

***Myanmar Country Paper for
Revisiting Primary Health Care***

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I. Background

The foundation of Primary Health Care and its evolution

The Thirtieth World Health Assembly in 1977 identified the attainment by all peoples of the world by the year 2000 of a level of health that would permit them to lead socially and economically productive lives as a main social target of governments, international organizations and communities. This was reaffirmed by the International Conference on Primary Health Care in 1978 held in Alma Ata, Kazakhstan in September, 1978.¹ The declaration of Alma-Ata formally adopted primary health care as means for providing a comprehensive, universal, equitable and affordable healthcare service for all countries. It was unanimously adopted by all WHO member countries at the Primary Health Care Conference.

The conference defined PHC as "essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford. The ideology behind Primary Health Care is based on the recognition that health promotion and protection are essential for sustained economic and social development and contribute to better quality of life. PHC is a cost-effective approach and its principles include social-justice, equity, human rights, and universal access to services, community involvement and priority to the most vulnerable and underprivileged."^{1,2}

National governments throughout the world adopted PHC as their official blueprint for total population coverage with essential PHC services. Goals and targets were set for Achieving Health for All by the Year 2000. Indeed the Report of International Conference on PHC 1978 and the Alma Ata Declaration itself were taken as a conceptual basis for health development in Member Countries.

A few years after Alma-Ata, a new concept of "Selective Primary Health Care" (SPHC) had been advocated providing only interventions that contributed most to reducing child (< 5 years) mortality in developing countries.^{5, 6} There were arguments that cost limits made full PHC not possible and emphasis was made on highly cost-effective programs as "interim strategy".^{5,6} The Selective PHC approach, being implemented in some countries gained some important achievements but has multiple shortcomings such as low or no community participation, little or no coordination between vertical programs and almost sole emphasis on women and children.⁵ SPHC reintroduced vertical programs at the cost of comprehensive PHC.⁵

The commitment to global improvements in health was renewed by World Health Assembly Resolution WHA 51.7 (1998) in which Member States reaffirmed their

intent to ensure availability of the essentials of Primary Health Care as defined in

the Alma Ata Declaration and set out in the Health-for-All policy for the 21st century.³ A meeting on future strategic directions for PHC in Madrid, Spain (2003) called for a consideration of incomplete PHC implementation, new health challenges, social and political factors that influence health and crises such as epidemics and emergencies that have revised earlier gains.⁴

The adoption of Primary Health Care Approach in Myanmar

Historically, Myanmar adopted the PHC approach even before the declaration of Alma Ata. PHC approach was named in 1977 in pilot townships in the country. After Alma-Ata, it became a strong advocate and supporter of Health for All global strategy. Country health planning methodology (CHP) which was a problem-oriented, need-based type of planning was introduced and series of People Health Plans were implemented since 1978 aiming to achieve Health for All by Primary Health Care approach. The first cycle of People's Health Plan was implemented during 1978 to 1982, aimed at raising the health standard of the people with the main objective of overall development of human resources. PHP II was implemented from 1982 to 1986 for better coverage- and quantity; the third PHP III was implemented from 1986 to 2000 with the theme "from quantity to quality".

The government changed in 1988 and set political, economic and social objectives; one of the four social objectives is uplift of health, fitness and education standards of the entire nation. The government has shown its commitment to ensure highest possible standard of health as one of the fundamental rights of every citizen

The National Health Committee was formed on 28 December 1989 as part of the policy forms. It is a high level inter-ministerial and policy making body concerning health matters. This Committee takes the leadership role and gives guidance in implementing the health programmes systematically and efficiently. It is chaired by the Secretary (1) of the State Peace and Development Council and includes Ministers of related Ministries as members. The Deputy Minister for Health is secretary of the National Health Committee. (Annex 1)

The National Health Policy was developed with the initiation and guidance of the National Health Committee in 1993. The Policy has 15 statements; the first statement clearly stated its objective of achieving "Health for All" goal as the primary objective using Primary Health Care approach. The other statements include community participation, expanding health services not only to rural but also to border areas, intensifying and expanding environmental health activities. (Annex 2)

In addition to achieve these objectives, the Ministry of Health summarized its two main objectives as "to enable every citizen to attain full life expectancy" and secondly "to ensure every citizen is free from disease".

Myanmar has been implementing all elements of PHC from the beginning and *has never promoted selective PHC* such as GOBI-FFF (growth monitoring, oral rehydration, breast feeding and immunization-female education, family spacing, food-supplements). The National Health Plan covers all elements of PHC with four basic underlying principles embedded in the PHC approach for health development, as enshrined in the Alma Ata Declaration: (1) universal access to health care in addressing health needs (equity) (2) community involvement and self-reliance (solidarity) (3) use of appropriate technology and cost-effective interventions (technology) and (4) multisectoral actions for health.

II. Present Status of PHC in Myanmar

(b) Eight Elements of PHC

1. Health education

In all the pre-service as well as in-service trainings for health personnel, health education has always been described as the principle duty of all the basic health personnel working at various levels of health centers. It is clearly stated as their main function in the "Job-description for basic health personnel" ⁸. Methodology on health education was taught at in-service trainings for all health personnel. Within the past decade, the concept of health promotion has brought the scope of health education into a wider vision; behaviour change communication strategy was introduced and practiced in project townships mainly on reproductive health.

The routine Health Management Information Service (HMIS) collects monthly reports which include frequency of health education provided by the BHS on four topics: family health, environmental sanitation, immunization, and disease and health problems.

Table1. Indicator for health education

Indicator	2005
• average frequency on family health education per BHS per year	17
• average frequency on immunization health talks per BHS per year	21
• average frequency on disease and health problems health talks per BHS per year	16
• average frequency on environmental sanitation health talks per BHS per year	17

Source: Health Management Information System, DHP, MOH

Figure 1. Basic health personnel providing health education in a rural area.

Figure 2. Disseminating the health message to mothers and children

2. Nutrition

2.1 IDD elimination

Nutrition promotion and intervention programmes were being implemented in Myanmar since early 1960s. ***Iodine deficiency disorder (IDD) elimination*** is one of the most remarkable successes in the public health history of the country¹⁰. Myanmar started its IDD control activities in 1968; in 1969, the Goitre Control Committee started distributing iodized salt to northern Chin Hills where goitre prevalence was as high as 91.5% for both sexes in 1967. As a result, prevalence of goitre dramatically dropped within the following three years to 24.7%.⁹

Injections of iodized oil and distribution of iodized oil capsules were also used as methods of IDD control in 1982 and afterwards. The Central committee for Control of Iodine Deficiency Disorders (CCCIDD) was formed in 1991 under the guidance of the National Health Committee. The Ministry of Health, in collaboration with Myanmar Salt and Marine Chemicals Enterprise of the Ministry of Mines, has adopted Universal Salt Iodization (USI) as the long-term strategy for control of IDD in Myanmar.^{9,10} Myanmar, as a member country of WHO, endorsed the decision of the World Summit for Children, 1990, to eliminate IDD. Learning from the experiences of short-term interventions such as iodized oil injection and iodized capsule programmes, Myanmar decided to adopt universal salt iodization (USI) as a single, long-term strategy for eliminating iodine deficiency disorders.⁹

Table 2. Indicators for Iodine Deficiency Disorders Elimination (IDDE)

Impact Indicators	1994	1997	2000	2005
Visible goitre rate (6-11 years)	33%	25%	12%	5.5%
Iodised salt consumption	10.8%	50%	79%	90%

Source: National Nutrition Center, 2007

Figure 3. Conducting a school survey for visible goitre rate2.2. Growth

Monitoring

The National Nutrition Centre (NNC) of the Department of Health (DOH) has been implementing nutrition promotion and intervention programmes in order to control **Protein Energy Malnutrition (PEM)** among children. Proportion of the under-weight children (WFA < - 2 SD, NCHS Reference Data) among under-3 population has declined from 36.7% in 1991 and 31.2% in 1994 to 28.2% in 1997. Proportion of the severely under-weight children (WFA < - 3 SD, NCHS Reference Data) has also decreased from 11.2% in 1991 and 8.3% in 1994 to 7.2% in 1997. (Source: National Nutrition Surveys, National Nutrition Centre, DOH.)

Table 3. Indicators for nutrition (Protein Energy Malnutrition)

Indicators	1997	2000	2005
% children underweight	38.6%	35.3%	31.8%
% children stunted	41.6%	33.9%	32.2%
% children wasted	8.2%	9.4%	8.6%

Source: Multiple Indicator Cluster Surveys, Department of Health Planning, MOH

Figure 4. Members of NGOs helping in growth monitoring

2.3. Vitamin A Deficiency

Vitamin A deficiency used to be a public health problem among Myanmar children during the early 1990s. But prevalence of Bitot's spot among under-5 children has dropped thanks to the introduction of regular supplementation with high potency vitamin A capsules in 1993. The last xerophthalmia survey in the year 2000 revealed that the prevalence of Bitot's spot among under-5 children was 0.03% in both urban and rural communities, far below the cut-off level of the public health problem, which is 0.5%. Assessment of serum vitamin A status of a sub-sample of children in the survey of 2000 indicated that all children in the rural community and 96% of urban children had normal serum vitamin A status while only 4% of the urban children had mild sub-clinical deficiency.⁹

Table 4. Indicators for nutrition (Vitamin A deficiency)

Indicators	1991	1994	1997	2000
% Bitot's spot among < 5 year old children	0.6%	0.38%	0.23%	0.03%

Source: National Nutrition Center, Department of Health Planning, MOH

3. Maternal and Child Health⁹

The national health system accords special priority for health care to pregnant mothers and children. Maternal and child health care services are provided both in urban and rural settings and it is also a crucial component of National Health Plan. The National Health Policy acknowledges the importance of delivering high quality care towards making reproductive health a reality for all. It aims to strengthen health services throughout the country, including rural and border areas where reproductive health issues need particular attention. Twelve broad programs were identified in the National Health Plan: maternal and child health and birth spacing is second priority component of the community health care programme.

National Population Policy has been drafted since 1992 and includes reproductive health implementation in family health care project. It focuses on health, especially maternal and child health, birth spacing, and adolescent health, so that the nation can provide the maximum productive life for all citizens who will in turn work for the nation's development.

In accordance with the targets that were set out in the current NHP, Myanmar Reproductive Health Policy was developed during a workshop in 2001 and

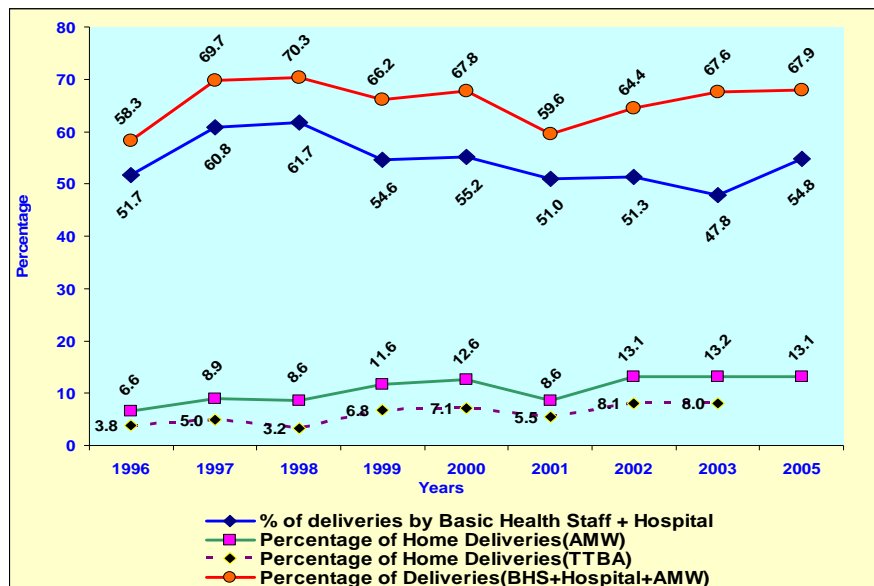
approved in 2004. The policy document is supported by a background document

which acts as a guide for policy implementation. Maternal Mortality was targeted to be reduced by three-fourth between 1990 and 2015; based upon the survey findings, the Maternal Mortality Ratio was 3.16 per 1,000 live births (*Nationwide Cause-specific Maternal Mortality Survey, DOH/UNICEF*).

The last half-decade has seen major gains in maternal and newborn health as benefited from making pregnancy safer evolution. In order to reduce the country's burden of maternal and perinatal morbidity and mortality, safe motherhood initiatives have been expanded into a national movement. Department of health promotes all pregnant mothers to be delivered by skilled birth attendants to ensure achieving Millennium Development Goals (MDG).

Approximately 1.3 million women in Myanmar give birth each year. Among that majority of deliveries occur in rural area especially at home. Regarding the proportion of births attended by skilled health personnel, HMIS reported as 40.1 % in 2001 and 60 % in 2004. About 40 % of pregnant mothers delivered with skilled birth attendants mainly midwives, 12.5% with auxiliary midwives (AMWs) and 7.5% with traditional birth attendants (TBAs). It is much needed to intensify efforts to increase the low proportion of birth attendants by skilled birth attendants.

Figure 5. Proportion of births attended by skilled health personnel in Myanmar



Source: HMIS,, DHP, MOH

According to HMIS report, antenatal care coverage of all pregnant women in the country is 65.6% (2006). The mean number of AN care visit during the last completed pregnancies is 4.1.

Table 5. Indicators for Maternal and Child Health

Impact Indicators	1996	2000	2005
% AN coverage (K4)	58%	61%	63.1%
% of births attended by skilled birth attendants	51.7%	55.2%	65.1%

Source: Department of Health Planning, MOH

Although there have been significant improvement in quality of MNH service delivery and awareness of community, estimates today indicate that the current rate of maternal mortality has not achieved its targets. According to the “Nationwide Cause-specific Maternal Mortality Survey”, carried out by the Department of Health and UNICEF in 2004-2005, maternal mortality ratio was estimated at 316 per 100,000 live births at the national level and 89% of all maternal deaths were reported from the rural areas. The main causes of maternal mortality and morbidity are due to complications during antenatal and delivery periods and 80% of the maternal deaths occurred at home. The majority of the maternal deaths could have been prevented.

The Nation-wide Cause Specific Under-five Mortality Survey carried out by Department of Health (DOH) in 2002-2003 reported neonatal, perinatal and still birth rates as follows:-

- Neonatal Mortality Rate – 16.3/1000 LB
- Peri-natal Mortality Rate – 26.2 /1000 LB
- Still Birth Rate -- 16.6 /1000 LB

Three leading causes of Neonatal Deaths are low birth weight/prematurity (30.9%), neonatal sepsis (25.5%) and birth asphyxia (24.5%). During past few years, maternal health care has been strengthened through promoting community awareness on their reproductive rights, building capacity of health staff on updated knowledge and providing quality services using effective tools such as partograph and standard guidelines. For clean and aseptic deliveries, clean delivery kits are supplied to the all basic health staffs.

Figure 6. A midwife on her way for home delivery

Figure 7. A mother and child being referred to a hospital in a bullock-cart

4. Water and Sanitation ^{9,10}

Myanmar's national sanitation programme gained an impetus fully at the launching of IDWSSD in 1980. The country set a national target in line with the Decade Programme. Consideration was duly given to the existing situation of coverage, level of service, institutional infrastructure and manpower resources that could be viable for the implementation of the country's Decade Programme in attaining targets.

Keeping the level of service in sight and the policy of narrowing the gap of disparity between the urban and the rural, a realistic target of equal coverage of 50% for water supply and sanitation was set forth for both the rural and urban areas which was to be achieved by 1990. Venturing further, a 100% coverage for both water supply and sanitation in both urban and rural areas was aimed at by the end of century, the year 2000. A nation wide effort was made to meet the target.

However, the achievement fell short of the target set. The percentage attained in sanitation was 40.04% for the urban areas and only 34.71% for the rural areas in 1990. In 1995, the coverage was 56% for the urban and 36% for the rural areas. But because of great effort taken during the end of the decade the coverage for urban area was markedly increased to 83.6% and the rural to 56.5%.

Due to low coverage in sanitation the impact of the adverse effect in health was fully felt. A high incidence of excreta related diseases has been recorded for several years. However, during the period of 1995 and 2000 a great improvement in sanitation coverage was made. This was mainly attributed to the changes in strategy and high political commitment. The over all sanitation strategy came into scrutiny and the strategy was reviewed and duly evaluated in 1996. It was found that the community had become too much dependent upon the free supply of plastic pans and pipes for construction of latrines from donor agencies. The community did not take any appreciable initiatives in sanitation programme. Their participation in sanitation programme was obligatory to achieve success. Therefore the government and the donor agencies decided to change the conventional, cost-sharing, supply-driven, top-down approach to self-help and self-reliance, need-based driven community participatory approach using "social mobilization" process.

The first National Sanitation Week (NSW) was launched in May 1998. This was a turning point in the history of Myanmar's sanitation programme whereby high political commitment was accorded and placed on high priority in the health policy. Processes encompassed in the new strategy were fully utilized and implemented in this NSW and was launched with the goal of constructing one million new sanitary, fly proof latrines on self-help basis throughout the country. The goal was duly achieved, giving a big boost for national sanitation programme by achieving remarkable coverage within a short period. Evidence of good coverage has been found in NSW campaign. This programme has been implemented with basis health staff, health volunteers, local NGOs and the community. Encourage by the success of the first NSW, similar NSWs were successfully launched yearly since 1999 with good results.

Findings of a survey conducted in 2001 by Myanmar Marketing Research and Development Services (MMRD) confirm earlier findings from MICS that National Sanitation Week activities and Social Mobilization strategy have led to an 18% increase in household access to sanitary latrines from 45.0% in 1997 (one year before National Sanitation Week) to 63.1% in 2000 (2 years after the first National Sanitation Week). The 2001 level of access to sanitary latrine according to the MMRD survey is 67%. The trend is significant, especially in light of only a 2% increase from 1995 to 1997.

Social mobilization project started in 1986 with UNICEF support. It started as community based health education project for WATSAN focused on active community participation in project areas with provided facilities and hygienic behaviour related to WATSAN. Central Health Education Bureau of the Ministry of Health had supported ESD Project since 1981. In 1995, project was renamed as Social Mobilization for WATSAN. Strategy changed from community based to training of trainers and advocacy for broader areas to mobilize for self-help latrine construction.

Social mobilization includes the intensive advocacy campaigns, awareness promotion through various communicable activities comprising of newspaper, television and radio network, the distribution of IEC materials, hygiene education using various media and channels of communication to reach the grass root level. The activity also includes the introducing of school network, training of mobilizers, alliance building and mobilizing all possible resources as well as seeking wider partnership. In the communities the project was well known as Three Cleans Project (clean toilet, clean water and clean hands). Clean food was added to the project and changed the project as four cleans.

Community resources are mobilized to strengthen participation to a wider degree for fostering the spirit of self-reliance and self-help. Enhancing community

participation and capacity building also empowers the community to take

appropriate and compatible actions not only on sanitation but also on other health activities. Such activities include development, production and distribution of IEC materials comprising video presentations on sanitation and personal hygiene, self-help latrine construction, flip chart for training, posters and monitoring forms. Social mobilization also helps the community to become aware of environmental and health problems connected with poor and inadequate sanitation. During 1987 to 2003, more than 60,000 mobilizers had been trained and project implemented in more than 60% of Myanmar townships.

The experiences in the promotion of sanitation and hygiene in Myanmar provide good examples of how people can be motivated to construct sanitary latrines and adopt hygienic practices. These activities have contributed to a significant increase in access to sanitary means of excreta disposal, from 45% in 1997 to 67% in 2001. Hand-washing with soap and water after defecation has also increased from 18% in 1996 to 43% in 2001. Success is attributable to high level political commitment, state and divisional level action and community mobilization by village health authorities. Multilevel efforts have raised greater awareness of sanitation and hygienic issues and led to construction of latrines on self-help basis. Community participation with their strong dedication in self reliance and self-help financing system, further facilitated by easy access to locally produced materials such as pans, pipes and pumps produced by the private sector, lead to accelerated programme performance achieving appreciable increase in coverage percentage.

Table 6. Percentage of population with access to sanitary excreta disposal

Year	1990	1995	1997	2000	2003
Urban	40.04%	56.0%	65%	83.6%	92.6%
Rural	34.71%	36.0%	39%	56.5%	70.8%
National	36.0%	43.0%	45%	63.1%	76.1%

Source: 1990- Joint Monitoring Program (DOH/UNICEF/WHO)
1995to 2003- Multiple Indicator Cluster Survey, Department of Health Planning,
MOH

Table 7. Percentage of household residents with access improved water sources

Year	1990	1995	1997	2000	2003
Urban	38%	78.1%	87.9%	59.7%	92.1%
Rural	30%	49.6%	59.9%	66.0%	74.4%
National	32%	65.8%	65.8%	71.5%	78.8%

*Source: 1990- Joint Monitoring Program (DOH/UNICEF/WHO)
1995to 2003- Multiple Indicator Cluster Survey, Department of Health Planning, MOH*

Many different agencies including International NGOs such as Save the Children (UK), BAJ, AMI etc, are involved in the development of the country water supply and sanitation system. Among them, National Sanitation Programme of the Ministry of Health, Water Supply Programme, Environmental Sanitation and Hygiene Programme, (UNICEF), Community Water Supply and Sanitation Programme (HDI-UNDP) and Rural Community Water Supply Programme (Department of Development Affairs) are the most prominent programmes.

Cooperation and coordination exists among the UN agencies and other International Organizations. Strong cooperation from local NGOs like Myanmar Red Cross Society, Auxiliary Fire Brigade, Myanmar Maternal and Child Welfare Association, etc have also received at all levels. Collaboration efforts among the government agencies like Education, Information, Communication and Culture are also being made through school network, newspaper, television, and radio network and public shows, traditional dances and dramas. Private sector collaboration is also received through video spots shown in private video parlors, which are very popular among the rural community.

In order to give guidance and over all supervision of the programme, a "Central Supervisory Committee" was formed with the Director General, Department of Health as the Chairman and responsible persons from various departments and non-governmental organization as members.

5. Immunization ⁹

The EPI program was launched in 1978 within the first People's Health Plan cycle with four antigens namely BCG, DPT and TT. At that time, it covered only 176 townships out of 320. Later, the program was expanded as Universal Child Immunization program targeting all under one year age group. Measles and Polio

vaccines were introduced in 1987. By 1990, EPI achieved 80% coverage of

operational areas and in 1995, 305 townships were covered. By means of special crash program conducted in hard to reach areas, almost all (324) townships were covered by EPI program in 1997. Installation of solar-refrigerators and conducting crash programmes during favourable seasons for the very hard-to-reach areas made the EPI operational coverage for the whole country possible.

Table 8. Indicators for immunization

Indicators	1987	1994	2000	2006
BCG %	54.0	83.0	88.0	80.0
DPT3%	28.0	77.0	82.0	74.0
OPV3%	10.0	77.0	86.0	73.0
Measles%	17.0	77.0	84.0	74.0
TT2%	28.0	68.0	81.0	70.0

Source: Central Epidemiological Unit, Department of Health, MOH

Figure 8. Political commitment to reach the hard-to-reach for immunization

Figure 9. All means of transport are used for universal coverage of immunization

Figure 10. Providing OPV to a child in remote ethnic village

5.1 Poliomyelitis ^{9,11}

The occurrence of poliomyelitis in Myanmar could be traced as far back as 1927. Polio was endemic in Myanmar, especially around Yangon city area. In 1964-65 the disease occurred in epidemic form. In 1975, the estimated annual incidence of poliomyelitis was 5/1000 children in the 0-4 year of age.

The EPI programme was launched in May, 1978 with the commencement of People's Health Plan (1) (1978-82). As the immunization coverage increased over the years, the incidence of clinical poliomyelitis dramatically declined to very low levels. Prior to 1996 in Myanmar, poliomyelitis cases were reported every month through the routine reporting system. Surveillance of polio was passive

and by the time the Central Epidemiology Unit and EPI received the report, it was

too late to mount an effective response. In 1996, an active surveillance system for polio was established using acute flaccid paralysis (AFP) as a screening case definition. Since then the country has strengthened the surveillance system and AFP surveillance performance in Myanmar improved over the years. Morbidity trend of poliomyelitis decreased during 1988 to 1995 due to the Polio Eradication Program Activities. Because of the introduction of Integrated Weekly Surveillance system for AFP, Measles and NNT, number of polio cases reported increased for 5 years (1996 to 2000) and there was no more case beyond February 2001. Myanmar was certified as polio-free in February, 2003 and got Regional Certification in 2005. IN May, 2006 , once case of Vaccine Derived Polio Virus was found in Pyin Oo Lwin and sub-NIDs had to be conducted in 80 townships which are 100 miles around the area.

Polio-eradication was achieved through the four-pronged strategy which comprises of high routine immunization coverage with OPV, supplementary immunization in the form of national immunization days or mass campaign, effective surveillance and in the final stage, when very few cases or no cases are occurring, door to door immunization campaigns ("mopping up") in areas where the virus persists. The first national immunization days (NID) were organized in Myanmar in February, 1996 and March, 1996, targeting all children under five years of age regardless of previous immunization status all over the country using extensive social mobilization. NIDs showed strong political commitment at different levels down to the grassroots administrative units. Operational success of NIDs demonstrated strong leadership and managerial skills. MOH coordinated and directed the running of the campaign with the full collaboration and cooperation of other ministries, departments and sectors and voluntary NGOs.

Figure 11. Providing Oral Polio Vaccine in a field.

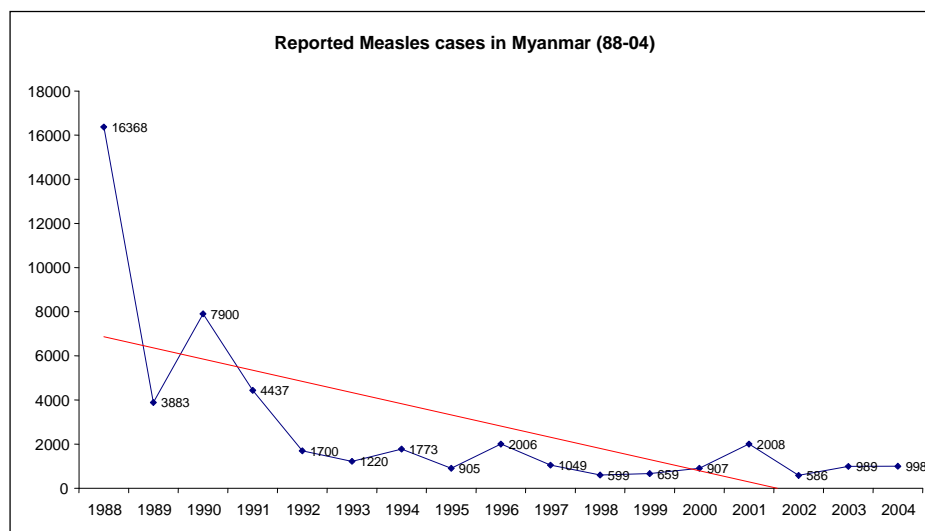
Figure 12. Providing Oral Polio Vaccine at a worksite.

5.2. Measles ^{9, 11}

Measles Control programme started in 1987 with the objective of 90% reduction of measles cases and 97% reduction in measles deaths. The programme was implemented with a campaign approach in Yangon and Mandalay and expanded to other Divisions in 1997. Records show that in 2002-2003, immunization coverage in 10 states and divisions was on average 88%.

Morbidity and mortality of measles showed substantial decrease in trend after introduction of measles immunization in 1987 (Figure 12). With the objectives of reducing measles mortality and morbidity in measles control program, EPI program had conducted Mass measles campaigns in all townships of the country in 2002-2004. However sporadic measles outbreaks still occurred in many parts of the country especially in 2003 and majority of the age group affected was under 5 years age group.

Figure 13. Trend of reported measles cases in Myanmar



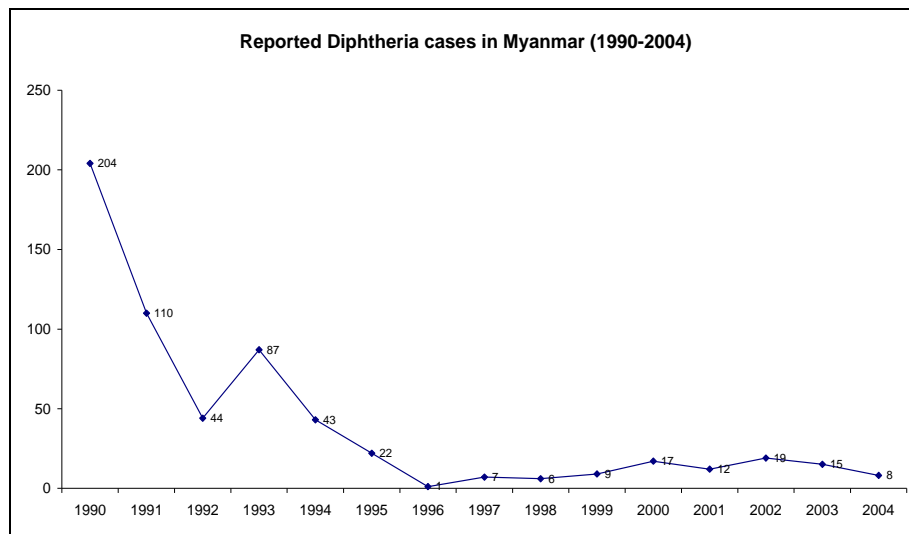
Source: Central EPI department, DOH

Figure 14. Minister for Health opens the Mass Measles Campaign in 2007

5.3 Diphtheria

Morbidity rate of diphtheria was markedly decreased due to the effort of EPI program. However sporadic outbreaks still occurred in some townships in recent years indicates the need to maintain the achievement of high coverage of DPT3 vaccine in all townships of Myanmar. Geographical distribution of cases in 2004 showed that most of the cases occurred in densely populated area like Yangon, Ayeyawady and Bago Division.

Figure 15. Trend of diphtheria in Myanmar



Source: Central EPI department, DOH

5.4. Neonatal Tetanus

After polio and measles, Neonatal Tetanus (NNT) is the disease targeted for elimination. One of the strategies for NNT elimination includes conducting Tetanus Toxoid (TT) campaigns in high risk areas or townships. It aims to reduce NNT incidence to < 1/1000 LB in every township in Myanmar.

6. Locally endemic diseases ^{9,11}

Myanmar has undertaken activities to protect the health of the people and developed disease control programmes since independence in 1948. Four major disease control programmes were established in the decade of 1950 viz Venereal Disease, Leprosy, Malaria and Pulmonary Tuberculosis. In response to the WHO initiative, Myanmar organized Smallpox Eradication Programme in 1963 and declared eradicating in 1971. Trachoma control which was initiated in 1964-65, moved very fast and reached the targeted epidemiological control in

1978 and the programme was converted into Prevention of Blindness

Programme. Leprosy, Poliomyelitis and Iodine Deficiency Disorders (IDD) Control, elimination and eradication also had proceeded so well that by December, 2000, there was a definite trend to achieve targets as planned. ¹⁰

Apart from smallpox (eradicated since 1971) and Trachoma (Epidemiological control in 1978), the control/elimination and eradication of IDD, Leprosy and Poliomyelitis were projected, using the baseline data and the trend in 2000. As projected and indicated the IDD prevalence using Total Goitre Rate (TGR), as indicator, was down to 5% in 2004. Leprosy was eliminated by February 2003 and Poliomyelitis eradication achieved since 1995 was declared eradicated in February 2003. ¹¹

6.1 Tuberculosis ⁹

Tuberculosis is one of the major public health problems in Myanmar. Annual Risk of Tuberculosis infection was 1.66%. According to the tuberculin survey conducted in 1972, 0.83/1000 population was sputum positive. According to the nation-wide survey carried out in 1994, sputum-positive point prevalence was 1.042/1000 population. Most of the TB patients are in the socially and economically productive age group of 15-54 years.

National Tuberculosis Programme (NTP) was established in 1966 and integrated with the Primary Health Care activities since 1978. The standard regimen containing Streptomycin and Isoniazid was replaced with Short Course Chemotherapy (SCC) and introduced in 18 townships and 8 States and Divisional TB centers in 1994. In 1997, NTP adopted the WHO recommended Directly Observed Treatment Short Course (DOTS) strategy. In 1999, NTP was covering 64.9% of the country population in 168 townships and implementing DOTS strategy through primary health care approach, in coordination with other government sectors and non-governmental organizations such as Myanmar Women Affairs' Federation, Myanmar Women and Child Welfare Association, Myanmar Medical Association etc. Basic health personnel carried out the community-based health education talks on TB at the township level down to the RHC level.

In 2000, DOPTS coverage extended up to 71% (covered 231 out of 324 townships). In 2001, NTP covered 259 townships (80% of total townships) and covered 90% of population. In 2002, NTP covered 310 townships (95.7%) of total townships and 95% of the population. Universal coverage of DOTS strategy was achieved in November, 2003. TB control activities were implemented according to the new "STOP TB Strategy" to achieve the global targets within the framework of Millennium Development Goals (MDGs). The NTP programme aims to achieve at least 70% case detection rate, 85% treatment success rate

under DOTS. In 2006, the treatment success rate was 99% and treatment

success rate was 84% (cure rate: 77%). The defaulter rate was 5% and case fatality rate was 6%. Case detection rate is poor in remote Chin State and treatment success rate is poor in provinces where HIV prevalence is high.

Collaboration and coordination with national and international NGOs play an important role in the DOTS implementation of TB control. Partnership with private sector has also been established; private practitioners had been trained through Myanmar Medical Association as trainers for Public-Private Mix-DOTS.

Figure 16. DOTS by family member supervised by a midwife

Figure 17. DOTS by members of Myanmar Child welfare Association

6.2 Leprosy^{9,11,12}

Leprosy has been endemic in the country for many centuries. In 1891, the total reported prevalence was 8.6/10000 population for the whole country and 14.4/10000 in central Myanmar. WHO Leprosy Advisory Team in 1963-64 estimated an average of 25/1000 (about 590,000 cases) where in some areas of central Myanmar the prevalence can be as high as 40 /1000. The National Leprosy Programme Prevalence and Assessment Survey reported estimated the prevalence of 24.24 /1000 population in 1973.¹²

In consultation with the World Health Organization the government launched an intensive programme for Leprosy Control in 1952. Leprosy treatment centers were established by appointment of Leprosy Inspectors and Junior Leprosy Workers where they started case finding and treatment. DAPSONE was used for treating cases at that time. Pilot Project Areas were started in 1957 and expanded to the whole of Central Myanmar in 1962. The project expanded to cover the whole country by 1969-70. On its 25th Anniversary, the WHO recognized the Leprosy Control Programme in Myanmar as one of the best WHO-assisted programmes in the world.

It was decided in 1969, to gradually handover the specialized leprosy control services to the basic health service. After initial trials, full integration trial was started in 1973. In the People's Health Plan (1), new category of health workers were introduced into the RHC organization, PHS 1 and II and are supported by voluntary health workers.¹²

From 1958 to 1982, dapsone monotherapy was the standard regimen for the

treatment of leprosy. A major challenge in Leprosy Control Programme occurred

in 1988, when WHO recommended MDT (Multi-Drug Therapy). MDT was introduced in six hyper endemic divisions and was initially provided on a domiciliary treatment by the leprosy control programme personnel and later by the BHS personnel in 1991. As a result of the integration of leprosy control programme into basic health personnel using MDT therapy, there was marked reduction in registered prevalence from 59.3/10000 population in 1986 to 2.5/100000 in 1998. An average of 8000 to 10000 new cases was detected annually from 1986 till 1997. Effective capacity building of BHS staff was achieved so that the first primary referral can be taken care of by the BHS.¹²

Information, education and communication (IEC) activities were intensified with the involvement of basic health service and voluntary health workers. Community-based rehabilitation (CBR) of leprosy patients was initiated in selected areas. A coordinated supervision and monitoring system was intensified and research activities were intensified. During 1995 to 1998, MDT reached every village making the geographical coverage 100%. All registered cases and new patients are treated with MDT in the villages as a domiciliary service approach by the basic health personnel. This integrated approach proved to be very effective and sustainable.¹²

In 1996, all registered cases were covered with MDT in 320 townships (out of 326). The outcome was reduction of prevalence from 6.11/10000 population in 1994 to 2.5 per 10000 population in 1998. During 1997 and 1999, special case finding activities known as "Leprosy elimination campaigns" (LECs) were carried out in 118 township in endemic areas. As a result of LEC, many hidden cases turned up voluntarily for diagnosis and treatment. The number of registered patients grows up again from 2.95/10000 in 1997 to 3.4/10000 in 1999.

LEC is a success story in public health history of Myanmar. Apart from the activities guided by WHO, there were some innovative and additional approaches, eg, conducting advocacy meeting at different levels, various kinds of mass media used for IEC, village authorities and volunteers reporting suspected cases for screening, examination of patients and persons affected with leprosy during field visits and active case detection of suspect cases. The total population covered during the National Leprosy Elimination Campaign was 98% of total population including special population groups such as armed forces personnel and their family members, work forces, factories and school children. Special Action Projects for the Elimination of Leprosy (SAPEL) was also implemented from 1998 to 2000 to provide MDT services for the population living in remote or difficult areas. It is an initiative aimed at providing MDT services to the patients living in special difficult areas or those belonging to neglected population groups. The special teams screened suspects, diagnosed and treat

leprosy cases on the spot while demonstrating cases to the basic health personnel and the volunteers.

Leprosy elimination at the national level was declared at the end of January, 2003 as the registered prevalence cases became 0.51/10000 population. The prevalence rate was lower than 1/10000 population all states and divisions in the country. At the end of 2003, hyper endemic divisions achieved elimination level. The objective of achieving Leprosy Elimination became a reality, in spite of many difficulties, with limited resources, difficult terrain, and security problems in border areas. Leprosy Elimination had been achieved due to high political commitment combined with the support of the community and the local authorities.

Table 9. Essential Indicators for leprosy control

Indicators	1991	1995	2000	2006
Registered prevalence rate/10,000	19.3	4.7	2.2	0.49
New case detection rate/100,000	23.2	14.7	21.8	6.59
MB % among new cases	44.22	52.6	54.00	63.02
Grade II% among new cases	14.1	9.3	7.50	11.31
<15% among new cases	11.69	14.2	9.02	6.80

Source: National Nutrition Center, Department of Health Planning, MOH



Figure 18. Distributing Posters during LEC

Figure 19. Conducting a LEC session in a remote ethnic village

6.3 Malaria ⁹

Malaria has been ranked as a priority disease and has also been a national concern ever since the People's Health Plan started in 1978. Malaria is the major public health problem in Myanmar due to climatic change, migration of non-immune populations into malaria endemic areas in connection with various development activities, gem mining, logging, agricultural, plantations and construction etc. ¹³

In Myanmar, 30% of the population lives in high-risk area and 24% in moderate-risk area. Case fatality rate is 3%; about 10% of total out-patients and 15% of in-patients are malaria cases. Malaria morbidity rate per 1000 population is 9.51 and malaria mortality rate per 100,000 population is 2.91 in 2005. Malaria epidemics frequently occur due to population migration and climatic changes.

Malaria control programme was started in 1951 as "Pilot Project" at Lashio of Shan State, Sittwe of Rakhine State, Myitkyina of Kachin State and Mawlamyaing of Mon State. After 5 years of implementing the pilot project, Malaria Eradication Programme (MEP) was established in 1957 as a vertical programme for the whole country. Surveillance system, presumptive treatment with chloroquine, and Regular Indoor Residual Spray were the key activities of MEP. There were four phases in MEP namely Preparatory Phase, Attack Phase, Surveillance Phase and Vigilance Phase.

The Malaria Eradication programme was transformed into Malaria Control Programme" in 1970, due to the appearance of chloroquine resistant Pf. Malaria parasite, resistance of vectors to the DDT spray, behavioral change of vector due to DDT, increase population migration and increasing operational cost for DDT spray. The Malaria Control Programme was carried out according to the stratification in terms of Stratum I, II, III and IV, V ; Drug Area, Spray Area, Surveillance Area, Vigilance Area and Malaria Free Area respectively .

In 1978, malaria control programme is integrated into the Basic Health Services and activities were carried out using Primary Health Care approach by BHS staff and malaria staff. At the same time, Malaria, DHF, Filariasis and Japanese Encephalitis control programme came under the umbrella of Vector Borne

Diseases Control Programme. The control activities were carried out under

Stratification of malarious areas; regular spray programme was changed to Selective Indoor Residual Spray according to the National Spray Policy which recommended sprays to be conducted in epidemics and epidemic prone situations only.

Currently, MOH is carrying out malaria control activities in line with Global Malaria Control Strategies; micro-stratification of malaria has been done up to the township level for appropriate allocation of resources to maximize the impact. New Antimalarial Treatment Policy has been jointly developed and adopted in Myanmar with UN agencies, bilateral partners, national and international NGOs and since 2002.

Microscopic facility for malaria diagnosis has been expanded up to 700 rural health centers and Rapid Diagnosis Kits have been distributed up to sub-rural health center level. Supplies such as antimalarial drugs (ACT therapy) have been distributed to 325 townships up to the sub-RHC level. Due to these measures, even people from rural and remote areas can easily access to early diagnosis and appropriate treatment services without delay which in turn reduces severe malaria and deaths.

To prevent from malaria, National Malaria Control Programme provides 50,000 Long-Lasting Insecticidal Nets (LLIN) annually since year 2000 to malaria endemic and hard to reach areas of national races. Since the year 2000, around 300,000 to 400,000 bed nets were impregnated with insecticide annually; about 679,000 bed nets were impregnated in 2006. Mobile malaria teams carry out malaria epidemic prevention and control activities in epidemic prone regions.

Because of these interventions, trend of both malaria morbidity and mortality are declining. The success of malaria control programme is due to the concerted efforts of MOH, UN agencies, bilateral partners, national and international NGOS and local communities. Three Diseases Fund (3DF) has been formed to support scaling up malaria prevention and control in Myanmar in 2006.

Table 10. Indicators for Malaria

Indicators	1976	1990	1995	2006
Malaria Morbidity rate /1000 pop:	18.68	24.35	14.65	9.51
Malaria mortality /100,000 pop	2.37	12.62	5.5	2.91
Case Fatality Rate%	1.68	3.32	3.54	2.62

Source: National Malaria Control Programme, Department of Health, MOH

Figure 20. Treating bed nets with insecticide for the community

Figure 21. Raising community awareness about impregnated bed nets

Figure 22. An out-reach malaria clinic in a hilly area.

6.4 Filaria⁹

The first case of elephantiasis was found in 1877. In 1925, Night Mass Blood Survey (NMBS) was done for diagnosis and treatment of Mf positive cases. In 1959, Antifilaria campaign by Municipal Council of Rangoon conducted culex larval control by using fenthion insecticide. Since 1960, Anti-filariasis Division of Health Department had carried out case finding with NMBS and treatment of positive cases. In 1962, WHO established Filariasis Research Unit in Rangoon. After the completion of the research project, Pilot Vector Control Programme was launched in Rangoon during 1966-69 by using 50% EC fenthion as larvicide.

The National Filariasis Control Project was established in 1970 under the Directorate of Health Services with case finding and treatment of positive cases. In 1978, the programme has been integrated into Vector Borne Diseases Control

(VBDC). In 1983, culex larval control was stopped because of occurrence of

vector resistance to insecticide. In 2001, the Global Strategy of Elimination of Lymphatic Filariasis (ELF) was adopted and National Task Force for ELF was formed. Since 2001, Mass Drug Administration (MDA) by using Diethyl Carbamazine Citrate and Albendazole has been started in Magway Division. Activities such as Mapping of Filariasis Endemic areas, Mass Drug Administration and Morbidity Control, training, monitoring and evaluation were carried out according to the global strategy of ELF. Mapping activities were completed in 2007. The endemic areas were to be covered by MDA and morbidity control. Up to 2007, 101 townships of 4 State/ Divisions such as Magway , Sagaing, Mandaaly and Rakhine with 18 Million population were covered with MDA. Reduction of Mf rates was seen in some Implementation Units from 1-10% to < 1% within 5 year period.

6.5. Trachoma ^{12,13}

For centuries, Myanmar has known blinding trachoma and suffered its debilitating consequences. The first road-side survey done in 1962 in central dry zone reported that 80% of the people lying on the road side was suffering from trachoma and 57% of the blindness was attributable to the same disease. ¹³ MOH started the Trachoma Control Programme in 1964. The project covered the whole of dry zone with the population of 6.5 million. Initial surveys reported prevalence of active trachoma rate of 30% ; the majority of cases were found in under 10 years of age group and active trachoma with scarring was still present in 60 year and above age group. When the project started in 1964, control activities were carried out using vertical approach. The mass treatment programme distribution and application of eye ointment, supervision, health education , trichiasis survey etc were performed by trachoma project personnel. In 1978, the vertical approach was changed to integrated approach. Voluntary health workers are also trained to deliver primary eye care services in addition to trachoma control activities.

SAFE strategy (Surgery, Antibiotic, Facial Cleanliness, Environment improvement) was used to control blinding trachoma. In addition, health education, community participation and integrated approach with intersectoral and international coordination are essential for the successful implementation of SAFE strategy. Myanmar Trachoma Control Programme did extremely well and achieved the targeted control situation long before 2000. In 2004, the trachoma rate was less than the accepted level of 5% in all the entire country, and less than 1% in most townships. The programme was converted into Prevention of Blindness Programme since 1978 and is now focusing on implementing the Vision 2020-the right to sight. Under Vision 2020, trachoma still will be monitored and treated, operating cornea opacities and expected to complete operating 300000 backlog of cataract during this period.

Figure (23) An outreach eye clinic by the Prevention of Blindness Programme

7. Treatment of common illness and injuries

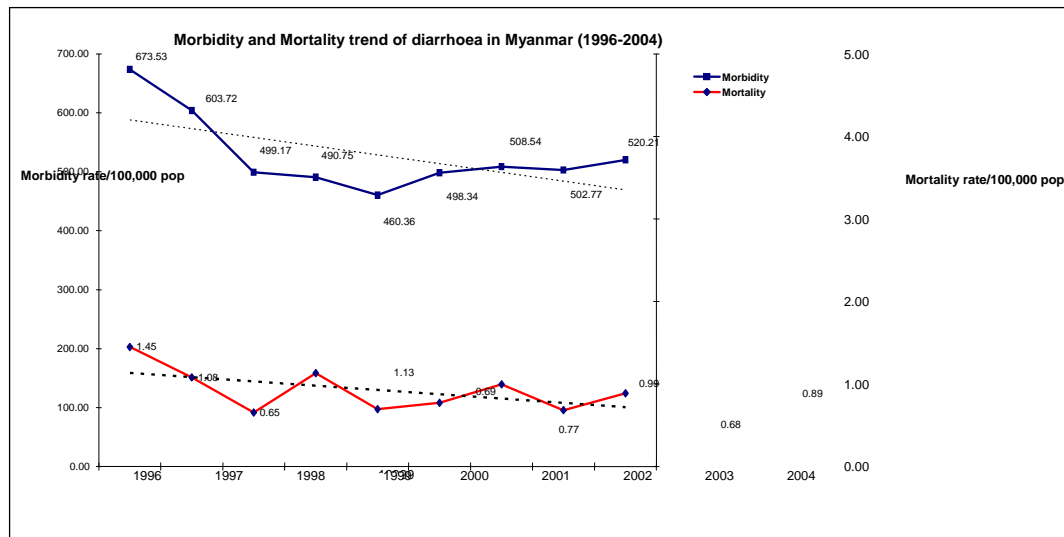
As a tropical country Myanmar have had its own share of prevailing disease for centuries and communicable diseases still constitute the major public health problem in Myanmar.

7.1. Diarrhoea Diseases (Diarrhoea, Dysentery, Food poisoning, Typhoid & paratyphoid, Viral Hepatitis)

Diarrhoea diseases are one of the major public health problems and are presented with diversified signs and symptoms caused by multiple etiologies. During the decade of 1970s and 1980s while malaria was single leading cause of morbidity among cases treated in township hospitals (proportion ranging from 8% to 12% of total cases), gastrointestinal disorders altogether contributed more than 15% of total cases.

According to the priority ranking of diseases based on scoring system in National Health Plan III, diarrhoea and dysentery ranked 4th position, viral hepatitis on 13th and cholera on 16th. Overcrowding, rapid urbanization, population migration, poverty, poor sanitation and inaccessibility to safe water are the major contributing factors.

Figure 24. Trend of morbidity and mortality of Diarrhoea in Myanmar



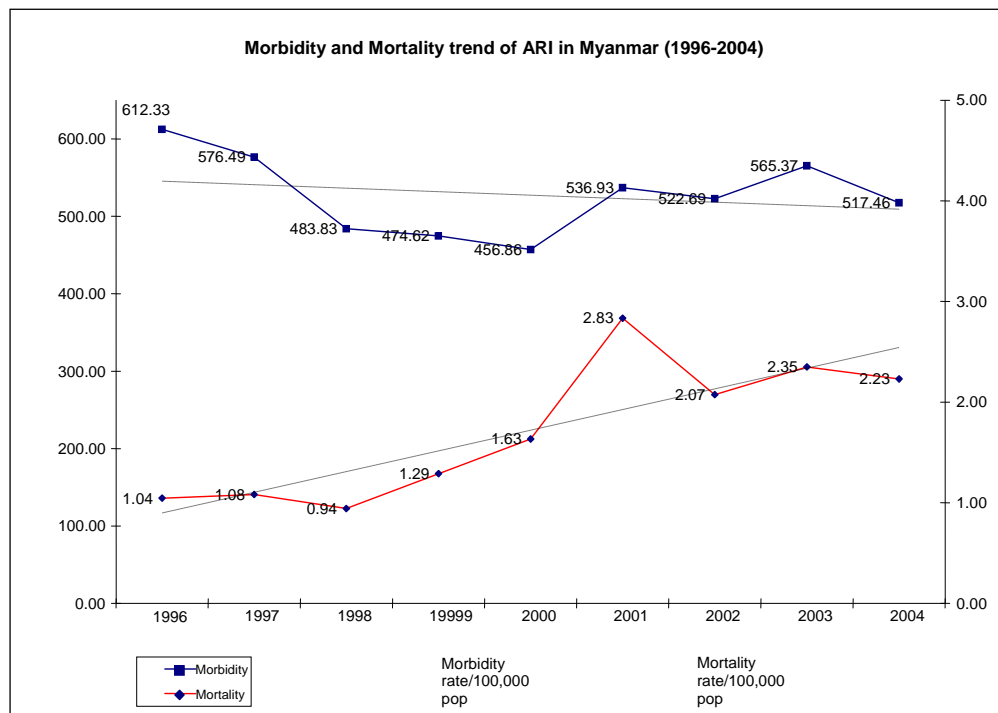
Source: Central EPI Department, DOH

Morbidity and Mortality trends of diarrhoea cases were shown in Figure (18). Morbidity rate of diarrhoea per 100,000 population ranged from 673.53 in 1996 to 520.21 in 2004. The trend was decreasing but it has inclined slightly between 2000 to 2004. The mortality rate showed slightly decreasing trend. The Case Fatality Rate (CFR) also decreased due to increased utilization of Oral Rehydration Salt.

7.2 ARI / Pneumonia

ARI was recognized by WHO as a major health problem in children under 5 in developing countries. It is one of the five leading causes of morbidity and mortality in most of the states and divisions and high morbidity also coincides with high population density. Reported morbidity trend showed slight decreasing of ARI/pneumonia but mortality trend was increasing. Although the disease affected all age groups, high mortality rate was found in <1 year age group.

Figure 25. Trend of ARI/Pneumonia



7.3 Injuries ^{14,15}

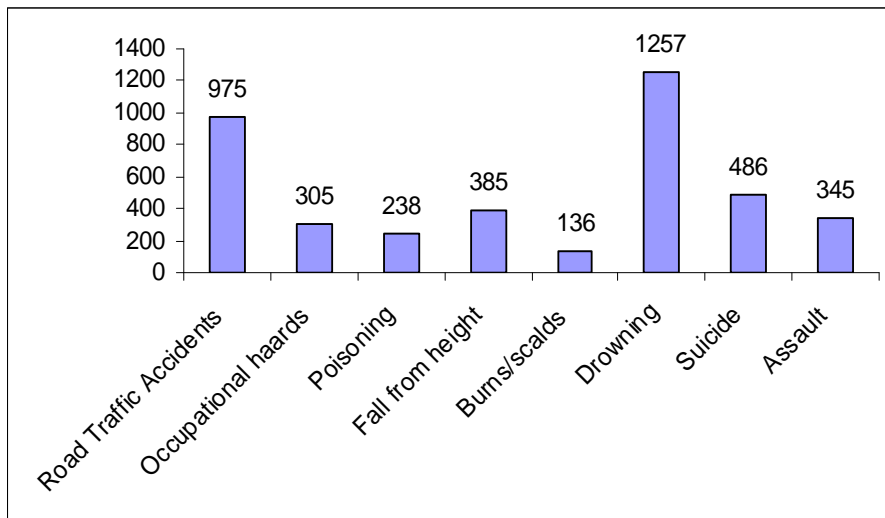
According to hospital statistics, injury is the third leading cause of mortality during

2003 to 2005. ¹⁴ There is a rise in road traffic accidents and industrial accidents.

Accident prevention measures had been implemented as a project in collaboration with WHO since 1990. There is no uniform system of reporting and recording data on accidents and injuries. At present, data are collected by MOH through the Health Management Information System (HMIS), Road Transport Administration Department and Police Forces. Data on accidents and injuries were included in HMIS only since 2005.

The Accident Prevention Project had done some surveys in 2003 and 2005 in trauma centers throughout the country to develop an injury surveillance system that would facilitate injury prevention and control at both local and national levels. The survey findings showed that the leading causes of death due to injury are drowning and road traffic accident.

Figure 26. Distribution of deaths due to injuries and accidents in 2005



8. Essential Drugs ^{9,15}

Essential drugs are those satisfy or most needed for the majority of the population, they should therefore be available at all times in adequate amount and in the appropriate dosage forms and at a price that individuals and the community can afford. Myanmar Essential Drugs Project was established in 1988-1994 and transformed into Myanmar Essential Drugs Programme (MEDP) in 1994-95 with extension of activities to all townships in the primary health care level. The project has replicated phase by phase and now, all townships have been covered with essential drug concept, rational use of drugs, estimation of drugs requirement, systematic management of drugs supply system and drugs counseling, information, education and communication relating to use of drugs to community for compliance to essential drugs. ¹⁵

The list of essential drugs had been developed based on the problems identified by the basic health personnel prescribe treatment using these standard guidelines. Due to MEDP, essential drugs are available at all different levels. Use of generic drugs ensures affordability due to reasonable price (cheaper than brand and trade drugs) with assured quality. Careful selection of essential drugs prevents acute shortage of essential drugs and prevents piling of unused non-essential drugs. There is improvement in the quality of care at grassroots level due to use of Standard Treatment Guidelines prepared by experienced public health experts, pharmacologists, pharmacists and senior clinicians for four different levels of health care facilities. The treatment guidelines are reviewed and revised periodically.

During replication of project activities, it has adopted Community Cost Sharing-

(CCS) for drugs in all townships for sustainability of essential drugs. The CCS

system has incorporated into the Revolving Drugs Fund system (RDF) at township level for replenishment of drugs locally independently. The Township Medical Officer has to establish the drug shop with revolving drug funds and replenish the required essential drugs with the approval and agreement by the Township Health Supervisory Committee which supervises and monitors the CCS. RDF serves as mean of establishing drug financing for the townships , MEDP has also extended its activities to general practitioners in private practice through the Myanmar Medical Association, and had advocated them to select from the essential drug lists according to their area of organization and services on the principles of essential drugs programme of WHO.

(b) Other elements of PHC

1. Non-communicable disease control

Myanmar, as a developing country, has its share of the burden of NCDs. Knowledge of the epidemiology of NCDs in Myanmar is poor as there are only a few small scaled studies. Most of the data available are from the health reports and returns which would not reflect the true status of the disease in the community.

A small scale study (community-based cross sectional study conducted in Yangon Division among adults 25-74 years of age) reported prevalence of diabetes as 12.64% of females, 11.51% of males; prevalence of hypertension as 28.8% of females and 31.8% of males; obesity as 11.05% of females and 5.38% of males. Surveys conducted in different parts of the country have reported that hypertension is found in approximately 20% of the population, diabetes mellitus in 8-12%; overweight in 16-18% of the population and smoking prevalent in 20-23%. Deaths due to NCDs contribute 51% of all deaths & 44% of overall morbidities (Hospital Statistics,2005.DHP.)

In 2003-2004, diabetes project of the Ministry of Health has undertaken a STEPwise approach survey on prevalence of diabetes mellitus and prevalence of risk factors for major non-communicable diseases (NCD) in rural and urban areas of Yangon Division. It was a collaborative effort between the diabetes project and the nutrition research division of the Department of Medical Research (Lower Myanmar), in response to the urge by WHO SEAR to study the risk factors for major non-communicable diseases in the country. This survey reported prevalence of diabetes among 12.6% of females and 11.5% of males, prevalence of hypertension as 28.8% of females and 31. 8% of males, and prevalence of obesity as 11.05% of males and 5.38% of males ¹⁶ among the sample population.

The World Health Survey (2003-2004) reported prevalence of insufficient intake of fruit and vegetables (less than 5 servings of fruit/vegetables /day)as 83.6% ; prevalence of insufficient physical activity (less than 150 minutes/week spent on walking/moderate activity/vigorous activity) as 10% of the sample population.

The same survey reported prevalence of smoking as 22.6% of total population, 35.3% of males and 10.4% of females ; prevalence of non-heavy drinkers as 14.7% of the population, infrequent heavy drinkers as 0.8%, frequent heavy drinkers as 0.7%.¹⁴

The WHO STEPwise survey in Yangon Division (2003-2004) also reported core behavioral measures and physical measures as follows⁶:

Table (11) Behavioral measures and physical measures in Yangon Division

Item	Male	Female	Total
% who eat less than 5 servings of fruits and vegetables /day	98.6	98.7	98.7
% of inactivity	7.3%	7.8%	7.6%
Average time spent sitting/day (minutes)	1683.2	1617.9	
Average time spent in moderate activity/week (minutes)	704.9	728.6	
Average time spent in vigorous activity/week (minutes)	91.4	9.1	
% who are obese (body mass index ≥ 30 kg/m ²)	0.39	0.96	0.6
% with high blood pressure	20.04	27.54	23.54
% with elevated blood glucose	8.86	9.87	8.52
% with elevated serum cholesterol	21.2	35.1	26.3
% who smoke currently daily	36.0	11.1	23.2

The Ministry of Health of Myanmar is implementing NCD control programme as one of its priority health programmes within the context of National Health Plan. NCD Projects in Myanmar include :- Cardiovascular Disease Control (CVD) Project, Tobacco Control Project, Diabetes Control Project, Nutrition Project, Cancer Control Project, Accident Prevention Project, Mental Health project, Drug Abuse Control Project and Accident Prevention Project.

Projects under the NCD control programme such as Cardiovascular Disease Control programme and Diabetes Control programme promotes healthy lifestyle,

balanced diet and physical activity; disseminating education messages through

all forms of media. The National Nutrition Center is implementing projects which address all aspects of nutrition, both over-nutrition and under-nutrition and micronutrient deficiency. National dietary guidelines had been drawn up and disseminated. Food safety and food security is also being taken care of by various departments of the Ministry of Health. School Health programme includes nutrition and physical education to promote healthy diet and to counter food fads and misleading dietary advice. Life-skills education programme, implemented at basic education schools incorporates nutrition and physical activity in its curriculum.

2. Tobacco Control

The National Programme on Tobacco Control was officially launched in January 2000 with the drafting and approval of the National Policy on Tobacco Control and Plan of action. The National Tobacco Control Committee was formed in March 2002, headed by the Minister for Health and included heads of related departments and chairpersons of several national NGOs as members. The Committee set guidelines for the tobacco control measures to be implemented in the country.

The Ministry of Information prohibited advertisement of tobacco on television and radio and from all electronic media in the year 2000. Tobacco advertising billboards were banned from the vicinity of schools, hospitals, health facilities, sports stadiums and maternity homes in May 2002 and from other places in April 2003. Tobacco advertisement was also banned from the newspapers, journals and magazines in early 2003. Smoking was prohibited at all hospitals and health departments, at all basic education schools, all sports stadiums and sports fields and at some workplaces.

In May 1999, the World Health Assembly-the governing body of the World Health Organization, adopted a resolution (WHA 52.18) which paved the way for starting multi-lateral negotiations on the WHO FCTC and possible related protocols. Myanmar along with fellow Member States actively participated in the negotiating process of the WHO FCTC and strongly supported the convention. Myanmar delegates expressed their strong commitment towards comprehensive tobacco control measures and voiced for the need of a comprehensive ban on all forms of tobacco advertisement including cross-border advertising. Myanmar proudly hosted the 4th Inter-country Consultation Meeting on Framework Convention on Tobacco Control in August 2002, where the countries of South-East Asia Region issued the "Yangon Declaration".

Myanmar became a signatory to the FCTC on the 23rd of October 2003 and became a Party to the Convention on the 20th of April, 2004; it was the 11th

country to become Party to the Convention. Minister for Health, Professor Dr.

Kyaw Myint, received the “World No-Tobacco Day 2004” award for his excellent leadership in the area of tobacco control in Myanmar.

Table (12) Prevalence of tobacco use at sentinel townships in 2001 and 2004

Item	2001(%)	2004(%)
Current tobacco user	39.8 (± 2.0)	40.2(±0.0)
Current smoker	31.1 (± 2.0)	28.5(0.0)
Current smokeless	14.9 (± 1.6)	15.0(0.0)

Source: Tobacco Control Programme, DOH, MOH

The Control of Smoking and Consumption of Tobacco Products Law was adopted on 4th May, 2006 as the State Peace and Development Council Law 5/2006. The adoption of the law was a very significant milestone in the history of public health of Myanmar.

According to this law many public places including hospital buildings, offices, medical treatment centres and clinics; stadiums and indoor playing fields; children drill sheds and playgrounds; teaching buildings, classrooms, offices, compounds, opera houses, cinema halls, video halls and other buildings of entertainment; marts, department stores, stores and market sheds; museums, archives, public libraries and reading rooms; elevators and escalators; motor vehicles and aircrafts for passenger transport; air-conditioned public rooms; public auditoriums etc are non-smoking areas. Places to which the public have access in certain buildings, vehicles and crafts are non-smoking areas except the private offices and rooms. However, specific places where smoking is allowed, shall be arranged in such areas which include buildings of offices and departments; buildings of factories and workshops; buildings of hotels , motels, guest houses and lodging houses; buildings of railway stations, airports, ports and highway bus terminals; restaurants; trains and vessels for passenger transport.

The tobacco control law which came into force one year after its adoption strictly prohibits tobacco advertisement in all forms; it also prohibits sale of tobacco to and by minors, sale of cigarettes singly or in a package containing less than 20 to enable easy purchase and smoking. The law also states that it is an offence to produce, distribute or sell cigarette and other smoking tobacco products without a health warning in Myanmar language.

Figure 27. A tobacco free school

Figure 28. A tobacco free Rural Health Center.

3. Mental Health ^{9, 15}

Provision of mental health care has started in Myanmar since 1948, when Myanmar regains independence. In the early days, mental health care system began in hospital setting in Yangon and then extended to Mandalay. In 1990, mental health care was included in National Health Plan.

Mental illnesses are now becoming one of the emerging health problems. A community survey revealed that prevalence of all mental disorders is about 85/1000 population with psychosis 6/1000, epilepsy 4/1000 and mental retardation 5/1000 population.

Approaches to mental health need to be decentralized and institutionalization as well as stigmatization should be avoided. Attempts have been made to shift mental health care from hospital setting to community settings to ensure effective care. The main aim of Mental Health project is to integrate into existing PHC delivery system; care and support of mentally ill patients to be given by trained BHS and psychological and social support to be given by families and the community. Mental health education is being provided through local NGOs and training of BHS, community health workers and NGOs are being conducted.

4. Primary Oral Health Care ^{9, 15}

Dental caries and periodontal diseases are the two major and most common oral diseases in Myanmar. Prevalence of these diseases is high in all ages of the population and knowledge, attitude and practice of oral health is poor among the community. Oral health needs of 70% of the country's population are unmet to a great extent, due to lack of awareness and lack of access to services.

The Primary Oral Health Care Project (POHC) formed in 1991 has expanded and covered 87 townships in 14 states and divisions throughout the country. The project provides central level training of trainers courses to dentists and township retraining courses are conducted for health assistants and other basic health staff in each project townships. POHC project's community services are focused on oral health education and promotion, basic and emergency care, primary and secondary referrals. In primary schools of the project townships, after lunch tooth-brushing drills are a special feature, organized and lead by school teachers and basic health staff, trained on oral health.

The essence of organizing school tooth brushing drills is to socialize oral hygiene habits as important component of the grooming behavior for primary school children in their future lifestyle.

5. School and Youth Health ^{9, 15}

The student population is about 7.7 million in 2006. School Health Programme has been implemented with the objective of promoting the health standard of entire student youth through health promoting school programme. School Health has been already integrated into PHC and other health development programmes since implementation of PHP1 (1978-79).

Since 1998, Myanmar has implemented the health promoting school programme with the support of WHO. All schools are covered with health promoting school programme by the year 2006. Annual coverage of schools examined varies within 80 to 85% of schools and 65 to 70% of students.

Five year strategic plan for adolescent Health (2006-2010) has been developed to ensure a logical and coordinated response to the priority health needs of young people in the Union of Myanmar.

Figure 29. Hand-washing practices at a primary school.

6. Occupational Health and Safety ^{9,15}

Occupational Health (OH) is one of the environmental health issues described by WHO in 1996. The OH Division of DOH is providing services such as medical examinations of workers, trainings to the factory management and workers and advice regarding the practice of Healthy Workplace.

Dispensaries have been set up in governmental and private factories where number of employees is large, to provide curative services. Employees and laborers of small factories and cottage industry have to rely on social security dispensaries and township health facilities. Apart from curative services, these workers are unable to enjoy the benefits of promotive and preventive services. OH division is facing difficulties in inspecting these places for health purposes since there is no legal provision to support the activities. Measures to collect and compile data on factories and enterprises that are expanding with continuous in the industrial sector are still in process.

The OHD is implementing the activities such as advocating preventive measures to protect the public's health including workers' health, fostering community capacity to manage healthy environment, health impact and risk assessment and epidemiological surveillance of environment-related diseases according to the plans of action in the projects.

7. Food and drug safety ¹⁶

In accordance with the provisions of the National Drug Law (1992) and National Food Law (1997), Food and Drug Administration (FDA) has tested the quality and safety of drugs and food produced locally as well as those imported. To promote and safeguard the health of consumers down to the grassroots level, field laboratory services are extended to states and divisions as well as remote areas using Mobile Laboratory Vehicle. Equipped with necessary laboratory materials, the mobile laboratory can perform market surveys and sample collection, organoleptic examination, microbiological and chemical examination of food and water, identification and potency assay test of drugs and microbial contamination tests for syrup preparations.

With advancing scientific technology and increasing use of chemical and atomic energy, mankind and environment have been increasingly exposed to toxic hazards. As the country is on its way to overall development through industrialization toxic hazards to the community and the environment are increasing. In pursuant to the directives of the Head of State and in response to the needs to protect people and environment from these hazards a National Poison Control Centre has been established in the Ministry. With the objectives of preventing and mitigating toxic hazards through surveillance, research, community education, timely intervention and control measures some organizational changes have taken place in the Department of Medical Research (Lower Myanmar) and the Department of Health where new divisions have been set up or older ones reorganized and upgraded.

8. Health Care for the Elderly ^{9, 17}

Health Care of the Elderly Project was initiated since 1992-93 starting with six townships and expanded yearly. The project townships were provided with special instruments for eye, ear, nose, throat care for the elderly as well as for dental care. Free distribution of reading glasses and free insertion of intra-ocular lens to the elderly patients was part of the project activity.

Elderly clinics are opened at Rural Health Centers once a week; minor illnesses are taken care at the Rural Health Center from which those needed to be referred are being referred to the nearest township hospital. Basic Health Staff as well as local NGOs and volunteers were trained for basic elderly care and medical personnel from the hospitals were trained on case management of elderly patients.

Capacity building of the basic health staff includes understanding the underlying causes of the illnesses and influencing factors of the social, mental and health

problems that the aged are facing; health education and counseling, training on

physical activities to demonstrate to the elderly patients and to collect base-line survey of the elderly in the community. Elderly Day is usually held all over the country on the 1st of October and on that day, elderly are provided with medical care by health personnel assisted by NGOs and gifts are also offered to them.

Figure 30. Promoting elderly health.

9. Gender and Health

In Myanmar, the issue of gender equity and equality in health is still new and little research exists on the real situation of women and men in communities. During the biennium 2004-2005 research on “Role of Gender in the rural communities of two selected townships in Myanmar” and “Knowledge, Attitude and Practice on gender issues amongst Basic Health Staff” were conducted by the Gender and Women’s Health project in collaboration with the Department of Medical Research (Lower Myanmar). From the role of gender in rural communities study it was found that there was no marked gender discrimination among poor people in rural areas of Myanmar. For the biennium 2006-2007 one study on role of gender in urban and peri-urban areas was conducted to complement the results of previous year’s research. As regards gender mainstreaming issue, module for Gender and Health in the community and module for facilitator’s guide for Gender and Health in the community were developed, followed by field testing in two townships. Later Gender and Health issues will be disseminated to Basic Health Staff and familiarize them with gender equity issue in service provision. At the same time sensitization on gender and health at the health manager level was done by a two-day workshop emphasizing on gender and TB using gender analysis tools and gender mainstreaming tools. All these activities will lead to development of strategies for integrating gender equity into programmes, policy, and capacity building in the health sector.

10. Emerging Diseases

10.1 HIV/AIDS^{9,16}

AIDS is a disease of national concern and one of the priority diseases included in the National Health Plan of Myanmar. However, the short term plan has started in 1989 for the technical and systematic efforts. The National Health Committee has laid down clear guidelines to respond to HIV and AIDS. Established in 1989, the National AIDS Committee serves as an active multisectoral body for

formulation of National Strategic Plan to prevent and control HIV and AIDS in

Myanmar. The working committee, state/division/district and township level committees were also formed in the same year. Currently, the forty five AIDS/STD Prevention and Control teams strategically situated in all states and divisions of Myanmar form the core of the National AIDS Control Programme. The action plan for AIDS and STD prevention and control activities is subsumed under the National Health Plan.

The active surveillance of HIV and AIDS began in Myanmar since 1985. The first comprehensive surveillance system was developed in 1992 including surveillance amongst blood donors and AIDS reporting by health facilities. The first person with HIV infection was diagnosed in 1988, and the first person with AIDS was reported in 1991, an injecting drug user. Biennial HIV sentinel surveillance began in 1992; however, since 2000 it has been conducted once a year and has now covered 34 townships across all States and Divisions. The populations sampled for HIV sentinel surveillance are injecting drug users, male STD patients, and commercial sex workers, pregnant women attending antenatal clinics, TB patients and military recruits. In collaboration with National Tuberculosis Programme the TB patients from TB clinics were included in HIV sentinel surveillance since 2004.

Based on AIDS case reporting in 2002, it has been estimated that 68 percent of cases were attributable to sexual transmission, and 30 percent to injecting drug use. Two percent of cases may be attributed to vertical transmission and transmission through the blood supply and through unsafe injection practices.

Official surveillance data from 2004 show a slight decrease in rates of HIV infection among high-risk groups, but with seemingly ascending trends between 2004 and 2005. By 2005, HIV prevalence in male clients of STI clinics was 4.07%, sex workers 31.98% and injecting drug users 43.24%. A decreasing trend was reported between 2003 and 2005 in donated blood (0.73%) and new military recruits (1.33%) testing positive, while there was a decrease within pregnant women attending antenatal clinics between 2004 and 2005 (1.32%).

The magnitude of the epidemic had been recognized and the efforts to respond to it had indicated strong commitments of many partners to focus prevention, care and support efforts on the most vulnerable populations. Government, international and national non-government and private entities had contributed to the national response. The National AIDS Programme had well coordinated the inputs of national and international partners and tools and technical guidelines had been produced for a broad range of programme components. Coordination and cooperation has been made with 19 International NGOs, 17 Local NGOs and the other in line ministries with accountable relationship based on the enlightened

and progressive principles of openness, respects and unity.

With the tremendous increase in prevention efforts, especially those focusing on condom promotion for sex workers and their clients, 100% Targeted Condom Promotion Programme have expanded from four sites in 2001 to 170 sites in 2006; and on drug users, various elements of a harm reduction strategy were implemented in pilot areas since February 2006. Some effective interventions were in place for mobile populations, the blood safety programme had made progress covering most of the public hospitals, and HIV education was provided for youth in schools. Care, support and treatment were gradually made available, including provision of antiretroviral therapies in 14 State/Divisional General hospitals and Waibagi specialist hospitals and a prevention of mother to child transmission programme has been expanded to 89 townships and 37 State/Divisional and district level hospitals. Community and Home based care has been expanded to 40 townships over the country in 2005. The syndromic management of sexually transmitted infections was readily implemented in 314 townships.

Milestones of HIV/AIDS

- Systematic studies on diagnosis, prevention and control activities on HIV and AIDS were initiated since 1985
- Ad hoc studies for HIV started in 1985
- First HIV infected case was recorded in 1988
- AIDS control programme started in 1989 with a short-term plan
- National AIDS Committee established in 1989. Working committee, state/division/district township level committees were also formed in the same year.
- First AIDS case reported in 1991
- HIV Sentinel Surveillance started in 1992
- Behavioural surveillance and STD (syphilis) surveillance started in 1997
- Prevention of mother-to-child transmission programme started in 2000
- 100% condom use programme started in 2001
- Nation wide coverage for blood safety achieved in 2004
- National level exhibitions on HIV and AIDS conducted in 2003 and 2004
- Public sector antiretroviral therapy for people living with AIDS started in 2005
- External review on health sector response to HIV and AIDS conducted in 2006
- The National Strategic Plan for 2006-20 10 approved in 2006

Peer education among out of school youths

Figure 31.HIV education activities

10.2 Avian Influenza ⁹

The first wave of HPAI outbreaks in poultry in Myanmar occurred in March and April 2006 in Sagaing and Mandalay in central Myanmar. The second outbreak occurred in Yangon and its vicinity in February/ March in 2007 affecting the seven farms. The outbreaks reoccurred in Yangon again in May and recently in Mon State and West Bago Division although the scales of the outbreaks were much smaller than those in Mandalay in 2006 and in Yangon in March 2007. Control measures were quickly put in place in both animal and human sectors. No confirmed human cases have been reported.

In close collaboration with LBVD, reports of any poultry deaths and surveillance of live bird markets were received on a daily basis. Health education was given to poultry owners, workers and their families on AI prevention and control measures.

Myanmar has recently acquired the capacity to detect and identify H5 in Human and animal. Rapid test kits are now available for the diagnosis of influenza A in either humans or birds. Starting early 2007, with the provision of supplies and equipments as well as physical upgrading of the laboratory and laboratory personnel training, the National Health Laboratory (NHL), and the Department of Medical Research Laboratory (DMR) have been upgraded and are now able to perform AI diagnostic testing.

In addition to supporting the NHL, and DMR in H5N1 identification, an equally important goal is to establish the National influenza Center at NHL. Both WHO and MOH are working towards establishing the National influenza Center (NIC) at NHL. Physical upgrading and renovation of AI laboratory at NHL is underway.

As part of the national stockpiling for pandemic preparedness and response, PPE such as N95 masks, surgical masks, gloves, goggles, etc and antiviral (Tamiflu) have been procured and stock piled..

11. Health Management Information System (HMIS) ¹⁷

Myanmar HIS started in 1978 with the introduction of first PHP (1978-1082). Before the PHPs, health data was focused on hospital and public health statistics mainly on hospital admissions, discharges, maternal and child health and disease control. Main sources of the system were service and administrative records. There were changes and expansion of data collection strategies during the PHP period. Disease control programs were mostly vertical and collected data only with their own concern previously.

With the introduction of PHC approach, the scope of health data collection became wider. Most of the vertical disease control programs were reformed by integration and data was collected by health workers who were trained for multipurpose health work such as disease control and environmental sanitation. Similarly, the scope of data collection on community health care became wider. Previously, community health services were mainly focused on maternal and child health care. With the introduction of primary health care approach, other activities such as nutritional care, environmental sanitation, referral and other primary health care services were added and data collection of all those services were done by BHS.

With the change of political system in 1988, HMIS was introduced with a new concept of minimum essential data set. HMIS was established since 1990, with the aim to provide health information that could be used in monitoring and evaluating programmes and projects included in the national health plans. It is also designated as a tool for enabling local health managers to assess health situations and identifying health problems in their respective regions to formulate health micro-plans. HMIS reviewed and revised records and returns to reduce the workload of basic health workers at the grass-roots level. It is a monthly routine reporting system and includes two major components namely Hospital Information System and Public Health Information System.

Vital registration system (VRS) was introduced in 1962 covering only urban areas at first. Then it expanded to cover rural areas and currently it covers 79% of total population of the country. Data collection for VRS was carried out by Department of Health and data processing, data analysis and dissemination was done by CSO from the Ministry of National Planning and Economic Development. There was a major concern for a high percentage of under-reported deaths. Proportion of ill-defined causes of death was 28% as of 2002.

VRS underwent a number of reforms to increase coverage as well as improve quality of data.

Facilitating factors for HIS—

- strong political commitment for conducting national surveys and introducing new technologies—E-Health
- capability of national staff able to apply advanced technology
- strong intersectoral collaboration in all stages of data collection, data management and dissemination
- contribution of local administrators, civil organizations and communities in data collection

Impeding factors for HIS:-

- weak legal provision for collecting and compiling of data at all levels.
- poor quality of statistics generated.

- low interest of decision makers in utilization of reliable information for planning and programme management
- technical and resource constraints in generating data
- lack of feedback mechanisms for data reliability and representativeness
- poor collaboration with private sector in collection, compilation, analysis and dissemination of information.
- constraints in dissemination of data for planning and programme use.
- health service based information data source obtains data from very few private facilities

Challenges/Constraints for HIS

- No national roster of public and private sector health facilities as a database.
- Identifier codes and Global Positioning Satellite (GPS) coordinates cannot be included.
- Maps showing the location of health infrastructure, health staff and key health services are not available.
- No national database on human resources for health. National database that tracks the number of health professionals by major professional category and that tracks the annual numbers graduating from all health training institutions was not established.
- No up-to-date legislation covering all aspects of HIS.
- Very few financial records available and system for tracking budget and expenditure is very weak.
- Health infrastructure mainly rely on health staff and health facilities at the village and ward level, township level, district level and S/D level. Computers are accessible in some townships only. Internet access is available only at S/D level. Electricity supply and transportation are the main issues at the township level for data collection and compilation. IT equipment maintenance support is also available at the central level only.

III. Translating the values of PHC into policy and actions

1. National Health Policy and Health Development Plans^{9,15,16,18,19}

Historically, Myanmar adopted the PHC approach even before the declaration of Alma Ata. PHC approach was named in 1977 in pilot townships in the country. After Alma Ata, Myanmar became a strong advocate and supporter of Health for All global strategy. Myanmar introduced country health planning methodology (CHP) which was a problem-oriented, need-based type of planning and implemented series of **People's Health Plans** since 1978 aiming to achieve Health for All by Primary Health Care approach. The first cycle of People's Health Plan was implemented during 1978 to 1982, aimed at raising the health standard of the people with the main objective of overall development of human resources. PHP II was implemented from 1982 to 1986 for better coverage- and quantity; the third PHP III was implemented from 1986 to 2000 with the theme "from quantity to quality".¹⁸

The **National Health Committee** was formed on 28 December 1989 as part of the policy forms. It is a high level inter-ministerial and policy making body concerning health matters. The National Health Committee takes the leadership role and gives guidance in implementing the health programmes systematically and efficiently. (Annex 1)

The **National Health Policy** was developed with the initiation and guidance of National Health Committee in 1993. The National Health Policy has placed the Health for All Goal as a prime objective using Primary Health Care approach. (Annex 2)

National policies highlight equality aspects and services are needs-based. The PHC approach led changes in health planning from a top-down disease targeted approach to a community-based approach with increased commitment to "social equity" in order to improve 'total population health, reduce health effects of socioeconomic gap and strengthen community participation. Community participation and involvement had become a major theme in many health programmes after the adoption of the PHC approach.

From 2001, People's Health Plans were changed into **National Health Plans**; the National Health Plan forms an integral part of the National Development Plan and is in tandem with the national economic plan. National Health Plan (2001-2006) had been completed and Myanmar Ministry of Health is currently implementing National Health Plan (2006-2010) which is also in the framework of the objectives for the short term 5 year period of the Myanmar Health Vision 2030. The objectives include enhancing the quality of health care and coverage

and accelerating rural health development plan. The main components of the

National Health Plan include community health care, disease control, hospital care, environmental health, health systems development, human resources for health, health research, traditional medicine, food and drug administration, laboratory service, health promotion and health information system.

Monitoring of implementing programmes under the National Health Plan was carried out at every level of health administration in continuing basis. With the objective to evaluate implementation status, assess the impact and formulating policy and to provide supervision, guidance cooperation, a National Health Plan Monitoring and Evaluation Committee have been formed under the National Health Committee. Besides, **Health Management Information System (HMIS)** has been established in the Department of Health Planning to evaluate the status of implementation and assess the impact of National Health Plans. The HMIS serves as a mechanism to evaluate public health service provision and hospital care services on continuing basis and publish respective reports. Monitoring and evaluation components were included in every project under the NHP, monitoring, supervision and evaluation was carried out by each township, state and division wise and also at the central level.¹⁵

The **Myanmar Health Vision (2030)** aims to ensure universal coverage of health services to the entire nation. It aims towards total eradication or elimination of communicable diseases and also to reduce the magnitude of other health problems. It also aims to ensure availability in sufficient quantity of quality medicine and traditional medicine throughout the country.

In order to narrow the gap between urban and rural development, the **Rural Development Plan** has been implementing with the following Strategies-

- a. Ensuring Smooth and Better Transportation in the rural areas
- b. Securing Water in the rural areas
- c. Uplift of the Education Standard of the rural people
- d. Uplift of Health Care System for the rural people
- e. Development of the Economy in rural regions

The **Rural Health Development Plan** started in 2001 is being implemented with the objective to improve the health status of the rural populace and the reduction of poverty. The Rural Health Development Plan aims to achieve universal access to primary health care and to improve quality of health services provided at the rural areas; targets are to have one RHC / 20,000 populations, and one sub-RHC /5000 population.

In order to foster homogeneous development in the country, the Government has established **24 special zones** where in each zone consists three Universities/Colleges and a 200-bedded hospital are opened. A total of 134

Universities/Colleges, 7434 schools from primary level to high level and 17

hospitals, 32 general hospitals and 64 under 100-bedded hospitals have been constructed in 24 Special zones

2. Rural Health Development ⁹

As 70% of the population lives in the rural areas, Myanmar has initiated comprehensive health care approach and aim for universal access to health care since early 1950s through **rural health scheme** with the development of health infrastructure and health policies. The first batch of Health Assistants was graduated in 1953 after 2 years basic training in HA training school. Employing all the newly graduated HAs and supported by other basic health staff, Rural Health Centers (RHS) were opened all over the country in 1954 with one, two or three RHCs in each district. Rural Health Centers and sub-centers were expanded with the aim to increase health care coverage and improve access to health services Basic health staff, mainly midwives became the backbone of the health system; currently, each and every township in the country has four or five RHCs which is expected to serve for about 20,000 to 25,000 people per RHC.

At present there are 1476 RHCS with 4 to 6 sub-RHCs under each RHC. Each main-RHC is staffed with one health assistant, one lady health visitor and one mid-wife, each sub-RHC is staffed with one midwife and one PHS II. One midwife has to take care of 5 to 10 villages with a population of 2000 to 5000. In difficult terrains or frontier areas, the population covered by one RHC can be as small as 3000 per RHC.

All of basic health staff (BHS) are mainly trained for providing primary health care and integrated health service delivery. The RHCs and sub-RHCs are responsible for all elements of Primary Health Care. Their main function is for health education, immunization, and nutrition, control of endemic diseases, MCH, water and sanitation.

3. Community participation and volunteerism ^{18,19}

Community participation and volunteerism in health activities had existed in Myanmar even before the adoption of PHC approach (i.e, before Alma Ata). A long tradition of Theravada Buddhism which preaches the concept of doing something good to others with real 'setana'- (deeds of heart and soul without remuneration) forms the basis for community involvement and voluntary contributions in cash and kind as well as in the form of community services. With the adoption of primary health care approach, community based health actions became under the lime light.

A Study by UBCIEF/WHO Joint Committee on Health Policy recorded that in Myanmar communities contribute to the People's Health Plan with money, materials or labour, and at the local level, members of the Party and the People's Council are active for health promotion and play a role.

“The religious and socio-cultural values and political system in Burma (Myanmar) embody the principles of community involvement as articulated in the declaration of Alma-Ata. Community involvement and participation are State Policies in all aspects of development, including health. In the field of health development, successes have included sanitation campaigns, natural disaster relief, control of rat-induced plague epidemics and mass small pox vaccination; in each of these initiatives, community participation was a vital component. Communities have also contributed to health development in other ways.” *(Extract from Peter Oakley's Community involvement in health development, Geneva 1989)*

Community based health actions are enhanced by the spirit of mutual assistance, which is a deep-rooted culture of the Myanmar people. Local financing practice is also traditional in the country to raise funds through cash and kind contribution made by community to the health sector. The community contributes to capital and recurrent cost for health and health related activities through various ways including proportionate donation, individual donation, voluntary contribution, funds from farm products, social-welfare fund, cumulative safety deposit and contribution in kind and labour. These kinds of community contributions ensure continuity of health provisions to the community.

Significant CB activities include

- social mobilization for sanitation (National Sanitation Week activities where community actively participate for construction of sanitary latrines and improvement of water resources);
- community contributions to construct sub-rural health centers;
- community participation in immunization activities;
- community based activities for active and passive detection of leprosy cases;
- community based rehabilitation for leprosy patients;
- community based activities for TB control;-----
- community-based activities for HIV/AIDS control etc. -----

3.1 Community Health Workers (CHWs)

The CHWs had been trained since 1978, about 1000 a year with the aim to cover all villages in the country (there are over 60,000 villages in Myanmar). The objective is to have a trained CHW in each and every village of the country to

provide health education, detect epidemic outbreaks, and assist in sanitation and

immunization activities and to coordinate with health centers for early referral of cases and other health activities. Up to date over 40,000 CHWs had been trained and provided with manuals and first-aid kits. Most of the CHWs are males, about 20% are females. Of the 43,942 CHWs, about 38% had lost contact with the basic health workers, currently over 25,000 are working in coordination with the BHWs.

The training was conducted by skilled trainers at the district (township) level for 4 weeks. Curriculum includes health education methods, maternal and child health, immunization, environmental sanitation, nutrition, communicable diseases and treatment of minor disease such as providing ORS in diarrhea diseases.

3.2 Auxiliary Midwives (AMWs)

Myanmar National Health Plan places high priority on training and deployment of professional midwives as primary birth attendants and seeks to support, expand and promote their profession. The midwives have to undergo 18 months of comprehensive training in an accredited program, and are equipped to assist normal births, as well as to diagnose and manage complications during child birth. In order to institute an effective safe motherhood program at the grassroots level, Myanmar has recommended the ratio of one midwife to every 5,000 population. In some areas of the country, a midwife practically covers more than 15,000 populations, as much as four times than the expected population. In this situation, skilled birth attendants including midwives are unable to cover all villages under their jurisdiction. Inevitably, untrained birth attendants take care of considerable proportion of deliveries with unsatisfactory outcomes. To solve this problem, during the period where human resources for health cannot meet the standard, volunteers have to be trained to support existing midwives for delivery at rural areas and to gradually phase out traditional birth attendants.

The AMWs had been trained since 1986; during 1986 to 2000, about 1000 AMWs per year had been trained with the support of UNICEF. From 1998 to 1999, about 1800 AMWs had been trained with the support of UNDP. Currently AMWs are being trained about 1000 a year by Ministry of Health in collaboration with UNICEF and WHO, and also many AMWs are being trained with the support of local authorities in collaboration with MOH.

Originally the target was to have a trained CHW in each and every village and an AMW in every two village of the country to have full primary health care coverage and full maternal and child health care coverage. As the target of one in two villages had already been achieved, the target is now set to have one AMW in every village. AMWs are trained to provide antenatal care, safe and clean home delivery for mothers who are unable to come to the health centers, to assist

midwives in MCH services, to assist in immunization activities, to provide health

education, detect and report epidemic outbreaks, organize and assist in sanitation and immunization activities and to coordinate with health centers for early referral of cases and other health activities. Up to date over 30,000 AMWs had been trained and provided with manuals and AMW kits. Out of them more than 20,000 are still functioning and coordinating with the BHWs (30% attrition rate).

4. Integration ²⁰

Introduction of special disease control works started in Myanmar as early as 1951. Smallpox Eradication Programme (SPEP) was launched in 1964; it was planned and implemented in an integrated manner. The entire SPEP was implemented by BHS. SPEP is the only national disease control programme implemented in an integrated manner by BHS not only in Myanmar, but in the whole world.

Myanmar developed its general health services while single tracked programmes to tackle the problem of special diseases. As the government changed in 1962, the new health policy was laid down with particular emphasis on preventive health care. With the aim of providing better medical care and services to the rural population which comprised about 85% of total population in Myanmar, the Directorate of Health Services was reorganized in 1965. It was the major attempt to integrate curative and preventive works through reorganization of the entire Basic Health System.

The need for integration had been recognized in Myanmar in the early years of 1960, after realizing the existence of a variety of single purpose campaigns not endeavoring to work with basic health services. Several trials with alternative methods of integration were tried in the late 1960s with the objective of gradual extension to other areas and ultimately to the whole country; these trials serve as valuable models of alternative approaches towards a better health system. The trial experiences have been effectively transferred to the Primary Health Care era with some revision and improvements.

Successful attempts have been initiated well ahead of the introduction of the concept of integration by WHO. Smallpox eradication in Myanmar (1970) was a victory achieved by the township medical officers and the BHS staff without any support from the vertical workers or campaign staff. BCG consolidation scheme was implemented since 1960 and later, BCG programme was effectively merged with EPI in 1978. In addition, removal of trachoma from the leading causes of blindness also marked a milestone in the history of integration. For Myanmar's timely achievement of leprosy elimination in January, 2003, all responsible

personnel from leprosy control programme gave special credits to the BHS staff

of grassroots level. So also was polio eradication achieved in the same year due to the combined efforts of all health personnel at different levels working successfully for seven years. As for IDD control, Myanmar health infrastructure was fully utilized since the beginning. For TB control, the responsibility of positive case finding and treatment with DOTs had been transferred to the BHS.

5. Inter-sectoral actions for health

The National Health Committee comprises of Ministers from related ministries such as education, sports, information etc. This facilitates implementing health programmes in coordination with other sectors. Health Committees at State and Divisions and townships are also formed with heads of related departments such as education, information, planning, city development committees etc.

Specific committees had also been formed at central level for better coordination with related sectors in specific health programmes: examples are National Iodine Deficiency Disorder Elimination (IDD) Committee, National Tobacco Control Committee, and National Supervisor Committee for Immunization etc. Inter-sectoral actions have achieved remarkable success in National Sanitation Week activities, National Immunization Day activities, IDD activities, School Health Week and Health Promoting School Activities.

IV. Lessons learnt

1. Achievements related to Primary Health Care

PHC has been adopted into National Health Policy and health service deliveries are being provided with the involvement of the community and civil society. Myanmar has always stuck to the comprehensive health care approach and has never promoted selective PHC concept. All health programmes are based on the concept of PHC and the HFA goal.

Revisiting PHC after thirty years found remarkable achievements in public health. Remarkable progress had been made in health service development and control of diseases in the last couple of years. Smallpox was eradicated in 1970 and officially declared eradicated in 1977. Leprosy was declared eliminated in 2003; trachoma had been controlled since 1978 and now monitored by Prevention of Blindness project and Vision 2020 activities. IDD elimination programme had been gradually developing since 1977 when Universal Salt Iodization (USI) was adopted as main tool for IDD control. In 2004, Visible Goitre Rate (VGR) was down to 5% and production and consumption of iodated salt is being maintained at high level. Polio eradication was declared in 2003; neonatal tetanus

elimination and measles elimination could be foreseen in the near future.

As for provision of basic health services, access to primary health care has increased over the years. Voluntary health workers had been trained to meet the target of one AMW at every two villages, community health workers had been trained to meet the target of one volunteer per village. Percentage of population with access to sanitation and improved water sources has significantly improved. Births attended by skilled birth-attendants are increasing; maternal mortality ratio, infant mortality rates and under-five mortality rates are declining and life-expectancy has increased over the past three decades.

Factors facilitating achievements related to PHC within the macro context

Factors associated with these achievements within the macro context could be identified as:-

- Political commitment towards Health for All based on the Primary Health Care approach.
- Health Plans based on PHC approach and in line with the economic development plans.
- Inter-sectoral coordination and collaboration
- Community involvement in PHC.
- Strong partnership with local NGOs.
- Integration of vertical programmes into basic health services.

Factors facilitating achievements related to PHC within the structural capacity

Factors associated with these achievements within the structural capacity could be identified as:-

- Health infrastructure: Rural Health Centers (RHCs) and sub-RHCs situated at the grassroots level and close to the community.
- Dedicated health personnel committed to PHC.
- Capacity building programmes for BHS.
- Community participation and self-reliance.
- Social mobilization activities for water and sanitation
- Community-based health volunteers and the spirit of volunteerism
- Existence of volunteers and NGOs at almost all villages.
- Four-pronged strategy for polio-eradication.
- Routine health information systems.
- Surveillance system for AFP and epidemic outbreaks.

2. Lesser achievement related to PHC

Weaknesses in the health service delivery within the framework of PHC had also

been identified by several studies.^{21,22, 23}

Access to primary health care has increased but yet to meet universal coverage of health care. BHS still have to take care of large areas /villages under their jurisdiction; the target of one RHC/20000 population has not met.

Current rates of maternal mortality have not achieved its targets. The majority of maternal deaths could have been prevented as the main cause of maternal mortality and morbidity are due to complications arising during antenatal periods and 80% of maternal deaths occurred at home.⁹

Sanitary latrine coverage still fluctuates around 80-90% in spite of efforts to achieve 100% coverage; diarrhoea diseases still remains at the top ten list of morbidity.

In spite of growth monitoring and nutrition education, PEM still remains high and is still a public health concern. Beri-beri becomes an issue during the past decade.

HIV/TB co-infection and multi-drug resistant TB have become issues of public health concern during the past decade.

After the declaration of polio-eradication in 2003, wild polio viruses had been reported sporadically.

Health Information System fails to cover the private sector. Private Sector Law has been adopted but need strengthening of law enforcement measures.

NCDs are on the rise. Public awareness of NCD is negligible. Tobacco Control Law has been enacted but still requires multisectoral partnership for full enforcement.

Lack of health insurance system and paucity of alternative health care financing could lead to catastrophic out-of-pocket expenditures on health, the majority of which will have to be borne by the poor. There is no safety-net system.

Factors impeding achievements related to PHC within the macro context

Factors associated with impediments within the macro context could be identified as:-

- Lack of decentralization and a strongly hierarchical system in health systems. Management culture of DOH practices hierarchical and authoritarian structures and behaviors- dominant top-down approach to the planning and implementation of public health programs such as EPI, HIV/AIDS, TB and Malaria. Highly centralized vertical disease programs

are the major factor that impedes successful elimination of diseases.²¹

- Weak district level micro-planning; priorities are still set according to top-down directives and not bottom-up.
- Highly centralized vertical programmes and "essential packages" in selective PHC areas such as MCH, immunization- track the decision-making power away from the communities and delivered it to donors and technical expertise in these specific areas.⁵
- Donor-driven health programmes. Priority setting, planning and implementing according to the guidelines set by donor agencies.
- Highly vertical specific programmes against the spirit of integration. " Programmes under the lime-light" tend to receive greater political attention and enjoy major share of scarce resources affecting the ability of PHC and maintenance of comprehensiveness at the cost of low-cost, cost-effective , appropriate technology.
- Inappropriate use of and allocation of resources for high-cost technology.
- Unbalanced distribution of and weak support for human resources.
- Economic inequity. As economic development and income increases, gap between the poor and the rich widens.
- Tertiary services still consumes huge portions of health budget creating problems in increasing access to primary health care. Health resources still continue to be directed to the huge urban-based hospitals. Political priority leans towards building new hospitals and upgrading the hospitals than investing in public health. The government health expenditure for curative care is 29.57% versus 9.45% for prevention and public health, high out of pocket expenditures for health care - 73.4%.²¹

Factors impeding achievements related to PHC within the structural capacity

Factors associated with impediments within the structural capacity could be identified as:--

- (a) Hard to reach and never reach areas²¹.
- Hard to reach areas which include :geographically inaccessible areas; urban poor, socially or economically marginal populations and populations living in conflict areas²¹
 - High transportation cost
 - Language barriers due to different ethnicity
 - Inadequate transportation means
 - Less incentives for providing services in those areas
- (c) Work overload

Integration of vertical programmes into basic health services had increased the workload of BHS, especially midwives who have to take responsibility of immunization, DOTS for TB, case detection and treatment of leprosy etc. They have a huge burden on their shoulders for disease control at the expense of their main responsibility of maternal and child health care.^{22,23}

(d) Weak supervision, monitoring

- Checklists are available but not used (too long and cumbersome)
- Availability of funds for supervisory visits varies by year and is not fixed. Small amounts for per-diem are available but insufficient.
- Transportation costs are paid out-of-pocket by TMO/THO and claims for reimbursement- require time
- Few plans are prepared for supervision
- Little recording or analysis of the outcome of supervisory visits at all levels
- Supervisory visits conducted by disease specific programs with their own checklists & funds are also uncoordinated.^{21,22,23}

(d) Reporting^{17,21}

- Most of the information reported is incomplete (no implementation data or because of vacancies in facilities such as RHC) & not possible to compare and analyze the data and arrive at conclusions.
- State/Divisional levels provide no analysis of reports submitted by TMOs nor give them any feedback on the contents of the report.
- Little information generated at township level is *used* for the purpose of program management and monitoring at that level.
- Consequently in the case of EPI, program managers cannot know the status of coverage and drop out rates and wastage of vaccines in some areas. For MCH the same would be true for tracking the antenatal coverage by midwives.

(e) Referral

Referral system is weak at all levels; lack of transportation for referral is the major constraint; high cost of transportation and non-existence of community fund for referral contribute to poor referral and/or late referral.

(f) Supplies and logistics²¹

Studies showed that supply system of drugs and logistics have much room for improvement. The users experience a number of important problems affecting service delivery because of the way the system functions:

- the untimely or late delivery of supplies;
- distribution not matching the needs of the services resulting in

oversupplies or undersupplies of medicines;

- delivery of inappropriate supplies such as bicycles in hilly or mountainous regions;
- high transportation costs;
- no monitoring of users' needs;
- no differentiating between users' requirements in terms of materials and equipment and timing of deliveries...

(g) Management ²¹

Health personnel working at the district level have received very limited training on management. Monitoring and supervision is weak at all levels; feed back is almost negligible. Team-building is critical in health systems.

V. PHC and the current health issues and context

1. Demographic changes and epidemiological transitions

Like all developing countries in the region, there are many challenges and issues that lie ahead. Communicable diseases still remain to be conquered whereas on the other hand, **NCDs** continues to rise; with the **emerging of new diseases** such as Avian Influenza, SARS etc. the burden of diseases could be stated as "Triple" rather than double.

With rapid urban growth and globalization, there will be change in values and change in the structure of nuclear families; with both parents working and less time for family and child care, **adolescent reproductive health issues** will become a major challenge. Problems such as STD, HIV, TB-HIV co-infection, teen age pregnancy, unwanted pregnancy and abortion etc will continue to be public health concerns. Children and adolescents are spending too much time on computer games and indoor entertainment leading to lack of physical activity; childhood obesity and **NCD** in young age could also be foreseen.

In the hugely competitive world, **stress** is a major concern for mental and physical health. Stress, sedentary life-style, change in eating behaviour, increasing popularity of junk food and instant food among the youth and school children, rising popularity of "barbecue shops" and "fast-food" plus change in lifestyle, all of these lead to a rise in NCDs mostly diabetes and cardiovascular diseases.

Switch from "family" values to "individual" values and lack of support from friends and professionals could lead to **mental health issues** such as depression and stress disorders. Existing Mental Health programme still focuses on institution based trainings on treatment of mental disorders, it is still lacking of measures to

educate the community on how to scope stress and how to promote mental well-being.

With the increase in life-expectancy, there will be an increase in aging population and an increased need for **elderly health care**. Increased coordination between MOH and Ministry of Social Welfare is required for elderly care. Elderly Health projects should pay more focus on the community-based activities.

With population movement and irrational prescribing, spread of infections which are **resistant** to current drugs could become a threat to ongoing disease control programmes.

Rapid socio-economic changes and development if not carefully planned could lead to a rising trend on traffic **accidents, injuries and occupational hazards**. Current measures for prevention of road traffic accidents is not adequate to meet the future trend, there is much room for improvement in research, education, promotion of community awareness, training of health and traffic personnel and law enforcement. Lack of uniform system of reporting for accidents and injuries is a major drawback in preventive measures.

Myanmar will also have to tackle the issue of **environmental pollution** like many other countries. Careful planning and intersectoral coordination is much needed to tackle issues that could arise from deforestation and establishment of industrial zones and other development projects.

Internal migration will continue in the coming decades; **epidemic outbreaks** are likely to occur due to large population movements to development areas such as industrial zones, mines, road construction, dam construction etc. Loss of family life and loss of traditional and social values could lead to spread of HIV/TB, STI and adolescent RH problems.

Emerging diseases such as Avian Influenza, SARS, HIV/TB co-infection will continue to threaten in the coming years. **Drug-resistance** could become a major concern.

2. Public private partnership

Health sector will continue to face issues arising from rapid growth in private hospitals and clinics. There will be continuation of decline in general clinic attendance in Rural Health Centers and out-patient-clinics of government hospitals. There is very weak partnership between public and private sector. Lack of information and almost negligible reporting system from private sector is

a major concern. Control and monitoring system of the private sector needs to be strengthened systematically.

3. Integrating vertical programme and improving quality of care

Highly centralized vertical programmes and donor –driven projects impede the actual integration of vertical programmes into basic health services. Projects at the central level still lack coordination and collaboration. There is lack of coordinated micro-planning and integrated supervision.

VI. The way forward

Revisiting PHC has strongly indicated that PHC has brought about marked gains in the health system of Myanmar. Principles of PHC are still relevant for Myanmar and MOH will continue to adopt the PHC approach in all its health policies, plans and programmes. The policies and plans may be needed to adapt to global challenges within the context of PHC. MOH has never promoted "Selective PHC" and will move on implementing health services with the comprehensive PHC package towards HFA and MDG goals.

The National Health Plan, based on PHC approach will continue at 5 yearly basis; it may need to reflect recent changes and current trends and policies in global practice but care has to be taken not to direct away from the PHC concept. Essence of integration, appropriate technology, cost-effectiveness, multisectoral approach and community participation will still be enshrined in future health development plans. Areas to be strengthened include : decentralization, resource allocation for PHC, equity in health financing, identification of feasible measures for alternative health financing, establishment of community health insurance schemes, managerial capacity at district level, referral system within the PHC hierarchy, improving quality as well as coverage, coordination and partnership, public-private partnership, HIS, aligning and integrating support systems such as supplies and training.

Ongoing programmes such as Rural Health Development Plan, Myanmar Health Vision 2030 will be continued both of which are based on PHC approach. New programmes such as Health Systems Strengthening for GAVI/HSS will further enhance the commitment towards PHC.

All efforts will be directed to achieve Millennium Development Goals. Health development plans will also be in line with other programmes such as poverty alleviation, economic development, border-area development, special development zones etc.

Annex 1. National Health Committee (NHC)

The National Health Committee (NHC) was formed on 28 December 1989 as part of the policy reforms. It is a high level inter-ministerial and policy making body concerning health matters. The National Health Committee 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 co-ordination. It also provides guidance and direction for all health activities. Under the guidance of the National Health Committee various health committees had been formed at each administrative level.

For the monitoring and evaluation purpose, National Health Plan Monitoring and Evaluation Committee was formed at the central level. Built-in monitoring and evaluation process is undertaken at State/Division and Township level on regular basis. Implementation of National Health Plan at various levels is carried out in collaboration and co-operation with health related sectors and NGOs.

Composition of National Health Committee

1.	Secretary (1), State Peace and Development Council	Chairman
2.	Minister, Ministry of Health	Member
3.	Minister, Ministry of National Planning and Economic Development	Member
4.	Minister, Ministry of Home Affairs	Member
5.	Minister, Ministry for Progress of Border Areas and National Races and Development Affairs	Member
6.	Minister, Ministry of Social Welfare, Relief and Resettlement	Member
7.	Minister, Ministry of Science and Technology	Member
8.	Minister, Ministry of Education	Member
9.	Minister, Ministry of Sports	Member
10.	Minister, Ministry of Immigration and Population	Member
11.	Mayor, Nay Pyi Taw	Member
12.	Director, Directorate of Medical Services, Ministry of Defence	Member
13.	Deputy Minister, Ministry of Health	Secretary
14.	Director General, Department of Health Planning, Ministry of Health	Joint Secretary

Annex 2. National Health Policy

The National Health Policy was developed with the initiation and guidance of the National Health Committee in 1993. The National Health Policy has placed the Health For All goal as a prime objective using Primary Health Care approach. The National Health Policy is designated as follows:

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" goal, 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 resource for health locally in the context of broad frame work 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 delivering 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 system 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 service 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.

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