

SDC Health Assessment in Southeast Region of Myanmar

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Disclaimer

The views and ideas expressed herein are those of the authors and do not necessarily imply or reflect the opinion of the Swiss Agency for Development and Cooperation.

Acronyms

AMW	Auxiliary Midwife
ART	Anti Retro-viral Treatment
ASEAN	Association of Southeast Asian Nations
BHS	Basic Health Staff
CBO	Community Based Organization
CHF	Swiss Franc
CHW	Community Health Worker
CSPM	Conflict Sensitive Program Management
CTHP	Coordinated Township Health Plans
DAC	OECD Development Assistance Committee
EPI	Expanded Program for Immunization
EMOC	Emergency Obstetric Care
GAVI	Global Alliance for Vaccines and Immunisation
GCA	Government Controlled Area
GDP	Gross Domestic Product
GF	Global Fund

GP	General Practitioner
GOM	Government of Myanmar
HA	Health Assistant
HCCG	Health Convergence Core Group
IMR	Infant Mortality Rate
INGO	International Non-Governmental Organization
IDP	Internally Displaced Person
JICA	Japan International Cooperation Agency
JI-MNCH	Joint Initiative on Maternal and Neonatal Child Health
KDHW	Karen Department for Health and Welfare
KnMHC	Karenni Mobile Health Committee
KNPP	Karenni National Progressive Party
KNPLF	Karenni National People's Liberation Front
KNU	Karen National Union
LDC	Least Developed Countries
LHV	Lady Health Visitor
MCH	Maternal and Child Health
M-CCM	Myanmar Country Coordinating Committee
MDG	Millennium Development Goal
MIMU	Myanmar Information Management Unit
MMA	Myanmar Medical Association
MMK	Myanmar Kyat
MMR	Maternal Mortality Rate
MNCH	Maternal Neonatal and Child Health
MOH	Ministry of Health
MNHC	Mon National Health Committee
MRCS	Myanmar Red Cross Society
MW	Midwife
NCD	Non Communicable Disease
NGO	Non-Governmental Organization
NMSP	New Mon State Party
NSA	Non State Actors
NSAG	Non State Armed Group
ODA	Official Development Assistance
PHC	Primary Health Care
PHS	Public Health Supervisor
RHC	Rural Health Centre
SBA	Skilled Birth Attendance
SC	Sub-Centre
SCS	Swiss Cooperation Office in Myanmar
SDC	Swiss Development Cooperation
TA	Technical Assistance
TBA	Traditional Birth Attendant
TSG	Technical and Strategy Groups
3DF	Three Diseases Fund
3MDG Fund	Three Millennium Development Goal Fund
UNOPS	United Nations Operations and Procurement Services
USAID	United States Agency for International Development
VSD	Vocational Skills Development
WHO	World Health Organization

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1 Executive Summary

Switzerland is committed to make significant contribution to a peaceful and prosperous future of Myanmar. Building on the almost twenty years experience of engagement in Myanmar context, the Swiss Cooperation Strategy Myanmar 2013-2017 will support the on-going government reforms with interventions in four domains, (1) employment and vocational skills development; (2) agriculture and food security; (3) health, social services and local governance; and (4) promotion of peace, democratisation and protection. The geographical focus of the SDC programs will be in South Eastern Myanmar. The goal for Domain 3, health, social services and local governance is: “rural communities have access to improved social services and are enabled to foster their local governance”. In June 2013, SDC commissioned a health identification mission to provide SDC with comprehensive information on the health sector in Myanmar and make recommendations on possible immediate entry points and options for longer term support for a health program within Domain 3. The two consultants who authored this report were contracted to undertake a health assessment mission in the south eastern region of Myanmar. It was carried out jointly with a team from SDC between the period of 20 June to 24 July 2013. The following report is a result of the health assessment mission.

Findings and recommendations are summarized below.

High morbidity and mortality rates in Myanmar are due to a mix of communicable and non communicable diseases. Communicable diseases in particular Malaria, TB and HIV are amongst the leading causes of premature death. Maternal, neonatal and child mortality rates are also still high though rates have decreased in the past decade. Prevalence of non-communicable diseases is rising as well.

The health situation in the southeastern region is worse as a consequence of a long history of conflict, poverty, and underdevelopment. Health systems and access to health services in the rural areas are poor. Poor accessibility is mainly due to high cost of transportation and services, and lack of knowledge; poor availability due to insufficient number of qualified staff, infrastructure and equipment; poor acceptability due to language, weak communication, and local customs and beliefs.

The situation is exacerbated in the NSA controlled areas. Currently there is a parallel health care system run by health sectors/ departments of NSAGs which mainly rely on mobile clinics. Staff operating in those areas are not trained through the government institutions but through partners/ INGOs based in Thailand. Funding for these programmes are significantly reducing as the momentum of the peace process builds up. Infrastructure including roads are usually worse in those areas hence making access more difficult. Until recently partners were barred from working in those areas. This has changed only in the past few months.

During our field visits, both government and NSAs made it clear that peace is the topmost priority for the southeast and that caution must be taken not to jeopardize the peace process in planning or implementing any health or development programme. Both sides acknowledge that communicable diseases and MNCH are priority issues.

So far most of the health programmes in the southeast have focused on the three diseases and there are only few new programmes planned for Primary Health Care and MNCH under 3MDG Fund. 3MDG

Fund currently covers approximately 10-20% of the population, therefore there will still be large populations and areas to cover.

There is a substantial need to strengthen primary health care MNCH services in particular at the community level in rural, remote and impoverished areas in the southeast – in areas where the 3MDG Fund is not covering, and especially in areas where IDP and refugees may return to.

Given these circumstances this health assessment proposes two main recommendations as follow:

- 1) To contribute funds to the Three Millennium Development Goal Fund (3MDG), a country wide initiative focusing on MNCH; TB, Malaria & HIV; and health systems strengthening.
- 2) To mandate a Primary Health Care project with an initial focus on Maternal Neonatal and Child Health (MNCH) through partnership with an implementing partner (or a consortium of) in both government and Non State Actor (NSA) controlled areas of the South East. Partner/s are to be selected through an international tender process.

The PHC project should be structured on three key components:

- Basic health services starting with MNCH and later expanding to include services for common ailments in the coming years. Activities will aim at strengthening the role, competency and skills of basic health staff,
- Community empowerment in support of continuum of care. The PHC project will support activities that promote participation of most vulnerable groups including IDPs and returnees, and enhance accountability and community empowerment.
- Systems support through policy dialogue and technical assistance. Lessons learned from the implementation of the project should be reflected in the policy dialogue at national and state/region level.

In all three components, conflict sensitive program management will be a central element of the PHC project. Even though ceasefire agreements have been reached between NSAGs and the GOM in the Southeast, peace negotiation process is still on-going. Therefore it is imperative that CSPM considerations are implicitly applied in all components and stages of the PHC project.

SDC should allocate about 50% of its resources for health in NSA controlled areas in order to support the perception of Switzerland as a neutral partner. The financial volume for SDC health program is roughly CHF 1 million in 2013 up to CHF 4 million per year in 2017.

The following report is the outcome of this mission and will serve as a guiding document for preparation of necessary bidding documents for SDC health programme.

The consultant team concludes that while there are many exogenous factors that will influence health and development in the Southeast both in terms of opportunities and risks; the current peace process suggests that there is presently a will and desire to strengthen services in many remote parts of the region. This may pave the way for further convergence of health plans and ultimately unification into one common system.

2 Background and rationale for the assessment

Myanmar is situated between South and Southeast Asia, located at the crossroads of China, India, Thailand, Laos and Bangladesh. The population is reported to be close to 60 million people and the country is geographically and culturally diverse, with 135 groups speaking over 100 languages and dialects. Ethnic groups comprise an estimated 35-40% of the population and approximately 70% of the population lives in rural areas. Largely due to decades of conflict, poverty, and isolation, human development indicators remain low and lag behind other least-developed countries of the region. With sanctions and restrictions imposed over the last two decades, Myanmar received very low levels of aid assistance, which was restricted to only humanitarian aid. Until recently, Myanmar received the lowest levels of ODA per capita (US\$ 7) of all 48 Least Developed Countries in the UN list.

Myanmar has been isolated under military rule since 1962 until the government of President U Thein Sein took office in March 2011. At present Myanmar is in the midst of three major transformations: away from authoritarian military rule towards democratic governance; from a centrally-planned economy to a market-driven one; and in the direction of a peace process that represents the country's best opportunity in half a century to resolve ethnic conflicts. Notwithstanding these positive developments, the current reforms face many challenges and may take many years to bear fruit.

The political, economic, social and administrative reforms led by President Thein Sein have been widely applauded by the international community as encouraging. In response to this process, many DAC-countries have lifted sanctions and restrictions on Myanmar, paving the way for Myanmar to re-engage with the international community. The world's largest creditor countries cancelled almost half of Myanmar's debt worth approximately six billion dollars in January 2013. Foreign direct investments have increased and so have ODA loans and grants. ODA has increased from US\$ 209 million in 2011-2012 to US\$ 1 billion received just in the first quarter of 2013, as part of the total pledged for 2013-2014, with the latter 3-4 times higher.

Basic services in Myanmar have been seriously underfunded and under-resourced for many years, leading to widespread concern that there is insufficient infrastructure and human capacity in the country to absorb the sudden influx of investment and financial resources. Following years of internal conflict, education and health services are fragile and civil society organizations are few and have limited capacities to implement or fill political space to advocate for appropriate policies and programs. Given the high levels of poverty and socio-economic inequity in the country there are concerns that the resources may not benefit the poorest and the most vulnerable populations. The Myanmar government has indicated that it is ready to receive support from foreign governments, international organizations, the private sector and NGOs to support the social, political and economic reform processes.

Within this historic context, Switzerland commits to make a contribution to the development of a peaceful and prosperous future for Myanmar. In November 2012 Switzerland opened an Embassy that under a whole-government approach has started to build up its political, economic and cultural relations as well as its cooperation programme and peace promotion engagement. Building on the long-standing experience of the Swiss Agency for Development and Cooperation (SDC) Humanitarian Aid that has engaged in the Myanmar context for nearly twenty years, Switzerland will focus in particular on the

south eastern region of Myanmar. Swiss development cooperation will align with government and development partners according to the Naypyitaw Accord for Effective Development Cooperation. In support of the ongoing reform process in Myanmar, Switzerland will substantially increase its cooperation from 11 million CHF in 2012 to around 35 million per year by 2017.

The Swiss Cooperation Strategy Myanmar 2013 -2017 (SCS) overall goal is to contribute to political, social and economic transitions in Myanmar that aim towards a peaceful, inclusive and equitable society practicing democratic governance. Switzerland will support four domains: (1) employment and vocational skills development; (2) agriculture and food security; (3) health, social services and local governance; and (4) promotion of peace, democratisation and protection. Important transversal themes are gender equality, good governance and climate change/disaster risk reduction. The core target population will be disadvantaged women and men of all ethnicities including the conflict-affected.

In response to the needs and challenges, SDC has formulated the following goal for the domain 3: “rural communities have access to improved social services and are enabled to foster their local governance”. Expected outcomes are i) access to, use and public financing of basic public health services has improved, ii) equitable access to and use of quality community infrastructure and services, especially in conflict-affected areas and areas of potential return, have improved, and iii) citizens, in particular women and vulnerable groups, can voice and address their needs, exercise their rights and participate in local decision-making. The financial volume which is foreseen at this stage for SDC health program in Myanmar is roughly CHF 1 million in 2013 up to CHF 4 million per year in 2017.

In order to carry out the objectives of domain 3, the SDC has recruited two consultants to assist with a health assessment/identification mission in the south eastern region of the country. The main purpose of this mission is to provide SDC with comprehensive information on the health sector in Myanmar, and make recommendations on entry points for the SDC program and propose options in view of the preparation of a program proposal and its related tendering process. The following report is the outcome of this mission and aims to serve as a guiding document for preparation of necessary bidding documents for the SDC health programme.

3 Methodology

The health assessment/identification mission consisting of two consultants and a team from SDC, visited Kayah, Kayin, and Mon States and North Tanintharyi and Bago Regions between 20 June and 18 July 2013. Tools used for collecting data and information and analyses were as follows:

- Meetings with concerned ministries and departments (Ministry of Health, Planning, Social Welfare and Border Affairs) at central, state and regional levels;
- Interviews with key informants identified from among stakeholders (INGOs, NGOs, CBOs, NSAGs, UN agencies, private sector, bi and multilateral donors; research institutions)

- Field visits to health facilities and potential target communities in 5 states/ regions for direct observation and key informant interviews with health care providers, community health workers, village committees, patients; collect data from clinic records (RHCs, Township Hospitals, clinics, etc); direct observation at various community places.
- Visits to relevant institutions and sites (Midwifery Training Institute Bago, Large-scale infrastructure development project site in Dawei)
- Other sources of data: State/ Township Health Profiles and database; MIMU Devinfo Database; project documents of relevant organizations; annual reports; assessment and review reports; strategy papers; evaluation reports; e-mail communication; national health plans and strategy papers.
- Desk review: relevant reports, studies, strategy and position papers.

Details of the itinerary and places visited and people met/ interviewed, and documents reviewed were attached as annex.

Limitations of the mission: It was a rapid assessment carried out in a relatively short time frame, therefore was unable to select a random sample of health facilities, staff or communities required for a comprehensive health assessment. In a number of instances, the team was not able to gather more than preliminary impressions of the situation because of the limitation in time and communication (language), availability and quality of data and research. Quality of care was a gap area which the health assessment team has not been able to look into. The team would have liked to meet with many more patients than this and conduct in depth interviews; however time and logistical constraints had prevented from doing so. Given that the field visits also served as introductory visits for the newly arrived SDC team, the focus of the field visits were in part consumed by protocol and meetings.

4 General Analysis

4.1 Situation analysis

Kayah, Kayin, and Mon States and Bago east and Tanintharyi Regions are situated in the southeast of Myanmar. The size of population in each state/region ranges from 277,428 (Kayah) to 2.1 million (Mon State) and 2.4 million (Bago East), with approximately 1.4 million each in Kayin and Tanintharyi. Although some health indicators have improved in the past decade, Myanmar still lags behind its neighbours in the Southeast Asia region, as shown in the table below.

Table 1: Health impact indicators in Myanmar and selected countries in Southeast Asia

Indicator	Myanmar		Malaysia		Thailand		Vietnam	
Maternal Mortality Ratio (per 100,000 live births)	420 (1990)	240 (2008)	56 (1990)	31 (2008)	50 (1990)	48 (2008)	170 (1990)	56 (2008)
U5 Mortality Rate (per 1,000 live births)	112 (1990)	66 (2010)	18 (1990)	6 (2009)	32 (1990)	14 (2009)	55 (1990)	24 (2009)
Infant Mortality Rate (per 1,000 live births)	79 (1990)	50 (2010)	16 (1990)	6 (2009)	27 (1990)	12 (2009)	39 (1990)	20 (2009)

Sources: ADB 2012b; MDG1 2012; MNPED, MOH, and UNICEF 2011, WB-WDI 2012 (ADB 2012: Extracted from *ADB 2012: Myanmar in Transition. page 9 Table 5*)

The leading causes of morbidity and mortality in Myanmar are a mix of communicable and non-communicable diseases, with top 10 causes of death, 5 attributable to communicable diseases, and 5 to non-communicable diseases. High burden of communicable diseases is caused mainly by malaria, HIV and TB. HIV is the leading cause of death with 260,000 people living with HIV, with only one third of those who need treatment receiving ART. Malaria also remains a leading cause of mortality and morbidity. Even though rates have declined in recent years, Artemisinin resistance has emerged as a threat with a potential to spread beyond Myanmar borders. Myanmar has one of the highest TB prevalence rates in the world with almost 600 persons per 100,000 populations infected with Tuberculosis, and has been classified as a high-burden TB country by WHO. A recent assessment by WHO indicates that non-communicable diseases (NCD) have contributed to approximately 40% of all deaths in Myanmar. Cardiovascular diseases, cancers, and chronic respiratory diseases are reported to be the major contributing factors to NCD disease burden.

The health situation in the southeast region of the country is even poorer because of the distinct socio-economic and environmental determinants that are commensurate with long years of conflict, poverty, and underdevelopment. Displacement of population, high levels of in and out migration, landlessness, lack of education and job opportunities, difficult terrain, poor transportation system and infrastructure, all impede people's accessibility to health services. Restrictions on humanitarian access into conflict affected areas from government areas has been the previous Myanmar government's policy for many years, leaving local communities to fend for themselves or access assistance across borders. Many decades of conflict have displaced hundreds of thousands of people, with as many as 400,000 over the years in Kayah, Kayin, Mon, Tanintharyi and Bago east. Majority of the estimated three million migrants in Thailand came from the southeastern region of the country, in particular, from Kayin and Mon States. Whilst there has been a significant in-migration towards the south east of the country from other parts of Myanmar primarily for work in rubber plantations, many townships in the south east have seen very significant out migration of local young people of working age migrating to Thailand or Malaysia.

Apparently, the rates of labor migration are still increasing, given that government regulations have relaxed and job and education opportunities remain limited.

Although the regional level health indicators are not significantly different from the national data, township level indicators vary depending on location, level of security, economy, and other factors. According to the township health profile available from the State Health Department, MMR in Kayin State was 1.9 per 1,000 live births in 2010 (MIMU DevInfo Database Sept 2012). According to the same source, the rates at the township level were higher (2.2 to 2.4) in some townships closer to the border such as Hlaingbwe, Myawaddy and Kawkareik. On the other hand, the MMR in NSA controlled areas are apparently much higher at 7.21 per 1,000 live births in the same period, as reported by the Kawthoolei Department of Health and Welfare (KDHW 2013). Similarly, while IMR in Kayin State was 10.2 per 1000 live births in 2010, it was higher in Hpapun township at 14.3, whereas the IMR among the internally displaced population (IDP) in Eastern Myanmar in the same period was many times higher at 73 per 1000 live births. Likewise under 5 Mortality Ratio (U5MR) differs significantly - 14.6 per 1000 live births in Kayin State 2010, compared to 25 in Hpapun and 138 per 1,000 live births among IDPs in the same period. It should be noted that quality of data is unsatisfactory at the moment and should be used with caution. (The census will be conducted in 2014 and will provide a basis for studies and research and should provide more accurate data on Maternal Mortality).

4.2 Needs assessment

4.2.1 Health delivery system

Accessibility of health services vary according to different areas. For those in the remote areas, lack of access to health services is mainly due to physical distance, high cost of transportation and service fees, difficult terrains, and heavy rains. Insecurity, landmines, checkpoints, travel restrictions can be added as barriers for areas with security problems and NSA controlled areas. Out of pocket expenditures account for up to 82.3% of all expenditures, only 8.49% being publicly funded, and 9.21% externally funded. From a demand side, barriers to accessibility include patients' lack of knowledge on what services are available in the health facilities, misconceptions and irrational health behaviour, as well as better accessibility for basic services provided for by informal providers, many of whom are unskilled and untrained.

Ethnic communities and organizations have built up their own health provision structures during the decades of conflict, and these entities remain as the main provider of health care in the conflict affected and remote areas. Relying mostly on mobile health teams and back-packer medics operating from across the border, access to health services such as emergency obstetric care in NSA controlled areas is extremely restricted. A retrospective mortality survey undertaken in the Eastern region of Myanmar in 2010 indicated that access to emergency obstetric care in some areas was as low as 5%.

Problems with availability from a supply side are mainly lack of qualified health staff, inadequate number of health facilities, and until recently, lack of essential medicines and supplies. Many midwifery schools are producing sufficient numbers of midwives per year but government is not able to recruit the midwives in the needed area as soon as they graduated. Therefore, after finishing school, many midwives work as special nurses in the private hospital in cities and some may never come back to join the government services. In the NSA areas, some RHCs and SCs may only exist on the map but are literally uninhabitable or in a state of disrepair. Because of outreach activities of midwives, opening times of rural health centres are usually 3 days per week and around 5 hours per day, which is another factor impeding utilization of services.

Midwives to population ratio in the SE region overall is 1 MW to a population of 5000 at present, though the ratio at the township and rural health centres are much lower in remote rural areas. Basic health staff including midwives who are assigned to these facilities are often reluctant to take the post because of difficult transportation and communication, and also because of real or perceived threat to security. Furthermore, the basic health staff (BHS) assigned to remote areas have to limit their outreach activities as they don't receive enough funds for outreach and have to finance it on their own resulting in a limited coverage. Likewise these same factors limit effective supervision and efficient referral system. In terms of staffing in health services, there used to be a restriction to two thirds of sanctioned posts because of inadequate funds. This restriction has been lifted and now staff can be employed as needed. In the new National Health Plan 2011- 2016, it is proposed to increase the number of doctors working in the public sector from 10,243 to 10,927 in 2015, and the number of midwives from 9,785 in 2012 to 10,985 in 2015. Subcentres are ideally staffed with midwives and public health supervisor 2 (PHS 2) although most PHS 2 positions are still vacant. Main focus of their work is communicable diseases e.g. immunization and data collection, in order to relief the work overload of midwives. A plan to establish 5,000 new sanctioned posts for public health supervisor 2 is underway, in order to achieve a national target of 1 midwife and 1 PHS 2 for every sub centre in the country.

Community health volunteers such as auxiliary midwives and community outreach workers were trained; however attrition rates are considerably high. For instance, Kayin State Health Department reported that in 2012, there were 1249 trained AMWs of which only 661 were functioning (State Health Profile, Kayin State 2012). This tallies more or less with the situation in some RHCs that the team has visited where only 3 or 4 AMWs out of 10 trained were functioning. In such cases, the midwives don't seem to have enough time to supervise the AMWs, besides the fact that there is no clear supervision guidelines and format. However this situation is not uniform. In some subcentres, midwives and AMWs complement each other well and work as a team, while midwives regularly provide supportive supervision to AMWs.

According to State Health Profile, the proportion of births attended by skilled health personnel reported in 2011 was 64% in Kayin State, higher than Mon and Tanintharyi (both at 55%), Kayah at 62% and Bago East at 49.7% (MIMU Devinfo Database Sept 2012). However, these figures significantly became lower at the village tract level. For instance, in an RHC in Hlaingbwe township during the same period, only 43% of births were attended by midwife whereas 26% were attended by AMW, 15% by TBA, and the rest by "others" which include neighbours, relatives, and referral cases (Htee-lone RHC 2012 Annual Patient Record). The rates of SBA became even lower in NSA controlled areas. According to a survey conducted

among IDPs in Eastern Myanmar in 2010, 64% of births were attended by traditional birth attendants (KDHW 2013).

Acceptability and utilization of health services also depend on, among other factors, the level of education from the demand side, and approach and methods of communication from the supply side. Communication between health staff and communities in hard to reach areas is weak. Language barrier, low level of education from patients' side, lack of mutual trust and understanding (in the parallel services) were major constraints that affect acceptability of health services especially in NSA controlled areas. People in rural areas were, in most cases, not informed of what services are available where and when, and how much the cost is; and whether there are any changes or new promotional programs such as free-of-charge services available. Health education is not regarded as a priority for allocating resources or implementation. In remote and NSA controlled areas, most people speak local dialects, therefore literacy and language remain a large barrier in reaching out to the most vulnerable population. Communities abide by their local customs and beliefs and therefore are not ready to adopt all safe reproductive health behaviours, for example giving birth at a health centre outside of one's home.

4.2.2 Health financing

Cost is an important factor which determines the utilization of health services. For instance, for a woman to deliver in a rural health sub-centre provided by the SDC, she needs to pay 5,000 MMK (equivalent to about USD 5) as donation for the maintenance of the facility, plus a fee for the midwife, normally ranging from 10,000 to 20,000 MMK or more. For a complicated case or a severe case which needs referral to a secondary or tertiary health facility, there will be an added cost for transportation, accommodation and medicines, etc. According to a feasibility study of the Community Health Initiatives for MCH in Myanmar conducted by MOH and WHO in 2010, costs of delivery at a health facility could be as high as 67,379 MMK, two times higher than the cost of home delivery (MOH, WHO, HITAP 2010). Some station hospitals have had their own ambulance - but for a fee. Every health facility seems to have a local mechanism to cover expenses for the destitute, however none is based on a structured or a sustained system. One survey in the SE suggested that as many as 18% of households seeking health care faced catastrophic health expenditure.

Myanmar has had a universal free health care that was put in place since post independence. Following the market reform which took place after 1988, it became increasingly difficult to maintain the health financing system and hence a cost-sharing system started in 1993. Total expenditure on health as a percentage of GDP has increased four-fold to around 3%, yet it is still lowest in the region. Planning is underway to improve health financing system for reducing of out of pocket expenditure by different strategies such as increasing tax base financing, social health insurance etc.

Recently State and Regional Health Departments have received financial support which is principally for salaries and infrastructure. Budget allocations for individual states/ regions were calculated based on the number of hospital beds available across the state/region. As the first tranche, Mon State has received 35.5 million MMK (approximately 35,500 USD), Kayin 28, Tanintharyi 23.5 and Bago (east and west) a total of 65 million MMK in second quarter of 2013. There is as yet no nationwide model for

allocation of operational funds for comprehensive needs-based plan for States/Regions or for Townships.

4.2.3 Health Information

Health Information System needs much improvement. There is a surveillance system in place but is inadequate. Routine health management information system collects data on monthly basis, however with many loopholes. There is no disaggregation of data by sex or by socio-economic groups. The system does not report on resource allocations. There is no data disseminated for public information on availability of services (where facilities/ services are located). Using of health data and information for decision making and resource allocation is a rare practice. Data and information for NSA controlled areas are not available, partly because of the system and partly because of lack of communication between the different parties. At present, there is no shared or accurate information on the number of IDPs, potential returnees and the time schedule, let alone health specific information and data (on IDPs and potential returnees).

4.2.4 Leadership and governance

The health sector is presided over by a system of health committees from national to regional and down to township level. The National Health Committee is the country's lead policy making body. This committee and the Township Health Committees across the country are the principal agents for inter-sectoral action on health. However, a recent health system assessment undertaken by WHO indicates that these committees need to be reactivated. Decentralization has been identified as a priority in the GOM's reform process though currently there is no clearly defined policy yet on decentralization for the health sector. Establishment of State/ Regional governments led by chief ministers was a step towards political decentralization, with an aim to improve the functional capacity and accountability of sub-national entities. Health (and education) is included in the portfolio of the social minister who is part of the state/regional government.

At the national level there is a country coordination mechanism (M-CCM) for management and oversight of the 3 diseases that serves as a representative multi-stakeholder forum, along with respective Technical and Strategy Groups (TSGs). Recently, Myanmar Health Sector Coordinating Committee (M-HSCC) was established as an expansion of the scope of work and areas of oversight of the former M-CCM, as well as supervising the implementation of maternal and child health strategies and the achievements of Millennium Development Goals. The Committee has a broad mandate as a national coordinating body for all public health sector issues. The Governance Manual lay out the guidelines for the M-HSCC members to guide the Ministry of Health in strengthening the Health Sector.

At the state/ region level however, coordination among stakeholders takes place only in the form of quarterly coordination meetings organized by the State Health Department, and besides, the main purpose of the meeting is for information sharing

According to the system of health committees, every village tract was supposed to have a village health committee under the previous administration. However these committees were literally formed top-down and members were made of local administrative elites, had no clear roles and responsibilities, and were far from inclusive and participatory. Poor people from remote villages, vulnerable groups, and women were not represented in the committees. There were no mechanisms for communities either to hold the committee accountable, or to give feedback on the health services they were (or were not) receiving.

4.3 Priorities and reforms of the Government

During the health assessment mission, local authorities from both government and NSA made it clear that, consolidation of peace in the region is the top priority and that it is vitally important not to jeopardize the peace building process both at the community and state levels while developing and implementing health plans.

In May 2012, the four south eastern based ethnic health organizations, including the KDHW, KnMCH, MNCH and the Shan Health Committee (SHC) along with four community-based health organizations formed a Health Convergence Core Group (HCCG). (Please see Annex 10 of HCCG Statement) This group aims to prepare the ethnic health organizations along with their community based health networks for a future wherein it becomes possible for these organizations to work together on health with the Myanmar government, its decentralized institutions, international donors, INGOs, local NGOs and CBOs/CSOs. The objectives are to assume dialogue and communications with all parties, continuing to develop respective health programs and systems and start convergence once recognition and registration are possible. Restructuring and integration of systems will be possible depending on the progress made on the political front. Whilst all parties including the government are suggesting that this process cannot be rushed, discussions are being held with: the Karen State Health Department; potential donors for program implementation and restructuring; information and health technical discussions with health authorities and UN and; policy discussions with concerned non-governmental organizations.

In terms of thematic priority, MDGs 4 and 5 (reducing child mortality and improving maternal health respectively) are identified as national as well as state/ regional priority in the southeast region, with the targets set on reducing MMR and neonatal death, as well as IMR and U5MR. GOM has recently announced commitments to the Global Strategy for Women and Children's Health and these include: to ensure 80% antenatal care coverage; 80% of births attended by a skilled attendant; 70% access to emergency obstetric care; 80% coverage for prevention of mother-to-child transmission of HIV and integration within MCH care. The commitments also include: universal childhood immunization coverage increased; coverage of newborn care increased, increased contraception prevalence and reduced unmet need for contraception.

In line with these commitments to MNCH, the MOH aims to operationalize a new human resources for health plan for 2012-2015. Human resource targets include, among others, target to improve the

midwife to population ratio from current 1:5,000 to 1:4,000, and to establish 5,000 new sanctioned posts for PHS II (1 midwife and 1 PHS II for every sub centre). PHS II will be tasked with disease control responsibilities such as immunization and data collection in order to take some workload off the midwives. The current ratio is 10 midwives to every PHS 2.

MoH has given instructions to health facilities to provide free health services starting in April 2013. The package includes child delivery, EPI, MCH including emergency obstetric care, treatment for minor ailments, communicable disease control, and environmental health. This was followed by a provision of essential medicines and supplies to rural health facilities (Station Hospital and below). Many of the health facilities have just received the supplies and yet to embark on actual operationalization procedures. There are over 200 medicines on the essential medicine list and a shorter list of medicines has been approved for use in RHC and sub RHC levels.

The government's Framework for Economic and Social Reform (FESR) disseminated in January 2013, emphasized the importance of rapidly improving the quantity and quality of primary health care in Myanmar, with special focus on innovative health financing as a "quick win". The Framework stated that GOM will focus on exploring a number of innovative measures in health financing such as a voucher scheme for maternal and child health care. Subsequently, a pilot on MCH voucher scheme has been initiated in Yedeshe Township in the Bago east in May 2013.

4.4 Existing programmes, partners and potential of cooperation

The Myanmar National Health Plan of 2012-2016 and the Myanmar Health Vision 2030 set out the medium to long term objectives of the health sector, with objectives directed at, - solving the country's priority health problems, promoting rural health development, realizing the Millennium Development Goals, strengthening the health system and improving the determinants of health. Aiming to achieve 'health for all' through a primary health care approach, the current national health plan, will continue to give priority to maternal, newborn and child health (MNCH), communicable diseases and health systems strengthening, as well as to sector coordination. Expanding health services to rural areas, but also to border areas is an emerging policy priority which will require the production of sufficient as well as efficient human resources for health, augmented by increased infrastructure and an expanding role for the private sector and non-government organizations in delivery of health care.

Developed by the Ministry of Health (MOH) in partnership with international donors, the Government of Myanmar has proposed the roll out of Coordinated Township Health Plans (CTHP) as well as developing a Health Sector Investment Plan for Universal Health Coverage and has expressed its commitment to achievement of the health-related Millennium Development Goals (MDGs).

Most relevant projects and programs are presented below:

4.4.1 The Government Health Sector

The Ministry of Health is the major provider of basic health services care having a pluralistic mix of both public and private systems for the financing and provision of services. The MOH is organized at three levels: at central, state or region, and at township level and has seven departments of which the Department of Health, is the largest, responsible for the preventive, curative and rehabilitative services in the 14 regions and states, 66 districts and 325 townships. As described under chapter (4.2.4) Leadership and governance, the health sector is presided over by a system of health committees from national to township level with the National Health Committee at the central level. In addition to the Myanmar Health Sector Coordinating Committee (M-HSCC) the health sector working group, a TSG for MNCH has recently been established and existing steering committees for reproductive and child health will be integrated into this structure. The M-HSCC brings together the MOH, UN agency and international NGO representatives, under its broad mandate as a national coordinating body for all public health sector issues. Bilateral donor participation is limited so far although the Ministry of Health along with UN agencies and donor institutions are getting more involved in the coordination of the health and water sanitation sectors.

Some States and Regions, including those in the Southeast, have started to develop Meso plans however it is not clear whether there is funding for these plans and what mechanisms for resource allocation will be employed.

4.4.2 International Development Partners

GAVI HSS: The Global Alliance on Vaccines and Immunization collaborates in Myanmar with WHO and UNICEF on supporting the GOM to achieve improved service coverage for essential PHC components (immunization and MCH) through health system strengthening. With a combined budget of US\$55 million for the period 2001-2016, GAVI seeks to strengthen service delivery by applying supply side and demand side strategies in hard to reach areas at all levels of the health system particularly at the township level. The aim is to extend support to 180 townships. In the SE region GAVI extends to six townships (among 20 first-phase townships): Demawso (Kayah), Hlaingbwe (Kayin), Thaton and Mudon (Mon), Yedeshae (Bago East), and Myeik (Tanintharyi).

3MDG Fund: Three Millennium Development Goal Fund is a second phase of a multi donor funding platform that was established as the Three Diseases Fund (3DF). The new phase of funding under the 3MDG will continue to provide joint donor support to address the basic health needs of the most vulnerable people in Myanmar and expand the scope of support beyond the three diseases to encompass maternal and child health and longer term sustainability. The 3MDG Fund has committed funds in the range of US\$250 million to \$300 million over 5 years and 75% of funding will be going to MNCH, 14% to HIV/AIDS, TB and Malaria and 11% to health system strengthening. The 3MDG will support 40 priority townships in 8 states/regions. These include Kachin, Northern Shan, Kayah, Chin, Magway, Rakhine and Yangon.

The Global Fund to Fight AIDS, Tuberculosis and Malaria in Myanmar: In 2009, Myanmar submitted a successful Round 9 proposal to the Global Fund for US\$320 million over 5 years to support national program responses to 3 diseases in more than 284 townships. Support commenced in January 2011. In June 2013 the GF announced a 'New Funding Model' for all three diseases which will allow scale up of key interventions. The effectiveness of the Myanmar Country Coordinating Mechanism (M-CCM) was highlighted by the Global Fund as one of the deciding factors in the provision of the new grants.

Ji-MNCH: The Joint Initiative on Maternal, Neonatal and Child Health, funded by Australia, Norway and the UK with commitments of US\$12.8 million over a three year period 2009-2012, targeted 5 townships in areas affected by Cyclone Nargis. The JIMNCH was implemented through international organizations and has now received for support through the 3MDG mechanism.

JICA: Japan has provided support for TB and malaria programs, and plans to continue support for communicable disease control. Japan is also financing the construction and refurbishment of rural health facilities in the dry zone and of warehousing for drug stocks at state and region level, and provision of equipment for Rural Health Centers and sub-centers. Another project is developing the capacity of MOH trainers of Basic Health Staff, focusing on training methodology. Support is planned for a new maternal and child health project, which will include training for midwives.

USAID: In addition to supporting relief and recovery in Cyclone Nargis affected areas, the United States is supporting a humanitarian program in Mandalay, Magway, Sagaing, Yangon and Kayah, which will focus on maternal and child health as well as the establishment of village health and development funds and women's empowerment groups. This 5 year program with a budget of US\$54 million is being implemented in a consortium of 5 international NGOs under the direction of PACT. In addition USAID has been developing a Regional HIV, TB and malaria program, in collaboration with URC which will extend significant support activities in Myanmar.

UN Agencies: There are 13 UN agencies operating in Myanmar. WHO, UNICEF, UNFPA and UNAIDS support the MOH on policy development and implementation. WHO and UNICEF are working with the MOH on GAVI HSS and to address gaps in national policy and guidelines on community-based newborn care and community case management of pneumonia and diarrhea in children. UN agencies channel funds through the government and through international and local NGOs for service delivery.

4.4.3 The private sector

The private sector is another important provider of health care which provides mainly ambulatory care. Most private sector providers are mostly concentrated in cities however village level GPs are becoming more known. An estimated 61% of all medical staff in 2010 was partly employed in 103 private hospitals, 192 special clinics and 2891 general clinics. Out of pocket expenditures on health care are spent on private procurement of essential health care by the population.

4.4.4 INGOs, local NGOs and CBOs

There are reported to be 63 registered international NGOs, 101 local NGOs and 455 community based organizations (CBOs) operating in Myanmar although not all are officially registered. There are 17 national Health NGOs and several professional associations including the Myanmar Medical Association (MMA) with 15,000 members, Health Assistant Association (MHAA), the Pediatric Association and the Myanmar Nurses and Midwives Association (MNMA). The Myanmar Red Cross society (MRCS) and Myanmar Maternal and Child Welfare Association (MMCWA) are also active with a wide network of volunteers across the country. Local community based organizations and faith based organizations have been reforming more recently, specifically for ambulatory care and social health protection activities in hard to reach areas. Main interest and expertise of the health INGOs include WASH, the 3 diseases, medical services and disaster response. Several INGOs are seeking to start expanding primary health care services to hard-to-reach areas and populations in the South East.

According to the Myanmar Information Management Unit (MIMU) in May 2013, there were 58 organizations active in health in the South East of Myanmar. A majority of these are INGOs, although many local NGOs and CBOs who are active may not be self reporting to MIMU. Most INGOs identified are addressing the 3 diseases, with others starting new activities in PHC and MNCH. The main funding is coming from 3MDG and GF.

Table 2. MIMU 3 W Map Health (See annex for the map)

<i>Location</i>	<i>Bilateral</i>	<i>CBO</i>	<i>BBO*</i>	<i>UN</i>	<i>Red Cross</i>	<i>NNGO</i>	<i>INGO</i>	<i>Total</i>
<i>Kayah State</i>		1	1	1		2	3	8
<i>Kayin State</i>	1	1	1	3		4	5	15
<i>Mon State</i>	1	1	1	4	1	1	7	16
<i>Tanintharyi</i>		1	1	3		2	4	11
<i>Bago East</i>		1	1	2	1			8

* BBO indicates Border Based Organizations

4.4.5 NSAGs and related civil society actors

The place and role of non-state armed groups (NSAGs) and related civil society actors in provision of health services delivery is significant in Myanmar, both in adjacent government controlled areas as well as in ceasefire areas. The strategic role and influence of these actors will depend in part on the context of the ceasefires between the government and the armed ethnic groups and on the ongoing national peace process.

In the Southeast, the three main NSAGs who also represent ethnic nationality groups are the Karen National Union (KNU), the New Mon State Party (NMSP) and the Karenni National Progressive Party (KNPP). These groups represent political, economic, social and cultural identities and have military branches that often exert control over ceasefire areas and the communities within them. Geographically, boundaries between groups and between the government system vary as do differences in governance style and the provision of social services.

In Karen State, the Karen National Union has a Karen Department of Health and Welfare (KHDW), one of the 13 departments under the KNU, tasked to extend health and welfare services through an integrated mobile health clinic and backpacker program to populations that reside in the seven districts of the state. With a population of approximately 1.35 million, with many more Karen communities residing in neighboring states and regions, the KHDW extends services to Karen state and KNU held areas which often have minimal infrastructure such as roads, electricity and water systems. In terms of services rendered, the KHDW supports primary health care within mobile health clinics that covers: basic medical care, trauma management, malaria testing and treatment, basic dental, reproductive & child health care, vaccination, vitamin A and de-worming, nutrition, patient referral and TB treatment. In terms of human resources, there are over 1,560 health workers; 4 doctors, 176 medics, 437 CHW and 447 TBA, many who operate in mobile health clinic settings that are mostly concentrated in northern Karen State. Each mobile clinic is supposed to cover between 3,500 and 5,000 people. There are currently 10 clinics, however these need restructuring and rebuilding. The KHDW is assisted in its work by 4 community based organizations, including the Burma Medical Association (BMA), Back Pack Health Worker Team (BPHWT), Mae Tao Clinic (MTC) and the National Health and Education Committee (NHEC) and receives support from 5 (border based) INGO partners.

In Kayah State, the KNPP has a Karenni Health Department (KHD) and a Karenni Mobile Health Committee (KnMCH) that extends primary health care services to areas under their ceasefire. Assisted and structured along the lines developed by backpack groups from the Mae Taw Clinic, the KHD currently has 20 mobile groups and 67 backpackers. Services that are rendered include curative care, maternal and child health care and health education. The KDH receives support from 2 border based INGOs, 4 INGOs based in Yangon and two local faith based NGOs. The KnMCH teams have collaborated together with the Karenni National People's Liberation Front (KNPLF) and the KDH has founded a joint health care committee with the KNPLF and Kayan New Land Party, two other ceasefire groups from Kayah state.

In Mon State, the NMSP has a Mon National Health Committee (MNHC) that also extends primary health care services to three districts that are under their ceasefire area and are structured similarly to the KHDW through a network of mobile health clinics. On the border, MNHC operates nine clinics and three health posts, and has a staff of about 60 medics. Annually MNHC provides health care to approximately 10,000 patients. There are no clinics yet in the ceasefire area. Although its own training facilities have trained over 150 medics and 20 lab technicians, they cannot expand the coverage as funding for the health sector remains small, which came mainly from the party's overall budget. The MNHC receive assistance from the Mae Taw Clinic and other partners and provides similar services to the KHDW. Currently the MNHC has 7 community based partners and gets some support from a number of Yangon based INGO and donors, although gaps in coverage and resources requirements remain very significant.

4.5 Main opportunities and risks

Exogenous factors that may support health projects in the Southeast include:

- The momentum of the peace process has generated a strong desire from both sides to strengthen services in the remote areas of the region. This represents also an opportunity to further the convergence between the government and the NSA health systems, into one common system. Recent suspension of government restrictions on access into some of the conflict-affected areas in the Southeast as part of the national reconciliation process, has led to the expansion of humanitarian assistance and possibilities for broader political space and socioeconomic development.
- The strong increase of the health budget, even if it is still insufficient, and delivery of free medicines demonstrates a new commitment of the political leadership in health. A change of attitude is also notable in terms of openness and sharing of data and information, at national and varyingly at state level.
- The country's economic growth is very likely to translate into higher revenues for the government budget, and therefore health budget. In addition, the government and parliament seem intent to increase the current share of the budget going to health in the next years. With the lifting of sanctions, the flow of ODA has increased, with a significant amount expected to benefit the health sector.
- IDPs and refugees are expected to return in the coming months or years to these regions. Having projects already active in the areas close to their likely 'resettlement areas' will allow to respond to these 'new' needs in a rapid way. This is particularly important from a conflict sensitive perspective.
- The new political and social environment allows for 'new' community empowerment and civil society strengthening.
- SDC enjoys good credentials with both government and NSA, which should facilitate project steering and implementation.

On the other hand, a number of external factors may impede programming, including:

- The future of the peace process is uncertain and there might be set-backs in negotiations especially in the time leading up to the national elections in 2015. Furthermore, health is not a first priority in the peace talks. Although this is beyond the control of SDC supported health program, appropriate measures for early recognition and mitigation of risks could be taken by incorporating conflict sensitive management as a core element in the project cycle.
- There are no proper plans yet for IDPs and returning refugees. It is not clear exactly where they will resettle, or where they would want to resettle, in terms of district, townships and villages. Nor there is any information on their numbers or the timeframe. It is important to coordinate regularly with NSA health departments, NGOs and CBOs working in NSA areas, and organizations

involved in the repatriation process such as UNHCR, NRC and others, - to get timely information for efficient planning.

- Authorization, acceptance and collaboration with 'new' implementing partners may be a problem in some cases. There are very few implementing partners yet with experience working both with NSA in the Southeast and the government, and distrust still persists. Furthermore, the procedure to get registration and MoU to work in certain areas can be long and difficult. This may limit the number of implementing partners from which to choose. A consortium of partners led by registered organization/s may provide a platform for eligible community based organizations which are still in the process of getting registered.
- Rapid scale-up of new programmes poses coordination challenges among donors, implementing partners, and government. At the implementation level, state/regional health departments do not have enough capacity to coordinate with multiple partners because of limited human resources and increased workload. Formal coordination mechanisms may need to be improved at the Regional or State level to better align different projects, programs and implementing partners. Investing in an efficient coordination mechanism at state/ regional level will minimize opportunity costs of coordination. There is also a risk of overlap and duplication of interventions which could be mitigated through active coordination.
- Communications between the various ethnic groups and the government remains limited in NSA areas and this will largely impact on the acceptability of health services. Confidence building measures are imperative and should be given priority under the community component of the PHC project.

5 Recommendations for a SDC Health Programme

Based on the findings of the health assessment, the consultants have outlined two options as main recommendations for SDC to consider for funding. The two options recommended are:

- 1) A contribution to the 3MDG Fund
- 2) A Primary Health Care project (mandate)

5.1 Contribution to 3MDG Fund

It may be in SDC's interest to allocate a portion of the health budget to contribute to the 3MDG Fund. Its governance structure offers all donors an equal place on the Fund Board. Although 3MDG Fund is a new phase of a multi-donor funding platform, it is a continuation of the Three Diseases Fund (3DF) which was an effective funding mechanism. 3MDG has good governance structure and operating system in place, as well as professional management and technical staff. Geographically, it will cover eight states/regions in the country, though this will amount to 10-20% of the population. In the Southeast, it will cover Kayah

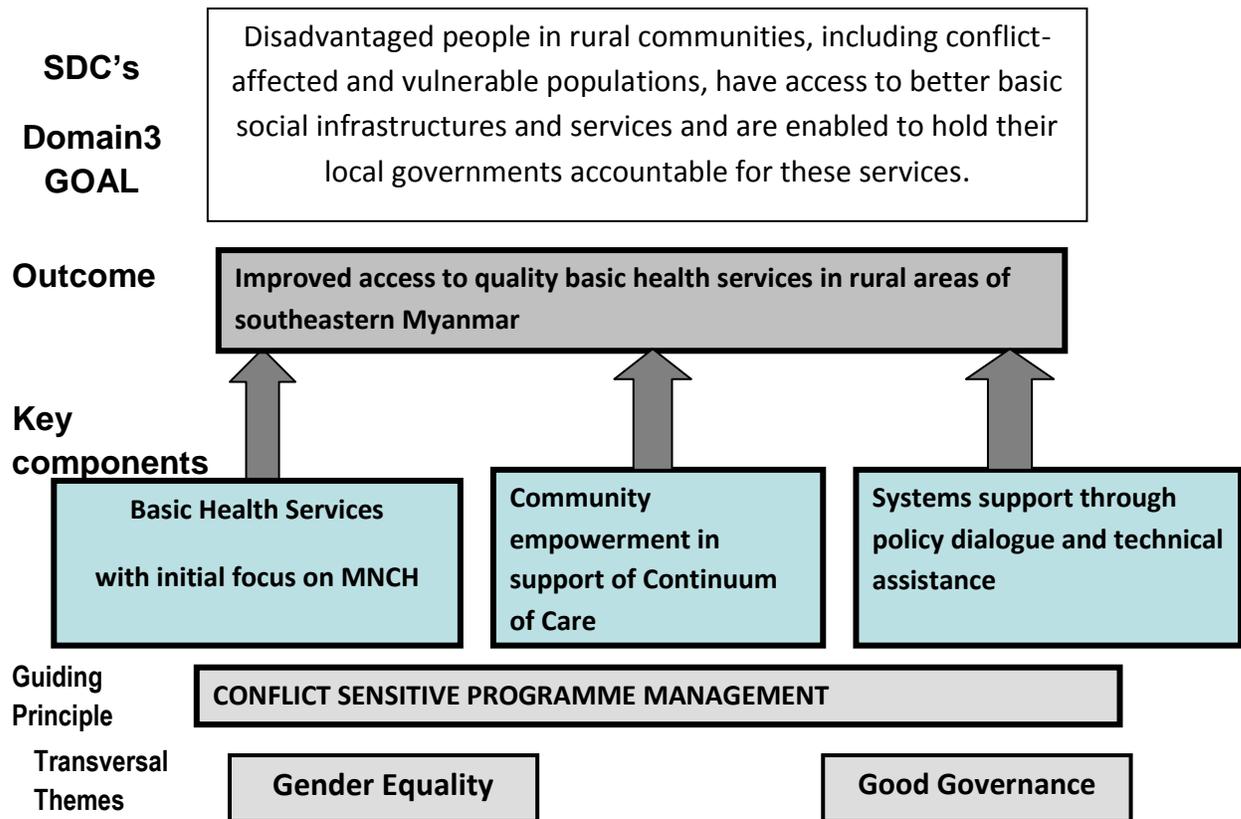
state in the first phase and some townships of Kayin in the second phase. By contributing to 3MDG Fund, Switzerland could influence and learn from 3MDG through its policies and operations such as health system strengthening, and contribute to policy dialogue. Other advantages may include: increase population coverage of 3MDG Fund; avoid duplication of health interventions by aligning and coordinating with other stakeholders; minimize costs of coordination with MOH; enhance overall effectiveness in terms of coherent impact in areas most in need; and avoid unfair distribution of resources to beneficiaries; and enable shared risk management with other donors (in a challenging operational context in conflict affected areas).

5.2 A Primary Health Care Project (mandate)

Based on the findings of the health assessment, as well as on SDC expertise and Cooperation Strategy for Myanmar 2013-2017, the consultants recommend SDC to mandate a primary health care project, strengthening primary health care both from supply and demand side. At this stage the project ideas outlined are intended to provide a framework for preparation of tender process for SDC's longer term engagement. Key components should include:

- Basic health services
- Community action for health in support of continuum of care
- Systems support through policy dialogue and technical assistance

A Primary Health Care Project



5.2.1 Basic health services

Basic health services can substantially contribute to reducing the burden of disease at community level. Supporting basic health services should be done in close coordination with the state/ township health authorities and as part of their plans. It is proposed that the project start with MNCH and then expand the number of services to respiratory tract infections, diarrhoea and other common ailments. There is a substantial need to strengthen MNCH services at the community level in the Southeast especially in rural, remote and impoverished areas.

The recommended PHC project can have an important impact on MNCH in the Southeast where the 3MDG Fund is not covering. Within the framework of the PHC project, this component will facilitate coordinated township health plans. It will also facilitate the work of midwives through different possible interventions: supporting their outreach efforts by assisting in transportation and communication, training and continuous medical education on essential health services, and improving means of communication to receive technical support and guidance, on the other hand, providing supportive supervision to and coordination with auxiliary midwives and community health workers.

Midwives need supportive supervision, particularly technical support, from Health Assistants and Lady Health Visitors stationed at the rural health centre. Some RHCs and SCs may need refurbishment of the infrastructure and equipments while a significant number will need strengthening of staff capacity.

Other interventions should also include supporting training and continuous medical education of health assistants, lady health visitors and midwives, on basic emergency obstetric and newborn care; and regular supply of delivery kits and supplies to RHCs and SCs. Some midwives are already using mobile phone system to connect with their supervisors (health assistants) for technical advice in case of medical emergencies. This should be explored as a viable option for strengthening communication and supervision.

While midwives are a key element in provision of MNCH services at the community level, AMWs also render services to a considerable proportion of women not covered by midwives. In areas which are out of reach (by midwives), training and supervision of auxiliary midwives should be encouraged as a transition measure, until a more qualified midwife is hired.

Particular attention should be paid to increase utilization of health services by women and children. Measures such as using flexible clinic hours to accommodate women's needs, tailoring health education and outreach services for most vulnerable women including adolescent girls, IDP, refugees and migrant women, etc.

5.2.2 Community empowerment in support of Continuum of Care

The main focus of this component is fostering community empowerment by working with rural communities to strengthen their capacity in health promotion, self organization, representation, networking and advocacy for continuum of care. Possible interventions for health promotion may include: mobilization and training of community health workers and volunteers for health prevention campaigns and activities, training of women outreach workers for screening of at-risk pregnancies, and early recognition of need for referral health service, etc.

One of the factors leading to high mortality rates is delay in accessing to emergency care (e.g. emergency obstetric care) which is mainly due to transportation and cost barriers. These barriers can be overcome by improving referral system, and mitigating barriers through community approaches. Good practices have been developed in country on how to overcome these barriers. For example, MOH has been exploring a number of innovative measures for health financing including a MCH voucher scheme pilot for maternal and child health care. These need to be introduced in the Southeast.

Delay in demand for services is another important concern and should be addressed through community approach. Community volunteers can be mobilized to encourage people to utilize qualified health services at local level. Communities can be empowered to take actions to promote health on a more systematic way at village level. In terms of local governance the project should support accountability mechanisms through community based structures, such as village health committees – to demand more accountability for better services. It is important to ensure that these committees are representative, include vulnerable groups and women in decision-making level. Special attention should be paid to

gender equality issues, to ensure that women take a lead in community mechanisms such as in women’s support group which can become instrumental in early identification of at-risk pregnancies. There are a number of good experiences to learn from within SDC and other INGOS and NGOs in the Southeast as well as other regions in Myanmar. Community complaint mechanisms need to be looked at. It should be linked to the formal health system e.g. to provide feedback to health care providers.

The community component of the PHC project will encourage strengthening of local community networks which had taken part in rendering of relief and social welfare services in conflict affected remote border regions for many years in the past. Their participation in the current project will not only enhance health promotion activities, but also support the project in conflict sensitive programme management.

5.2.3 Systems support through policy dialogue and technical assistance

Lessons learned from the implementation of the project should be reflected in the policy dialogue at national level and state level. And key discussions at that level should inform the steering of the project. Although national policy dialogue will not be a strong focus of the office in the health sector, it should contribute in an efficient and flexible way to relevant discussions. The PHC project should therefore produce key documents to inform stakeholders, and in certain circumstances, provide technical support when linked to the implementation of the project. The project should actively involve in the state/ regional level coordination mechanism in close collaboration with other stakeholders.

This component may include placement of technical assistance in the policy level. The current conditions are favorable to working with the formal health system through placement of TA. TA needs at state/ regional level may include: decentralization, data and information management, MCH vouchers, etc. The type of TA to be supported will be determined on the need basics, as well as on linkage to the project and feasibility. In the initial stage, the PHC project should select a specific area which is essential for the project and is not yet covered by other actors. Service Availability and Readiness Assessment (SARA), an updated version of Service Availability Mapping (SAM), for example, can be considered for identifying gap areas in both government and NSA controlled areas. The project should contribute to the evidence base through assessments and studies relevant to the project.

Table 3. Key features and considerations of main components of a PHC project

Key components	Key features and considerations
1. Basic Health Services	
Strengthen the role, competency and skills of basic health staff delivering essential services in RHCs, SCs and community clinics, in order to improve	<p>Allows SDC to target support to poor, hard to reach and marginalized groups.</p> <p>Opportunity to prepare basic health care services in NSA areas with potential for returning IDP and refugees</p> <p>Support to capacity development of basic health staff (e.g.</p>

access to and quality of basic health services, with focus on MNCH	<p>midwives) and complement community health workers</p> <p>Selected support to infrastructure and equipment in NSA-controlled areas</p> <p>Support township level planning for MNCH services</p> <p>Support training of basic health staff for basic emergency care</p>
2. Community empowerment in support of Continuum of Care	
Foster community empowerment to support continuum of care and local health governance	<p>Support training and supervision of community health workers to take specific role in health promotion and prevention</p> <p>Support village health committees (or other similar structure) to promote continuum of care</p> <p>Strengthen accountability mechanisms between communities and the health system; strengthen community complaint mechanisms</p> <p>Support referral systems both in GCA & NSA areas</p> <p>Strengthen safety net mechanisms for the poor including for referral and essential health services,</p> <p>Build synergy with domains 1, 2 & 4 to empower community support groups.</p>
3. Systems Support Through Policy Dialogue and Technical Assistance	
Contribution to policy dialogue & coordination with MOH and development partners, TA support to state/ region level, support NSA health organizations	<p>Strengthen coordination mechanism at the state and township levels</p> <p>Placement of TA at state/ region level</p> <p>SDC positioned to influence MNCH policy and program direction in the southeast</p> <p>Contribute to evidence base through assessments and studies</p> <p>Support SARA and the mapping of available human resources, services and health facilities in both government and NSA-controlled areas</p>
Conflict Sensitive Program Management	
With Partner Ministries, development partners, INGOs, NGOs, CBOs and NSA health organizations, develop appropriate modalities for dialogue and collaboration	<p>Acknowledge the presence of parallel health systems</p> <p>Encourage all partners to establish a do no harm approach in the strategies and implementation modalities</p> <p>Initiate activities that link groups/ facilitate the convergence of the NSA and government health systems.</p> <p>CSPM part of criteria for partner selection in the tender process</p>

5.3 Transversal themes and guiding principles

5.3.1 Conflict Sensitive Program Management (CSPM)

Conflict sensitive program management will be a central element of the PHC project. Although ceasefire agreements have been reached between NSAGs and the GOM in the Southeast, peace negotiation process is still on-going and may need time for consolidation. Therefore it is imperative that CSPM considerations are implicitly applied in all components and stages of the PHC project.

SDC will encourage implementing partners to establish a do no harm approach in the strategies and implementation modalities that cater to the Southeast and particularly so in areas with specific needs for the IDPs, returnees and other vulnerable populations including migrants. This entails acknowledging different local communities, enhancing participatory processes, supporting activities that can link groups and areas and enhancing synergies with SDC's other domains. At the same time, do no harm approach warrants implementing partners to discourage and be vigilant of policies and practices that will divide communities.

SDC should allocate about 50% of its resources for health in NSA controlled areas in order to support the perception of Switzerland as a neutral partner. CSPM considerations will be part of the elaborating criteria for partner selection in the tender process. Implementing partners, through their interventions, should envisage facilitating the convergence of the NSA and government health systems in close collaboration with both sides, so that eventually there will be one common health system in the long term. In the short term however, strategies and implementation modalities may need to be slightly adapted to cater for the specific needs of the concerned areas and health systems in place.

These initiatives may include, but not limited to: supporting the primary health care services of the ethnic health organizations (EHOs), joint training programmes for basic health staff from both sides, recognition of health staff accreditation, using common tools and standard procedures, etc.

Serving as catalyst, the PHC project can initiate use of a set of common "core metrics" to monitor the status and capacity of their respective health systems. Service Availability and Readiness Assessment (SARA), for example, could start with the State Health Departments and the township health authorities in the GCA area, and simultaneously extend to NSA controlled areas and include active participation of the non state ethnic health departments.

5.3.2 Gender equality

Gender equality will be promoted in all components of the PHC project. Adherence to this theme calls for gender awareness analysis and measures for gender mainstreaming in all interventions, for sex-disaggregated outcomes and respective monitoring data as well as for gender targets in each

component of the project. Basic health services component will use approaches which are responsive to the special needs of vulnerable women - such as flexible clinic hours to increase utilization, enhancing outreach services for most vulnerable women including adolescent girls, IDP, refugees and migrant women. Activities that will empower women will be encouraged, such as capacity development of women's support groups, recruitment and training of women community health workers, representation of women in village health committee, etc. The SDC health domain will seek to build synergies with domains 1 and 2 to further enhance women's empowerment in aspects other than health.

5.3.3 Good governance

Good governance is based on five principles to which a state should adhere to exercise good governance practices: accountability, participation, non-discrimination, efficiency and effectiveness, and transparency. Based on government's overall commitment for decentralization there is a clear need for building up local governance capacities, concepts and interventions, along with improved basic community services. The PHC project should proactively support non-discrimination and participation of disadvantaged people in rural communities, ethnic and other vulnerable groups including IDPs, returnees and internal migrants, by improving their access to information and services, and by strengthening their capacity to take active role in community action for health.

The project should promote transparency and accountability through community based structures, such as community networks, support groups, village health committees and community feedback mechanisms – to demand more accountability for better services. The constitution of the village health committees (VHC) should be participatory and inclusive, with representatives of vulnerable population groups and women involved in decision making and local governance. The establishment and functioning of a community feedback mechanism should be supported and its utilization by vulnerable population groups including returnees, migrants and women, made feasible. The mechanism should be linked to the health care system and its service providers to give feedback on the effectiveness and efficiency of the health services.

By fully aligning with other actors, the PHC project should ensure fairness of distribution of resources to beneficiaries. The project should closely collaborate with the State Health Department and other partners in the region to enhance coordination among stakeholders and to support roll out of township coordinated health plans in hard to reach areas as well.

5.4 Geographic coverage

Building on the success of nearly two decades of Swiss humanitarian support to the context of Myanmar, Switzerland will focus its support in the south eastern region of the country. The south eastern region includes Kayah State, Kayin State, East Bago Division, Mon State and northern Tanintharyi Division, and is home to a number of ethnicities. The southeast has been the focus of several of the longest-running armed conflicts in the region, with resulting displacement of persons and loss of assets. Cease-fire agreements have been achieved with the major ethnic armed groups, nevertheless, hundreds

of thousands still remain in refugee camps or internally displaced along the border areas, who are likely to return to their home areas in the southeast. Due in part to the conflict, access to social services in these areas remains very limited with poor transportation, infrastructure and local governance structures. The focus on rural primary health care is very important in the south east as significant parts of the five states and regions are critically underfunded and underserved and require targeted support.

The PHC project should start in no more than two of the five southeastern states. Since Kayah will be covered by the 3MDG Fund, it will probably be excluded. Area selection criteria need to be transparently established. Considerations related to remoteness and poverty, duplication with other PHC projects and presence of other partners, presence and synergy with the Humanitarian Aid projects as well as other future Swiss projects, balance between NSA areas and government controlled areas, will be taken into account during the planning process to decide more specifically on geographical focus. Special consideration should be given to areas where IDPs/ refugees are likely to return to. Ideally, poor health indicators should be included in the criteria; however in the absence of reliable, consistent and valid data, it will not be possible to do so at this stage.

The project should aim to work at both township levels as well as in village level, with coverage of 70-100 villages to start with and increase to 300 to 400 villages within 4 years. Total number of population covered may vary as the size of villages may differ greatly from one another in the range of 500-1,000 people per village. It may be more strategic to identify target villages within a number of townships, using area selection criteria, instead of going for entire township/s.

6 List of Annexes

Annex 1 A log frame of a primary care project

Annex 2 An estimation of financial requirement for the recommended Health Program

Annex 3 A Risk Analysis of Proposed Engagement and Mitigating Issues

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Annex 5 Inventory of all relevant stakeholders

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Annex 9 Itinerary of the health assessment mission

Annex 10 Health Convergence Statement

Annex I: Logical Framework – SDC-supported Primary Health Care Project

Hierarchy of objectives Strategy of Intervention	Key Indicators	Data Sources Means of Verification	
Impact (Overall Goal)	Impact Indicators		
Disadvantaged people in rural communities, including conflict-affected and vulnerable populations, have access to better basic social infrastructures and services and are enabled to foster their local governance through increased individual and institutional capacities	<ul style="list-style-type: none"> Measurement of disparity in mortality, poverty status, nutritional status, health coverage and resource distribution in targeted rural communities as compared to national average 	HMIS, Population-based surveys, project progress reports	
Outcomes	Outcome Indicators		External Factors (Assumptions & Risks)
Outcome 1 Equitable access to and use of quality basic health services by communities is improved in rural areas of target townships in Southeast Myanmar	<ul style="list-style-type: none"> Number of people treated in target health centres Balanced coverage of target groups (remote/ conflict affected/ migrant communities) Percentage of pregnant women reporting at least 4 visits of AN care Percentage of skilled birth attendance in target communities Percentage of RHCs providing basic emergency care Immunization coverage of DPT3 and measles Number of basic health staff using 	HMIS, project progress reports, Population-based surveys, partner reports	<p>Assumptions</p> <ul style="list-style-type: none"> Essential drugs for key diseases are available through support from DoH and free health care for essential services sustained Adequate number of midwives deployed to all RHCs/ SCs according to allotted sanctions, and are retained Current salary incentive attracts midwives to work in hard-to-reach areas <p>Risks</p> <ul style="list-style-type: none"> Financial sustainability for free health care initiated in April 2013 may not be sustainable Collaboration and agreements between

Hierarchy of objectives Strategy of Intervention	Key Indicators	Data Sources Means of Verification	
	standard case management package for MNCH <ul style="list-style-type: none"> • Stock-outs of essential medicines and supplies 		social and health sector may be challenging <ul style="list-style-type: none"> • Insufficient pool of eligible candidates in NSA areas who meet criteria to enrol in midwifery training • Permission needed to roll out coordinated township health plan in NSA areas
Outcome 2 Community empowerment fostered in support of Continuum of Care	<ul style="list-style-type: none"> • Percentage (and number) of villages in target communities which have active village health committees (or similar community based structures) • VHCs include representation of vulnerable groups, ethnic minorities and women in decision making level • Number of villages which actively participate in community initiatives/ campaigns for health prevention • Number of community health workers and auxiliary midwives trained and are functioning • Number of referrals to health services facilitated by community based structures • Number (percentage) of women of reproductive age utilizing public health services 	Project progress reports HMIS	Assumptions: <ul style="list-style-type: none"> • Building synergies with other domains (and other components within domain 3) will enable community based structures including self help groups to receive non-health support (e.g. VSD, livelihood) • Financial and logistic barriers to timely referrals mitigated through community approaches • Utilization of public health services by local communities have increased • CBOs working in health sector are strengthened in its organizational development and advocacy capacity Risks: <ul style="list-style-type: none"> • I/NGOs & CBOS that have good relationship with local communities may have difficulty in having registration/ MOU to work in target areas • Absorptive capacity of CBOs for resources + organizational capacity may be inadequate • Power groups try to control/ influence VHC for their own agenda – political or otherwise

Hierarchy of objectives Strategy of Intervention		Key Indicators	Data Sources Means of Verification	
				<ul style="list-style-type: none"> • Traditional decision makers interfere with community's decision making • Community complaint mechanism seen as negative criticism by health care providers
<p>Outcome 3 Health Systems in the southeast Myanmar coordinated and strengthened through Policy Dialogue and Technical Assistance</p>		<ul style="list-style-type: none"> • Number of policy dialogue and technical forum • Number of key policy/practice documents produced to inform stakeholders • Number of assessments and studies for evidence base commissioned • Evidence of health policies and practices adopted by State health authorities 	<p>Project progress reports MOH and Health Sector Coordination Committee Report Partners report</p>	<p>Assumptions:</p> <ul style="list-style-type: none"> • Government decentralization process progresses in states/ regions/ townships in the southeastern region as planned • Access to health information system has improved and is being utilized for programme management. • Government commitment to enhancing equitable access to health care within health system strengthening framework is sustained <p>Risks.</p> <ul style="list-style-type: none"> • Inadequate coordination capacity with stakeholders at state/ region level • High expectations for multiple TA support could be a challenge • Decentralization of responsibilities to state/ region & township health departments delayed
Outputs (per outcome) and costs		Output Indicators		
For outcome1:				
Output 1	Coordinated township health plans rolled out in target area	Number (and percentage) of townships which have rolled out the coordinated health plans		MoH's commitment to roll out township coordinated health plans sustained both in GCA and NSA controlled areas

Hierarchy of objectives Strategy of Intervention		Key Indicators	Data Sources Means of Verification	
Output 2	BHS trained on standard procedures & treatment protocols related to MNCH including basic EmOC	Number (and percentage) of BHS in target area who are trained on standard procedures & treatment protocols related to MNCH inc. basic EmOC		Rural health centres and sub centres in target areas are functioning with full staff capacity and are equipped with essential medicines and supplies
Output 3	Midwives capacitated to provide supportive supervision and teamwork with AMWs	Number (and percentage) of MWs in target area providing supportive supervision & teamwork with AMWs		Full sanction of MWs deployed to RHCs and SCs; adequate number of AMWs functioning in target area
Output 4	Rural Health Centre and Subcentres in target areas (which are in poor condition) refurbished	Number of RHCs and SCs in target areas which have been refurbished		RHCs and SCs which need refurbishment were properly assessed, in collaboration with health authorities and communities
Output 5	Midwives' outreach activities and communication facilitated	Number of MWs who have received assistance for better outreach activities and communication		Infrastructure including roads, telecom network coverage, weather conditions, and security favourable
Costs of outputs for outcome 1:		In case of joint projects: 1) amount of SDC contribution:	2) in % of total cost:	3) Total cost:
For outcome 2:				
Output 6	Community based structures are formed, capacitated and managed with inclusive local participation	Proportion of representatives from vulnerable population groups and women at decision making level in village health committees or similar community based structures		Vulnerable groups and women have interest and confidence to participate in community based structures
Output 7	Target communities are mobilized to take part in specific health prevention efforts	Number of villages which mobilized at least 4 community health prevention movements/ campaigns per year		Communities are not distracted by any political and economic turmoil or natural calamities

Hierarchy of objectives Strategy of Intervention		Key Indicators	Data Sources Means of Verification	
	and studies			
Output 13	Contributed to policy and dialogue forum at state/region level as well at national level	Evidence of health policies and practices adopted by State health authorities		MoH open to and supportive of policy dialogues
Output 14	Strengthened coordination mechanism for management and oversight of MNCH established at state and township levels	Number of state and township level coordination mechanisms supported		Central Government, state authorities and other stakeholders are committed to strengthen coordination mechanism
Output 15	Health convergence plan facilitated	States/ regions which have acknowledged convergence plan; States/regions which are using a common health system in both GCA & NSA areas;		Peace process progresses without disruption; health and development plans addressed as priorities within the negotiation process
Output 16	Health Information System at state/region level supported on a focused area	Coverage and quality of the health information system		MOH is willing to provide support
Costs of outputs for outcome 3:		In case of joint projects: 1) amount of SDC contribution: 2) in % of total cost 3) Total cost:		
Activities (per output)		Inputs		
<u>List of activities for output 1:</u> - Coordinate and collaborate with state/region health department and stakeholders to roll out coordinated				

Hierarchy of objectives Strategy of Intervention	Key Indicators	Data Sources Means of Verification	
<p>township health plans in target townships</p> <ul style="list-style-type: none"> - Train midwives on standard procedures and treatment protocols on MNCH - Train BHS (HA, LHV, MW) on basic emergency obstetrics and newborn care) - Support development of supervision guidelines and format for midwives to facilitate supportive supervision and teamwork with AMWs - Assess and refurbish RHCs & SCs which are in need - Support midwives to enhance their outreach capacities; and to improve communication with communities and with RHC for technical back-up 			
<p><u>List of activities for output 2:</u></p> <ul style="list-style-type: none"> - Facilitate re/establishment of community based structures inc. village health committees in participatory and inclusive manner - Mobilize community participation in health prevention activities/ 			

Hierarchy of objectives Strategy of Intervention	Key Indicators	Data Sources Means of Verification	
campaigns - Train CHWs/AMWs on focused areas/ roles (e.g. identifying at-risk pregnant mothers and refer to RHSC/MW) - Mentor village health committees to promote accountability & local governance - Facilitate establishment of community feedback mechanism - Technical and financial support to the establishment of referral system			
<u>List of activities for output 3:</u> - Coordinate with MoH and state health authorities to identify specific area most needed for TA support, and actual placement of TA - Provide TA and financial support to coordinate state level policy dialogue and technical forum - Identify gap/ conduct assessment and studies to contribute to evidence base - Support strengthening of			

Hierarchy of objectives Strategy of Intervention	Key Indicators	Data Sources Means of Verification	
<p>coordination mechanism at state and township levels</p> <ul style="list-style-type: none"> - Facilitate joint activities such as joint immunization campaigns, joint training of BHS, and others such as advocate for flexing of enrolment criteria at training institutions for candidates from NSA areas, advocate for accreditation of health staff trained externally, facilitate meetings for actual operationalization of a road map to a convergence plan - Provide technical and financial support to strengthen a focused area in Health Information System (e.g. ability to report on services availability, services responsiveness, planning for resources allocation and collaboration with NSA areas to improve access to BHS and quality of MNCH) 			

Annex 2: An estimation of the financial requirement for SDC Health Programme

Description	2013	2014	2015	2016	2017	TOTAL
1) Contribution to 3MDG Fund	CHF 1 million	CHF 1 million	CHF 1 million	CHF 1 million		CHF 4 million
2) A Primary Health Care Project (mandate) Percentage of total annual budget						
2.1) Basic Health Services with focus on MNCH	0	20%	20%	20%	20%	20%
2.2) Community empowerment in support of Continuum of Care	0	20%	20%	20%	20%	20%
2.3) Systems support through policy dialogue and technical assistance	0	10%	10%	10%	10%	10%
Management and consultants costs	0	40%	40%	40%	40%	40%
Conflict sensitive programme management,	0	5%	5%	5%	5%	5%
M&E	0	5%	5%	5%	5%	5%
TOTAL for PHC Project	0	100%	100%	100%	100%	100%

Rationale behind suggested allocation

1. Forty per cent of total budget is allocated for management and consultants costs as this kind of project (for mandates) usually requires high management costs.
2. One fifth of the budget is allocated to BHS/ MNCH component because of larger number of interventions expected in this component, most of which can be costly (training of midwives and BHS staff, supplies, supervision, transportation, outreach, financing mechanism, etc), Cost of renovation of (some) health centres in NSA areas should be factored in. The absolute figure will increase as the annual budget increases each year, and this should enable gradual expansion of the coverage.
3. Most activities under community component are likely to be low cost yet labour intensive. However if a small grants scheme and/or transport costs voucher scheme were to be included, this component will require funds as much as the first component, if not more. Though geographic coverage may increase in Year 3, the percentage allocation remains the same as increased funds in absolute terms would suffice to cover the expansion.
4. Budget for component 3 policy dialogue and technical assistance will be on placement of TA, convening policy forum, commissioning papers and studies, and possible exposure visits.
5. A specific amount of budget should be allocated to CSPM for capacity development and monitoring. This will need expertise from within SDC.
6. M&E budget in the initial period should be invested in collecting baseline data. Midterm and final evaluation should be planned/ costed.

ANNEX 3: A Risk Analysis of Proposed Engagement and Mitigating Issues

The overall risk rating is moderately to high. The SDC health program may wish to regularly undertake internal as well as an annual independent risk monitoring which can take into account the wider risks related to the context. The key risks are identified in the table below.

Risk	Description	Response
A Restrictive Operating Environment	Sluggish reform process, setbacks in peace negotiations, weak governance within health system, political factionalism in the lead up to general elections.	Transparent advocacy at all levels to ensure access to and independence of program activities that can ensure that adequate levels of human resources are available to maintain effective monitoring, with monitoring plans made well in advance.
Negative environmental conditions	The risks and challenges that are attached to very poor infrastructure, transportation and communications systems and weather patterns in the SE.	Flexible project management, guided by local decision making on the ground. Sufficient financial resources and improved communication systems so as to facilitate coordinated implementation
Registration and MOU process for INGOs, NGOs and CBOs	Lengthy registration and approval process, particularly for new organizations and increased risks for NGOs operating without MOU. New NGO law would penalize this behaviour with one year jail terms. Travel authorizations and approval processes result in friction.	Development of a transparent and inclusive partnership model that enacts early engagement in MOU processes as well as providing timely guidance for implementation processes. Draw on national, state/ region and local governance for endorsement of INGOs, NGOs, and CBOs.
Market realities and inappropriate private sector action	Current supply of medicines and equipments is centralised and vertically controlled by the MOH through the CMSD. This system is opaque and poorly managed. The commercial sector is controlled by large pharma companies who dominate the market. Local vendors are unreliable and quality standards are problematic.	It is advisable for the SDC health program to adopt similar practices and methods as are being utilized by the 3MDG and possibly align with the 3MDG and GF and other large initiatives in terms of purchase and distribution practices.
Financial sustainability of public health care services	Financial sustainability for selective UHC initiated in April 2013 may not be sustainable. Current Government health	The SDC program can make a targeted contribution to supporting public health services in the SE and this needs

	budget 3% is inadequate, under-resourced and underfunded continue to limit public health coverage, particularly for remote areas.	to link to improving health financing performance. Support for alternative health financing mechanisms is needed.
Exchange Rate Issues	The budget for the Health program are in CHD and converted to USD, in the past year the value of US Dollar value has depreciated by 20/25% from the previous year against the Kyat, (local currency) and has recently started to appreciate again	The SDC will have to monitor the exchange rate impacts on program interventions and take action accordingly.

ANNEX 4 : Analysis of Potential Synergies with other Domains as well as within Domain 3

Domains	Expected Outcomes	Potential Synergies
<p>Domains one: Employment and Vocational Skills Development</p>	<p>1. <i>Increased access</i> to relevant vocational skills development offers has furthered employment and self-employment of disadvantaged women and men of all ethnicities in peri-urban and rural areas.</p> <p>2. Contributions to <i>systemic sector changes</i> have enhanced the responsiveness of the VSD sector to national and regional labour market demands.</p>	<p>Building synergies with domain 1 may enable rural community structures, including women, youth and minority ethnicities to develop promotive and preventive health activities that compliment their vocational skills development.</p> <p>By establishing vocational skills development linkages with partners that receive support from the SDC health program for the delivery of basic public health services and/or MNCH will enhance the basket of services that the INGOs, NGOs and CBOs are rendering to their respective beneficiary communities.</p>
<p>Domain two: Agriculture and Food Security</p>	<p>1. Access to land and productive resources - Rural populations, including women and minority ethnicities, have more secure and more equitable access to and control over land, forest and aquatic resources.</p> <p>2. Food security and productivity – Smallholder farmers and landless improve food security and increase productivity through diversified household production, public and private extension services, and food assistance as needed.</p> <p>3. Income – Smallholder farmers have increased income through access to functioning value chains that cater to more efficient local and regional markets.</p>	<p>Building synergies with domain 2 may enable rural community structures, including women and minority ethnicities and other self help groups to develop promotive and preventive health activities within their core food security, agricultural livelihood activities.</p> <p>By establishing linkages with partners that receive support from the SDC health program for the delivery of basic public health services and/or MNCH will enhance the basket of services that target beneficiary groups of Domain 2 will have access to.</p> <p>As the SDC health program intends to strengthen the role of civil society in developing complementary health services through the involvement of volunteer Community Health Workers (CHW) who can provide health education and a basic package of essential health interventions, target beneficiary groups of Domain 2 will be strengthened.</p>

<p>Domain three: Health, Social Services and Local Governance</p>	<ol style="list-style-type: none"> 1. Access to, use and public financing of basic public health services has improved. 2. Equitable access to and use of quality community infrastructure and services, especially in conflict-affected areas and areas of potential return, have improved. 3. Citizens, in particular women and vulnerable groups, can voice and address their needs, exercise their rights and participate in local decision-making. 	<p>Building synergies within Domain 3 should be explicitly promoted as bringing the three outcome objectives together will improve overall outcomes.</p> <p>Linking the 3 outcome objectives together is possible through the development of a partnership policy or model, contract, agreement that is developed by the SDC domain 3 programs. Various partnership agreements are currently recognized in the SE including those of the Norwegian Relief Centre and the Community Development Association.</p>
<p>Domain four: Promotion of Peace, Democratisation and Protection</p>	<ol style="list-style-type: none"> 1. Key negotiating parties have articulated their aspirations and have presented them in the cease-fire and political peace negotiations which lead towards a democratic and inclusive Myanmar. 2. Shared democratic and human rights norms and values within Myanmar society and institutions are enhanced. 3. Conflict-affected people from selected areas can live in, or return to, a place of their choice in dignity and without fear, and have access to assistance as required. 	<p>Potential synergies between Domain 3 and 4 are significant, of particular interest in the short to medium term are the synergies between outcome 3 and establishing linkages with partners that receive support from the SDC health program for the delivery of basic public health services and/or MNCH that may enhance the basket of services that target beneficiary groups of Domain 4 will have access to.</p> <p>In the longer term a focus on outcome 2 in domain 4 works well with the outcome 3 in domain 3.</p>

ANNEX 5: Inventory of Stakeholders, their key objectives, working fields and potential interest to Partner with SDC

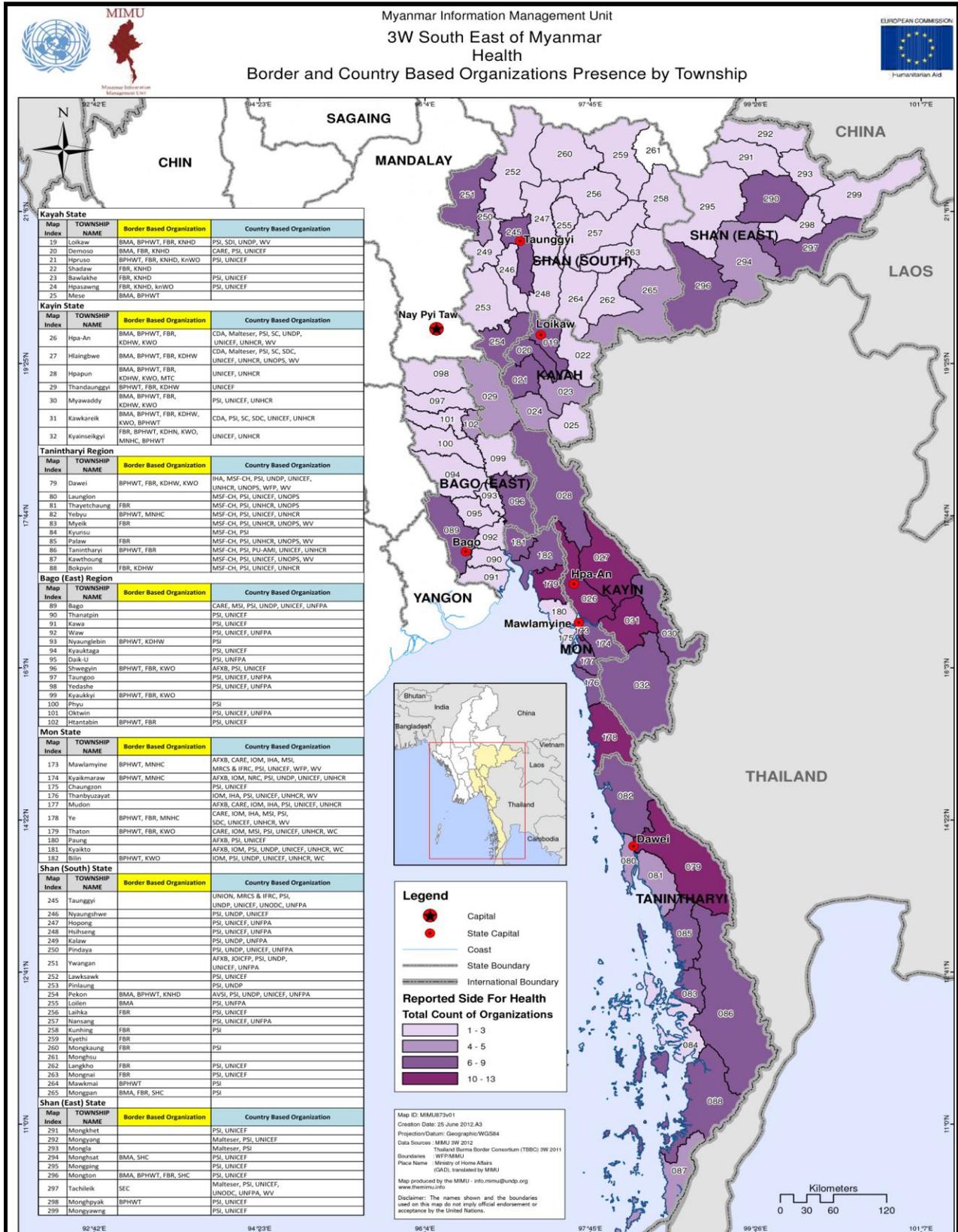
Stakeholders	Key Objectives	Working Fields	Potential SDC Partnering
AMI PU	Medical Humanitarian Assistance to Vulnerable Populations	PHC and Training of Health Staff, Water & Sanitation and Food Security	Potential Partner for BHS and MNCH in Kayin State
Malteser International	Humanitarian Assistance and Development Aid to Vulnerable Populations	Health (PHC, RH, TB, HIV/AIDS, Malaria) W&S and DDR	Potential Partner for BHS and MNCH in Kayin State
Marie Stopes International	Sexual and Reproductive Health Care	Family Planning, Maternal Health HIV/STI, Delivery Care	Potential Partner in Mon and Bago East
Medical Action Myanmar	Humanitarian Assistance and Development Aid to Vulnerable Populations	PHC and BSH (TB, HIV/AIDS, Malaria and Family Planning, Childhood Illnesses and Nutrition	Potential Partner in Kayin, Mon and Bago East
Norwegian Refugee Council	Humanitarian Assistance and Development Aid to Vulnerable Populations	Durable Shelter, Education, Food Security, Protection	Core activities not in health, do work with SDC on Protection (Individual ID cards in SE)
PACT	Humanitarian Assistance and Development Aid to Vulnerable Populations	Micro-Credit, W&S, Livelihoods , MCH, Community capacity building	Supported by USAID, leading a Consortium of INGOs, active in Kayah
CARE	Humanitarian Assistance and Development Aid to Vulnerable Populations	PHC, Nutrition, HIV/AIDS, Food security, livelihoods, W&S, shelter and DDR	Partnering with numerous other organizations, expanding into Kayah
AFXB	Supporting Vulnerable Populations affected by HIV/AIDS	HIV/AIDS, Vocational Training, Basic Education, Family support	Core activities in HIV/AIDS, active in Mawlamyiang

MSF/Swiss	Medical Humanitarian Assistance to Vulnerable Populations	PHC and BHS (Malaria, TB, HIVAIDS, and MNCH)	Potential Partner for MNCH in Thanintharyi Region
ACF	Humanitarian Assistance and Development Aid to Vulnerable Populations	Nutritional support, Food security, livelihoods, W&S	Potential Partner in Nutrition in Kayah
CPI/FFH	Partnership Organization Development Aid for Community Groups	Health (Communicable diseases, RH, HIS) Capacity building	Potential Partner and facilitator for Ethnic Health Organizations and CBOs
Merlin	Relief and Medical Humanitarian Assistance to Vulnerable Populations	Health and Water and Sanitation Health Worker Training, MNCH,	Potential Partner although Merlin is not active currently in SE
Karuna Myanmar Social Services	Faith Based Social Organization welfare and relief services for vulnerable populations	Health, HIV/AIDS, W&S, Early Childhood, Agriculture, Micro-credit, SALT, DRR	Potential Partner with extensive networks in Kayah, Kayin, Bago
Kayin Babtist Convention	Faith Based Social Organization welfare and relief services for vulnerable populations	Livelihoods, HIVAIDS, W&S, Capacity Building and DDR	Potential Partner with extensive networks in Kayah, Kayin, Bago
KDN	Inter-Faith Social Organization welfare and relief services for vulnerable populations	Community Capacity Building, Livelihoods, Nursing Aid, Education,	Potential Partner with extensive networks in SE
KnMCH	Ethnic Health Organizations responsible for Health to NSA	Mobile Clinic and Back pack network providing PHC	Potential Partner in KNPP Areas of Kayah

KDHW	Ethnic Health Organizations responsible for Health and Welfare Support to NSA	Mobile Clinic and Back pack network providing PHC	Potential Partner in KNU Areas of Kayin, Thanintharyi, Bago
MNCH	Ethnic Health Organizations responsible for Health to NSA	Mobile Clinic and Back pack network providing PHC	Potential Partner in NMSP Areas of Mon, Kayin, Thanintharyi
Mayahthi	Community Based Organizations Supporting Vulnerable groups	HIVAIDS, Outreach to CSW, Education for Youth, Networks	Potential Partner in Mon and Kayin, Focus on Vulnerable
WHO	UN Agency	National Support to MOH with involvement in HSS and MNCH	Potential Partner for Health System Support and TA for MNCH
UNICEF	UN Agency	National Support to the MOH and Ministry of Social Welfare	Potential Partner for EPI, MNCH and Community Health
UNHCR	UN Agency	National Support for Refugees resettlement, protection	Potential Partner for Support to IDPs and Returnees
TBC	Humanitarian Assistance and Relief to Vulnerable Populations		
World Vision	Humanitarian Assistance and Development Aid to Vulnerable	Child protection, Health, HIVAIDS, Livelihoods, W&S, Education, DDR	Supported by many donors extensive reach in SE.
URC	Center for Human Services, research and USAID supported	Malaria (Quality Control, HSS, BCC, Research and Evaluation	Potential Partner in Control and Prevention of Malaria

Save the Children	Humanitarian Assistance and Development Aid to Vulnerable Populations	Child Protection , Child Rights Governance , Education, Health, HIV/AIDS, Nutrition, Livelihoods, W&S, DDR	Supported by many donors extensive reach in SE.
IOM	UN Agency for Migration	PHC, Malaria and TB, MNCH, Counseling, Community Support , Counter Trafficking	Potential Partner for MNCH for migrant populations in SE

Annex 6 : MIMU 3W Map Southeast Myanmar (Border and Country Based Organizations Presence by Township)





Basic Health Care

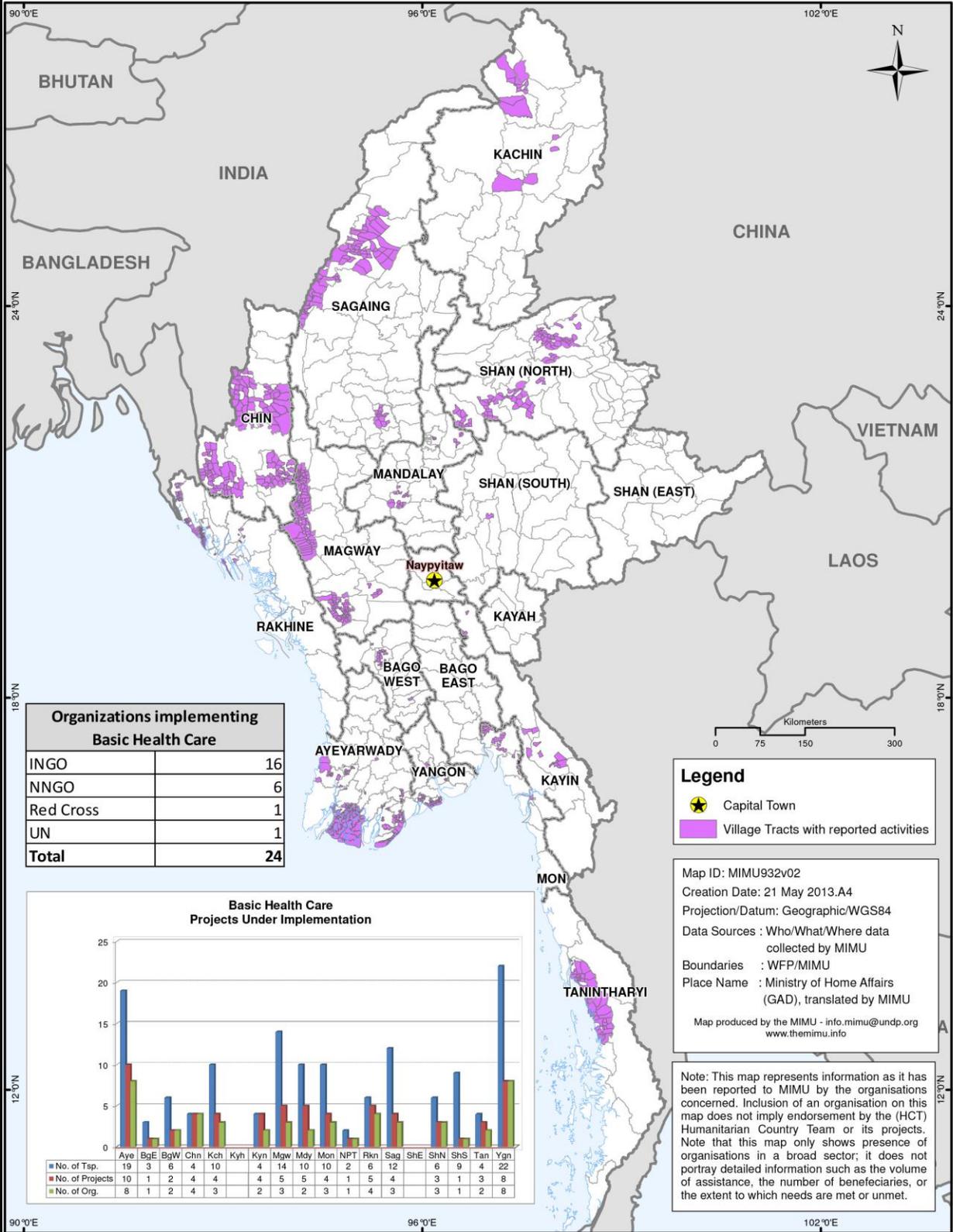
All Organizations' Activities by Village Tract

Reported to MIMU in April 2013

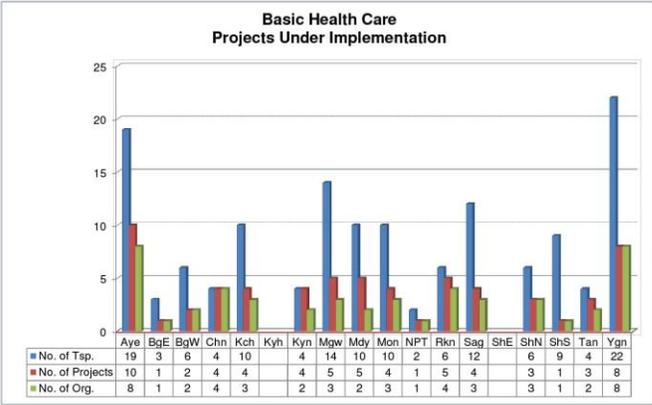


Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Embassy of Switzerland in Myanmar



Organizations implementing Basic Health Care	
INGO	16
NNGO	6
Red Cross	1
UN	1
Total	24



Legend

- ★ Capital Town
- Village Tracts with reported activities

Map ID: MIMU932v02
 Creation Date: 21 May 2013.A4
 Projection/Datum: Geographic/WGS84
 Data Sources : Who/What/Where data collected by MIMU
 Boundaries : WFP/MIMU
 Place Name : Ministry of Home Affairs (GAD), translated by MIMU
 Map produced by the MIMU - info.mimu@undp.org www.themimu.info

Note: This map represents information as it has been reported to MIMU by the organisations concerned. Inclusion of an organisation on this map does not imply endorsement by the (HCT) Humanitarian Country Team or its projects. Note that this map only shows presence of organisations in a broad sector; it does not portray detailed information such as the volume of assistance, the number of beneficiaries, or the extent to which needs are met or unmet.

Disclaimer: The names shown and the boundaries used on this map do not imply official endorsement or acceptance by the United Nations.



3W - Organizations implementing "Basic Health Care"
(Projects Under Implementation) as at 23 April 2013



Humanitarian Aid
and Civil Protection

Embassy of Switzerland in Myanmar

Organization	Ayeyarwady	Bago (East)	Bago (West)	Chin	Kachin	Kayah	Kayin	Magway	Mandalay	Naypyitaw	Mon	Rakhine	Sagaing	Shan (East)	Shan (North)	Shan (South)	Tanintharyi	Yangon
ADRA																		
AFXB																		
CAD																		
CARE																		
CARITAS-Thai (KMSS)																		
CESVI																		
CHAD																		
CHAD (CBCM)																		
FFH (SDG)																		
GNI																		
HAI																		
HAI (NAG)																		
HAI (YMCA)																		
HAI (YWCAM)																		
IRC (MCC)																		
KDN																		
KTCare																		
Malteser																		
MCS																		
MDM (MoH)																		
MERCY																		
MERLIN																		
MERLIN (MoH)																		
MRCS & IFRC																		
MSF-CH																		
MSF-H																		
SCI																		
UNHCR (Malteser)																		
WC																		

Note: The Village Tract locations of some activities may not appear on these maps if agencies provided only the Township location.

Annex 7. List of References

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ANNEX 8: List of persons met and/or interviewed

Name of Person	Organization	Contact information
Meetings in NayPyiTaw		
HE Dr Pe Thet Khin	Union Minister, Ministry of Health	Tel +95 (0) 67 411500, 411501 Fax +95 (0) 67 411503
Dr Min Than Nyunt	Director General, MoH	mintn2008@gmail.com +95 (0) 67 411001, Fax: +95 (0) 67 411022
Dr Kyaw Khine	Deputy Director, International Health Division	Tel +95-67-411353, 411355 95-9-5009723
Daw Than Than Lin	Director General, FERD	
U Soe Kyi	Director General Ministry of Social Welfare, Relief and Resettlement	
U Htwe Hla	Director General, Ministry of Border Affairs	
Meetings with INGOs, international organizations and UN agencies in Yangon		
Kelly Flynn	NRC	pm-aup@myanmar.nrc.no
Dr. Frank Smithuis	MAM	frank.m.smithuis@gmail.com
Greg Irving	IOM	girving@iom.int
Claire HaDuong Cedric Turlan Dr Zarni	AMI-PU	mmr.countrydirector@pu-ami.org mmr.dev@pu-ami.org
Matthew Tiedemann Dr Wynn Thane Dr Thida Lin	PACT	MTiedemann@pactworld.org
Dr Salma Burton	WHO	burtons@searo.who.int
Dr. May Aung Lin	URC	lmay@urc-chs.com
Dr Paul Sender Dr George Ionita Markus Buhler	3MDG	paulsender@unops.org georgei@unops.org markusb@unops.org
Myint Su	CPI	muintsu@cpintl.org
Birke Herzbruch	Malteser International	Malteser.yangon@gmail.com
Meetings in Mon State		
Dr U Hla Oo	State Social Affairs Minister, Mon	057-24730, 057-24942
U Than Htun Aung	State Health Director, Mon	09 540 8973
U Khin Maung Kyi	Director Natala, Mon	09 5322595
Naing Win Hla Naing Chay Mon Naing Tala Nyi	NMSP Deputy Director MNHC	
Nai Hongsa Boungh Khine	NMSP	
Dr. Win Win Khine	AFXB, Mawlamyine	09-49807540
Daw Myint Myint Than	Mayahthi Women's Organization, Mawlamyine	

U Sein Aung Min	Field Facilitator SDC Mon/Kayin	
U Phone Myat Su	Construction Engineer SDC Mon/Kayin	
U Saw Myat Htun Aung Kyaw	Field Facilitator SDC Mon/Kayin	
Mark Haeussermann	Project Manager SDC,Southeast Project	
Markus Casanova	Former Project Manager SDC,Southeast Project	
U Kyaw Thein Htike	Construction Engineer SDC Field Office Mawlamyine	Kyawtheinhtike100@gmail.com 057-21381, 057 26896, 0949322076
Daw Thwe Thwe Win	Midwife Thingangone Rrural Health SubCentre	
Dr Khin Saw Win	TMO Ye Township	Tel : 057 50011, 50350
Min Banyar Theik	MSI, Ye	thaik.thenest@gmail.com 09 421 004229, 09 498 20760
Meetings in Kayin State		
Col Aung Lwin	Kayin State Government Hpa-An	
U Chit Hlaing	State Social Affairs Minister	058 21233, 058 21083 (fax)
Major Thet Naung	Natala, Hpa-an	058 21162, 09 49575671
Dr Win Naing	State Health Director, Kayin	drwinnaing2011@gmail.com 0949220450
Dr Kyaw Swar Myint	Deputy Director ,Kayin State Health Department	0949770290
U Zaw Win	Officer Health Planning	
TMO Hlaingbwe		
Saw Eh Ka Lu Shwe Oo	KDHW	
Khu Oo Reh	KNPP	
Saw Tha Du Mu	KNU	
Khu Daniel	KnMCH	
Meetings in Dawei, Tanintharyi Region		
Dr Win Aung	Regional Social Affairs Minister, Tanintharyi (Region)	
Dr Kyaw Zeya	Regional Health Director Tanintharyi	Tel: 0949867555, 059-23584 Fax: 059 21079
U Aung Kyaw Myint	Deputy Director, Natala	09876264, 059 22126
Duncan Bell	MSF-CH	msfch-myanmar-hom@geneva.msf.org
Hope Wall	MSF-CH	msfch-dawei-fieldco@geneva.msf.org
U Zaw Thura	DDA Dawei Civil Society Organization	
Meetings in Loikaw, Kayah State		
U Koe Yae	State Social Affairs Minister	083-23017
U Saw Win	State Education Director	
U Win Kyaw Thwin	Deputy Director Natala	Tel +95-83-21644, 09-95601142

Bishop Sotero		
Father Albino	KMSS Kayah	09-43068165
Daw Mu Aye Aye Khine	LHV, Kone-thar RHC Loikaw, Kayah	09 49402969
Meetings in Bago, Bago Region		
Dr Nay Myo Ohn	State Health Director Bago	
Dr Ni Ni Aye	Deputy Medical Superintendent, Bago General Hospital	09 5300834
Dr Nyan Tun Oo	Deputy Regional Health Director, Bago Region	0943026551
Nurse Trainers	Midwifery Institute Bago	
Meetings with SDC/ Swiss Embassy in Yangon		
Peter Tschumi	Minister, Deputy Head of Mission/ Director of Cooperation Embassy of Switzerland	
Thomas Fisler	Deputy Director of Cooperation, Humanitarian Aid Southeast Asia	
Claudine Haenni D.	Peace and Human Rights Advisor	
Ei Hnin Phyu Htun	National Programme Officer	
Iris Sao Siri Rupa	National Programme Officer	
Lisa Karien Magnollay	Programme Manager Myanmar, East Asia Division	Joined the first part of field visits
Anne Claire Hassberger	First Secretary & Head of Health and Local Governance Domain in Myanmar	Joined all field visits to five states/regions
Dr Thet Win Aung	SDC National Programme Officer for Health, Social Services and Local Governance	

Annex 9: Schedule of the Health Assessment Mission (17.6.2013)

<i>Date</i>	<i>From</i>	<i>To</i>	<i>Mode</i>	<i>Remark</i>
19th June	<i>Briefing at Office and desk review</i>			
20th June	AM Travel to NPT PM Meetings in NPT	Nay Pyi Daw	by Car	- Meeting with Social Welfare DG -Meeting DG, Border Affairs (Natala)
21st June	AM Meetings NPT PM Travel YGN	Yangon	by Car	-Meeting with Minister Pe Thet Khin and DG of Health - Meeting with DG National Planning and Economic Development
23 th June (Sunday)	AM Travel to Maw PM Meetings	Mawlamyaing	by Car	-Travel to Mawlamyaing -Meeting with SDC staff Overnight
24 th June (Mon)	AM Travel to Ye PM Meeting	Ye	By Car	Meeting with Social Minister and Meeting with Natala (morning) - Travel to Ye township (overnight in Ye township) Meeting implementing Partner-NSA Community Partners Overnight
25 th June (Tue)	AM Travel to Maw PM Meeting	Mawlamyaing	By Car	Travel to SDC Health Center at Thin Gan Gyunn village and meet with health committee members (morning) -Travel back to Mawlamyaing and meet with State Health Director -Meet Implementing Partner Overnight
26 th June (Wed)	AM Travel to HPA PM Meetings	Hpa Ann	By Car	Meeting with Health organizations in Mawlamyaing (morning) -Travel to Phar Ann and meet with Social Minister and Natala ,State health Director (afternoon) Overnight
27 th June (Thur)	AM Meeting PM Travel	Hpa Ann	By Car	Travel to SDC health center at Ah Htet Ye Puu Village and meet with health committee members (morning) -Meet Implementing Partner -NSA Community Partners Overnight
28 th June (Fri)	AM Travel to Maw PM Travel to YGN	Yangon	By Car	Travel back to Ygn

30 th June (Sun)	AM travel to Daw PM meetings	Dawei	By flight	Meeting implementing Partner-NSA Community Partners Overnight
1 st July (Mon)	AM Meetings PM Field Visit	Dawei	By car	Meeting with State Social Welfare , State Health Director Meet Implementing Partner - NSA Community Partners Visit to Sea Port Overnight
2 nd July (Tue)	AM Travel to YGN	Yangon	By flight	Travel
3 rd – 8 th July	Meeting with Stakeholders at Ygn			
9 th July (Tue)	AM Travel to Kayah PM Meeting	LoiKaw	By flight	Meeting with Township Health Dept. Meeting implementing Partner-NSA Community Partners Overnight
10 th July	AM Meetings PM Travel	LoiKaw	By Car	Meeting with State Social Welfare and township health Dept Implementing Partner -NSA Community Partners Overnight
11 th July (Thur)	AM Travel to Lkw PM Travel to YGN	Yangon	By flight	Travel
12-14 th July (Yangon)				
15 th July (Mon)	AM Meetings PM Field Visit	Bago	By Car	-Meeting with Bago State Health Dept -Meeting with Bago Social Overnight
16 th July (Tue)				
17 th July				
18 th July				
19 th July	Internal briefing with SDC office			
24 rd July (Wed)	Validation meeting with Stakeholders			
5 nd August	Submission of first draft report			
13 th August	Feedback from SDC on the draft Report			
19 th August	Submission of the final report			

ANNEX 10: Statement by the Health Convergence Core Group

Building Trust and Peace by Working through Ethnic Health Networks Towards a Federal Union

March 11th, 2013

We, the members of the Health Convergence Core Group (HCCG), welcome the prospect of future political dialogue between the government of the Republic of the Union of Myanmar and the United Nationalities Federal Council (UNFC) to establish a genuine federal union.

During this time of prospective dialogue, it is vitally important that humanitarian health assistance be provided in a way that will build peace at both the community and state levels.

During the decades of conflict, ethnic communities and organizations have built up their own health provision structures which continue to be the main provider of health care in the conflict affected and remote areas. It is vital that these networks continue to function until such time as the convergence of state and national health systems can be achieved through political dialogue.

Formed in May 2012, the HCCG is composed of four ethnic health organizations (EHOs) and four health community-based organizations (CBOs). The HCCG aims to prepare existing community based health networks inside Burma/Myanmar for future possibilities to work together with State and National government health agencies, ethnic authorities, international donors, International Non-Governmental Organizations (INGOs), local NGOs and CBOs/CSOs.

Therefore, the HCCG has developed the following principles related to health provision in order to support a peaceful transition towards a federal system of government:

1. Current health services, which are based on the Primary Health Care approach, must be maintained and expanded.
2. The role and structure of the EHOs must be maintained.
3. Communities and community-based health organizations must be involved in the decision-making process and the implementation of health care services in the Ethnic States.
4. INGOs must cooperate with local CBOs and EHOs by promoting their roles and capacity.
5. Health care programming should not create conflict among the community and between the health care providers.
6. Development of a national health policy and system should be according to the framework of a Federal Union.
7. Health programming and policy should complement and support the federal aspirations of the ethnic peoples throughout the peace process.
8. Any acceptance of health-related humanitarian and development aid must be in line with the existing health infrastructure that has been established by EHOs and CBOs.
9. The implementation of any health activities in ethnic areas should have approval from the local ethnic health organizations.

HCCG Members:

Burma Medical Association (BMA)

Back Pack Health Worker Team (BPHWT)

Karen Department of Health and Welfare (KDHW)

Karenni Mobile Health Committee (KnMHC)

Mae Tao Clinic (MTC)

Mon National Health Committee (MNHC)

National Health and Education Committee (NHEC)

Shan Health Committee (SHC)

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