environment; improving information base for decision making; strengthening health systems and capacity for delivery of reproductive health services; and improving community and family practices. As 70 percent of the total populations reside in rural areas, resources and interventions are centred to rural residing beneficiaries, who are mother,



Source: Myanmar Health Statistics 2010, Ministry of Health

new-born babies and under-five children in rural areas. It includes proper antenatal care, promote skilled and institutional deliveries and post natal care, post-abortion care and quality birth spacing,

ensuring emergency obstetric and new-born care, provision of essential new-born care, strengthening adolescent reproductive health, involvement of male in reproductive health, cervical cancer screening and promoting referral system. (Fig. 8)

The interventions for **maternal, new-born and child health care** services are being carried out on a continuum of care approach to achieve MDGs under the guidance of NHP 2011-2016. The main thrust of the strategies include regular home visits of new-born care and death review, case management of pneumonia and diarrhoea cases, referral of sick new-borns, children and mothers, antenatal and postnatal care and community capacity development. During 2011, a child survival forum for new-born networking and mapping of maternal child health services has been conducted. A community based new-born care (CBNBC), as a comprehensive strategy to reduce the death of new-born by allowing the trained Volunteers to participate in Essential New-born Care such as early and exclusive breastfeeding, hygienic umbilical care, and skin to skin care has been extended to additional 5 townships.

Health System Strengthening (HSS) in Myanmar is to achieve improved service delivery of essential components of immunization, MCH, Nutrition and Environmental Health and communicable diseases by strengthening programme coordination, health planning systems, and human resources management and development, in support of MDGs 4,5 and 6. In 2011, HSS implementation was initiated in first 20 townships. Maternal and Child Health Voucher Scheme is designed in response to the need for exploring health financing options for improving maternal and child health services in Myanmar with technical and financial support from GAVI and WHO. The new initiative scheme will mainly focus on improving accessibility of the vulnerable group (poor pregnant women) in terms of social health protection. The cost and effectiveness of this scheme is pilot tested in Yedarshey township in 2013 and will be later expanded to an additional township. Guidelines for health systems assessment at township level were developed and at the end of 2011, the assessment was conducted; assessing: planning and management, hard to reach mapping, human resources, community participation, infrastructure & transport, essential drugs and logistics system, finance and financial management, data quality auditing (DQA) and service quality assessment (SQA). Following the assessment results RHC and Station Health Unit plans were drawn and compiled into the Coordinated Township Health Plan (CTHP). CTHP includes health system assessment, M&E baseline, annual plan and costing for package service tour, supervision and monitoring of RHCs and township level as well.

The national response to **HIV and AIDS** is being implemented in the context of National Strategic Plan (2011-2015), developed with the participatory inputs from all stakeholders. The national strategic plan has a vision of achieving the HIV related MDG targets by 2015. The strategic priorities are: prevention of the transmission of HIV through unsafe sexual contacts and use of contaminated injecting equipment; comprehensive continuum of care for people living with HIV; and, mitigation of impact of HIV on people living with HIV and their families. In this conjunction, the established HSS programme, Donor Referral System for Blood Safety Programme of JICA support and National External Quality Assessment Scheme (NEQAS) of HIV testing played as a cross cutting support for this strategic plan. Based on Asia Epidemic Model spread sheet for Myanmar, the distribution of new cases of HIV among populations was estimated and projected. It shows that the incidence of HIV has been declined yearly following its peak in late 1990s. However, the new infection is levelling out after 2011 indicating the need to intensify the momentum of prevention and control measures as well as to provide interventions tailored to MSM, IDU and female partners of these Most at Risk Populations (MARPs).

The major approaches of **Malaria Control Programme** are: increasing accessibility to quality diagnosis and appropriate treatment according to national treatment guideline; and scaling up the Long Lasting Insecticidal Nets (LLIN) and ITNs programme throughout the country. These approaches are supported by IEC programme and HSS through capacity building and programme management. The main thrust of activities are: information, education and communication; stratification; epidemic preparedness and response; early diagnosis and appropriate treatment; and capacity building.

In the *National Tuberculosis Programme (NTP)*, the overall goal is to reduce morbidity, mortality and transmission of TB till it is no longer a public health problem, to prevent the development of drug resistant TB. Targets under the MDGs are: to have halted by 2015 and begun to reverse the incidence of TB and to halve the TB prevalence and mortality rates in 2015 as compared to 1990. NTP is implementing care and preventive activities in line with the National Strategic Plan (2011-2015), and the 2012 update of the National Strategic Plan, which is composed of: pursue high quality expansion and enhancement; (as confirmed by the 2009-2010 nationwide TB prevalence survey); address TB/HIV, MDR-TB and the needs of poor and vulnerable population; contribute to HSS based on primary health care; engage all health care providers; empower people with TB and communities through partnership; and, enable and promote research. The government has increased the budget for TB control gradually. Technical partners are guided by the TB Technical and Strategic group to ensure harmonization and alignment of control strategies. A number of financial partners are supporting the fight against TB with the Global Fund being the most important donor.

National immunization coverage, 1980-2011

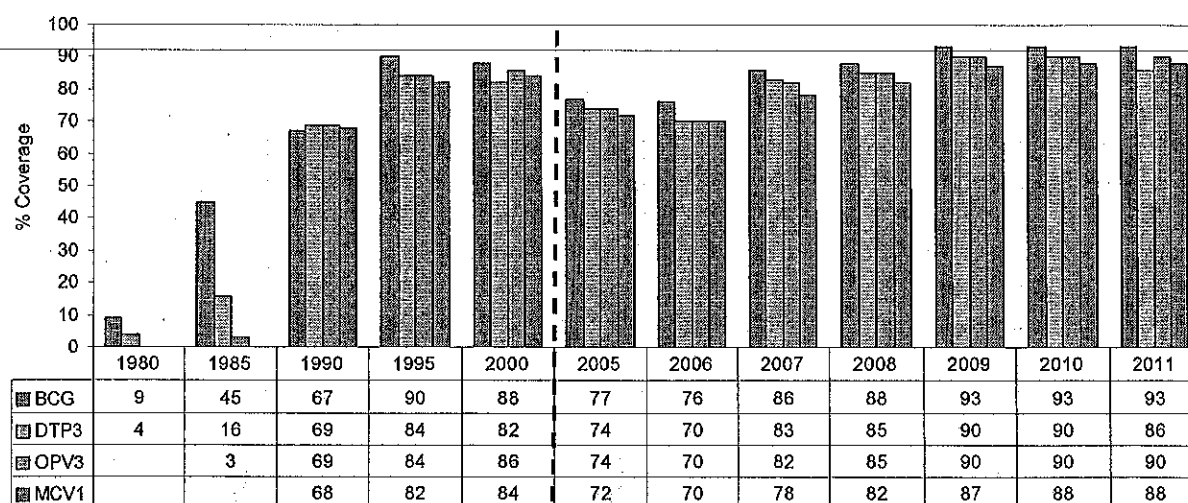


Figure 9 National Immunization Coverage 1980-2011

Source: Joint WHO/UNICEF reporting form

Within the framework of NHP 2012-2016, a comprehensive Multi Year Plan (cMYP) for EPI covering the period of 2012-2016 has been developed as a follow up of the previous cMYP 2007-2011. It has been jointly prepared by MOH, WHO and UNICEF using health system analysis. Some of the salient features includes: plans to introduce two new vaccines in 2012; strengthening safe vaccine delivery; introduction of school based immunization for tetanus and diphtheria (Td) in a phased manner in 2014; strengthening of Polio eradication strategies and Measles elimination goals; intensification of routine immunization to reach the unreached children specifically in hard to reach areas, migratory population and activities for effective vaccine management and cold-chain improvement based on findings of EVM assessment. All these strategies are targeted to achieve MDG 4. The country is also strengthening its disease surveillance network, including sentinel surveillance for rota virus, typhoid, sero surveys and cold chain capacity to prepare for future introductions of new vaccines such as Rota virus. Pneumococcal HPV etc. In 2012 the Government has co-financed the pentavalent vaccine cost and partners. GAVI, WHO and UNICEF are committed to support the immunization program, however and there is still a funding gap of about 32 percent of the total requirement.

Surveillance, risk assessment and outbreak response capacity all continue to be priorities for Myanmar. Establishing timely, representative and high quality information from Indicator-based surveillance (IBS) systems continues to be a challenge for Myanmar. The country has establishment of event-based surveillance (EBS), the effectiveness of these arrangements in detecting acute public health events is not always assessed. Encouraging a structured and systematic approach to risk assessment is an

important national policy. Similarly, efforts to strengthen outbreak response capacity continue, both through support to Field Epidemiology Programs as well as through training on international outbreak response.

In order to prevent the international spread of communicable diseases, the Central Epidemiological Unit works closely in collaboration with National IHR Focal Point, the International Health Division (IHD) of the MOH, implementing the International Health Regulation, IHR 2005. In, addition, the existing communicable disease surveillance activities have also been integrated with the regional surveillance systems like ASEAN Disease Surveillance Network (ADSNet) and Mekong Basin Disease Surveillance (MBDS) Network. Laboratories continue to play a central role in the early detection and verification of acute public health events due to of infectious and non-infectious causes. Myanmar has the basic capacity to use PCR for diagnostic purpose and regional laboratories have been identified to provide additional diagnostic services to less common infectious diseases. The National Polio, Measles and Influenza laboratories are certified or accredited to international standards.

Reported cases of vaccine preventable diseases, 2002-2011

Year	Wild Polio	Diphtheria	Pertussis	Total Tetanus	Neonatal Tetanus (% of all Tetanus)	Measles	Rubella	Mumps	Japanese Encephalitis
2002	0	60	61	257	72 (28%)	786	ND	ND	-
2003	0	21	19	260	48 (18%)	830	ND	ND	-
2004	0	1	100	187	49 (26%)	1,274	ND	ND	-
2005	0	5	11	186	39 (21%)	302	ND	0	-
2006	0	3	12	224	41 (18%)	735	0	0	0
2007	11 ^b	5	13	259	49 (19%)	1,088	2	ND	28
2008	0	2	15	147	25 (17%)	883	5	ND	5
2009	0	19	3	229	34 (15%)	217	13	ND	8
2010	0	4	0	96	19 (20%)	190	11	ND	18
2011	0	7	5	178	32 (18%)	2,046	103	ND	20

^a Excludes one type 1 VDPV

^b Excludes four type 1 VDPV

^c Excludes one type 2 VDPV

ND = No data

Table 2 Reported Cases of Vaccine Preventable Diseases 2002-2011

Source: Joint WHO/UNICEF reporting form

2.4.2 Development processes

Poverty and vulnerability of the population, especially hard to reach rural settlements, are the main critical barriers in enhancing the human development and growth and for reaching the 2015 targets of MDGs. Over and above the limitation in accessibility due to terrain, transport and communication and other economic reasons, in Myanmar the arms conflicts of the ethnic groups date back to over 60 years and efforts for building a lasting peace was under the clouds of doubt. With many ethnic groups, creating a harmonious social cohesion is a key challenge. The country does not have the poverty reduction strategy for some operational reasons. However to alleviate all the pressing issues, UNDP with an active national collaboration instituted a Human Development Initiative (HDI) to response the acute poverty condition since early 1994, started with a set of projects providing assistance to poor rural communities in 63 townships in 11 different regions of the country. So far about 5 million populations in about 8000 villages are benefited.

Realizing the rising momentum of the Initiatives, its fourth phase has gradually been extended up to 2012 and already completed for 18 years duration. The Self-Reliance Groups (SRG), a product of the Initiative have demonstrated greater competency in planning and prioritizing interventions at the household and community level to alleviate their poverty and vulnerability conditions.

Integrated Household Living Conditions Assessment (IHLCA), is one of the projects of HDI. Accurate statistical information about the living standards of the population, especially the vulnerable groups and the extent of poverty is an essential instrument to assist the Government in diagnosing the problem, in designing effective policies for reducing poverty and monitoring and evaluating the progress of poverty reduction. The Integrated Household Living Conditions Assessment (IHLCA-II) has been conducted in 2009-2010 with an active participation of the Ministry of National Planning and Economic Development (MNPED), UNICEF and Swedish International Development Cooperation Agency. Several relevant ministries also involved closely in the process.

The Poverty Profile provides information on levels and trends in key indicators of well-being, and their correlates, with a view to inform public policy decisions. It synthesizes the issues of poverty and inequality; demographic characteristics of households; economic activities of households; the labour market; housing, water and sanitation; health and nutrition; and education. Poverty dynamics is a concerned with changes in the poverty status of individual households overtime. Specifically it analyses those households which: remain poor (chronically poor) escape from or enter in poverty (transitory poor) and remain non-poor. Overall, transitory poverty appears to affect close to 3 times the number of households as chronic poverty, 28 percent vs 10 percent of households respectively. The extent of both descents into (11 percent of households), and escapes from (16 percent of households), poverty appears significant. For policy and decision making purposes, a better understanding of the reasons for descents into, and escapes from, poverty is necessary.

The MDG Data Report presents the data from the IHLCA-II survey on selected MDG indicators. It provides information on trends of those indicators with a view to inform public policy decision. It differs from standard MDG report in that it relies exclusively on survey data and present seven goals dealing with poverty and hunger; primary education; gender equality; child mortality; maternal health; HIV/AIDS, malaria and other diseases; and environmental sustainability. Overall, these data suggest a general, but modest, improvement across a range of dimensions of well-being in Myanmar between 2005 and 2010. These are based on analytical findings of the changes in the living conditions of people in Myanmar since IHLCA-I in 2005. In some areas of the country, natural disasters have contributed to lower levels of health access and poorer infrastructure and human resources. The poor people are with low adaptive capacity, and are vulnerable to environmental shocks such as droughts, floods and extreme weather conditions that are expected to increase in frequency and intensity as a result of climate change.

2.5 Health systems and services, and the response of other sectors

The Ministry of Health (MOH) is responsible for raising the health status of the people through provision of comprehensive health services: promotive, preventive, curative and rehabilitative measures. It has 7 seven departments for Health, Planning, Medical Sciences, three departments for Medical Research (for Lower, Upper and Central Myanmar), and Traditional Medicine. The largest is the Department of Health, which employs 93% of over 58,000 personnel employed and accounts for approximately 75 percent of the ministry's expenditure. It is responsible for supervising both technical and administrative functions of the health departments in the state and divisions and township levels as well as hospitals and clinics.

Table 3. Hospital Facilities Development, 1988-89 to 2011-2012

Health Facilities	1988-89	2007-08	2008-09	2009-10	2010-11	2011-12
Hospitals (Public Sector)	631	839	846	871	924	987
Ministry of Health	617	813	820	844	897	921
Other Ministries	14	26	26	27	27	66
Total number of Hospital Beds	25,309	36,949	38,249	39,060	43,789	54,503
No. of Primary and Secondary Health Centres	64	86	86	86	86	86
No. of Maternal and Child Health Centres	348	348	348	348	348	348
No. of Rural Health Centres	1,337	1,437	1,481	1,504	1,558	1,565
No. of School Health Teams	80	80	80	80	80	80
No. of Traditional Medicine Hospitals	2	14	14	14	14	14
No. of Traditional Medicine Clinics	89	237	237	237	237	237

The health implementation level is at the Township Health Department level which serves between 100,000 and 200,000 people and headed by Township Medical Office. At township level, a hospital and clinics will take care of curative functions and public health component will be taken up by the health department. Urban Health Centre, School Health Team and Maternal and Child Health Centre are taking care for urban population. Each township has at least one or two station hospitals and 4-7 Rural Health Centres (RHCs) under its jurisdiction to provide health services to the rural population. RHCs are staffed by a Health Assistant (HA), Lady Health Visitor (LHV), and a Midwife. At each RHC there are four to five sub-centres each of which are staffed with a midwife and a Public Health Supervisor of grade 2. Each sub-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). The development of health facilities of the country from 1988-89 to 2011-12 is presented in table 3.

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 (MRCS) 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.

The National Essential Medicine Policy and FDA Regulatory authority, and a CMSD for procurement and distribution has been practiced for the last several decades. The national policy related to essential medicines focused on to satisfy the priority health care needs of the majority of the population. Approximately about 80 percent of essential medicines are produced through domestic sources but more may be needed externally as there are changes in essential medicine policy. In the review, the focus will on providing universal access to essential medicines free of charge to the rural population. However, Studies and Assessments reports highlighted medical technologies has been one of the key problems and added to the high out of pocket payments – more than 80 percent. For rural retention of midwives in hard to reach areas, 'adequate supply of medicines and equipment', was a key motivation factor, and may overrule the other envisaged factors like financial incentives. Deficiencies in supply chain system for delivering medical supplies, advocating materials, vaccine to the service delivery points are barriers to the service delivery, especially at the rural settings.

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. One unique feature is the existence of traditional medicine along with allopathic medicine. With encouragement of the State, scientific ways of assessing the efficacy of therapeutic agents, nurturing famous and rare medicinal plants, exploring and sustaining and propagation of treatise and practices can be accomplished.

While private sector health care has expanded rapidly and is estimated to provide 75%-80% of ambulatory care, 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 are providing trainings on public health issues such as reproductive health and malaria. So also Myanmar Maternal and Child Welfare Association, Myanmar Red Cross Society are also taking some share of service provision and their role are becoming prominent.

As far as human resources are concerned, it is estimated that there are 88,975 public sector workers. This includes 26,435 medical practitioners, 25,544 nurses and 19,556 midwives. This is equal to 1.49 health workers per 1000 population, (WHO recommended 2.3 per 1000). Currently the midwife to population ratio is 1:6000 when the aim is 1:4000. 58.9 percent of medical practitioners are practicing in the private sector. The main issue of the HR production is inadequate funding and infrastructure. However the NHP 2011-2016 proposed to increase doctors in public sector from 10,243 to 10,927 in 2015 and midwives from 9785 in 2012 to 10985 in 2015. Necessary process for creating posts has

already initiated. Health staff are distributed evenly between urban and rural areas. However understaffing in rural areas was confirmed by the HSS Assessment in 20 townships where in 50 percent of locations, BHS staff is covering from between 4,000 – 10,000 population and only 8 out of 108 RHCs surveyed had the standard requirement of 13 BHS staff. Every RHC in the sample had unfilled post. The assessment also confirmed that the important barriers to retention of health staff include: lack of motivation; high transportation charges and daily expenditure for food and lack of motivation. Under the NHP 2011-2016, a National Health Workforce Strategic Plan is drafted. Ministry is currently formulating an implementation plan which will aim to operationalize and prioritize the strategic direction. The development of human resources in health from 1988-1989 to 2011-2012 is presented in table 4.

Table 4. Human Resources in Health Development

Health Manpower	1988-89	2007-08	2008-09	2009-10	2010-2011	2011-2012
Total No. of Doctors	12268	21799	23740	24536	26435	28077
Public	4377	7976	9583	9728	10927	11460
Cooperative & Private	7891	13823	14157	14808	15508	16617
Dental Surgeons	857	1867	2092	2308	2562	2770
Public	328	793	777	703	813	848
Cooperative & Private	529	1074	1315	1605	1749	1922
Nurses	8349	22027	22885	24242	25644	26928
Dental Nurses	96	177	244	262	287	316
Health Assistants	1238	1788	1822	1845	1899	1536
Lady Health Visitors	1557	3197	3238	3278	3344	3371
Midwives	8121	18098	18543	19051	19556	20044
Health Supervisor 1	478	529	529	529	541	612
Health Supervisor 2	674	1444	1484	1645	2080	1718
Traditional Medicine Pract.						
Public	290	945	950	890	890	885
Private	250	5163	5397	5737	5737	5867

Source: Health in Myanmar 2012, Ministry of Health

Health care in the private sector is growing up gradually. It is estimated that 61 percent of the medical staff in 2010 are employed in the private sector. A law relating to private health care services was enacted in 2007. The sector is expanding particularly in cities and towns. However recently it has been reported that there are village level GP practices in some locations. In 2010 there were 103 private hospitals, 192 special clinics and 2891 general clinics. There are some reports on the effectiveness of public private partnerships for management of TB and malaria in some locations.

For an evidence based decision, strengthening of health information system is crucial and a principal priority of the MOH. Health Information is a division of the Department of Health Planning responsible for data collecting, processing, analysis and dissemination of health care services to hospitals, public health and to communities in collaboration with DOH. Related to communicable diseases and health related issues, ICD-10 revision has been instituted and continuous training programmes are being conducted for field teams. System analysis of health information and GIS database banking are being promoting for an effective delivery of health services. As the overall the macroeconomic dimension is rapidly changing, it is vital to strengthen data and information management systems to contribute to effective policy making as well as to appropriately and timely modification of the service performance.

The health system assessment 2012, highlights the major constraint to service delivery relate to availability, acceptability and accessibility of services to the population. In terms of *availability* of services, the main constraints include inadequate human resource numbers at different levels of the system and particularly overwork of BHS staff, low health expenditures, essential medicines shortages and lack of infrastructure development and lack of programme reach. Midwives are overburdened – all programmes rely on the midwife with lack of support from other staff, including lack of training opportunity to other staff. In terms of acceptability, weak communication between health staff and community, skills and attitudes of health professionals effects demand. From the consumer side, there is a lack of knowledge on what services available. In many cases, better accessibility is provided for traditional providers (home based care). In terms of accessibility, hard to reach areas remain due to distance, road conditions, partial season access, insecurity of mobile and migrant populations.

2.6 Similarities with other countries

The country's GDP is likely to grow by about 6.0 percent in 2012 and 6.3 percent in 2013 (ADB estimates) which is very much comparable to the neighbouring countries. However, it is estimated that in 2010, it stands the lowest per capita GDP in purchasing power parity despite relatively good growth during 2000-2010. IHLCA indicates that one in every four is considered poor (MNPED, 2011), which is very much comparable to Asians peers; Cambodia at 27percent and Lao PDR at 32 percent. As far as renewable water resources is concerned, it stood at 24,352 cubic meter per inhabitant per year, higher than nearly all other economies in Asia. It is a key energy resource.

The country progress towards attaining its MDGs lags behind that of its ASEAN neighbours, especially Malaysia and Thailand. The country has yet to improve further its performance in health related MDGs aside from the IMR, U5MR and the MMR. The HIV prevalence remains high and so also malaria and TB. However in literacy rate of 15-24 years olds in 2010 is high at 95.8 percent, which is comparable to the 96.9 percent figure posted by Viet Nam in 2000. The ratio of girls to boys in primary school is 0.93 in 2009, similar to ASEAN countries. However, the ratio of girls to boys in secondary school is relatively high at 0.96 and is even higher than Indonesia and Viet Nam.

2.7 Summary

Table 5. Key health achievements, Opportunities and challenges

Achievements/opportunities
<ul style="list-style-type: none"> Consistently strengthening its national health systems and public health functions, based on principles of PHC and UHC, reaching to the poor and hard to reach vulnerable groups, addressing equity issues. NHP 2011-2016 formulated within the framework of the Myanmar Health Vision 2030, aligned with the national socio-economic growth development. Government committed to bring down poverty rates from 26 to 16 percent by 2015. A large youthful population, will contribute their effort and skills to enhance their productivity. MMR, IMR and U5MR are on declining trends. A 50 per cent reduction in malaria morbidity and mortality achieved since 2007; TB-MDG mortality target met and incidence target on tractand epidemics of HIV/AIDS, considered stabilized since 2000. Polio free status and Immunization programme is reaching more than 85% of all beneficiaries with all basic antigens. New life saving vaccines introduced in EPI program (Haemophilus Influenza type B and Measles 2nd dose). Impact of HDI is robust in poverty reduction, alleviating vulnerability and upgrading the capacity of self-reliance in the community. Some MDGs: food poverty incidence, U5MR, MMR and sanitation are on track to achieve by 2015.
Challenges
<ul style="list-style-type: none"> The country has poor people with low adaptive capacity, and is vulnerable to environmental shocks that are expected to increase in frequency and intensity due to climate change. Need to scale up HIV treatment, which now covers only about 1 in 3 of those in need and for providing preventive services to MSM. Additional efforts needed to meet the MDG target of a 50% reduction in TB prevalence in 2015 compared to 1990 MDR-TB diagnosis, treatment and care must be scaled-up from the current 7% to offer MDR-TB testing to all MDR-TB contacts, retreatment cases and TB patients living with HIV/AIDS (and proper treatment and care to all confirmed MDR-TB cases). Health system constraints: service delivery barriers; organizational, management and coordination barriers and human resources barriers, need further attention. Demand side barriers relate not only to the question of affordability, but also to the accessibility and acceptability of health care services by the population. More focus in coverage of basic health care for MCH services. NCD contributes 40% of all deaths. NCD prevention and management responsibilities reaching to PHC level is a challenge. Availability of IT know how and equipment at all levels will be a key investment. Use of disaggregated data should be encouraged in sharpening the policy making.

Section 3: Development Cooperation and Partnerships

3.1 The aid environment in the country

Official Development Assistance (ODA) plays a significant role in health sector programmes. The total amount that ODA has committed was USD 109.5m in 2002 to USD 390.7 in 2009. Out of which commitments for health was USD22.6m (20.7percent) in 2002 to USD 61.2m (15.7percent) in 2009. Based on the country population of the respective years of 2002 and 2009, ODA for health, commitments per capita was USD 0.5 and 1.2 respectively. However the Regional Average of ODA for health commitment was USD 0.6 and 1.0 in respective years. (Table 6)

Table 6. ODA commitments for health for year 2002-2009

	2002	2003	2004	2005	2006	2007	2008	2009
Population as at 30 June of each year, millions	47.4	47.7	48.0	48.3	48.7	49.1	49.6	50.0
ODA Commitments*	109.5	126.7	139.0	152.5	171.7	209.5	324.8	390.7
ODA for Health Commitments*	22.8	34.3	35.9	34.0	32.3	47.8	48.9	61.2
ODA for Health as % of Total ODA	20.7	27.1	25.8	22.3	18.8	22.8	15.0	15.7
ODA for Health Commitment per Capita	0.5	0.7	0.8	0.7	0.7	1.0	1.0	1.2
Regional Average ODA for Health Commitments per Capita*	0.6	0.6	0.7	0.9	1.2	1.4	1.3	1.0
Total Health Expenditure per capita (US\$)	2.9	3.8	4.7	4.9	5.6	7.2	10.0	12.5
General Govt. Health Expenditure as % of Total Health Expenditure	15.2	12.3	13.5	9.0	14.4	11.7	8.8	9.7

* millions constant 2008 US\$ Source: Creditor Reporting System (CRS) - OECD

Official Development Assistance is projected to increase through commencement of various partnerships which has a sustained effort in supporting of MDGs. For health sector it is in areas of HIV/AIDS, malaria and other diseases, Reproductive health, other health purposes and unspecified component. USD 41.3m, that is, 67.5 percent of ODA fund was committed to the MDGs component in the year 2009 (Table 7).

Table 7. Component wise ODA commitments in health sector from 2002 – 2009

	2002	2003	2004	2005	2006	2007	2008	2009
MDGs: HIV/AIDS, Malaria, TB and other diseases	6.6 (29.2%)	16.4 (47.9%)	18.1 (51.2%)	18.86 (54.7%)	16.7 (51.8%)	33.7 (70.5%)	33.5 (68.6%)	41.3 (67.5%)
Reproductive Health	3.7 (17.2%)	3.0 (8.7%)	3.1 (8.6%)	2.7 (8.1%)	3.4 (10.6%)	3.1 (6.5%)	4.9 (10.0%)	5.3 (8.6%)
Other Health Purposes	12.3 (54.4%)	13.8 (40.1%)	12.5 (34.8%)	9.3 (27.4%)	8.4 (26.1%)	7.4 (15.4)	7.3 (14.9%)	12.7 (20.7%)
Unspecified	0.1 (0.2%)	1.2 (3.4%)	2.3 (6.4%)	3.3 (9.8%)	3.7 (11.4%)	3.7 (7.7%)	3.2 (6.5%)	1.9 (3.2%)

Source: Creditor Reporting System (CRS) - OECD

Source: Creditor Reporting System (CRS) – OECD

3.2 Stakeholder analysis

Bilateral sources of ODA Commitments include: Australia, Denmark, Finland, Germany, Ireland, Italy, Japan, Republic of Korea, Norway, Netherlands, Spain, Sweden, United Kingdom and United States of America. The Multilateral sources include European Commission (EC), GAVI, Global Fund, UNAIDS, UNDP, UNFPA, UNICEF and UNTA. Among all these bilateral and multilateral sources of funding support, five largest contributions of ODA for health in 2009 were: United Kingdom (18 percent), EC (14percent), Japan (17 percent), Sweden (9 percent) and UNICEF (9 percent), which in total was 63 percent of total commitment of ODA for health, (Table 8).

The presentation was focussed for ODA disbursement for health in Myanmar for the year 2009. However there are other bilateral and multilateral sources which have contributed in other years. Development assistance to health sector is channelled through global partnerships such as GAVI, WHO Global Malaria Programme, Global TB Drug Facility, Global Fund and Three Diseases Fund (3DF); and directly to INGOs and NGOs working in the country. The UN plays a major role in contributing health activities. The main contributors in health include WHO, UNICEF, UNDP, UNFPA and FAO.

Table 8. Stake holder analysis, 2009. (in millions of constant 2008 USD)

	Bilateral Sources of ODA in 2009						Multilateral Sources of ODA in 2009				
	MDGs	RH	Other	Unspec.	Total		MDGs	RH	Other	Unspec.	Total
Australia	0.236	0.0	2.519	0.0	2.756	EC	8.845	0.0	0.0	0.0	8.845
Denmark	2.259	0.0	0.136	0.0	2.395	GAVI	0.0	0.0	1.602	0.0	1.602
Finland	0.0	0.0	0.153	0.0	0.153	UNAIDS	0.965	0.0	0.0	0.0	0.965
Germany	1.177	0.928	0.296	0.0	2.401	UNDP	0.245	0.0	1.319	0.0	1.564
Ireland	0.0	0.0	0.052	0.0	0.052	UNFPA	1.675	2.836	0.788	0.0	5.299
Italy	0.0	0.361	0.221	0.0	0.582	UNICEF	3.007	0.832	1.842	0.0	5.68
Japan	3.239	0.304	2.383	1.947	7.873						
R. Korea	0.0	0.0	0.018	0.0	0.018						
Norway	0.928	0.0	0.737	0.0	1.665						
Spain	0.0	0.004	0.024	0.0	0.028						
Sweden	5.672	0.0	0.001	0.0	5.673						
UK	10.166	0.0	0.576	0.0	10.743						
USA	2.874	0.0	0.0	0.0	2.874						

Source: Creditor Reporting System (CRS) - OECD

GAVI

The Government is receiving financial support from GAVI funds to introduce new vaccines, strengthen vaccine management and cold chain system in EPI and to develop guidelines and training material for strengthening human and institutional capacity for immunization. Phase 1 of GAVI support for Immunization Services (ISS), New Vaccine Support (NVS), and Injection Safety (INS) was implemented from 2002 to 2007. Introduction of Hepatitis B vaccine and Auto Disabled Syringes were introduced in EPI program. Major activities supported by GAVI-ISS were training, micro planning, operational cost for outreach services, strengthening of cold chain, monitoring and supervision. GAVI has later supported the Health System Strengthening (HSS). In all these engagements, GAVI is working together with key bilateral partners, Australia, Japan and New Zealand and multilateral partners UNICEF and WHO, (Table 9).

The main objective of the HSS programme in Myanmar is to improve services coverage for essential PHC components of immunization and maternal and child health in support of 2/3 reduction in under 5 child mortality between 1990 and 2015, through strengthening programme coordination, improving health planning systems and strengthening of human resources management. This goal directly addresses the three main health system barriers: service delivery barriers; management and organizational barriers; and human resource barriers. The HSS programme was for the period 2008-2011 and the funding was amount to USD 32.780 million.

Table 9. The GAVI disbursements to Myanmar by type of support from 2002-2012:

Category	Sub-Category	2002	2003	2004	2005	2006	2007
HSS	HSS						
INS	INS	578,647	956,320		678,362	-39,718	-89,634
ISS	ISS			1,074,800	1,717,240	903,020	903,020
NVS	HepB	1,022,679	1,159,670	2,137,383	4,723,841	2,959,191	-1,752,439
	Measles						
	Penta						
Vac. Intro.	Vac. Intro.				100,000		
Total for the year		1,601,326	2,115,990	3,212,183	7,219,442	3,822,493	999,052
Category	Sub-Category	2008	2009	2010	2011	2012	Total USD
HSS	HSS				2,833,405		2,833,405
INS	INS						2,083,978
ISS	ISS				2,812,000	297,000	7,707,080
NVS	HepB	3,160,246	601,905	91,706	-270,570		13,833,610
	Measles					994,743	994,743
	Penta					6,120,703	6,120,703
Vac. Intro.	Vac. Intro.					453,500	553,500
Total for the year		3,160,246	601,905	91,706	5,374,835	7,868,946	34,127,019

Source: GAVI

The annual report of 2011 reflected that there was a substantial improvement in its health system foundations to better manage and improve the access to PHC service for hard to reach areas in priority 20 townships: the capacity of the township health managers were upgraded in the field of planning and financial management; introduced the need based planning and develop the culture of participatory approach involving of all relevant stakeholders, community health leaders, INGOs and NGOs; realigned the health service delivery mechanism and forming a package of service – EPI, MCH, nutrition and

environmental health for hard to reach rural setting; and provision of competency based training not only to rural health workers but also investing 1200 volunteers in 2011 to reduce the burden of midwives.

WHO Global Malaria Programme (GMP)

GMP convenes experts to review evidence and set global policies. GMP's policy advice provides the benchmark for national malaria programmes and multilateral funding agencies. GMP's activities are focussed on providing an integrated solution to the various epidemiological and operational challenges. This is done by promoting sound, evidence-based and locally appropriate strategies. The program helps countries reach the most vulnerable population and ensure that needed interventions take into account, economic and environmental realities. Among others, GMP 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.

Global Drug Facility (GDF) – Stop TB Partnership

The Global Drug Facility, housed at WHO headquarters and managed by 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. This in turn catalysed DOTS expansion nationwide, raising the budget to more than USD 2 million for 2008, up from USD 0.25 million in 2001. A major contributor to the success of the NTP has been the GDF, which supported anti-TB drugs for Myanmar for seven years from 2002-2009. Through support from UNITAID and the Canadian Government GDF has also supported Myanmar with second-line anti-TB drugs and paediatric TB drugs.

Support for TB from USAID, JICA and CIDA

Bilateral support is provided by USAID and the Japan International Cooperation Agency (JICA). In May 2011, TBREACH, an initiative funded by the Canadian International Development Agency for increased TB case detection, announced the three organizations, (PSI, IOM, and the International Union Against Tuberculosis and Lung Disease) had been granted USD 2.5 million for one year. Collaboration is also ensured by the corporate sector, and Total/Yadana Consortium is supporting the Union with USD 0.8 million per year. The total costs for TB control from 2011 to 2015 have been calculated at USD 186 million with an expected funding gap of USD 67 million. .

Global Fund

Global Fund (GF) has provided a grant in Round 2 and 3 to fight AIDS, Tuberculosis and Malaria in Myanmar. The project began in January 2005 to tackle tuberculosis and initiatives in HIV/AIDS and malaria which commenced in April, 2005. Collectively, the projects were to have received USD 98.4 million from the GF over five years; USD 11.8 million of which has already disbursed. However GF later in August 2006, have decided to withdraw grants to the country. However donor community tried to secure the survival of the projects and finally coming up with a Three Diseases Fund (3DF) - cooperative effort from 6 countries and EU, which will be described separately.

However in 2011, GF support was reinitiated and the implementation of a Round 9 grant started for the three diseases. The Round 9 grants started implementation in Myanmar on 1 January 2011, targeting HIV, Malaria and TB prevention and treatment activities in 232 townships. For the daily management of the grants the Myanmar Country Coordinating Mechanism (M-CCM) has nominated Save the Children and United Nations Office for Project Services (UNOPS) as the PRs with a total funding of more than USD 300 million for the period 2011-2015.

Three Diseases Fund (3DF)

Following the decision by the Global Fund 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 United Kingdom and Denmark) established the Three Diseases Fund (3DF) to develop a project to fill the emerging critical gap in programme implementation. It was established in October 2006 as a mechanism for international pooled funds to support three countrywide programmes to reduce

transmission and enhance provision of treatment and care for Tuberculosis (TB), Malaria and HIV/AIDS for the most needed populations. In line with the European Union's Common Position, the project was implemented by UN Agencies, NGOs, the private sector and civilian administration at the township or lower level. From 2006 to 2011, USD 113 million was provided by 3DF to HIV, malaria and TB and integrated projects. The MOH requested WHO to be the executing agency for national programmes for TB, HIV/AIDS and malaria and WHO has to engage in a decentralized fund flow mechanism (FFM) to meet donor requirements.

Nongovernmental Organizations

Remote and hard-to-reach areas continue to present challenges in each of the six areas identified by UN theme group on health: malaria, tuberculosis, reproductive health, new born care, immunization and childhood illness. Funding levels varied widely and most NGOs focus activities and funding on specific townships. The MOH has signed MoUs with 30 INGOs and 14 national NGOs on collaboration in health development, particularly in areas of maternal and child 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.

UN Agencies

There are currently 15 UN agencies, funds and programmes operating in Myanmar. These are the UNDP, UNICEF, WHO, WFP, FAO, UNHCR, UNFPA, UNODC, UNAIDS, ILO, IOM, UNESCO, OCHA, UNOPS and UN Habitat. 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*. 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 90% of vaccines for children against the 7 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 through a special programme of assistance that covers 93 out of 324 townships in areas of: reproductive health services, behavior change communication, data analysis of fertility and reproductive health survey, adolescent reproductive health and prevention of HIV/AIDS. FAO is supporting 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.

3.3 Coordination and aid effectiveness in the country

It is mandatory to record all the external funding (grants) coming into the country in the health sector budget. All grant aid funds are reflected in the National Health Sector Budget – financial management done by Ministry of Health. The International Health Division, under the direct supervision of the MOH, 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 country has an active Myanmar Country Coordinating Mechanism (M-CCM), chaired by the Minister for Health and conducting meeting and discussion on regular basis including reviewing the

technical outcomes, barriers and constraints of all the intervention in programme implementation and policy directives for future planning. Under the MOH, the technical Units of all level are engaging in process monitoring throughout the implementation and constantly access the outcomes of the intervention taken. Financial Units are responsible for disbursement and financial management including the returns of financial report. Between the technical and financial units, transparency and accountability, effectiveness and efficiency of their delivery is well under control. As mentioned, there are several assessments in all the plans and projects have been taken place once in 2-3 years-time together with midterm and annual review and in some cases internal and independent external review are taking place to study and monitor the progress and assessing the performance and followed by impact of those interventions. Auditing mechanism, both internal and external, is in place.

At the UN agency level, all UN agencies are instituted with their own monitoring and evaluation mechanism and activities are discharging in a transparent and accountable manner. Internal and external auditing mechanisms are in place and also conducting external review team mission visits for respective technical matters.

Among Global Initiatives and technical partnerships, the GAVI Alliance Transparency and Accountability Policy (TAP) is an integral part of GAVI Alliance monitoring of country performance. In case of grant extension, ICC members have to confirm that the funds received from the GAVI Alliance have been used for the purpose stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management.

In case of 3DF, after 3 years of implementation, it has proven that aid can effectively be delivered within Myanmar, with USD 91 million in ODA, used between 2006 and 2009 alone. Tens of thousands of lives have been affected. For those living with HIV, resources are more widespread and easily accessed for supportive care and treatment; for people living in malaria-endemic regions and migrant workers, there exists improved access to insecticide treated bed nets, diagnosis and care; and free provision of tuberculosis diagnosis and treatment led to an 85 percent treatment success rate and far more than 41,000 smear-positive cases detected in 2009. By the end of June 2010, 3DF was supporting 27 HIV projects, 8 tuberculosis projects, 9 malaria projects four integrated projects. The MOH and local administrations are involved in the 3DF effort, through dialogue at central level and support for services provided at township level.

3.4 UN reform status and process

The UN System has been providing assistance to Myanmar since its independence and the largest provider of international humanitarian and development aid in the country with a total in-country programme of around USD 150 million per annum. The UN Country Team works as *One UN Approach* through a strategic framework. Four strategic priorities and key elements of the new Strategic Framework for the United Nations in Myanmar 2012-2015 was launched in 2011. The Strategic Framework is a testament to the commitment of the UNCT to work together with the Government and partners to help address the priority development needs and challenges that the country face. The four Strategic priorities are:

1. Encourage inclusive growth (both rural and urban), including agricultural development and enhancement of employment opportunities, (contributing to MDG 1, and with repercussions on MDGs 2,3,4,5,6 and 7)
2. Increase equitable access to quality social services, (contributing to MDGs 2, 3, 4, 5 and 6 with repercussions on MDG 1)
3. Reduce vulnerability to natural disasters and climate change, contributing to MDG 7)
4. Promote good governance and strengthen democratic institutions and rights, (foundation for progress on all MDGs, including MDG 8)

The UN Strategic Framework (2012-2015) provides a framework for coordinated UN assistance in line with UN Reform processes and the commitments of the Paris Declaration on Aid Effectiveness and

Accra Agenda for Action. The time broadly coincides with the first five years of the new Government, which Government recognizes as 'the most important in building a modern, developed democratic nation'. The UNCT works in partnership with NGOs and INGOs, particularly in the field implementation level, which inter alia adds value through capacity development and knowledge transfer to many local organizations.

Resources needed to address the Strategic Priorities will include both core resource allocations from concerned UN agencies as well as resources that would be mobilized from other sources over the implementation period. All Heads of UN Agencies remain accountable within their respective Agency mandates, and for their commitment to the UNCT and its Strategic Framework.

Each Strategic Priority will have linkages with the on-going UNCT Thematic Working Groups:

1. Strategic Priority 1 with the Food Security and Agriculture Thematic Group;
2. Strategic Priority 2 with the Education Thematic Working Group and Health Thematic Working Group, the WASH Thematic Group, the National Nutrition Network, the HIV/AIDS Theme Group and the Sexual and Reproductive Health Technical Working Group;
3. Strategic Priority 3 with the DRR Working Group and Environment Working Group;
4. Strategic Priority 4 with the UNCT Sub-Group on Human Rights, the National Protection Working Group, the Women's Protection Working Group, the Gender Theme Group, the Women's Protection Technical Working Group, the Country Task Force on Monitoring and Reporting, and the MDG/M&E Group.

The MDG/M&E Group will also engage national capacities evaluation, with a view to supporting the development of a national capacity for research and evaluation through appropriate institutions. The UNCT has a comparative advantage in bringing lessons-learned from nearby countries and thereby promoting south-south cooperation.

3.5 Summary

Table 10: Key health achievements, opportunities and challenges	
Achievements/Opportunities	
<ul style="list-style-type: none"> The country has opened up with strong commitment on reform and the development of policy options conference in February 2012 demonstrated a commitment to allocation of more resources to social sectors reflecting a proposal of 4 fold increase in the allocation to the health budget. More bilateral and aid agencies have come forward and strengthen the aid environment; including GF grant re-initiated in 2011. ODA commitment for health per capita is USD 1.2 though the Regional Average is USD1.0 and has committed 67.5 percent of its commitment to MDGs component in the year 2009. In complement to the national effort, UN System has also launched the UN Strategic Framework 2012-2015, coinciding with first five year national development plan of the new Government. All four priority areas of the UN Strategic Framework are directing towards achieving MDGs. 	
Challenges	
<ul style="list-style-type: none"> Further strengthening of governance and accountability to ensure that the grant aid in health sector being efficiently utilized, especially the capacity of the coordinating units in the MOH, for effectively and timely implementation of planned activities. In the proposed budget of some of the national strategic plans, such as TB and EPI Multi Year Plan, there are budgetary gaps, which need to be secured in time. For effective delivery of services especially in hard to reach areas, undertaking appropriate measures to sustain the motivation of the field staff, is critical. 	

Section 4: Review of WHO Cooperation over the past CCS cycle

4.1 Review of WHO cooperation with stakeholders

4.1.1 *Key aspects of WHO's contribution to the national ownership in national priority setting and plan formulation process*

Myanmar has collaborated with WHO since it became a signatory on 1 July 1948 followed by signing the basic agreement in 1957. WHO is the lead agency in health sector of the country. WHO has actively collaborated with health sector of the country in all the development processes and capacity building of the health system. It comprises of normative guidance, human resources development, and provision of extensive technical advice for further strengthening of the national health system. WHO has also effectively committed to aid coordination and national ownership in national priority setting, plan formulation processes. In all the stages of plan formulation, identifying strategies and plans, resource mobilization, implementation and monitoring, WHO has contributed and actively participated.

Among several of five-year strategic plans development, WHO act as a focal point for the child health programme and also supported a consultancy service for costing of the plan. So also in Reproductive Strategic Plan, formulation of NCD policy, alcohol policy and EPI Multi-Year Plan, WHO staff from the Country Office had played a crucial role. WHO has also provided technical support to the MOH for the implementation of package of essential NCDs (PEN) in pilot townships. 3DF is now moving forward for supporting the country for achieving MDGs under the project named 3MDG. In this process, WHO has played an honest broker role and provided a full technical support in formulating the project proposal. So also WHO was not only the broker role, but also prepared a project framework including the costing to AUSAID for humanitarian assistance in Rakhine.

4.1.2 *WHO's comparative advantage*

WHO is playing an active and leading role in the UN Country Team as well as among the development partners. Its technical capacity and coordination role in the health sector is well recognized. In the implementation of the UN Strategic Framework, WHO is actively participating in Health Thematic Working Group, the WASH Thematic Group, the National Nutrition Network, the HIV/AIDS Theme Group and the Sexual and Reproductive Health Technical Working Group. WHO is also secretariat of the TSGs for TB and malaria.

The landscape of the developmental partners in health has changed recently and the number has increased dramatically. WHO has constantly advocating both to the Government and partners in conducting policy dialogue on health policy, strategies and plans across the broad range of areas in communicable and non-communicable diseases and health system as a whole. WHO also provided technical advocacy to partners in help addressing in enhancing the participatory approaches at the community level and measures to address inequalities and disparities including a focus on vulnerable groups. WHO also supported the capacity of civil society, empowering it through knowledge sharing and training.

The MDG/M&E Group also engaged in national capacities evaluation, with a view to supporting the development of a national capacity for research and evaluation through appropriate institutions, such as establishment of a national evaluation association. The UNCT has a comparative advantage in bringing lessons-learned from nearby countries and thereby promoting south-south cooperation.

4.2 The consistency between CCS priorities over the cycle

The second Myanmar CCS for the period 2008-2011 focussed on the following three well-defined priority areas:

1. Improve health system performance,
2. Reduce excess burden of disease,

3. Improve the health conditions of mothers, children and adolescents.

These well-defined priorities areas of interventions are aligned with the national health status and its developmental strategies outlined in the Myanmar 30-years long term vision and the NHP 2006-2011 which is part of the fourth national economic development plan. The main intent of these priorities is geared towards the enhancement of national capacity to strengthen the health system. These priorities were implemented through the biennial collaborative work plans of 2008-2009, and 2010-2011. As the third CCS was not ready for many reasons at that time, the same priorities were also reflected in 2012-2013 biennial collaborative work plan. Reviews were undertaken during each planning cycle to ensure that the CCS priorities and their strategic approaches continued to provide a sound basis for the collaborative work plans and their outcomes as expected. The CCS priorities covered most of the Strategic Objectives (SOs) of the MTSP. Table 11 shows the linkage between the three CCS priorities and SOs.

Table 11 Linkages between CCS strategic priorities and SOs

CCS Priorities		Strategic Objectives
1.	Improve Health System Performance	SO10, SO11, SO5
2.	Reduce excess burden of disease	SO1, SO2, SO3, SO5, SO6, SO7, SO8, SO9, SO10, SO11
3.	Improve the health conditions of mothers, children and adolescent	SO1, SO4, SO10

The National Health Plan, NHP 2006-2011 has been formulated within the objective frame of the second five year period of Myanmar Health Vision 2030 and as such is a short term plan to accelerate endeavours to realize future vision of raising the health status of the nation. The broad objectives of the plan comprised of: to facilitate the successful implementation of the social objectives, "uplift of health, fitness and educational standards of the entire nations"; to implement the national health policy; to strive for the development of a health system, that will be in conformity with political, economic and social evolutions in the country as well as global changes; to enhance the quality of health care and coverage; and to accelerate rural health development. It spells out 12 major programme areas for the implementation of the plan. As noted in table 13, the CCS priorities were in consistent with the NHP strategic objectives and outputs.

The CCS was also well consistent with the UN Strategic Framework 2006-2011, particularly with the health and health related strategic objectives and plans. The immediate objective of the UNCT in Myanmar is to help provide for the basic needs of the population. The UN Strategic Framework focus on five broad thematic areas: alleviating acute income poverty; improving food security and nutrition; ensuring access to essential health and education services and interventions; ensuring protective environment; and reducing regional disparities. Harmonization and alignments between CCS and UN Strategic Framework is depicted in the table 13.

4.3 Internal Review

4.3.1 Allocation of Resources

Over the period of the second CCS of Myanmar, country biennial budget in 2008-2009 was USD 49.2 million of which USD 7.77million was AC fund. In 2010-2011 biennium, the biennial budget was USD

Table 12 Percentage of Financial Resources in three biennia of CCS Cycle 2008-2011

CCS Priority Areas		2008-2009		2010-2011		2012-2013	
		AC	VC	AC	VC	AC	VC
1	Improve health system performance	32.0%	0.06%	25.3%	5.3%	26.6%	7.3%
2	Reduce excess disease burden	35.2%	83.8%	29.0%	65.8%	35.1%	73.4%
3	Improve the health conditions of mothers, children and adolescents	8.8%	15.7%	8.3%	28.3%	7.03%	17.4%

Table 13 Consistencies between CCS 2008-2011 priorities and NHP 2006-2011 and UN Strategic Framework 2006-2011

CCS 2008-2011 Strategic priorities Major component	CCS 2008-2011 CCS subcomponent	NHP 2006-2011 Strategic objectives and/or expected outcome	UN Strategic Framework 2006-2011 Response
Improve health system performance	<p>Sub-component 1, Improve access and use of acceptable, affordable care for vulnerable groups</p> <p>Sub-component 2, Strengthen health system – HR, drugs and supplies, data collection and analysis to improve management</p> <p>Sub-component 3, Support operational research</p> <p>Sub-component 4, Provide support to University of Public Health.</p> <p>Sub-component 5, Strengthen IHD, MOH, a coordination unit for partners in health</p>	<p>Primary Medical Care and Referral of Patients Projects strategies 5-1, expansion of coverage of essential health care to all wards and villages in all townships in the country. 5-2, Expansion of BH institution and provision of PHC services through VHWs; 5-3 intensifying rural health development activities.</p> <p>In the Development of Human Resources Project, strategies 3-1, production of different categories of human resources for health by coordination and cooperation with other programmes.</p> <p>Myanmar Essential Drug Project, activities 6-8, enhancing the replenishment of good quality essential drugs for all townships utilising drug revolving fund.</p> <p>In Health Management Information Programme, strategies 5-2, systematic recording and maintenance of information.</p> <p>In Health Research Programme, strategies 5-3, promoting and accomplishing research activities on health systems with special emphasis on health delivery systems.</p>	<p>Alleviating Acute Income Poverty is the first priority in the UN Strategic Framework. Its intervention strategy is to promote the livelihood initiatives through alleviating urgent poverty issues including food security and poor health. The AIDS epidemic risks further impoverishing families and impeding any future progress in poverty alleviation. Improving Food Security and Nutrition priority includes: food assistance, intensive dietary diversification supplementation programmes, food-based approaches to nutrition improvement and nutrition education programmes.</p>
Reduce excess burden of disease	<p>Sub-component 1, Support improved surveillance</p> <p>Sub-component 2, Support increased coverage of malaria</p> <p>Sub-component 3, Support TB control</p> <p>Sub-component 4, Support HIV/AIDS control</p> <p>Sub-component 5, Support for surveillance and control new and re-emerging CD, preparedness and response.</p> <p>Sub-component 6, Advocate for prevention of NCD tobacco control</p> <p>Sub-component 7, Support the implementation of reduction programme, environmental health risk and nutrition issue.</p>	<p>In the Epidemiological Surveillance and Response Project, strategies 5-3 and 5-4, strengthening of epidemiological surveillance and rapid exchange of epidemiological information.</p> <p>The objective of National Malaria Control Project is to reduce mortality and morbidity due to malaria and thereby to reduce socioeconomic loss due to malaria. In National TB Project, the objective is to reduce the mortality, morbidity and transmission of TB until it is no longer a public health issue. The objective of National AIDS and Sexually Transmitted Disease Control Project is to reduce morbidity and mortality related to HIV and AIDS in the country, and mitigate the impact due to HIV and AIDS in the community particularly among infected and affected.</p> <p>In the Non-communicable Diseases Control Project, it spells out Cancer Control Project, Cardiovascular Disease Control Project and Prevention and Control of Diabetes Mellitus.</p>	<p>In Ensuring Access to Essential Health and Education Services and Intervention priority, action against a growing AIDS epidemic has been taken up as a priority basis. The Combating Major Health Problems priority areas include essential health intervention package; improved communicable disease surveillance; HIV/AIDS prevention, compassion, care and support; malaria and TB prevention and care, child health, water and sanitation.</p>
Improve the health conditions of mothers, children and adolescents	<p>Sub-component 1, Support, as a transitional strategy, a partnership of MMWs, AMWs and TBAs.</p> <p>Sub-component 2, Continue to support WHO collaborating centres</p> <p>Sub-component 3, Strengthen coordination, collaboration and partnerships among agencies in support of maternal, neonatal and child health.</p> <p>Sub-component 4, Continue to support Myanmar EPI.</p> <p>Sub-component 5, Continue to provide technical and financial support to states and divisions to conduct supplementary immunization activities</p>	<p>Maternal and Newborn and Child Health Project undertake activities for improving the health status of rural community, promoting community awareness and involvement; providing proper antenatal care, skilled and institutional delivery, post-abortion and quality birth spacing services; ensuring essential obstetrical care; providing essential newborn care; establishing adolescent reproductive health; strengthening male involvement in reproductive health care provision. It also taking care of immunization programme.</p>	<p>The Combating Major Health Problems priority areas also include: child health, immunization, adolescent health and reproductive health. Issues of quality and access both need to be addressed to improve the reproductive health situation as well as to reduce maternal mortality. It also advocates for an enabling environment of increasing in public budget in health, creating a supportive health policy and strengthening of effective and community participation in service delivery. For quality of health care services it is to ensure that the private sector complies with reasonable standards.</p>

33.3 million of which AC fund was USD 5.47 million and for 2012-2013, total allocation was USD 40.99 million of which AC was USD 7.46 million. As presented in table 11, the percentage of financial resources and its allocation is consistently within the priorities of the CCS, in all three biennia. In the first biennium of the CCS cycle, in 2008-2009 the overall implementation rate was 76 percent, in the second biennia, 2010-2011 it was 83 percent in AC component and 79 percent in VC component of the biennial budget. The third biennium of the CCS cycle, 2012-2013, the implementation is still in progress and up to the end of the first year of the biennium, the implementation rate for AC component was 46 percent and 50 percent for the VC component of the budget. In assessing the consistency between the CCS priorities and resources, it is also important to note that WHO continued to provide its normative core functions to support the national health system and its public health challenges even beyond the priority areas.

4.3.2 Human resources

The WHO biennial work plans are implemented by the WHO Staff in collaboration with the MOH. Major components of the implementation process are handled by responsible staff and unit of the MOH and WHO is constantly providing normative and technical advocacy to the nationals. In the Country Office there are provisions for Long Term Staff (LTS), Short Term Staff (STS) and Support Staff (GS). The organizational structure of the office depends on the support services that may be necessary to complement the national programme implementation. It is also adjusted to the biennial programme budget provision. As per biennial programme budget, the WCO also seek technical support from SEARO and WHO HQ. During the three biennia, for each biennium, in average there were about 45 Staff visits from SEARO and about 30 Staff visits from WHO HQ. The visits may be an individual Staff visit or in a group, depends on the technical requirement at the country level. Common areas of technical backstopping from the organization were: malaria, tuberculosis, HIV/AIDs, EPI, reproductive health, child health, health planning and data management. In 2008 and early 2009, several visits were for Nargis cyclone response and rehabilitation. Moreover, WCO also procure consultancy services, about 30 man-months in a biennium.

During the 2008-2009 biennium, the resources made available for staff component was USD 4.8 million which is 9.82 percent of the total available resources for the biennium. The total expenditure for staff was USD 4.1 million, that is, 85.2 percent of the available resources for staff. In 2010-2011, it was USD 9.1 million which is 20 percent of the total planned budget, but the resource was USD 5.5m (12 percent) only. However, the actual staff expenditure of the biennium was USD 5m, 55.5 percent of the planned cost. There was an acute shortage of staff in several programs of the country office. This was also reflected as low implementation rate at that time. The reason for shortage was departure of staff in critical units including EPI, HIV, TB as well as TGS staff. To fill the gap international P staff were recruited on short term basis and has taken longer period for recruitment process itself. Side by side, VC funding in some cases, though planned but not funded in time. The detailed structure and trend of human resources for priority areas is reflected in figure 10 and table 14 and 15.

Table 14 Distribution of total number of Country Office Staff for 2008-2009, 2010-2011 and 2012-2013.

	Fixed term		Temporary appointments			Total
	Professional	GS staff	TIP	TGS	TNP	
2008-2009	9	31	3	9	1	53
2010-2011	8	32	3	11	1	55
2012-2013	9	32	5	16	2	64

4.3.3 Programme performance review

The Country Office is constantly exercising the review of mid-term status in every biennium. This is to assess the implementation status, achievements, its constraints and decision for alternate measures for further achieving the targets. In the process, coding guide is in three levels: progress toward achievement (green); action needed for progress towards achievement (yellow); and achievement of the product is seriously jeopardized (Red). In 2008-2009 biennium, out of 205 products, it was reported that 79 were in progress toward achievement, 123 products were progressing with some action to overcome it. There were only 3 products that were seriously jeopardized: two were due to funding not forthcoming and the remaining one was due to change in programme management.

Table 15 Distribution of planned budget, resources and expenditure in USD on HR in respect of three priority areas.

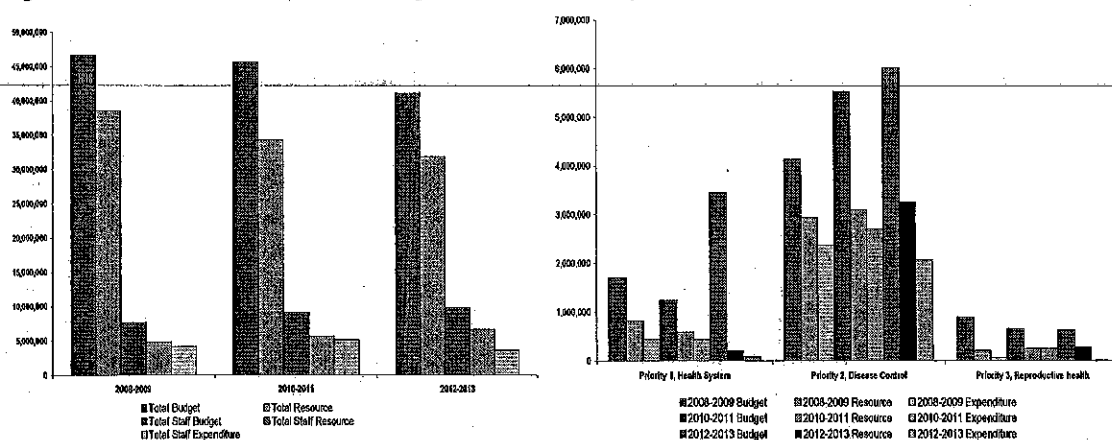
		Total Budget	Total Resource	Total Staff Budget	Total Staff Resource	Staff Expenditure / Budget	Staff Expenditure / Resource
2008-2009	\$	46,643,624	38,501,882	7,671,292	4,812,912	4,101,319	4,101,319
	%		83%	16%	10%	9%	10.65%
2010-2011	\$	45,533,500	34,176,028	9,115,500	5,597,475	5,061,578	5,061,578
	%		75%	20%	12%	11%	14.8%
2012-2013	\$	40,998,300	31,777,811	9,802,810	6,604,072	3,589,015	3,589,015
	%		78%	24%	16%	9%	11.25%

		Priority 1: Health System			Priority 2: Disease Control			Priority 3: RH/Child & Adolescents		
		Budget	Resource	Expenditure	Budget	Resource	Expenditure	Budget	Resource	Expenditure
2008-2009	\$	1,703,401	815,401	444,362	4,138,427	2,938,547	2,371,818	891,000	212,000	67,139
	%		48%	26%		71%	57%		24%	8%
2010-2011	\$	1,247,000	589,250	443,280	5,530,000	3,101,753	2,698,238	659,000	247,672	247,672
	%		47%	36%		56%	49%		38%	38%
2012-2013	\$	3,454,417	207,000	88,840	6,015,395	3,255,112	2,070,957	628,000	279,800	16,201
	%		6%	3%		54%	34%		45%	3%

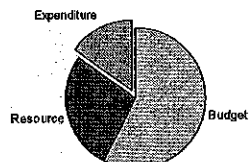
Source: WHO-SEARO, New Delhi

Note: For PB 2012-2013, implementation as of 15 Jan 2013

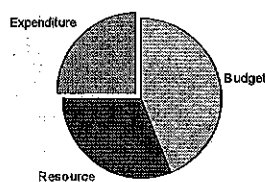
Figure 10 Presentation of planned budget, resources and expenditure on HR, in respect of three priority areas.



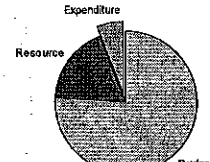
2008-2009: Priority 1, Health System



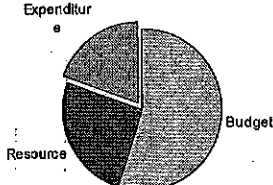
2008-2009: Priority 2, Disease Control



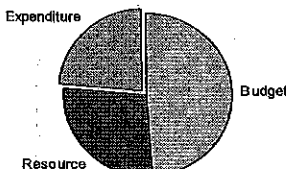
2008-2009: Priority3,RH/Child



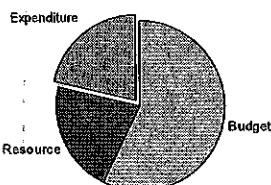
2010-2011: Priority 1, Health System



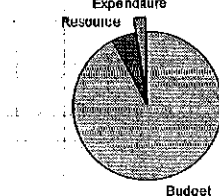
2010-2011: Priority 2, Disease Control



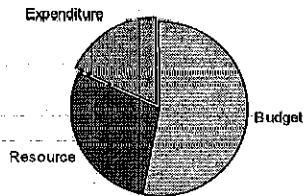
2010-2011: Priority3,RH/Child



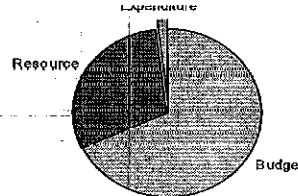
2012-2013: Priority 1, Health System



2012-2013: Priority 2, Disease Control



2012-2013: Priority3,RH/Child



In 2010-2011 biennium, WCO has a total of 107 products of which 9 were considered on track, 12 at risk and 1 was considered in trouble. Reasons specified for at risk and in trouble include lack of VC funding, change of programme managers in MOH and in coincidence with the national election process caused a delay in the implementation. Another critical issue was acute shortage of staff in several programmes of WCO to support and monitor implementation of activities. The reason for shortage was departure of staff members in critical units including EPI, HIV, TB as well as TGS staff.

4.4 Few selected achievements during the CCS cycle

4.4.1 Responds to Cyclone Nargis

On 2 May 2008, Cyclone Nargis made landfall in Myanmar, crossing the south of the country over two days, and devastating the Ayeyarwady Delta region – a total 37 townships were significantly affected by the cyclone which caused 85,000 people were killed and 53,800 went missing. It was estimated that as many as 2.4 million people were affected. Since it happened WHO in collaboration with MOH and health cluster partners played an active role in the immediate damage control related to health and rehabilitation of the victims in the areas. WHO has three field offices in the affected areas which coordinate with township health officials, hospitals and health agencies to provide a more location-specific response. Through intense community participation, the field team ensured that there were no treatment interruption and emergence of multi-drug resistance for TB. The dengue action plan was also instituted to prevent dengue outbreaks through active surveillance and vector control. WHO has also supported the MOH in deploying the mental health team to provide mental health care and psychological support services to the affected community. All health partners were provided information from the field to the bulletin through the Early Warning, Alert and Response System (EWARS).

WHO and its Health Cluster partners have approved a six-month USD 28 million Joint Action Plan to provide immediate health care for cyclone survivors, and support longer-term efforts to re-build the country's ravaged health care system. The overall objective was to prevent excess mortality, morbidity and disability for the population affected by the cyclone through: effective collaboration, monitoring health needs and surveillance; responds to health threats; and to restore the functionality of the health system. WHO has succeeded in reaching out to the worst affected people in Myanmar.

4.4.2 TB Prevalence Survey, 2009-2010

Myanmar is one of the 22 TB high-burden countries, though a consistent effort has been contributed for fighting against TB. It is essential for NTP to know the epidemiology of TB especially its scale and trends. Case notification rates vary significantly between regions and states, and the HIV/AIDS epidemic of the past decade has complicated TB epidemiology assumptions. A clear understanding of the TB situation is essential in order to review current strategies and formulate a more effective strategy not only to save people from TB infection but more so in alleviation poverty, especially the vulnerable population group.

Though initiated since 2005, due to financial constraints and many other administrative reasons a nationwide TB prevalence survey could not be materialized and finally NTP and WHO could jointly materialized it in 2009, which concluded in 2010. The outcome of the survey clearly reflected that the vast majority of TB cases remain undetected.. While the NTP has been successful in removing symptomatic smear positive cases from the community, the big gap between the TB prevalence and the notification rate of 2009 may be due to slow decline of TB incidence and/or due to limitations of the current case finding strategy. There is a need to accelerate case finding activities in Myanmar through improved access to diagnostic services, improved TB screening tools and algorithms and to expand partnerships for TB control.

4.4.3 Myanmar Artemisinin Resistance Containment

Myanmar has highest malaria burden in the Greater Mekong Sub-region (GMS). It reports some 75% of total malaria cases and deaths in the GMS. In 2009-2010 the country reported suspected Artemisinin resistance that was likely to flow from the Thai-Cambodia multi-drug resistant foci. The country took immediate action by developing the Myanmar Artemisinin Resistance Containment (MARC) framework through extensive consultation during 2010-2011. The MARC framework was endorsed by MOH and partners/donors in April 2011. The Three Diseases Fund (3DF) provided initial funding for rolling out the containment activities in July 2011. WHO served as one of the eight implementing partners in Year 1 of 3DF MARC project. With the fund flow mechanism set up during the 3DF project WHO provided managerial support to the National Malaria Control Programme (NMCP-

VBDC), the Department of Medical Research-Lower Myanmar (DMR-LM), the Food and Drug Administration (FDA) in containment activities besides its core function in providing technical assistance to the national programme and coordination.

The MARC Framework was planned for 5 years (2011-2015) with an estimated cost of 117 million USD. The budget for rolling out implementation by WHO and the national partners (within DOH/MOH) during the period Oct 2011 to December 2012 was 2.4 mil USD. The first year of MARC project that commenced in October 2011 and was extended to December 2012 with the financial support from the 3DF through the executing agency (WHO) has covered 31 townships in tier 1 areas.

One of the recommendations of the Joint Assessment Team (JAT) in 2012 is prioritizing Myanmar and strengthening technical and management capacity of WHO Myanmar. Therefore, a new project proposal was developed in response to country needs and recommendation of JAT to be implemented in year 2013 under 3MDGF (three millennium development goals). This new proposal has extended the containment activities to 73 Townships in Tier 1 and 2 areas and several Townships in Tier 3 areas which borders' areas to Tier 1 and 2.

4.4.4 Introduction of new vaccines in National Immunization program and achieving Polio free status

The immunization program in Myanmar is reaching more than 85% of all beneficiaries with all antigens leading to overall reduction of the burden of vaccine preventable diseases. The country has introduced two new vaccines in National Immunization Program: Haemophilus Influenza Type B; and Second dose of routine measles vaccine. Some of the other key achievements in last five years include: the country has been free from Wild Polio Virus transmission since 2007. Elimination of Maternal and Neonatal tetanus and a two third reduction in measles mortality and morbidity cases in comparison to 2000 baseline.

All these along with the new vaccines will lead to a greater reduction on childhood mortality which in turn has accelerated Myanmar progress towards achieving MDG4.

Section 5: The Strategic Agenda for WHO cooperation

5.1 Introduction

This section addresses the strategic agenda prepared for the 5-year (2013-2017) period for cooperation between WHO and the Government with Myanmar. It has been formulated in line with the NHP 2012-2016, and well harmonized with the UN Strategic Framework 2012-2015. In the development process, the social development emerging out of the national reform process and key challenges of health confronting the country was carefully synthesized. A close observation was given to the contributions to health development by other external partners and identified challenges and gaps in health sector cooperation and lesson learnt from a review of WHO's cooperation over the last CCS cycle. It also follows the guidance of the Twelfth General Programme of Work and regional orientations and priorities. A special consideration was also given in enhancing the achievement the MDGs, principally to the health related targets by 2015.

Five strategic priority areas for WHO cooperation have been identified for the period 2013-2017. The order in which the strategic priorities listed does not indicate the order of priorities nor the importance attributed to each:

- 1 Strengthening the health system;
- 2 Enhancing the achievement of communicable disease control targets;
- 3 Controlling the growth of non-communicable disease burden;
- 4 Promoting health through the life course;
- 5 Strengthening the surveillance systems and readiness to respond threats to health;

It is important to emphasize that each priority area will be addressed through a coordinated programme of work that will seek to harness the potential strengths of the stakeholders. For each of the strategic priorities, a set of main focuses and strategic approaches have been formulated. The main focuses which clarify the role of WHO in addressing the priorities, reflects WHO's comparative advantage, are areas where the potential for impact exists, and emphasize both the convening and policy adviser role of WHO. The strategic approaches reflect the ways and means WHO will adopt in undertaking actions identified under the main focuses. Given the cross cutting nature and inter-relationships among the strategic approaches, a strategic approach under one main focus may have positive impact on other main focus and priorities. In addition to the 5 priority areas, WHO will continue its core functions as directed by its governing bodies and will actively cooperate with Myanmar for any other public health challenges that the country may have it.

The work in these areas will be planned in a biennium-to-biennium mode through negotiation between WHO and national authorities. In summary, the WHO's approach in the next CCS will be to strategically focus WHO collaboration with the government on a number of public health challenges, primarily the five areas listed above.

5.2 The Strategic Agenda

5.2.1 The five priority areas are:

1 Strengthening the health systems:	
Objectives	1 Enhance the national capacity to strengthen the health system
	2 Support equity in health and increased access to services particularly for the underprivileged population and vulnerable group through promoting the partnerships and promoting community capacity
	3 Enhance faculty development programs and facilities for health institutions in order to improve the quality health personnel
	4 Consider private sectors as part of health system and encourage more private public partnership and promoting community capacity
	5 Promote equitable, adequate and sustainable health care financing
Main focus area 1.1 Improve access to quality care	
	1.1.1 Advocate and provide technical support for expansion of an effective comprehensive UHC throughout the country, covering health of the life course
	1.1.2 Provide technical and material support for further strengthening of health related universities and institutions, ensuring increase in the

Strategic approaches	availability of appropriate skill-mixed competent health workforce, particularly in remote and rural areas, and also assist in establishment of HR unit at the central level under the MOH
	1.1.3 Assist in strengthening of health facilities at all level together with strengthening of the health care volunteers system and integrated health care services especially in hard to reach areas, including availability of quality essential drugs and medical devices while reviewing the national drug policy to appropriately align with the country's socio-economic development, so also its supply chain of essential drugs.
Main focus area 1.2	Strengthen the implementation of National Health Plan
	1.2.1 Provide technical support for the development of equitable, adequate and sustainable health financing schemes to prevent barriers in accessing to health care
	1.2.2 Support data collection, storage and strengthen skills for data analysis, utilization, collaborate with MOH in formulating monitoring and assessing of policies, strategies, plans and optimal use of scarce resources, and assist in health research for further strengthening of health system
Strategic Approaches	1.2.3 Provide technical support and strengthen the International Health Division of the MOH in its effective coordination with partners in health, strengthen its capacity in resource mobilization.
Main focus area 1.3	Support the Government to strengthen national capacity for promoting traditional medicine / herbal medicine
	1.3.1. Provide technical support for enhancing capacity in research and development as well as production of quality assured traditional medicine
Strategic approaches	1.3.2. Facilitate MOH in promoting the use of traditional / herbal medicine in primary health care
2. Enhancing the achievement of communicable disease control targets;	
Objective	Achieve the targets of communicable diseases control and MDGs
Main focus area 2.1	To have at least 80% coverage of people needing ART under the national guidelines and to minimize the transmission HIV infection from infected mother to meet the global and regional targets for elimination
	2.1.1 Technical assistance for scaling up the health sector response to HIV
Strategic Approaches	2.1.2 Strategic information: The strengthening of SI is an integral part of the use of data for planning and resource mobilization.
	2.1.3 Strengthening the programme management capacity of the national programme through development of evidence based plans, capacity building for forecasting and quantification of HIV commodities for health sector response and advocating for integration of human resources support directly to National AIDS Programme (This will be depended on donor policies)
Main focus area 2.2	Further reduction of TB prevalence and mortality to achieve the TB impact targets.
	2.2.1 Provide active interventions to improve earlier TB case detection
Strategic approaches	2.2.2 Strengthen the expansion plan for the programmatic management of drug resistant tuberculosis
	2.2.3 Scale up for TB/HIV collaborative activities.
Main focus area 2.3	Intensify control of malaria in high malaria transmission areas along the international borders, and control and eliminate Neglected Tropical diseases.
	2.3.1 Strengthen national capacity in planning, implementing, monitoring and evaluating malaria control programme and Neglected Tropical diseases and further increase in access to affordable and quality diagnosis and treatment.
Strategic approaches	2.3.2 Intensify malaria control interventions and contain the drug resistant malaria, covering population at risk of malaria, including 'hard-to-reach' population, and border areas through partnership
	2.3.3 Eliminate vector borne diseases and Neglected Tropical disease.

	including DHF, blindness and leprosy through MDA, environmental management, community participation and behaviour change communication.
Main focus area 2.4	Strengthen Immunization Systems achieve at least 90% DPT coverages nationally and 80% in all townships, and expand planning and implementation of other vaccine preventable disease program
Strategic approaches	2.4.1 Increased immunization coverage achieved through routine and supplemental immunization activities and integrated health service delivery and innovative methods identified to increase and maintain uniform high immunization coverage, especially focused to hard to reach areas and vulnerable populations
	2.4.2 Introduction of underused and new vaccine and development of vaccine management systems including immunization safety and adverse events following immunization.
	2.4.3 Monitoring and evaluation of immunization program further strengthened.
	2.4.4 Strengthen case-based surveillance for VPD in all townships and strengthen the laboratory capacity, both workforce and equipment.
3 Controlling the growth of non-communicable disease burden;	
Objective	Control the growth of non-communicable disease burden and minimize the prominent risk factors in the environment.
Main focus area 3.1	Support the Government to expand activities for promoting practices of healthy lifestyles in the communities including tobacco control.
Strategic approaches	3.1.1 Facilitate the Government in raising awareness on dangers of tobacco use and exposure of tobacco smoke, enhancing capacity in tobacco surveillance and support for tobacco legislation.
	3.1.2 Provide technical support in disseminating appropriate health education messages throughout the country, particularly those related to global health priorities and develop community based initiatives on promotion of healthy lifestyles such as diet and physical activities.
	3.1.3 Facilitate MOH in enhancing capacity for strengthening health promoting school programme.
Main focus area 3.2	Support the Government to expand national efforts for prevention of injury, violence and disability.
Strategic approaches	3.2.1 Provide technical support for enhancing national activities for surveillance, prevention and management of injury and violence.
	3.2.2 Facilitate MOH in expanding community based rehabilitation.
	3.2.3 Assist in establishing injury unit in MOH.
Main focus area 3.3	Support the Government to strengthen the prevention and control of NCD.
Strategic approaches	3.3.1 Provide technical support for surveillance, prevention and control of risk factors, early detection, referral and management of cancer, diabetes, CVD and CRD.
	3.3.2 Provide technical support to strengthen community based mental health programme and disability due to hearing and visual impairment.
	3.3.3 Provide technical support to strengthen community based approach for prevention, early referral and management of snake bite.
4 Promoting health through the life course;	
Objective	Strengthen health system through improving health conditions of women, child and adolescent and ensure accountability through reporting on progress towards reproductive and sexual health and child health as part of achieving the MDGs.
Main focus area 4.1	A comprehensive, integrated package of interventions for Birth Spacing, Maternal, Newborn and Child Health.
Strategic Approaches	4.1.1 Provide technical and policy support for a comprehensive MNCH support by predictable and sustainable investment to ensure availability and accessibility of quality MNCH services and introduce evidence-based technologies, integrate delivery of health service and life-saving interventions.
	4.1.2 Increase the knowledge of families, communities, decision and policy makers, and target groups on MNCH in order to ensure favourable social, economic and political environment and mobilize the

	community
	4.1.3 Provide technical assistance to strengthen community-based nutrition programme for women and children and strengthening the monitoring and assessment of risk related to food, such as biological and chemical risk
Main focus area 4.2	Improve sexual and reproductive health including adolescence and women's health and health care for elderly
Strategic approaches	4.2.1 Improve Reproductive Health programme implementation including adolescent reproductive health and strengthen the capacity of adolescent and youth friendly confidential service and education, including awareness on gender equity issues, gender mainstreaming activities, domestic violence among all levels.
	4.2.2 Strengthen capacity of management for other gynaecological conditions, such as severe menstrual problems, obstetric fistulae, uterine prolapse, pregnancy loss, sexual dysfunction and cancer screening (cervical and breast).
	4.2.3 Facilitate MOH in enhancing capacity in elderly care services.
Main focus area 4.3	Support the Government to enhance safe water supply, improved sanitation and personal hygiene, and health education promotion.
Strategic approaches	4.3.1 Provide technical assistance to strengthen safe water supply, improved sanitation and personal hygiene.
	4.3.2 Provide technical assistance and materials and equipment for raising awareness of safe water, sanitation, personal hygiene and healthy life style.
5. Strengthening the surveillance systems and readiness to respond threats to health,	
Objectives	1. Prevent disease outbreaks and PHEIC through strengthening surveillance system.
	2. Strengthen rapid response to disasters and PHEIC (food, chemical, radiation) not only biological.
Main focus area 5.1	Preparedness, surveillance and response
Strategic approaches	5.1.1 Promote alert and response capacity through implementation of IHR 2005, covering areas of capacity building of implementers and focal points, quality of surveillance and infrastructure, intensifying measures to eradicate poliomyelitis by 2014.
	5.1.2 Early detection and rapid response to pandemic and epidemic diseases, through strengthening diagnostic capacity and laboratory services and develop coordinated plan and mechanism for disaster preparedness and response, other public health emergencies of international concern.
	5.1.3 Promote research capability with emphasis on operational research and vulnerability assessment and provide technical assistance in enhancing FEIP, information sharing and human resources development.
	5.1.4 Effective coordination and support provided to access all populations to interventions for the prevention and control and/or elimination of zoonotic diseases under one health program specifically implementing the Asia Pacific Strategy for Emerging Diseases (APSED).
Main focus area 5.2	Support the Government to reduce the health consequences of emergencies, disasters and minimize the social and economic impact.
Strategic approaches	5.2.1 Technical support to township health staff in disasters prone areas for disasters preparedness and response.
	5.2.2 Strengthen communicable disease surveillance and control in disasters and emergencies.
	5.2.3 Address public health needs and gaps during emergencies and post emergencies / recovery phase.

5.2.2 Rationale

5.2.2.1 Strengthening the health system

Myanmar is consistently strengthening its national health systems and public health functions, based on principles of PHC and UHC, reaching the poor and hard to reach vulnerable groups, addressing equity issues. However reflecting several constraints, the basic health services and rural health centre infrastructure itself has not kept pace with population growth, resulting the defect in accessibility and rural health care function affecting the equity issues. Measures will have to be taken to make health system responsive to the legitimate expectations of the people, which will be changing and growing with improvement in the social and living standards. Access barriers are attributed to lack of human resource numbers and skills, frequent stock-out of essential medicines and medical devices and high out of pocket expenditures for the population. It is necessary to establish a sustainable system for financing health that will protect people from financial burden in seeking health care, is equitable and ensure access to all with different socio-economic and demographic background and that will be suitable to the economic situation of the country. At the same time, it is essential to take measures and support for the modernization, perpetuation and extensive utilization of traditional medicine that has been entrusted traditionally. WHO will support in training and strengthening of capacities through continued support in education of human resources for health to develop a skill-mixed health workforce that is appropriate and capable to meet the needs in relation to disease and health problems prevailing in the country. In further development of evidence-based and integrated policy approach, it is critical that timely availability of essential comprehensive health information is a necessity, if possible, the disaggregated data to help track progress and in measuring national policies and plans including MDGs. Myanmar has launched the UHC and it is progressing very well, keep solving many of the health system issues. WHO will support for further strengthening of UHC and implementation of the NHP and medium term strategies derived from it, as a whole.

5.2.2.2 Enhancing the achievement of communicable disease control targets

As far as disease burden is concerned the country is putting all effort in its health system to achieve its targets of the communicable diseases control and halting the growth of the disease burden of non-communicable diseases. In respect of HIV/AIDS, if the present programme of coverage is maintained, but not increased, new HIV infections through the sharing contaminated injection equipment will constitute the largest source of new infections by 2015. Infections related to sex work and those from husband to wife decline relatively faster than other routes of transmission. However, these two closely linked transmission routes remain the most important source of new infections. The epidemic remains mainly in male population. The proportions of females who are HIV positive have stabilized at around 36 percent. The need of putting more and more people on treatment will remain a key area for scale up the program and the interventions to prevent mother to child transmission of HIV will remain a continuum of care channel to the provision of treatment, as it would directly have its contribution in simultaneously affecting the MDG4 and 5 in addition to MDG 6. Hence the key thrust areas that would be addressed by WHO, as outlined in the strategic approaches. In technical scaling up its response, it includes normative guidance, assessing evolving trends, developing linkages and referrals and integration of HIV response to a health sector moving away from the vertical programme. This translate into technical support for HIV counselling and testing care and treatment. The strengthening of strategic information is an integral part of the use of data for planning and resource mobilization. This would mean continued involvement of WHO in surveillance and M&E related activities: HIV sentinel surveillance, behavioural surveillance, early warning indicators, IBBS, HIV DR surveys, survival studies and research. The approach in transiting the field staff will enhance the program management capacity of the national AIDS programme.

A nation-wide TB prevalence survey 2009-2010, confirms a much higher TB burden than the previous estimates and NTP has revised the TB epidemiological data, impact targets, policies and control strategies and funding requirements for a better equipped to achieve the set MDGs by 2015. Additional efforts are needed to more actively screen for TB among subpopulations with poor health access and among risk groups. It is a necessity for NTP to scale-up the pace of diagnosis, treatment and care for patients suffering from multidrug-resistant, MDR-TB and efforts to reduce the dual burden of TB and HIV/AIDS among population at risk and affected by both diseases. With additional interventions in the strategic approaches, many of the unreached and undetected TB cases, such as screening of risk groups, contact investigations and mobile team activities in high prevalence communities, it is envisaged that additional TB cases will be detected. The remaining two approaches related to

MDR-TB and TB/HIV where more cases on drug resistant cases could be treated and treatment services would be made available in 100 townships compared to 22 in 2010. By the end of 2015, TUB/HIV collaborative activities will be made available all over the country and as much as possible be integrated at township level.

In 2005-2006, Thailand and Cambodia reported strong evidence of the Artemisinin resistant falciparum at the border between the two countries. Efforts to delay spreading of these parasites commenced in 2008. Myanmar detected early signs as strong evidence of suspected Artemisinin resistance at several eastern states and regions. Therefore surveillance of parasite resistance and effective malaria control in Myanmar are of greatest importance. Artemisinin containment resistance framework was developed in 2010 in order to respond the regional threat. The containment action commenced in Myanmar in 2011 and is not confined to Artemisinin but to all antimalarial drugs. Containment entails concentrated efforts and a high number of activities in a focussed area. This means that there is an even stronger need for coordination and mechanism backed up by a strong monitoring and evaluation system. Containment can only be achieved by a strong multifaceted approach focussing both on long and short term solution. It also involves intensification of malaria control interventions covering all population at risk with malaria including hard-to-reach population and increases their access to quality diagnosis and treatment with particular emphasis on aspects of cross border collaboration.

Historically, Dengue Fever / Dengue Haemorrhagic Fever have been a disease of urban areas in Myanmar, but since 1998, more cases have been reported in rural settings. In 2011, the distribution of DF/DHF cases is equal in urban and rural areas. Morbidity has been increasing during the last four decades. Lymphatic filariasis was a high burden disease, however in spite of several difficulties, MDA has been implemented in 22 of the 45 LF endemic districts covering about 20 million people. Elimination programme (MDA) relies heavily on external support. Though leprosy is no longer a public health problem in Myanmar, it still needs attention, in particular for issues such as further reduction of disease burden at sub-national level through intensified leprosy activities including IEC and awareness activities in selected high burden townships and strengthening participation of persons affected by leprosy.

During the period 2007-2011, the national EPI programme has gained in strength and has seen increases in reported coverage and a subsequent drop in incidence of VPDs. It has reached more than 85 percent of all beneficiaries with all antigens leading to overall reduction of the burden of VPDs. Currently under-served population, existing bottlenecks causes and corrective action to full immunization coverage need to be identified so that no community has less than 80% coverage (all vaccines) and there are no outbreaks of vaccine-preventable diseases. Focus will be to improve the equity of immunization services to reach. There is also a need to generate demand from the most vulnerable and underserved population through ensuring critical bottlenecks, causes and corrective actions are identified and taken through a participatory decentralized process. Participation of civil society groups and NGOs in support of immunization including paediatric and medical associations and religious groups who can play an active role in the design, provision and promotion of immunization services.

The cold chain backbone is gradually expanding to RHCs level and staff are well trained and experienced with both routine and various NIDs (polio), TT and measles supplementary immunization activities (SIAs). Myanmar has reached the goal of 90 percent measles mortality reduction; however, there are many challenges to sustaining these gains and progress towards elimination. Though polio was free in the period 2003-2005, 11 wild polio virus cases were detected in 2007 and in recent years. VDPV was reported in 2010. AFP surveillance has been strengthened to international and necessary measures will be taken up to eradicate polio by 2014. Polio will be included in priority 5 of the strategic agenda.

5.2.2.3 Controlling the growth of non-communicable disease burden

Non-communicable disease is also a growing burden to the country. It is responsible for about 41 percent of deaths and most common ones are cardiovascular, cancer, diabetes and chronic respiratory diseases, which are the same four global target diseases. The country has conducted several chronic disease risk factor surveillance survey (STEP) and studies and based on those results has initiated variable levels of intervention strategies in tackling the main risk factors which are amendable to modification by simple health promotion measures which include the use of tobacco and alcohol, an unhealthy diet (high in total energy, fat, salt and sugar, low in fruit and vegetables). It is a multi-sectoral issues and involves various ministries in which a multi-sectoral meeting to formulate draft NCD policy and a multi-sectoral meeting to formulate draft alcohol policy has been conducted to

address issues that can only be collectively reflected. In case of tobacco, 44.8 percent of males and 7.8 percent of females are regular smokers. Myanmar Tobacco Free Initiative Project was launched in 2000 and the Control of Smoking and Tobacco Products Consumption Law was enacted on 4 May 2006. Myanmar became a party to the WHO FCTC in 2005 and signed the protocol to Eliminate Illicit Trade in Tobacco Products on 10 January 2010. Health promotion activities including the practice of healthy lifestyles such as healthy diet and physical activity and controlling the use of tobacco products have been on-going in the community.

Chronic diseases, mainly CVD, diabetes, cancer and CRD have a large but unappreciated negative impact on individuals, families and countries and as such are major barriers to human development. Treatment for diabetes, cancer, CVD and CRD are extremely expensive and the cost involved, force families into catastrophic spending and impoverishment. Injury surveillance, prevention and care programme needs to be further strengthened through multi-sectoral collaboration. The impact goals of 12GPW with regard to NCD is the reduction in the probability of dying from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases for people aged 30-70 years by 25 percent by 2025.

5.2.2.4 Promoting health through the life course

Related to the third priority area, promoting health through the life course, Myanmar's consistent effort on Reproductive Health, Maternal, Newborn and Child Health are progressing in line with the targets of the respective national medium term strategic plans. There has been considerable progress towards targets of MDG 4 and 5. However MMR remains still high and estimated at 200 per 100,000 Live Births (LB) and needs further effort in bringing down the maternal deaths to 130 per 100,000 LB by the year 2015, which is the MDGs target. MMR in rural and hard to reach areas was estimated to be about 2.5 times higher than the urban. Effective implementation of those strategies and programmes are challenged by financial shortfalls for reproductive health services coupled by low investments in health system strengthening and improve motivation to improving coverage and availability of quality of reproductive health services. In strengthening the supportive environment, in collaboration with UNFPA, UNICEF and other partners, WHO will strengthen the health systems through improving the health conditions of women, child and adolescent with a comprehensive integrated package of interventions for family planning, safe abortion, maternal, new-born and child health. It will provide technical and policy support for a comprehensive MNCH with a sustainable investment; will improve the access of quality MNCH services; and will increase the knowledge of families, communities and policy makers of target groups on MNCH, ensuring an enabling and healthy livelihood. WHO will also focus on improvement of health of adolescent in their sexual and reproductive health, women's health and health of the ageing to ensure a well-being of the life course. As per demographic transition, an emerging issue is the growing number of older people. Among 6 millions of elderly ones, it is estimated that about 10 percent are vulnerable persons. The common health issues comprises of high blood pressure, heart disease, strokes, cancers, lung diseases related to smoking and musculoskeletal problems are common issues. Community-based health care for elderly has been taken up in NHP 1993-1996 and WHO in collaboration with development partners are providing support for health care for the elderly.

5.2.2.5 Strengthening the surveillance systems and readiness to respond threats to health

Myanmar has a long coast line of 2400 km, which covers almost the entire east coast of the Bay of Bengal. It is situated on the highly active fault line called the Sagaing fault. This leaves Myanmar a very short lead time for warning. Most of the coastal areas of Myanmar are within the risk zone. Other hazards include cyclones, storms, earth quakes and landslides. Urban fires in the central areas of the country are common during the hot, dry season and human induced. Climate change has led to a re-emergence of multi-drug resistant plasmodium falciparum and an insecticide-resistant vector. The country also faces several health hazards due to conflict related complex emergencies and natural disasters. These include diarrhoeal and gastroenteritis, dysenteries, cholera, malaria, leptospirosis and other water borne infectious disease. As such disasters preparedness and response mechanism has been established in disaster prone areas / townships by a collective effort of various sectors and stakeholders.

5.3 Validation of the CCS Strategic Agenda with NHSP Priorities and UN Strategic Framework Outputs

The National Health Plan 2011-2016 composed of 11 projects: communicable diseases, non-communicable diseases, neonatal and health care for life course, quality of hospital care, traditional medicine, health manpower, medical research, nutrition, health systems and rural health care projects. In aligned with the NHP, several areas have developed the five year national strategic plans and in this validation exercise reference has also made to HIV/AIDS, TB, Malaria and Reproductive Health national strategic plans have been referred. The UN Strategic Framework 2012-2015 was developed in 2011 by the UNCT, and launched in 2012. The strategic framework identified four priority areas: encourage inclusive growth; increase equitable access to quality social services; reduce vulnerability to natural disasters and climate change; and promote good governance and strengthen democratic institutions and human rights. The validation exercise of the CCS 2013-2017 Strategic Agenda with NHP 2012-2016 and UN Strategic Framework is presented in table 15.

Table 16 Validation of CCS Strategic Agenda with NHP 2011-2016 and UN Strategic Framework outcomes, 2012-2015

Strategic Agenda of CCS 2013-2017	CCS Strategic Priorities at main focus level	NHP 2011-2016 strategic objectives and/or expected outcome and National Strategic Plans	UN Strategic Framework 2012-2015 Outcomes
Strengthening the Health System	<p>The main objectives of strengthening of health system are: to enhance the national capacity to strengthen the health system; support equity in accessing the quality health care; and to promote sustainable health care financing. In area of access to quality care the approaches include expansion of UHC throughout the country, availability of skill-mixed workforce, strengthening of health institutions and availability of essential drugs. In the implementation of NHP, it includes health care financing, strengthening HMIS, provision of technical support in planning, monitoring, assessment, optimal utilization of resources. Strengthening of IHD in its coordination activity and promoting the use of traditional medicine.</p>	<p>The main strategies of Strengthening of Health System Project are: To develop health policy, strategies and plans; to formulate measures for preventing barriers of health expenditure in seeking health care; to enhance the health information system in collection, analysis for an effective utilization of data; cooperate with international partners for collaborative activities in health; enhance the effectiveness of township level health care; and promote the resource mobilization for health care. The strategies also emphasize on multi-sectoral and international collaboration to achieve the set goals of the health plan.</p> <p>PHC-based Border Area and Rural Health Care project emphasized on further development of rural health services with effected skill-mixed health workforce, availability of convenience for patient transfer, availability of essential drugs and medical devices to provide a quality care in an equitable manner</p>	<p>The first Strategic priority is to encourage inclusive growth, contributing to MDG1 and repercussions on MDGs 2,3,4,5,6 and 7. The first outcome addresses inclusive growth and will contribute to accelerated growth and poverty reduction. The second outcome addresses to food and most vulnerable groups less access to food and touching critical issues on landlessness. The third outcome addresses to rural finance. First priority will result in GDP growth in equitable manner and enabling to the accessibility to health.</p> <p>The strategic priority 2, increases equitable access to quality social services and the outcome two of this priority will make coordinate efforts to towards ensuring high quality and equitable health services, placing emphasis on strengthening health system processes in particular at the township level, and contribute towards effectiveness through support to service delivery, human resources development, leadership management, procurement and supply, health financing and health information system. Efforts will build on the existing spirit of public health service: commitment of health workers to be of service in spite of hardships and limited material incentives or professional recognition.</p>
Enhancing the achievement of communicable disease control targets	<p>The objective of this priority area is to enhance the achievement of communicable disease control targets and MDGs. The main focus area of HIV is to have at least 80% coverage of people needing ART under the national guidelines and to minimize the transmission of HIV infection from infected mother to child. TB's focus area is for further reduction of TB prevalence and mortality to achieve the TB impact targets; and malaria control is to contain the drug resistant malaria in high malaria transmission areas, along the international borders.</p> <p>For communicable disease surveillance, the focus</p>	<p>One of the principal strategies in communicable disease control is to strengthen the disease surveillance activity rapid exchange of information.</p> <p>For HIV/AIDS, the strategic priorities are: prevention of the transmission of HIV through unsafe behaviour in sexual contacts and use of contaminated needles; comprehensive continuum of care for people living with HIV; mitigation of impact of HIV on people living with HIV and their family.</p> <p>TB control strategic plans includes: Strategic</p>	<p>Under outcome 2 of strategic priority 2, the UN will ensure a continuous and uninterrupted supply of commodities to health including HIV prevention and treatment. HIV care and support services will strengthened and expanded through joint programmes with division of labour among members of the UNCT on HIV/AIDS aligned with national Strategic Plan for AIDS (2011-2015). The outcome 3 will also assist in collection, analysis, dissemination and utilization of data at township level. Likewise initiatives like GAVI will be closely associated.</p>

	area is to sustain polio free status, Maternal and Neonatal tetanus elimination and progress to eliminate measles and introduce new vaccine based on disease evidence..	plan on active case- finding 2012-2015; expansion plan for the programmatic management of drug-resistant tuberculosis, 2011-2015; and nation-wide scale-up plan for TB/HIV collaborative activities, 2012-2015. The goal of malaria control is to reduce malaria morbidity and mortality by at least 50 percent by 2015. Containment of drug resistance malaria in high malaria transmission areas, along the international borders is one of the critical approaches in reaching the goal. For EPI activities in 2012-2016 include reaching 90% DTP3 coverage nationally. Implementation of National Plan of Action for Integrated disease surveillance and Early Warning Alert and Response System (EWARS)	Nationally 90% coverage for all EPI antigens and 80% uniform coverage in all townships sustaining polio free status . ¾ reduction in measles morbidity and mortality to reach elimination goals. The outcome is to achieve active immunization by ensuring gaps in EPI coverage have been analysed and defined communities not being reached and identified major bottlenecks, causes and corrective actions to take in those communities.
Controlling the growth of non-communicable disease burden	The main objective of this priority area is to control the growth of non-communicable disease burden and minimize the prominent risk factors in the environment, with emphasis in CVD, diabetes, cancer, chronic lung diseases and mental health; and also of injury and snake bite. The main four risk factors are identified and tackling those factors in preventing the disease, promoting health practices in the communities.	The non-communicable disease component consists of CVD, diabetes, chronic lung diseases and cancer control projects. Mental health, injury prevention and snake bites are also priority areas. One of the main strategic approaches to non-communicable diseases is to prevent the risk factors: Tobacco and drug abuse control, I prevention of accident and deafness, snake bite are priorities in this area.	The Strategic Framework, Priority 2 ensure universal access to quality social services, an essential conditions for establishing an inclusive and equitable society. Under outcome 1, it ensure the vulnerable to access the quality health and social services.
Promoting health through the life course	The objective of the promoting health through the life course priority is to strengthen health system through improving health conditions of women, child and adolescent and ensure accountability through reporting on progress towards reproductive and sexual health as part of achieving the MDGs. The focus area includes: provision of integrated packages for intervention, improve health adolescent and advocate sexual and reproductive health; women's health and support for active ageing	Maternal and Newborn and Child Health Project undertake activities for improving the health status of rural community; promoting community awareness and involvement; providing proper antenatal care, skilled and institutional delivery, post-abortion and quality birth spacing services; ensuring essential obstetrical care; essential newborn care; establishing adolescent reproductive health; strengthening male involvement in reproductive health care provision.	Strategic priority 2 contributes to MDG 2,3,4,5 and 6. Under outcome 2, UNCT will make coordinated efforts towards ensuring National Strategic Plans on Reproductive Health and Child Health including Women's Health. The joint UNCT action will aim at increasing the availability and accessibility to antenatal care, skilled attendance at birth, post natal care, birth spacing, neonatal and child health care and ensuring the integration of sexual and reproductive health services with HIV prevention, treatment, care and support.
Strengthening the surveillance systems and readiness to respond threats	In respect of disease outbreaks and emerging of new diseases in the country, surveillance work will be enhanced and implement the IHR 2005 and institute the EWARS and RRT networks. Technical advocacy and support on preparedness and rapid response will	The principal objectives of Disaster Management and Public Health Emergency project is to implement the disaster preventive activities effectively and to accelerate emergency preparedness activities and to	The priority 3, addresses to reduce vulnerability to natural disasters and climate change and contributes to MDG 7. It addresses support and advocacy for formalization of policies and plans related to disaster risk reduction; enhancement

to health	be provided. National capacity strengthened for detection, verification, risk assessment of and response to epidemics and other public health emergencies of national, regional and international concern.	strengthen surveillance activities for early warning and effective response in disaster prone areas. Capacity of hospital based laboratories to support communicable diseases further strengthened.	of knowledge information ; and strengthening capacities, awareness and resilience of communities, authorities in high risk, vulnerable locations , to respond to natural disasters and climate change effects. Strengthened national capacity in the implementation of IHR to meet IHR requirements by 2014.
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Section 6: Implementing the Strategic Agenda: implications for the entire Secretariat

6.1 Introduction

Myanmar opens up in a speedy manner with a strong commitment from the Government for a socioeconomic reform in all aspects of development process. The expected economic growth will certainly determine the promotion of human growth. The development goals among all sectors are synergistic, interlinked and crosscutting. It has been very much welcome by the global and regional communities. Several developmental partners are coming forward to assist in the reconstruction of the country. There are sweeping changes in the aid environment of the health sector and the current strategic policy of the MOH is to cooperate with all partners in all its collaborative activities in health.

WHO, since its inception of the relationship with Myanmar in 1957, has evolved with a close association and consistently assist in health development of the country. The critical challenge for the WCO will be adjusting and scaling up its capacity to provide an effective support for the required technical excellence that would be able to contribute meaningfully to and influence national health policy processes, that is, to influence the government's health agenda. It is also critical to note that WHO is also undergoing a reform process at the global level emphasizing in three objectives:

1. improved health outcomes, meeting Member States' and partners' expectation in addressing agreed global health priorities;
2. greater coherence in global health, with a leading role for WHO in enabling actors to play an effective role in contributing to the health of all people; and
3. being an *excellence-pursuing organization* (effective, efficient, responsive, objective, transparent and accountable).

WHO reform is also focussed on five core areas:

1. Communicable diseases;
2. Non-communicable diseases;
3. Health through the life course;
4. Health Systems; and
5. Preparedness, Surveillance and Response.

In line with the above, core features of CCS 2013-2017 will be WHO's support to the MOH by fostering health policy dialogue and technical advice to the authorities throughout the country in strategic priority areas of collaboration.

6.2 WHO's role and its presence

The role of WHO as broadly envisaged in the CCS strategic agenda is that of a technical adviser, trusted broker, and convener that engages with government and facilitates partner's contribution towards national health policies, strategies, and plans. In effectively perform this role, CCS strategic agenda and the objectives of the WHO reform process require refocusing and prioritizing the work at the country level. WHO will continue its normative functions as a core area of support; closely monitor progress towards the achievement of all health related MDGs; and provide technical support proactively to other important public health challenges that do not fall within the priority areas.

The structure and composition and competencies of the WCO will be subject to a review that will aim to recognize the office so that it will be better optimized and equipped to undertake new responsibilities as a consequence of the new CCS. However the current organizational structure of the WCO is appropriate to the needs and meets the targets of the CCS for 2013-2017. The organogram is regarded as flexibly functional which can always be reviewed according to the priority issues during the period of CCS cycle. Currently WCO has established thematic teams of technical programmes which are actively in function. The dedication and competence level of staff at the WCO is impressive. However it will be a better investment for the WCO to have a long term than that of the multiple short term contracts whenever it is feasible.

Steps will be taken for building stronger, more competent, more cohesive and dynamic teams to more effectively address cross-cutting issues relevant to the CCS agenda. Issue-specific, task-oriented interactions among the staff on a regular basis are a way forward in this direction. More specifically, reorientation of staff on health system and evolving issues; training in epidemiology and disease burden as tools for advocacy; and reorientation/training for country office staff in cross-cutting issues impacting health would be necessary. Moreover, periodic orientation on the programme management, monitoring and evaluation will be an asset for all staff engaging in the platform of result-based management.

The strategic priorities in this CCS cover a range of technical expertise available at SEARO and WHO Headquarters. A close working relationship between the country office and relevant technical units at the Regional Office and Headquarters will add value to the work of WHO in Myanmar.

6.3 Using the CCS - implications for the WHO Secretariat

The country Office will:

- widely disseminate the CCS document to the government, national and external development partners, non-governmental organizations, civil society organizations, and other stakeholders working in and with the country;
- use the CCS strategic priorities, main focuses and strategic priorities to guide current and future work plan development;
- use the content of CCS to help define and shape the health related UN Strategic Framework; and
- use the CCS for advocacy and resource mobilization for WHO's work in Myanmar.

The Regional Office and HQ will:

- widely disseminate the CCS document and CCS brief to all WHO departments and divisions, and to other relevant partners and stakeholders;
- ensure the CCS priorities are used as the basis for the preparation of strategic and operation plans including budgets and resource allocation; and
- Use the CCS for advocacy and resource mobilization for WHO's work with Myanmar

Working towards achieving the priorities spelled out in the CCS, in collaboration with MOH and partners calls for major adaptations in the way WCO plans, runs its budgets, works and organizes itself by focusing on WHO's own asset as a valued partner. Outward looking (external) and inward looking (internal) implications of the CCS, for the WHO Secretariat are addressed below:

6.3.1 External implications

1. WCO will develop an enabling approach, focussing on harmonization and integration of policy recommendations across groups, agencies and social sectors. It is necessary to shift the focus on technical assistance than that of budgetary support in strengthening the country's own capacity. More emphasis to be paid on policy dialogue and technical advice with MOH and partners.
2. Set up mechanism for periodic joint progress review of CCS implementation. WCO will give maximum priority to being focused, concentrating on priorities and ensuring that it delivers in time. A key change that needs to be made is moving from isolated programme management and input-related funding to integrated country work and expected results. A critical culture of health system performance will be promoted.
3. Shift to impact-ensuring practices in line with WHO's role as a specialized health agency of the UN. WHO will continue to provide top quality technical support as necessary, filling capacity gaps and concentrating on high value-added fields, such as, standards setting, quality assurance, stewardship mechanisms and tools, and economic functional evaluation.

4. WCO will review its human resource policies, budget allocations and structures in order to manage the policy dialogue and technical support work in order to improve relevance and impact.
5. Foster WHO-led technical activities to promote the corporate label of WHO. Efforts are needed to distinguish WHO from organizations whose prime function is to manage and disburse grants and loans.
6. Take inter-sectoral actions more seriously – engage with various stakeholders in foster health actions and policy decisions in other sectors that address the social determinants. Specific room will be made available for civil society institution with whom data and information will be widely shared.

6.3.2 Internal implications

1. Boost technical excellence in the Office, bring in international experience and strengthen health information and intelligence on Myanmar. The foremost priority for the WCO is reviewing its tool box. Expertise currently on board and what are the missing gaps in terms of the priority and the country's health challenges.
2. Upgrade internal and external communications, including website. Facilitating in communication provides an extra mile for productivity and performance of the office as a whole and extensively support in professional analytical work.
3. Align office structure with CCS implementation in the new context. Promote horizontal collaboration between programmes and reduce fragmentation.
4. Promote de-concentration of authority and responsible management with corresponding increased demands in terms of discipline and accountability for results.
5. Promote principles of programme management and maintain the culture of process monitoring in programme implementation.

6.4 Monitoring and evaluation of CCS

The Country Office in collaboration with the MOH and other stakeholders will undertake the review towards the end of the first biennium and towards the end of the CCS cycle. The focus of this assessment will be to assess WHO's contribution to the NHP, through implementation of the CCS strategic agenda.

As the strategic agenda laid out in the CCS, it is implemented through operational planning (work plans), the office shall also assess the degree of implementation of the CCS strategic agenda and consistency between the strategic priorities, main focus, and strategic approaches with the work plans for 2014-2015 and 2016-2017.

The findings and lesson learnt from these dual reviews will be used as an input into the development of next CCS and shared with other countries.

Annexes

Annex 1. Myanmar's Basic Statistics

Category	Year				
Economic	2007	2008	2009	2010 ^a	2011 ^a
GDP (\$ billion, current)	20.2	31.4	35.2	45.4	51.9
GDP per capita (\$, current) ^b	351.0	537.3	595.7	759.1	856.8
GDP growth (% in constant prices)	5.5	3.6	5.1	5.3	5.5
Agriculture, livestock, fishery, and forestry	8.0	3.4	4.7	4.4	4.4
Industry	21.8	3.0	5.0	6.3	6.5
Services ^a	12.9	4.2	5.8	6.1	6.3
Gross domestic investment (% of GDP)	...	...	...	...	...
Gross domestic saving (% of GDP)	...	...	...	...	...
Consumer price index (annual % change)	32.9	22.5	8.2	7.3	4.2
Liquidity (M2) (annual % change)	20.9	23.4	34.2	36.8	33.3
Overall fiscal surplus (deficit) (% of GDP)	(3.8)	(2.4)	(4.8)	(5.7)	(5.5)
Merchandise trade balance (% of GDP)	4.6	1.6	2.0	0.8	(0.5)
Current account balance (% of GDP)	0.6	(2.2)	(1.3)	(0.9)	(2.7)
External debt service (% of exports of goods and services)	4.6	5.1	4.3	3.1	3.9
External debt (% of GDP)	37.5	25.8	24.4	24.8	22.8
Poverty and Social	2000		2011		
Population (million)	50.1		60.6		
Population growth (annual % change)	2.0		1.3		[2009-2011]
Maternal mortality ratio (per 100,000 live births)	420.0	[1990]	240.0		[2008]
Infant mortality rate (below 1 year/per 1,000 live births)	79.0	[1990]	50.0		[2010]
Life expectancy at birth (years)	59.9		62.1		[2009]
Adult literacy (%)	89.9		92.0		[2009]
Primary school gross enrollment (%)	100.0	[1999]	116.0		[2009]
Child malnutrition (% below 5 years old)	34.3	[2005]	32.0		[2010]
Population below poverty line (%)	32.1	[2005]	25.6		[2010]
Population with access to safe water (%)	62.6	[2005]	69.4		[2010]
Population with access to sanitation (%)	67.3	[2005]	79.0		[2010]
Environment	2000		2010		
Carbon dioxide emissions (thousand metric tons)	4,276.0	[1990]	12,776.0		[2008]
Carbon dioxide emissions per capita (metric tons)	0.1	[1990]	0.3		[2008]
Forest area (million hectares)	34.9		31.8		
Urban population (% of total population)	28.0		33.9		

... = not available, () = negative, [] = latest year for which data are available, ADB = Asian Development Bank, ADF = Asian Development Fund, GDP = gross domestic product, M2 = broad money, OCR = ordinary capital resources.

^a Fiscal Year (or FY starts 1 April and ends 31 March, such that FY 2010 starts 1 April 2010 and ends 31 March 2011).

^b Estimates.

Sources: ADB 2012a; ADB 2012b; ADB 2012c; ADB 2011a; IMF 2012; MNPED, MOH, and UNICEF 2011; ESCAP, ADB, and UNDP 2012

Annex 2. Selected MDG Performance Indicators

	Myanmar		Indonesia		Malaysia		Thailand		Viet Nam	
	Earliest	Latest	Earliest	Latest	Earliest	Latest	Earliest	Latest	Earliest	Latest
	Year	Year	Year	Year	Year	Year	Year	Year	Year	Year
MDG 1: Eradicate Extreme Poverty and Hunger										
Poverty Incidence (% - \$1.25 PPP)	no data	no data ^a	54.3 (1990)	18.7 (2009)	1.6 (1992)	0.0 (2009)	5.5 (1992)	0.4 (2004)	63.7 (1993)	13.1 (2008)
Underweight Children Under 5 (%)	28.8 (1990)	29.6 (2003) ^b	29.8 (1992)	19.6 (2007)	no data (1999)	16.7 (1999)	16.3 (1993)	7.0 (2005)	36.9 (1992)	20.2 (2006)
Food Poverty Incidence (%)	47 (1990)	<5 (2010) ^c	16 (1990)	13 (2004)	<5 (1990)	<5 (2004)	26 (1990)	16 (2004)	31 (1990)	11 (2004)
MDG 2: Achieve Universal Primary Education										
Primary Level Net Enrollment (%)	84.7 (2005)	87.7 (2010)	98.3 (2000)	98.4 (2009)	97.7 (1990)	94.1 (2008)	93.2 (2006)	90.1 (2009)	95.8 (1990)	94.5 (2001)
Literacy of 15-24 Year Olds (%)	94.6 (2000)	95.8 (2010)	98.7 (2004)	99.5 (2008)	97.2 (2000)	98.5 (2009)	98.0 (2000)	98.1 (2005)	93.9 (1990)	96.9 (2009)
MDG 3: Promote Gender Equality and Empower Women										
Girls/Boys in Primary School (Ratio)	0.95 (1991)	0.93 (2010)	0.98 (1991)	0.97 (2009)	0.99 (1991)	0.99 (2008)	0.98 (1991)	0.98 (2009)	0.93 (1991)	0.95 (2001)
Girls/Boys in Secondary School (Ratio)	0.97 (1991)	0.96 (2010)	0.83 (1991)	0.81 (2008)	1.05 (1991)	1.07 (2008)	0.99 (1991)	1.09 (2009)	0.90 (1999)	0.92 (2001)
MDG 4: Reduce Child Mortality										
U5 Mortality Rate (per 1,000 live births)	112 (1990)	66 (2010)	86 (1990)	39 (2009)	18 (1990)	6 (2009)	32 (1990)	14 (2009)	55 (1990)	24 (2009)
Infant Mortality Rate (per 1,000 live births)	79 (1990)	50 (2010)	56 (1990)	30 (2009)	16 (1990)	6 (2009)	27 (1990)	12 (2009)	39 (1990)	20 (2009)
MDG 5: Improve Maternal Health										
Maternal Mortality Ratio (per 100,000 live births)	420 (1990)	240 (2008)	620 (1990)	240 (2008)	56 (1990)	31 (2008)	50 (1990)	48 (2008)	170 (1990)	56 (2008)
Births Attended by Skilled Personnel (%)	56 (1997)	78 (2010)	50 (1995)	75 (2008)	96 (1995)	99 (2007)	99 (2000)	99 (2009)	77 (1997)	88 (2006)
MDG 6: Combat HIV/AIDS, Malaria and Other Diseases										
HIV Prevalence (% of Population Aged 15-49)	0.2 (1990)	0.6 (2009)	<0.1 (2001)	0.2 (2009)	0.4 (2001)	0.5 (2009)	1.7 (2001)	1.3 (2009)	0.3 (2001)	0.4 (2009)
Malaria Incidence (per 100,000 population)	no data	7943 (2008)	no data	1645 (2008)	no data	75 (2008)	no data	55 (2008)	no data	no data
Tuberculosis Incidence (per 100,000)	393 (1990)	388 (2009)	88 (1990)	89 (2009)	127 (1990)	83 (2009)	137 (1990)	137 (2009)	204 (1990)	200 (2009)
Tuberculosis prevalence (per 100,000)	924 (1990)	597 (2009)	158 (1990)	131 (2009)	227 (1990)	109 (2009)	209 (1990)	189 (2009)	395 (1990)	333 (2009)
MDG 7: Ensure Environmental Sustainability										
Improved Drinking Water Source (%)	57 (1990)	69 (2010)	71 (1990)	80 (2008)	88 (1990)	100 (2008)	91 (1990)	98 (2008)	58 (1990)	94 (2008)
Improved Facility for Sanitation (%)	49 (1995)	79 (2010)	33 (1990)	52 (2008)	84 (1990)	96 (2008)	80 (1990)	96 (2008)	35 (1990)	75 (2008)
MDG 8: Develop a Global Partnership for Development										
Debt Service as % of Exports	18.2 (1990)	0.2 (2006)	25.6 (1990)	7.3 (2009)	10.6 (1990)	3.1 (2009)	11.4 (1990)	0.8 (2009)	3.2 (1996)	1.7 (2009)

MDG = Millennium Development Goal.

^a Based on IHLCS 2011, poverty headcount ratio under national poverty line is 25.6 in 2010.^b Based on IHLCS 2011, Severe cases account for 9.1, while moderate cases account for 32% in 2010.^c Based on IHLCS 2011, actual figure is 4.8%.

Sources: ADB 2012b; MDGI 2012; MNPED, MOH, and UNICEF 2011, WB-WDI 2012

References

1. Asian Development Bank, August 2012. *Myanmar in Transition- Opportunities and Challenges*, Manila, ADB.
2. Countdown to 2015, 2010 Report, *Maternal, Newborn & Child Survival – Myanmar*.
3. ESCAP, 2012, *Statistical Yearbook for Asia and Pacific 2012*. ESCAP, UN
4. GAVI Alliance, 2008, *GAVI Alliance Health System Strengthening (HSS) Proposal for Myanmar*, March 2008, GAVI
5. Ministry of Health, 2012, *Health in Myanmar 2012*, MOH, Nay Pyi Taw.
6. Ministry of Health, 2012, *Myanmar Multi Year Plan, (cMYP 2012-2016), EPI*, Nay Pyi Taw, DOH, MOH
7. Ministry of Health, 2012, *Health System Assessment for Universal Health Coverage*, October-November 2012. MOH, Nay Pyi Taw.
8. Ministry of Health, 2010, *Myanmar Health Statistics 2010*, Naypyitaw, MOH
9. Ministry of Health 2010, *Myanmar National Strategic Plan and Operational Plan on HIV and AIDS 2011-2015*, Nay Pyi Taw, MOH.
10. Ministry of Health 2010, *Five Year Strategic Plan for TB Control 2011-2015*, Nay Pyi Taw, MOH.
11. Ministry of Health 2012, *Supplement to the Five Year Strategic Plan for TB Control 2011-2015*, Nay Pyi Taw. MOH.
12. Ministry of Health 2010, *National Strategic Plan for Malaria Prevention and Control 2010-2015*, Nay Pyi Taw, MOH.
13. Ministry of Health 2010, *Strategic Framework for Artemisinin Resistance containment in Myanmar (MARC)*, 2011-2015, April 2011, Nay Pyi Taw, MOH.
14. Ministry of Health 2009, *Five Year Strategic Plan for Reproductive Health 2009-2013*, Nay Pyi Taw, MOH.
15. Myint, U 2011, *GDP Growth Rates: Myanmar and Selected Countries*; Paper presented at National Workshop on Reforms for Economic Development of Myanmar at MLCC, 19-27 August 2011, Nay Pyi Taw.
16. United Nations Children Fund, 2011, *Myanmar Multiple Indicator Cluster Survey, 2011 by Ministry of Planning and Economic Development, Ministry of Health and UNICEF*, Yangon, UNICEF
17. United Nations Country Team in Myanmar, 2011, *Achieving the Millennium Development Goals in Myanmar*, Thematic Analysis 2011, Yangon, UNDP.
18. United Nations Country Team in Myanmar, 2011, *UN Strategic Framework 2012-2015*, Yangon, UNDP
19. United Nations Development Programme, September 2006, *Impact of the UNDP Human Development Initiative in Myanmar, 1994-2006*, Yangon, UNDP.
20. United Nations Development Programme, June 2011, *Integrated Household Living conditions Survey in Myanmar (2009-2010)*, Technical Report, Yangon, UNDP.
21. United Nations Development Programme, June 2011, *Integrated Household Living Conditions Survey in Myanmar (2009-2011)*, Poverty Profile, Yangon, UNDP.
22. United Nations Development Programme, June 2011, *Integrated Household Living Conditions Survey in Myanmar (2009-2010)*, Poverty Dynamic Report, Yangon, UNDP.
23. United Nations Development Programme, June 2011, *Integrated Household Living Conditions Survey in Myanmar (2009-2010)*, MDG Data Report, Yangon, UNDP.
24. United Nations Office of Project Services, 2010, *Strategic Review of Decentralized Funds Flow Modalities in the Health Sector in Myanmar*, (Independent Consultant Report) Yangon.
25. United Nations Population Fund, 1999, *A Reproductive Health Needs Assessment in Myanmar*, Yangon, UNFPA.
26. United Nations Population Fund, 2010, *Report on Situation Analysis of Population and Development, Reproductive Health and Gender in Myanmar*, Yangon, UNFPA.
27. World Health Organization, 2012, *WHO Reform, A65/5*, Geneva, WHO.
28. World Health Organization, 2012, *12th General Programme of Work (GPW) and Proposed Programme Budget 2014-2015*, SEA/RC65/6, New Delhi, SEARO/WHO.
29. World Health Organization, *Medium-Term Strategic Plan 2008-2013*, Geneva, WHO.
30. World Health Organization, 2011, *Medium Term Strategic Plan 2008-2013 – Interim Assessment – WHO/PRP/11.1 2011*, Geneva, WHO
31. World Health Organization, 2008, *WHO Country Cooperation Strategy 2008-2011, Myanmar*, Yangon, WHO.
32. World Health Organization, 2010, *Official Development Assistance (ODA) for Health to Myanmar, 2010* Geneva, WHO
33. World Health Organization, 2010, *Malaria in Greater Mekong Sub-region: Regional and Country Profiles*, New Delhi, SEARO/WHO
34. World Health Organization, 2012 *World Malaria Report 2012*, Geneva, WHO
35. World Health Organization, 2012, *Review of the National Tuberculosis Programme*, November 2011, Yangon, WHO
36. World Health Organization, 2011, *Non-communicable Diseases – Country Profiles*, Geneva, WHO.
37. World Health Organization, 2008, *Health System Working Paper: Health Systems Barriers to Improving Immunization and MCH Coverage in Myanmar including HSS Framework*, January 2008, Yangon, WHO
38. World Health Organization, 2010, *WHO Country Cooperation Strategies*, Guide 2010, Geneva, WHO HQ
39. World Health Organization, 2010, *Improvement of FFM Performance - Report*, WHO, Myanmar.
40. World Health Organization, 2007, *WHO Country Focus Policy, RoadMap 2006-2013*, Geneva, WHO

Abbreviations

3DF	3 Diseases Fund	IMMCI	Integrated management of maternal and childhood illness
AFP	Acute flaccid paralysis	IHLCA	Integrated Household Living Condition Assessment
AI	Avian Influenza	IHR	International Health Regulations
AMW	Auxiliary midwife	IDD	iodine deficiency disorders
ART	Anti-retroviral therapy	IMR	Infant Mortality Rate
ARV	Antiretroviral	IDA	Iron deficiency disorder
BHS	Basic Health Staff	JICA	Japan International Cooperation Agency
CEU	Central Epidemiological Unit	LHV	Lady Health Visitor
CNR	case-notification rate	LCS	local cost subsidy
CCS	Country Cooperation Strategy	MDR-TB	Multi-drug resistant tuberculosis
CSO	Central Statistical Organization	MEP	Management Effectiveness Programme
CVD	Cardiovascular disease	MW	Midwife
DOH	Department of Health	MNPED	Ministry of National Planning, Economic And Development
DOTS	Directly Observed Treatment Short-course (for tuberculosis)	MOH	Ministry of Health
DST	Drug Sensitivity Test	MoU	Memorandum of Understanding
EC	European Commission	MICS	Multiple indicator cluster survey
ECE	Early Childhood Education	MMCWA	Myanmar Maternal and Child Welfare Association
EPI	Expanded Programme on Immunization	MDGs	Millennium Development Goals
GDP	Gross Domestic Product	MRCS	Myanmar Red Cross Society
GPW	General Programme of Work	NAP	National AIDS Programme
GFATM	Global Fund against AIDS, Tuberculosis and Malaria	NEQAS	National External Quality Assessment Scheme
GAVI	Global Alliance for Vaccines and Immunization	NCDs	Non-communicable diseases
GMP	Good manufacturing practices	NGO	Non-Governmental Organization
GPN	Global Private Network	NIPPP	National Influenza Pandemic Preparedness Plan
GOM	Government of Myanmar	NMR	Neonatal Mortality Rate
GSM	Global Management System	NSP	National Strategic Plan
HA	Health Assistant	NSS	New sputum smear
HMIS	Health Management Information System	NTP	National Tuberculosis Programme
HIV/AIDS	Human immunodeficiency virus/acquired Immunodeficiency syndrome	ODA	Official Development Assistance
ICC	Interagency Coordination Committee (for GAVI)	PMCT	Prevention of Mother-to-child transmission
ICD-10	International Statistical Classification of Diseases	PHC	Primary Health Care
IEC	Information education and communication	PEM	Protein energy malnutrition
INGO	International Non-Governmental Organization	PHS	Public Health Supervisor
		RHCs	Rural Health Centers
		TB	Tuberculosis
		TMO	Township Medical Officer
		VPD	Vaccine Preventable Diseases
		WCO	WHO Country Office