

The work of WHO in Myanmar

4.1 Brief history of WHO in Myanmar

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

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

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

4.2 Country Cooperation Strategy 2002-2005

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

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

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

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

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

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

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

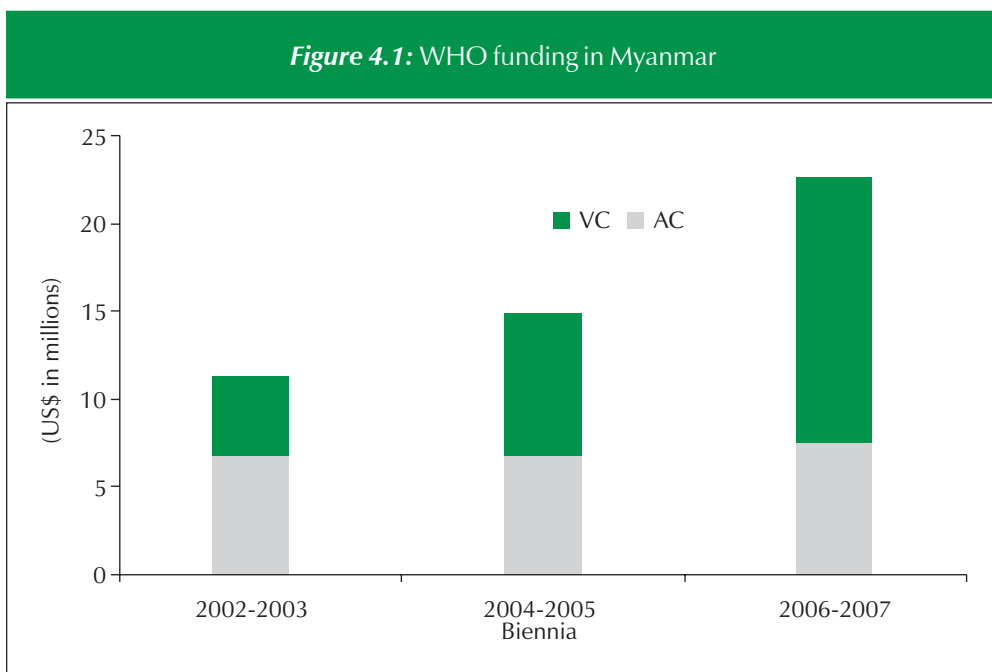
Major risk factors hazardous for health: The major emphasis here would be to ensure safe blood supply and reduce tobacco consumption, both key risk factors to health. Improved food safety would also be supported.

4.3 Financing the WHO-Myanmar collaborative programme

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

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

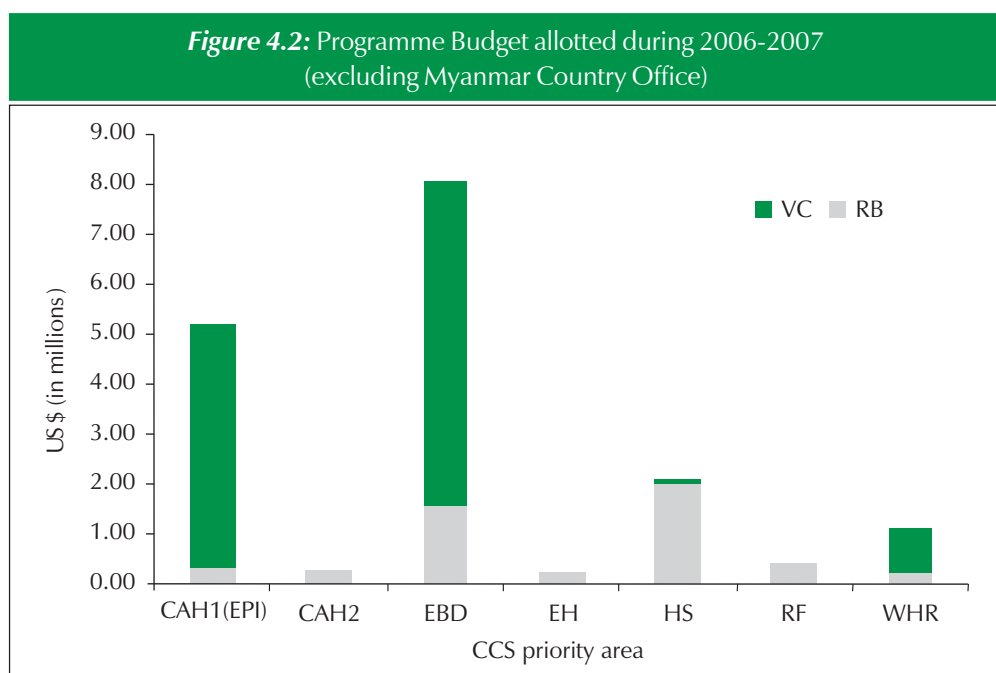
After the termination of the GFATM grants for TB (Round 2) and malaria and HIV/AIDS (Round 3) in August 2005, the 3Diseases Fund provided a direct grant of US\$ 1.7 million to WHO vide the Bridge Fund to cover the critical gap that ensued after the sudden termination of GFATM and before the 3DF became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



Source: VC allotments from AMS Grant Management System.

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

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



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

4.4 WHO Staff to implement the collaborative programme

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

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

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

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

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

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

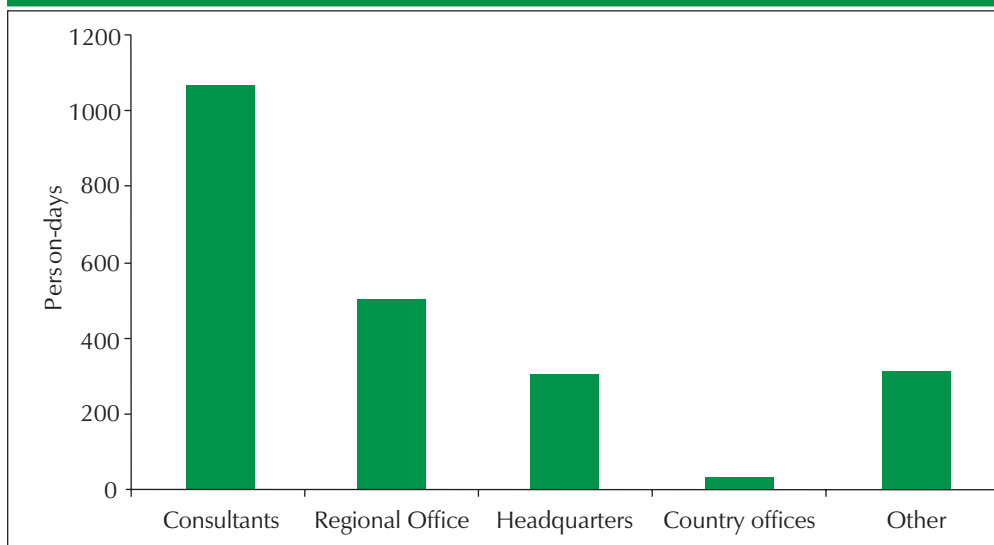
Table 4.2: Staffing trends

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

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

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

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



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

4.6 Conclusions

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

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

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