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## **FOREWORD**

In early 1999 the Director General of WHO initiated the development of a corporate strategy, which comprises a process of organizational development for the WHO secretariat. It is designed to meet the challenges posed by the significant changes in international health since the past decade. The strategy is inspired by the vision and values of Health for All, and is designed to enable WHO to make the greatest possible contribution to world health.

The elaboration of the corporate strategy should be seen as a process, which is meant to give rise to a number of different products. Apart from developing the individual WHO Country Cooperation Strategy (CCS) documents for each Member State, the corporate strategy will be a determinant for the next general program of work, which will provide a policy framework for the work of the Secretariat during the period 2002 - 2005. The policy framework sets out new emphases, strategic directions, core functions and criteria for defining specific priorities for the Secretariat. The proposed program budget 2002-2003 will be a reflection of the above.

In line with the guidelines and approaches suggested by the WHO Corporate Strategy, Myanmar embarked in the development of a WHO Country Cooperation Strategy for the period 2002 – 2005 during the months of January-June 2000. This provided an opportunity to rethink and prioritize the work of WHO in the country. Moreover, it allowed focusing on the collaboration and coordination with other development partners.

The formulation of the Myanmar WHO CCS involved extensive consultation and preparation at both country and regional offices of WHO prior to having the joint mission itself during the period 17 – 27 June 2000. The CCS mission team composed of three professionals from WHO SEARO and one from WHO HQ, who worked in close collaboration with the WHO country office staff; namely WHO Representative, the Public Health Administrator, two National Professional Officers and one CCS Consultant recruited to prepare the background document and serve as rapporteur.

During the CCS mission a National CCS Seminar was held in Yangon, 19–22 June 2000, attended by participants from the Ministry of Health, WHO and a number of interested partners operating in the field of health in Myanmar. The main outcome of this seminar was the formulation of the first draft of the Myanmar WHO Country Cooperation Strategy for the period 2002-2005. WHO's role, comparative advantage and core functions were reviewed and defined in the context of the current national health situation. Priority areas of work for the period 2002-2005 were identified. The WHO country office undertook the work of finalizing the draft document of the Myanmar WHO CCS.

WHO wishes to acknowledge the valuable contribution made by all partners throughout this process and expresses its sincere thanks for the time and inputs provided by representatives from the Ministry of Health, UN agencies in Myanmar, national and international NGOs and other stakeholders interested in the field of health.

**April 2001**

**Dr Agostino Borra  
WHO Representative to Myanmar**

## EXECUTIVE SUMMARY

The World Health Organization's Country Cooperation Strategy (CCS) for Myanmar, 2002-2005, aims to provide a basis for the detailed planning and implementation of WHO collaborative programmes and work plans and also for the prioritization of resource mobilization from external sources. The WHO CCS will also be shared with all partners in health for coordination purposes. It has enabled to identify priority areas in health, to formulate challenges and opportunities and to plan the WHO functional role in the country according to each priority area. The development of the WHO CCS for Myanmar involved not only WHO and the Ministry of Health, but also other U.N. agencies and the partners, who actively participated in the National CCS Seminar. This was an innovative approach which should facilitate further planning, collaboration, coordination and implementation of activities in health of all partners.

WHO has identified the following priority areas for collaboration over the period 2002-2005:

- **health systems;**
- **excess burden of disease;**
- **women's health / reproductive health;**
- **child and adolescent health;**
- **healthy environment;** and
- **major risk factors hazardous to health.**

A considerable emphasis of WHO's Country Cooperation Strategy in Myanmar is placed on ***technical and policy support, building and sustaining partnerships, advocacy, capacity building, evaluation, dissemination of scientific information, introduction and testing of new technologies, tools and guidelines, standard setting and logistics.***

The strategic agenda describes the way in which WHO, on the basis of its six core functions, will work to support the identified priority areas. This will then constitute the basis for the budgetary planning exercise for the biennia 2002-2003 and 2004-2005.

## INTRODUCTION

Significant political, socio-economic, demographic and epidemiological changes have occurred globally during the past decade. WHO needs to ensure that it continues to make the greatest possible contribution to world health within this changing context. Thus, there is a need to reform the way WHO carries out its work.

Launched by Dr Gro Harlem Brundtland, the Director-General of WHO, in 1999, the WHO Corporate Strategy provides a strategic tool for WHO to do its work better, do it more effectively and efficiently through collective and partnership action. The WHO Corporate Strategy is built upon the mission as enshrined in its constitution and the values and principles of the Global Health for All Policy reaffirmed by the World Health Assembly in 1998. It identifies four WHO strategic directions. The 105 session of the WHO Executive Board (EB) has endorsed the WHO Corporate Strategy (WHO EB 105/3, January 2000).

Based upon the Corporate Strategy and the regional and country challenges and directions, WHO country offices in the South-East Asia Region are now requested to develop a Country Cooperation Strategy (CCS) for the period 2002-2005. The Strategy (CCS) aims to set out the strategic health sector agenda and priority areas for WHO's support in the next four year period. The main purpose of the CCS is to enable WHO to respond to country needs more effectively and more efficiently (EB 105/2). In the process of developing the CCS, the WHO country office has worked closely with a Regional level team of 3 professionals assigned specifically to Myanmar. A detailed background paper analysing the national health situation and past WHO collaborative programmes was developed jointly by the country office staff and the regional level team during the period February – May 2000. During the second half of June 2000, a CCS mission was undertaken by 1 WHO HQ staff with health systems expertise and by the 3 professionals of the WHO SEARO. Work was carried out together with the WHO country office staff – the WHO Representative, Medical Officer (Public Health Administrator), two National Professional Officers and one Consultant. The objectives and expected outcomes of the mission in preparation of the CCS and methods of work for its development were as follows:

### **Objectives:**

1. To understand key health and development policy issues.
2. To have an overview of support provided by other development partners.
3. To examine WHO's current strategy and programme of work.
4. To identify processes and mechanisms for the organization to work as one WHO.

### **Expected Outcomes:**

An outline of the country's health and development policy issues and health priorities including support provided by other health partners. WHO's current strategy, programme of work, challenges and opportunities offered to WHO in the country. The priority areas for WHO's support in 2002-2005.

### **The Method of Work:**

From the outset, the formulation of the Myanmar WHO CCS involved all levels of WHO i.e. Country Office, Regional Office and HQ. Preparatory work started in January 2000. An outline for the plan of work was developed following a joint planning meeting between country and regional team members and subsequently through inputs from HQ, CO and RO, coordinated by the regional team. One very important feature of the Myanmar CCS mission was the in-depth country participation through a 4 day CCS seminar (19-22 June 2000). This was a strategically important process in the view of assuring country ownership and contribution.

The seminar was inaugurated by His Excellency, Prof. Mya Oo, Deputy Minister for Health and attended by 45 participants consisting of high level national officials, UN agencies (UNDP, UNFPA, UNICEF & UNAIDS), bilateral agencies (AUSAID, JICA), International NGOs (Population Council, AMDA) and National NGOs (MMA, MMCWA and MNCWA). The discussions during the seminar and its outcomes (especially identification of criteria for selection of priorities and health problems/issues identified for the period 2002-2005) were found to be extremely useful in developing the WHO CCS in Myanmar.

# 1

## NATIONAL HEALTH SITUATION

Myanmar is a country of 46.4 million people<sup>1</sup> with natural resources including land, water, natural gas, coal, petroleum, mineral and marine resources. Uplifting of health, fitness and education standards of the entire nation are among the twelve socio-economic development objectives stated by the Government.

The country has undergone considerable changes from a centralized to market oriented system since 1988. Economic changes have lead to a market-oriented economy and the creation of more employment opportunities but also increased population migration (mostly internal) which has health implications due to social and environmental changes. The population pyramid of Myanmar highlights a 'young population' where 33% are under 15 years of age.

As the country strives to attain its health objectives, positive trends in various health indicators are found as presented in Table1. The Central Statistical Office (CSO) estimates life expectancy at birth combined for both sexes at 62.6 years in 1997. In the area of child health, progress has been achieved primarily through the strengthening of Basic Health Services for all children with special focus on under-served areas. Major causes of under 5 mortality in Myanmar are diarrhoea, acute respiratory infections, measles, malnutrition, brain infections (non specific & TB), cerebral malaria, premature delivery and birth injuries. Infant mortality rate (IMR) and under 5 mortality rate (U5MR) have shown declining trends. Despite the linear decline in the utilization of institutional services (Statistical Year Book, 1998); there is an increasing trend in the coverage of antenatal and delivery services by trained personnel including treatment of childhood diseases. This may mainly be due to the domiciliary services provided by midwife and nurses, who provide basic services to the poor, free of charge. High maternal mortality ratio and high percentage of low birth weight, however, still remain a serious concern. Evidence suggests a difference in the health status of people living in urban and rural areas. Infant and child mortality rates and malnutrition outcomes are comparatively higher and access to health services generally lower in rural areas.

In the area of infectious diseases, malaria, tuberculosis and HIV/AIDS are of national concern. However, with the epidemiological transition, non-communicable diseases may, in the near future, cause a double burden of disease in Myanmar. The key issue for further improvement of the national health situation is to strengthen the health system, with special approaches to urban, rural and border areas.

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<sup>1</sup> Central Statistical Office, Yangon, Myanmar (1997)

**Table (1) Trends in Health Outcomes and Indicators over time, 1990-1997**

SR. NO.	INDICATORS	STATUS		
		1990	1995	1997
1.	Infant mortality rate (per 1000 live births)	94 <sup>a</sup>	-	74.7 <sup>d</sup> 63 <sup>c</sup>
2.	Under five mortality rate (per 1000 live births)	138 <sup>a</sup>	-	105.8 <sup>d</sup>
3.	Total fertility rate (urban) <sup>g</sup>	3.56	3.49	3.45
4.	Maternal mortality Ratio (per 100,000 live births)	-	-	230 <sup>e</sup> 580 <sup>f</sup>
5.	Births with some prenatal medical care (%)	-	61 <sup>a</sup>	76 <sup>d</sup>
6.	Women using contraception (%) <sup>d</sup>	17	22	46.9
7.	Children less than 3 yrs old with moderate and severe malnutrition (%) <sup>b</sup>	37	40	35
8.	Children with complete vaccination for (%) <sup>b</sup>	69	75	80
	◆ DPT3	68	75	81
	◆ Measles	70	75	82
	◆ Polio			
9.	Births attended by a trained attendant (%) <sup>d</sup>	-	46	56
10.	Cases of ARI medically treated (%)	-	26	56
11.	Cases of diarrhoea medically treated (%)	-	24	68
12.	Severe malnutrition among children under three	-	16	12
13.	Moderate and severe malnutrition among children under three	-	40	36
14.	Proportion of births weighing less than 2500 gms <sup>h</sup>	24	-	-

<sup>a</sup>Population Change and Fertility Survey (1991), Dept. of Population.

<sup>b</sup> UNICEF estimates from MICS

<sup>c</sup> Multiple Indicator Cluster Survey, 1997, Dept. of Health Planning

<sup>d</sup>Fertility and Reproductive Health Survey (1997), Dept. of Population

<sup>e</sup>FRHS 1997, The State of World's Children 2000 (UNICEF), UNFPA and MMCWA

<sup>f</sup> Revised 1990 estimates of MMR (A new approach by WHO and UNICEF – 1996)

<sup>g</sup> Statistical Year Book 1998, Gov't of the Union of Myanmar, Central Statistical Organization, Yangon

<sup>h</sup> National Nutrition Survey, 1991

While the government has set up a fairly widespread system of health care providers, utilization tends to be relatively low. It is interesting to note that while treatment at Traditional Medical Centers has risen more than four fold, the general usage of hospitals and dispensaries in 1996-1997 had fallen to less than 20% of the levels recorded 10 years before (Statistical Year Book, 1998). In depth interview with national experts indicates that this could be due the combined effects of three factors, i.e. the increasing private sector activity, the introduction of user fees in public institutions and inadequate responsiveness of the health system.

## **National Health System**

The last decade has been characterized by a number of political and economic changes, which have contributed to improving the overall health of the population, as shown by the differences in mortality rates of children and infants between 1990 and 1997, and the steady increase of life expectancy. Since poverty is a major cause of ill-health and reduces productivity of the work force, a major contributor to the economy, the challenge for Myanmar is therefore to ensure (a) adequate investment in health, especially for the poor and (b) fair distribution of the benefits resulting from economic growth.

A significant program of market-oriented economic reforms was introduced in Myanmar after the State Law and Order Restoration Council (SLORC) assumed power in late 1988 and has resulted in high GDP growth rates in the mid-1990s. However, in recent years economic activity has slowed down and foreign reserves decreased. To compensate for the decline in tax revenue and reduce the budget deficit, the government has cut down on capital and public expenditures. There has also been an expansion of the private sector. Efforts are being made to develop a supportive and regulatory mechanism for the private sector.

In 1990, a high level inter-ministerial and policy making body for health and health related matters, the National Health Committee (NHC), was set up by the government. The Secretary-1 of the State Peace and Development Council (SPDC)<sup>1</sup> chairs this Committee. It developed the still prevailing National Health Policy, which contains fifteen broad policy directions (Annex 1), some of which call for health sector reforms, especially as regards the reorganization and management of health services (including the private sector, as part of health systems decentralization), as well as health care financing.

### **Health Systems Performance**

Myanmar's health infrastructure system consists of 1,412 rural health centers, 348 maternal and child health centers, 359 dispensaries, 742 hospitals with 30,254 beds and over 14,350 doctors and 12,642 nurses. For every 10,000 people, there are approximately 6 beds in the government hospital, 3 doctors and 3 nurses. There is one government hospital available for approximately 100,000 population. In addition, there are 200 traditional medicine clinics and 8 traditional medicine hospitals. Access to health services is estimated at 80 %. Available data on health financing (Statistical Yearbook, Central Statistical Organization, Myanmar, 1998) suggest that per capita annual expenditure on medical care is Kyatts 570.- (approximately US\$ 2.- in 1998). The World health Report 2000 (WHO Geneva) indicates an annual per capita health expenditure of 78.- international dollars (1997) and a total expenditure on health of 2.6 % of GDP. Insufficient financial and foreign exchange resources have resulted in, among others, an inadequate supply of equipment and essential drugs. The performance of the public sector health system, its organization, management and financing, has been affected by a number of factors. The following issues, which cover the four main functions of the health system, need to be addressed.

#### **(a) Stewardship**

The government plays several roles within the health sector, which cover the planning and regulation of health care delivery, organizing, coordinating and financing health services as well as producing human resources and consumables. The following

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<sup>1</sup> The State Law and Order Restoration Council (SLORC) was re-organized and replaced by the SPDC in 1998.

aspects need to be addressed: (i) health sector reforms; (ii) centralized health system and the national health planning; (iii) input-based rather than result/performance oriented planning process; (iv) mechanisms regulating private sector activity; and (v) health legislation and management information system.

(b) Health Financing

Although there has been an increase in GDP, the health sector is not receiving a proportionate share. The proportion of out of pocket expenditure is 69.9%, although attempts are being made to provide safety net for the poor. The sustainability of alternative financing schemes, including a Social Security Scheme, need to be monitored in the light of rising costs due to the introduction of new technologies.

(c) Resources Development

There is a need to correct the imbalance of skills mix of health personnel characterized by the low ratio of nurses, midwives and basic health personnel to doctors. While an incentive system has been put in place for health personnel in remote areas, there is a need to ensure availability of equipment and supplies. The development of human resources relating to management needs to be strengthened and measures to assess performance require further development. The insufficient local production of consumables and shortage of essential drugs within the public and private sector need to be addressed. The complexity in drug management due to the multiplicity of providers and financial sources would also benefit from a review.

(d) Provision of Health Services:

There is need for coordination among health care providers from the Ministry of Health, other sector Ministries, Social Security and NGOs. The private sector services are and will play an increasing role in the future, thus creating the need for regulatory mechanisms in terms of service provision, costs and quality of care.

## **Partnerships**

External assistance is one of the major sources of financing in the health sector. Historically, the support of various partners, especially the UN agencies on health development activities in Myanmar started in the late 1940s. In the last decade of the 20<sup>th</sup> century, the pattern and mechanism of assistance from various partners changed. Major bilateral donors decided to scale down their assistance but a number of international NGOs came onto the scene. In 1996, external assistance had increased to US\$ 17.16 million, as a result of assistance from the international NGO partners. In addition, some UN agencies have developed new modalities for their assistance in the area of health development. Among the multilateral donors, WHO, UNICEF and UNDP are the major contributors. As one of the countries of the Association of South-East Asia Nations (ASEAN), Myanmar has adopted the activities of the ASEAN Medium Term Plan of Collaboration in Health and Nutrition 1998-2002, which constitutes a basis for partnerships in health between ASEAN countries. The main areas in which both international and national partners contribute are the following: (i) infectious diseases control (emphasis on malaria, vaccine preventable diseases, HIV/AIDS/STDs, tuberculosis, leprosy), (ii) reproductive health, (iii) health sector reform, (iv) anemia & malnutrition, (v) water & sanitation, (vi) health system development including quality of care and health manpower development, (vii) safe blood, (viii) accidents/disabilities, (ix) snake bite, (x) Information Education Communication, (xi) life style/tobacco, and (xii) health of the elderly. Collaboration and assistance from international NGOs has

increased in the areas of maternal and child health, primary health care, environmental sanitation, rehabilitation of the disabled and handicapped and prevention and control of communicable diseases.

The government, especially the Ministry of Health, recognizes WHO as the main technical lead agency in health. WHO's support to the government comprises support to national health development efforts at the country level; inter-country cooperation at the regional level; and inter-regional cooperation at the global level. WHO provides regular budget resources and extra budgetary funds for the above-mentioned support. A joint Government / WHO Collaborative Programme Co-ordinating Committee headed by the Deputy Minister of Health is responsible for planning, coordinating and evaluating WHO collaborative programmes. The results of the analysis of WHO's country programme during the past three biennia is presented in Chapter 2. The MoH and WHO jointly conducted an Aid Coordination Workshop in Myanmar in January 1998 and recommended regular coordination mechanism among the partners. While the MoH leads the role in co-ordination, WHO provides technical backstopping for this process. During the CCS seminar (June 2000), the possibility of holding once a year aid coordination seminar involving all present and potential partners was discussed as well as the introduction of monitoring meetings (at least twice a year). The joint Government / WHO Collaborative Programme Co-ordinating Committee, responsible for planning, coordinating and evaluating WHO collaborative programmes, is scheduled to meet every six months to monitor and evaluate progress. In the case of collaboration with NGOs, after completing administrative formalities within the Government structure, a Memorandum of Understanding (MOU) may be signed between the concerned health department and respective NGO.

The Co-ordination Division of the Department of Health Planning, Ministry of Health, is responsible for aid co-ordination among partners for health development in Myanmar. The co-ordination of the work of local NGOs is handled by this division and by the International Health Division (MOH) for the INGOs and bi-laterals. Partners involved in the field of health are listed in Annex 2. The International Health Division (IHD) of the Ministry of Health is the central coordinating body between donor agencies and various departments providing health care under the Ministry. In the case of external assistance from UN agencies, the IHD, the respective UN agency and the Foreign Economic Relations Department (FERD) or Ministry of Foreign Affairs (MOFA) communicate among them for co-ordination purposes.

External assistance represents 85.8 % of government health expenditure. There is a need to maximise the utilisation of existing resources. In principle, the Government has the basic responsibility to co-ordinate partners' assistance. Linkages between the partners include joint planning and joint budgeting exercises. As international assistance is one of the major sources of health care financing, it needs to be strengthened to mobilize more resources, ensure proper allocation according to national priority needs and monitor the effective and timely utilization of these resources.

## **Major Health Challenges and Key Issues for Health**

Analysis of the overall health situation suggests that **communicable diseases** remain major health problems that constitute excess burden on the people, health services and on the economy of the country. These indicate the need for interventions that aim at modifying life style and environment. **Common childhood diseases** particularly diarrhoea and acute respiratory infection are other areas of public health concern which require an integrated response. **Malaria** is a major concern for almost 60% of people of the country who live in high and moderate risk areas (National Malaria Programme, MOH, 1999). In 1998 alone malaria morbidity rate was 12 per 1000 and mortality rate was 6.7 per 1000; the proportion of malaria cases among out-patients was 9.4% and 16.2% of in-patients were attributable to malaria. **Dengue/DHF** is also becoming an increasing problem, a major epidemic occurred in 1998 with 13,000 cases (Report on Technical Implementation of WHO Collaborative Programme, Myanmar, 1998-1999). **TB** compounded by **HIV/AIDS** has reemerged as a major health problem particularly in the border areas. 5% of TB cases were HIV positive and 60-80% of AIDS patients had TB. With an estimated 1.6% of the population infected every year, about 100,000 people progress to develop tuberculosis. Over 29,000 new TB cases were reported and an estimated number of people infected with HIV was over 530,000 in 1999. To cope with the TB problem, Myanmar adopted DOTS in 1997. As of June 2000, 71 % of townships and 85 % of the population are covered by DOTS strategy. The **polio eradication** programme has made significant progress and is on track to meet the target. **Leprosy elimination** has become an achievable goal by the end of 2003 after intensified social mobilization efforts discovered more hidden cases and put them under complete MDT coverage. With longer life expectancy, major NCDs (cardiovascular diseases, cancer, diabetes, chronic respiratory diseases etc.) are emerging problems.

**Maternal health** is another area of health concern. The maternal mortality ratio in rural areas is significantly higher than in urban areas (CSO, 1998). Pregnancy-related deaths constitute the leading cause of loss of healthy lives among women of reproductive age. According to the on-going study on maternal mortality by MOH and UNFPA, 57% of maternal deaths occur at home and 4% on the way to the hospital; around 37% of deaths occur in public hospitals. Unsafe abortion, haemorrhage, sepsis and eclampsia constitute major causes of maternal deaths (Table 2).

Recognizing the pivotal role of health for sustainable development of the country, the MOH is committed to strengthening the **health system** to meet the needs of the people. Making "health" a crucial element to human development and ensuring equitable access to essential primary health services especially in the remote and border areas and for the poor are considered as key areas of concern.

Extensive **research in health** has been conducted by the Department of Medical Research, MOH. The key issue to be addressed is greater need in utilization of the research results to improve programme and health systems performance.

Table (2): Distribution of maternal deaths by cause in selected countries of the Region

Cause	Per cent of all maternal deaths				
	India (1994)	Myanmar (1989-90)	Nepal (1997-98)	Sri Lanka (1995)	Thailand (1996)
	(67) National survey in rural areas	(14) Study of 18 hospitals	(68) Community survey	(69) Health services data	(70) Health services data
Haemorrhage	23.7	14.6	36.4	20.1	26.2
Sepsis	10.6	12.9	8.4	9.3	1.7
Hypertensive disorders of pregnancy and eclampsia	13.1	10.8	9.8	15.7	8.0
Obstructed labour	6.4 <sup>a</sup>	-	11.4 <sup>b</sup>	-	37.1
Unsafe abortion	12.6	38.3	3.8	4.5	16.9
Other direct causes	-	-	-	5.0	6.8
All indirect obstetric causes	-	10.3	23.5	45.0	3.4
Anaemia	19.3	-	2.3	-	-
Other indirect causes	-	-	21.2 <sup>c</sup>	-	-
Unknown/non-classifiable causes	14.2	13.1	6.8	-	-

<sup>a</sup> Represents deaths due to malposition of the baby.

<sup>b</sup> Includes rupture of the uterus following obstructed labour.

<sup>c</sup> Includes 13% from infectious and parasitic diseases and 3% from suicide.

(source: Women of South-East Asia – A Health Profile. WHO SEARO, 2000)

To address **poverty and health**, the Ministry of Progress of Border Areas and National Races and Development Affairs has taken responsibility for health care of ethnic minority groups residing in border areas of the country since 1989.

**Nutrition** is an area that needs greater attention. Evidence drawn from the National Nutrition Center (NNC) surveys suggest that PEM under three years of age is 30.6%; IDD-visible goiter rate among 5-11 years is 33.1%; iron deficiency anaemia in pregnant women is 58%; vit A deficiency-Bitot's spot prevalence among under five is 0.4% and low birth weight in new born babies is 24%.

**Traditional medicine** is formally recognized and practiced as an integral part of the health services at different level. Training and research projects are carried out on various diseases. However, evaluation of cost-effectiveness of traditional medicine interventions would be required.

**Water supply and sanitation** are improving and current figures show rural water supply to be 42.2% and urban 70.1%. 43% have access to sanitation in rural and 70.5% in urban areas. The challenges to the provision of safe drinking water include the coverage, water quality and the further promotion of inter-sector co-ordination and collaboration.

Considering that **communities' contributions** in the spirit of voluntarism provided over 66% of the inputs in the form of funding, labor and transport, the community ownership should be encouraged through their involvement in programme

decision-making and monitoring at local level. The key issue here includes decentralization and fairer distribution of services in marginalized area.

With the increasing trend towards privatization and market-oriented mechanisms, the poor are at a greater disadvantage. Evidence of ***inequities in health*** is clearly shown in the difference in health status between populations living in urban and rural areas (National Nutrition Survey, 1991, FRH survey, 1997 and Statistical Year Book, 1998). The key issue is the need for public sector to protect the interest of the poor.

# 2

## WHO COLLABORATIVE PROGRAMMES

During the current and past two biennia, WHO Collaborative Programmes in Myanmar have embraced a broad-based approach towards meeting the national health needs. The major thrust of WHO Collaborative Programmes have been the priorities within the six broad areas of the National Health Plan: (1) community health care, (2) disease control, (3) hospital care, (4) environmental health, (5) health systems development, and (6) organization and management. In general, these collaborative programmes are in line with the National Health Policy (1993) and the National Health Plan (1996-2001).

Due to the country's limited access to external funding sources, the number of projects supported by WHO collaborative programmes has not been reduced; therefore, WHO's support could not be shifted from the "full menu approach" to a "selected priority areas approach". Consequently, the support provided through WHO collaborative programmes did not fully match with the priority ranking order of the health problems. For example, malaria stood out as the highest ranking problem in the last five NHPlan since 1978, but malaria was ranked 5<sup>th</sup> in terms of WHO collaborative programme under the regular budget. Similarly, tuberculosis, the second highest ranking since 1986, is ranked 21<sup>st</sup> in WHO collaborative programme (1994-1995) and 12<sup>th</sup> in 1996-1997. The third highest-ranking priority (ie. HIV/AIDS, diarrhea and dysentery) ranked 16<sup>th</sup> and 24<sup>th</sup> respectively in 1994-1995 WHO collaborative programmes.

Although spread across 40 projects or plans of action, WHO collaborative programmes have had catalytic role in producing some strategically important results. A paper on "Myanmar: Main Health Policy Issues and Country Strategy", developed by WHO ICO Mission in collaboration with senior officials of Department of Health Planning (1997), serves as the background paper in matters relating to future health policy and health development in the country. Another strategic outcome was the establishment of a WHO-Government coordination mechanism, which meets formally or otherwise, every six months. A flexible, but strategic approach, such as this one, has been instrumental in involving decision-making various levels in planning and implementing WHO collaborative programmes.

Under the area of *eradication of specific communicable diseases*, the successful implementation of National Immunization Days (NIDs) and sub-national NIDs for polio eradication have taken place and a National Certification Committee established. WHO has also provided assistance in the implementation of multi-drug therapy (MDT) strategy for the elimination of leprosy. The prevalence rate has dropped from 53.4/10,000 (1987) to 2.5/10,000 by the end of December 1998.

The *prevention and control of specific communicable diseases* continues to receive support from WHO. Efforts to reduce the dengue/DHF case fatality rate has made continued progress with the establishment of three dengue training wards using standard sets of equipment sent by WHO. The control of malaria has been identified as

a priority programme and is implemented under the primary health care approach. The Roll Back Malaria (RBM) Initiative has been endorsed and a plan of action for resource mobilization developed with the collaboration of the MoH, WHO, UNICEF and UNDP to support its implementation at local level. WHO has facilitated an inter-country collaborative programme for the control of border malaria (bilateral and multilateral approach). WHO and UNICEF work jointly under the RBM Mekong Project with countries in the Mekong Basin to address the problem of multidrug-resistant malaria. Tuberculosis continues to be an issue of primary concern and control is expected to become critical as treatment compliance fails and HIV/AIDS progresses. WHO continues rendering technical assistance in term of expertise, training and diagnostic tools and drugs.

WHO provides technical assistance in implementation of the comprehensive reproductive health approach, mainly capacity building in the area of *reproductive health and health of women and children*.

The government has shown high political commitment to *environmental health*, especially water and sanitation. WHO continues to provide technical assistance in capacity building for the rural water supply development programme, water analysis laboratory, environmental engineering in sanitation and pollution control. National figures for sanitation coverage show an increase from 45.2% (1997) to 61.7% (1999). With the change in strategy from supply driven donor-financing to self reliance and self help financing through social mobilization, the construction of 2 million latrines has been completed by the end of 2000.

# 3

## PRIORITY AREAS IN HEALTH FOR 2002-2005

As a concrete result of the CCS development work performed between January and June 2000, WHO has identified the following priority areas for collaboration during the period of 2002-2005:

- health system;
- excess burden of diseases;
- women's health / reproductive health;
- child and adolescent health;
- healthy environment; and
- major risk factors hazardous to health.

These areas have been selected on the basis of information provided in a large number of reference documents and reports (references in Annex 3), a list of selection criteria developed during the CCS seminar, adapted from an initial WHO global list and inputs contributed throughout the CCS seminar by the participants. (Detailed matrixes developed for each priority area are available at the WHO-Myanmar Country Office.) The main criteria used for the selection process were as follows:

- Potential for significant change in national burden of diseases with existing cost-effective interventions considering local situation.
- Health problems with major impact on socioeconomic development and a disproportionate impact on the lives of the poor.
- Opportunities to reduce health inequalities within (vulnerable groups, national races/localities) and between countries.
- Comparative advantage of WHO: particularly in relation to the production of public goods, building consensus around policies, strategies and standards, initiating and managing partnerships.
- Major demand for WHO support based on country's needs.
- Urgent need for applicable new technologies.
- Availability of support from other agencies and partners.
- Potential to strengthen development of human resources and research.

### **Health System**

Without a well functioning health system, technical interventions are not likely to have a major impact on health outcomes. The four health system functions, i.e. stewardship, health financing, resources development and provision of health services, need to be strengthened. Planning and coordination of external aid, health management information system and regulation & legislation are the areas where WHO support is expected. In the area of *human resources for health*, the main challenges where WHO assistance is required, are production of human resources, performance assessment and improving of managerial skills. WHO will continue its support in the area of *research*. The strategy is to conduct research on priority diseases and on health systems to develop and improve the infrastructure necessary for effective health research and to promote the utilization of research findings. WHO

will also focus its assistance in the area of *traditional medicine*, especially in evaluation of cost-effectiveness of traditional medicine interventions.

### ***Excess Burden of Disease***

Analysis of the overall health situation suggests that *communicable diseases* continue to be major public health problem and constitute a major part of the excess burden of disease on the people, on the health services, and on the economy of the country. Malaria is a major cause of morbidity and mortality. Tuberculosis is one of the major public health problems in Myanmar and is considered the second priority disease in the National Health Plan after malaria. HIV/AIDS is a disease of national concern and occupies the third position after malaria and tuberculosis. Leprosy and polio are on the verge of being eliminated or eradicated and efforts must be taken to ensure that final campaigns and interventions are completed. Dengue and dengue haemorrhagic fever is becoming an increasing problem in the country. These diseases are considered major challenges for the next 4-5 years period. Current available technical strategies for communicable disease control have already been accepted and adapted to country-specific needs. However, WHO technical support in implementing these strategies is required. In the area of *non-communicable diseases*, cardiovascular diseases, cancer, diabetes, chronic pulmonary diseases, accidents/injuries and mental health are considered priority issues for WHO support. Surveillance of major non-communicable diseases should be established. There is a lack of awareness in the community about the risks of non-communicable diseases. For the priority area of non-communicable diseases, WHO would focus its support to advocacy and technical assistance.

### ***Women's Health / Reproductive Health***

Pregnancy-related deaths constitute the leading cause of loss of healthy lives among women of reproductive age in Myanmar. Haemorrhage, eclampsia, obstructed labour, puerperal sepsis and unsafe abortion are the major causes of maternal deaths. Most maternal deaths are preventable. There is a need to equip the health system with cost-effective reproductive health interventions such as good family planning services, effective access to essential obstetric care including post-abortion care and emergency obstetric care through effective community-based referral systems. Reproductive tract infections, sexually transmitted diseases and HIV/AIDS also appear to be among the major causes of women's ill-health. A major issue in women's health is the lack of disaggregated health information by sex, age and other relevant variables. The focus should be on institutionalizing disaggregated data in health information system, and mainstreaming women's perspectives in all health policies and programmes. Violence against women is increasingly being recognized as a public health problem. During 2002-2005, WHO's support will be directed to technical assistance, partnership building and joint monitoring of achievements in surveillance, institutionalization and adaptation of WHO standards and guidelines.

### ***Child and Adolescent Health***

Although there has been a decline in the last decade, both infant mortality and under-5 mortality rates are still high. Since the adolescent population constitutes 20.5 % of the total population and their health habits set the health pattern for their entire life span, investments in adolescent health would provide many health dividends. The leading causes of death in under 5 children were reported to be acute respiratory infections, diarrhoea, malaria, dengue haemorrhagic fever and malnutrition; deaths were mostly due to insufficient quality of care caused by lack of diagnostic skills and inadequate recognizing of danger signs of the disease for referral. Only 30 % of the

health staff is able to give proper management of ARI and 80 % of the training courses are not conducted according to planned curriculum. Inadequate skills-based and participatory training methodologies have been used, including limitations in systematic and integrated planned training programme. The coverage of IMCI should be expanded and the quality of training, logistics and resources including supervision and monitoring should be strengthened. WHO's support during 2002-2005 would focus on the above areas. In adolescent health, technical and advocacy support is expected in the development of national policies and strategies to promote an integrated development of child and adolescent health and STD/HIV together with the prevention of other risk factors.

### ***Environmental Health***

*Safe drinking water and sanitation* have been identified as priority health issues under the heading. The coverage of safe drinking water for the whole country is currently estimated at 66 % and about 80 % for sanitation (especially sanitary latrines). The use of polluted water and unsanitary methods of excreta disposal by the population, combined with unhygienic practices and unsanitary environment result in the high incidence of diseases such as diarrhoea, dysentery, cholera, typhoid, viral hepatitis, etc. The challenges to the provision of safe drinking water include the improvement of coverage, the monitoring of water quality as well as information, education and communication to the public and the further promotion of inter-sector co-ordination and collaboration. Besides increasing coverage, the improvement in sanitation will also require information, education and communication to the public and the promotion of inter-sector coordination. These are identified as challenges to be addressed during 2002-2005. WHO's support in the area of environmental health would include technical assistance, capacity building and partnership development.

### ***Major Risk Factors Hazardous for Health***

*Tobacco* is a major risk factor for several other non-communicable diseases such as cancer, cardiovascular diseases and chronic respiratory disorders. Alcohol use is also a major risk for disease, particularly in the adult male population. In 1993-1994, a survey in Myanmar showed that 44.6 % of students aged between 10 and 20 years smoked. There is a clear need to develop long-term, comprehensive and multi-sector policies to stop the use of tobacco. Another challenge is to stimulate health awareness and responsibility and to promote conditions and behaviors which favor health. *Unsafe blood* is identified as another major risk factor hazardous to health. There is a need for resources to establish a proper quality assurance system in every level of blood transfusion services. The third major risk factor identified is *malnutrition and food safety*. The main challenge is the high prevalence of moderate and severe malnutrition among children under the age of 3; high nutritional anaemia among pregnant women (58%), low birth weight (24%) and inadequately trained staff in the programming and management of specific food inspection and control. During the period 2002-2005, WHO's support in this area will focus on advocacy and technical support (particularly training, information system base, setting standards and monitoring).

# 4

## Strategic agenda for the work of WHO in Myanmar

The overall goal of the World Health Organization in Myanmar is to contribute to the improvement of the health of the people of Myanmar. Health development will be supported by advocating health-promoting policies and providing technical leadership in collaboration with the government and other national and international partners in health, in line with WHO's core goals for health development. WHO support will emphasize the development and adoption of policies, norms and standards to be implemented through evidence-based technically sound interventions. WHO will work towards more efficient and more equitable health systems. The goal set above can effectively be achieved if an optimal mix of partnerships in health is developed. The WHO country office is also mandated to facilitate the exchange of experience, regionally and globally.

### Key strategic directions and functions

Broad *strategic directions* have been defined globally providing the framework for WHO's technical work:

- ♦ **To reduce the excess mortality and morbidity, especially in poor and marginalized populations**
- ♦ **To develop health systems that improve health outcomes equitably, are financially fair and respond to people's legitimate demands**
- ♦ **To promote healthy lifestyles and reduce factors of risk to human health that arise from environmental, economic, social and behavioural causes**
- ♦ **To develop enabling policy and institutional environments in the health sector and promote effective health dimensions to social, economic, environmental and development policies**

The objective of the WHO's strategy is to develop equitable, responsive and fair financing health systems by improving the process of developing health policy, planning, regulation and financing. WHO will work in co-operation with other development partners and contribute to policies and programmes addressing the needs of the poor. Priority areas of work have been set using criteria listed in Chapter 3. WHO's work in Myanmar during the period 2002-2005 will therefore focus on the following six areas of work identified as high priority:

- **Health systems,**
- **Excess burden of disease,**
- **Women's Health/ Reproductive Health,**
- **Child and Adolescent Health,**
- **Environmental Health, and**
- **Major risk factors hazardous for health.**

In the absence of significant bilateral and other sources of aid for health, WHO's support in Myanmar during the 1990s has been broad-based, covering a wide range of technical areas as well as support in implementation. This is the result, in part, of important gaps left unfilled. WHO's contribution has focused on the Ministry of Health (MoH) and consisted of technical assistance, training, fellowships, guidelines and support for international standards as well as supplies and equipment. This has been done through projects with limited scope but covered a large number of health areas, with particular attention to communicable disease control.

WHO's role over the last 10 years has been crucial in maintaining an inflow of technical assistance, capacity building and training (MoH) as well as in providing resources for disease control programmes. As long as external support to the country remains limited and supplies in the priority areas of work are insufficient, WHO will maintain its role in ensuring the provision of some of these supplies and equipment, in particular for malaria, tuberculosis, STIs and HIV/AIDS and reproductive health.

There is a need to support the health sector in developing responses and taking pro-active stances on issues linked to health care delivery, health sector reform and regulation as well as poverty reduction. Rather than support limited implementation in a range of areas, WHO's contribution will aim for a greater impact by a more strategic selection of activities. This involves work along six core functions, which consist of modes of assistance where WHO has a comparative advantage in technical terms and areas of expertise as well as in mandate. WHO's *core functions* are to:

- \* **Catalyze change through technical and policy support in ways that stimulate action and help to build sustainable national capacity in the health sector**
- \* **Stimulate the development and testing of new technologies, tools and guidelines for disease control, risk reduction, health care management and service delivery**
- \* **Set, validate, monitor and pursue the implementation of norms and standards**
- \* **Articulate consistent, ethical, evidence-based policy and advocacy positions;**
- \* **Negotiate and sustain national, regional and global partnerships**
- \* **Manage information, assess trends and compare performance of health systems; set the agenda for and stimulate research and development;**

It is clear that not all of these functions will carry the same weight across the six priority areas in health for 2002-2005 and their relative importance is detailed under each priority component below.

In view of the disparities and diversity throughout the country, an important direction for WHO's support will be the development, when necessary, of *differentiated approaches to programming for health in urban, rural and border areas*. In line with the government's efforts to improve access to health in border areas, highlighted by meetings such as the Myanmar-Thailand border meeting on bilateral cooperation in communicable disease control, held in July 2000, WHO will direct special efforts towards supporting work in border areas.

The WHO country office will also promote the following **initiatives** and provide support for their implementation: *Enhancing Health Systems Performance (EHSPI)*, *Roll Back Malaria (RBM)*, *Stop TB*, *"Making Pregnancy Safer" (MPS)* and *Tobacco Free Initiative (TFI)*.

## HEALTH SYSTEMS

The objective of WHO's strategy is to contribute to the development of equitable, fair financing health systems which are responsive to people's needs by improving the process of developing health policy, planning, regulation and financing. The central role of health in the sustainable development of Myanmar is recognized and the MoH is committed to strengthening the health system to respond to existing needs. An important evolution in the country over the past eight years has been the shift towards a market economy, reflected in the adoption of market and cost-sharing mechanisms in the health system.

WHO will extend support to the MoH under the functions defining the role of a health system: 1) stewardship, 2) financing, 3) resources development, 4) health services provision.

**First**, the development of national health policy and the next five-year health plan will be supported by WHO and will cover the process of identification of key issues across the health sector and policy objectives as well as strategy-development. This should contribute to a strong evidence-base for an objective-led and broad-based modernization of the health sector. Key support will also be provided in the elaboration of a framework, which regulates health sector activity and ensures standards, norms and quality of care in the public and private health sector.

**Second**, managerial and financial capability and capacity at all levels need to be strengthened and support for professional training will be promoted through partnerships. The efforts of the MoH in advocating for an increased share of government budget to the health sector will be supported as well as more operational research on health expenditure from all sources. Performance and impact monitoring of different financing schemes will be an important area of WHO support as it will provide the evidence-base that will facilitate sound policy development on financing.

**Third**, WHO will advocate for improved management, planning and distribution of resources. This will be done through the expansion of partnerships and by strengthening information and research on the availability, needs and use of resources, facilities and supplies. Another major area for support will be the development of planning and management capacity for human resources for health as well as research and guidance on the optimal production mix and utilisation of staff, based on needs. A review of the supply and availability of essential drugs and consumables is necessary to plan requirements and monitor needs and use and will also be supported. Co-ordination in the area of essential drugs will be advocated for by WHO which should also help to secure additional resources for essential drugs.

**Fourth**, technical assistance will facilitate the definition of essential packages of care for different levels of the health system. This will constitute important groundwork which will help in a) the planning and allocation of resources to ensure more equitable access to primary health care services, b) the definition/ clarification of provider roles especially for the township health teams.

### *Key directions*

- ♦ *Research and policy support to develop a broader approach to health involving the public and private health sector. Advocate for and support the development of objective-led modernization of the health sector*
- ♦ *Advocate for and strengthen the regulatory framework for health and provide norms and standards for adaptation, both in the public and private sector*
- ♦ *Help strengthen policy, planning and management for 1) human resources for health, 2) drugs and consumables, 3) health facilities and equipment*
- ♦ *Provision of health services*

## EXCESS BURDEN OF DISEASES

Reducing the excess mortality and morbidity, especially in poor and marginalized populations is one of WHO's four strategic directions. Major public health problems in Myanmar are malaria, still a principal contributor to mortality, tuberculosis, HIV/AIDS and STIs which all remain priority diseases under the National Health Plan and will benefit from a continued focus of efforts.

During the next five years, WHO will continue to support the MoH in designing and implementing effective and integrated communicable disease control programmes to reduce excess mortality, morbidity and disability, especially in populations with limited access to health services. The outbreak early warning system, surveillance and case management for malaria, tuberculosis, sexually transmitted infections, HIV/AIDS and other diseases such as dengue/ dengue haemorrhagic fever will need continual strengthening and support with increased emphasis on the broad range of existing providers across the health sector. Leprosy control will be further supported to achieve elimination. A crucial step will also be to ensure the quality of diagnosis and diagnostic tools throughout the health sector by advocating for quality assurance in testing facilities, supporting strategy development and capacity building as well as adapting necessary tools/ guidelines and ensuring supplies and maintenance.

Although communicable diseases currently contribute the bulk of the burden, non-communicable diseases are on the increase and monitoring needs to be established through surveillance. WHO will provide technical support for a Burden of Disease (BOD) study, which will assess the relative magnitude of communicable and non-communicable diseases in Myanmar, providing important baseline information. WHO will also advocate for strategy development in addressing CDs and NCDs using the BOD study as a tool for decision-makers, particularly in the process of prioritisation and resource allocation.

### *Key directions*

- ♦ *Strengthen advocacy at the state/division level for highest priority programmes to reach populations groups with low access to health services*
- ♦ *Support the strengthening of integrated prevention and control efforts for priority communicable and non communicable diseases, by encouraging a broad participation across the health sector, especially at the district and township levels*
- ♦ *Advocate the targeted use of social vaccines (Insecticide-treated mosquito nets, condoms, counselling) through appropriate partnerships at all levels (i.e. private companies, casual sex workers, institutions)*
- ♦ *Promote/explore modes of partnerships for the procurement of essential supplies in the absence of major donors/contributors*
- ♦ *Technical support will be provided along the seven main intervention areas defined, in co-ordination with the UN theme group on HIV/AIDS and the M.O.H.: (i) targeted condom use and reproductive health; (ii) behavioural development and change communications; (iii) compassion care and support for people living with AIDS; (iv) reducing the harmful consequences of injecting drug use; (v) blood safety programme covering remote areas and rural communities; (vi) improved multi-sector coordination and enhancing the capacity of national NGOs and the community; and (vii) surveillance system and research.*

## **WOMEN'S HEALTH / REPRODUCTIVE HEALTH**

Pregnancy-related deaths continue to be a leading cause of mortality in Myanmar and it is widely recognized that unsafe abortions constitute a major cause of morbidity and death among women of reproductive age. WHO's work in the coming period will aim to address key issues identified under this priority area: high maternal mortality, high prevalence of unsafe abortions, unmet demand for contraception, prevention and control of STIs, HIV/AIDS and violence against women.

A key area for advocacy and technical support will be the development of national policies, strategies and action plans on reproductive health that are applied down to the district and township levels. A life cycle approach to reproductive health will be promoted as well as the inclusion of sexually transmitted infections and HIV/AIDS prevention and control.

WHO will assume a leadership role in promoting and developing essential packages of services such as an Integrated Reproductive Health Package (covering STIs as well as RTIs and birth spacing) and standards of care for basic and essential obstetric care at referral level. Efforts to improve knowledge, availability and use of, prevention and contraceptive methods will be supported and broader access to reproductive health services will be advocated.

Basic and essential obstetric care will be strengthened and quality of care ensured by improving the management system, capacity of basic health staff and by adapting existing norms, standards and guidelines especially for midwifery practice and the integrated management of pregnancy and childbirth (IMPAC). Partnerships will be promoted, especially for the development of clear and targeted community messages on reproductive health care and the integrated management of pregnancy and childbirth as well as to increase the availability and ensure continuity of supplies for the programme.

### *Key directions*

- ♦ *support the development of national policy, strategies and action plans on reproductive health that will be applied down to the district and township levels*
- ♦ *leadership role in promoting essential packages of services such as an integrated reproductive health package and standards of care for Basic Obstetric Care & Essential Obstetric Care at referral level, in the framework of the redefinition of essential packages of care (mentioned under the Health Systems component)*
- ♦ *strengthen the provision quality of care, especially at the midwife and auxiliary midwife level through support in capacity-building, the adaptation of guidelines and partnerships as well as in implementing standards for practice*
- ♦ *Support the development of an effective referral system, for provision of essential obstetric care at referral level*

## CHILD AND ADOLESCENT HEALTH

The key challenges that WHO's work will address are the reduction in infant and under five mortality, the expansion/strengthening of immunization, improving the nutritional status of children under five, school health and adolescent health. To pave the way for a more integrated approach to women and child health development, WHO will promote the guiding principles of the life cycle approach, throughout interventions in child and adolescent health.

WHO will help to redefine/clarify the roles of peripheral health workers in the Integrated Management of Childhood Illnesses and assist in strengthening the quality of the current training at peripheral and referral levels.

Polio eradication will continue to be a major area of focus and like immunization programme in general will require constant support to improve surveillance, strengthen routine services and improve/ expand the cold chain to the rural health centre level. Efforts will particularly emphasise polio, neonatal tetanus and measles. WHO will also advocate and promote the provision of booster vaccination in schools as well as school-based mass treatment for helminths at the primary level. New vaccines, such as hepatitis B vaccine, will be introduced and vaccine administration made safer through the use of auto-disposable syringes. Data collection for vaccine preventable diseases will be improved.

In view of the evolving needs and context, an important direction of WHO's support will be reflected in the development of a national policy and strategy on adolescent health as well as a national programme. The definition of an integrated package of adolescent-friendly reproductive health services will constitute a major step as well as build capacity at national, state/division and township levels for the programming and provision of services.

### *Key directions*

- ♦ *Promote the establishment/strengthening of a perinatal/newborn care programme*
- ♦ *Support the strengthening of the Expanded Programme of Immunization and work in partnership with the Global Alliance for Vaccines and Immunisation (GAVI)*
- ♦ *Strengthen capacity for the implementation of the Integrated Management of Childhood Illnesses (IMCI)*
- ♦ *Promote and support the development of an effective referral system for the treatment of complicated childhood illnesses*
- ♦ *Support the development of national policy, strategies and action plans on adolescent health and advocate for increased access to adolescent reproductive health services*

## ENVIRONMENTAL HEALTH

Under the broad objective of promoting healthy lifestyles and reducing factors of risk to human health that arise from environmental, economic, social and behavioural causes, WHO support during the coming period will direct efforts towards promoting and developing the supply of safe drinking water and sanitation. The key directions of work in this area will be to advocate for increased coverage of safe drinking water across Myanmar (currently 60%) with an emphasis on quality monitoring to ensure that national standards of water quality are met, particularly in the fast-growing cities of the country. WHO will make support available for policy-development, planning and the use and adaptation of current technical guidelines, norms and standards. Support will also be provided in planning for sanitation and for the development of long-term solutions for waste disposal in hospitals across the sector and in cities. Support in this area will concentrate on process development and technical inputs based on WHO's expertise and comparative advantage. Effective partnerships will be promoted and encouraged for implementation purposes.

Community education and participation are an important condition of success in these priority areas and will be promoted by WHO through partnerships at the community, technical and ministerial levels to increase multi-sector participation. Effective partnerships across sectors should contribute to improvements in both water and sanitation but will require the development of implementation arrangements clearly defining responsibilities down to the ward level. In order to address the re-emergence of diseases such as dengue/dengue haemorrhagic fever, increased co-operation will be advocated between sectors to ensure that sanitation, water supply, construction and health are collaborating effectively to reduce hazards.

### *Key directions*

- ♦ *Support the elaboration and implementation of a National Plan of Action for Health and Environment as well as the development of policy and planning for environmental health*
- ♦ *Advocate for intensified efforts to increase national coverage for the supply of safe water*
- ♦ *Ensure the availability of technical support (assistance, guidelines, norms and standards) for the safety of water supply and sanitation*
- ♦ *Strengthen the planning process and development of long-term solutions for waste-disposal in hospitals across the sector and in cities*
- ♦ *Catalyze and support sustained multi-sector action and partnerships, with emphasis on environmental factors contributing to the re-emergence of diseases like dengue/dengue haemorrhagic fever and malaria*
- ♦ *Promote the concept of Primary Environmental Care and provide relevant support in information, education and communication*

## MAJOR RISK FACTORS HAZARDOUS FOR HEALTH

To more effectively address some of the current major risks to health, the priority areas of focus for the period 2002-2005 will cover safety of blood, the increasing health risks linked to the use of tobacco and food safety.

In a context of growing HIV prevalence, the establishment of a well-functioning quality control system, screening blood for HIV and hepatitis B at every level of the transfusion services is essential. This will be developed with WHO support to the MoH (National Health Laboratories and Blood Bank) in terms of policy and technical support, guidelines and regional/global experience. To ensure the safety of blood transfusions at the township hospital level and for essential obstetric care, WHO will support the training of medical officers, pathologists and laboratory technicians in transfusion medicine.

WHO has an important role in fostering and supporting health promoting policies which in the case of tobacco aim to protect the health of children, women and unsuspecting consumers from the proven dangers of smoking. Policies, which will limit the use of tobacco in public places, especially schools, clinics and hospitals and government ministries, limit the sale of tobacco in the proximity of such places and make compulsory the visibility of product content, will be encouraged. School-based health programmes are an important area of prevention work and WHO technical support may facilitate the integration of prevention messages on the risks of tobacco and drug use into school-health.

WHO will make available global and regional guidelines, norms and standards on food safety and will support the upgrading of the food safety control system.

### *Key directions*

- *advocate the publication and implementation of the National Blood Policy (in draft stage since 1998)*
- ♦ *support technically the establishment of a well-functioning quality control system, screening blood at every level of the transfusion services (i.e. for hepatitis B, HIV)*
- ♦ *provide technical support to develop the information system and research on tobacco issues in the country including production, consumption and tobacco advertising*
- ♦ *strengthen the development of policies and legislation on tobacco (advertising, use on premises, control measures and management of risk factors)*

# **ANNEXES**

## National Health Policy (1993)

ANNEX- 1

- 1) To raise the level of health of the country and promote the physical and mental well being of the people with the objective of achieving "Health for all by the year 2000" goals, using primary health care approach.
- 2) To follow the guidelines of the population policy formulated in the country.
- 3) To produce sufficient as well as efficient human resources for health locally in the context of broad framework of long term health development plan.
- 4) To strictly abide by the rules and regulations mentioned in the drug laws and by-laws which are promulgated in the country.
- 5) To augment the role of co-operative, joint ventures, private sectors and non-governmental organizations in the delivery of health care in view of the changing economic system.
- 6) To explore and develop alternative health care financing system.
- 7) To implement health activities in close collaboration and also in an integrated manner with related ministries.
- 8) To promulgate new rules and regulations in accord with the prevailing health and health related conditions as and when necessary.
- 9) To intensify and expand environmental health activities including prevention and control of air and water pollution.
- 10) To promote national physical fitness through the expansion of sports and physical education activities by encouraging community participation, supporting outstanding athletes and reviving traditional sports.
- 11) To encourage conduct of medical research activities not only on prevailing health problems but also giving due attention in conducting health systems research.
- 12) To expand the health service activities not only to rural but also to border areas so as to meet the overall health needs of the country.
- 13) To foresee any emerging health problem that poses a threat to the health and well being of the people of Myanmar, so that preventive and curative measures can be initiated.
- 14) To reinforce the services and research activities of indigenous medicine to international level and to involve in community health care activities.
- 15) To strengthen collaboration with other countries for national health development.

## Major partners involved in the field of health

- UNICEF
- UNDP
- UNFPA
- UNDCP
- Population Council
- Medecins Sans Frontier – Holland
- Medecins Sans Frontier – France
- Medecins Sans Frontier – Switzerland
- CARE
- Population Services International
- AMDA
- JICA
- World Vision
- Save the Children Fund (USA)
- Save the Children Fund (U.K.)
- Medicins du Monde
- International Committee of the Red Cross
- World Concern
- Association Francoise Xavier Bagnoud
- Marie Stopes International
- Artesen Zonder Grenzea (AZG)
- Myanmar Red Cross Society
- Myanmar Maternal and Child Welfare Association
- Myanmar National Council for Women Affairs
- Myanmar Medical Association
- Myanmar Dental Association
- Myanmar Nurses Association
- Myanmar Health Assistants Association
- Myanmar Academy of Medical Science

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